



MIDCENTRAL DISTRICT HEALTH BOARD

Te Pae Hauora o Ruahine o Taranaki

Primary Birth Centre for Palmerston North

Stakeholder engagement and findings
from the midwife and consumer
surveys

November 2014

A companion document to 'Primary Birth Centre for Palmerston North – Feasibility Report'

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1. Introduction	1
2. Stakeholder interviews and focus groups	2
3. Midwife survey	10
Methodology	10
Midwife survey findings	12
4. Consumer survey	24
Methodology	24
Consumer survey findings	27
5. Survey conclusion	44
Appendix A – Glossary and abbreviations	48
Appendix B – Midwife survey questions	49
Appendix C – Consumer survey questions	51

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1. Introduction

During the development of the terms of reference for the Primary Birth Centre Feasibility Project, the Oversight Group emphasised the importance of canvassing the views of stakeholders, particularly midwives and consumers.

In the first instance, advice was sought on the process from the Oversight Group, Maternity Quality and Safety Programme (MQSP) members, maternity information service providers (Mamaternity, Pahiatua Resource Centre, Community Birth Services) and the Te Tihi o Ruahine Whanau Ora Alliance. As well as stakeholders previously identified in the terms of reference, the process settled upon was small focus group meetings in a range of locations and two surveys.

The perspectives of other stakeholders were also included in the project; maternity related providers, primary and secondary health clinicians and managers, personnel in primary birth centres within the MidCentral district and across the country and other DHBs.

This companion document provides a summary of stakeholder engagement within the MidCentral district; interviews, the focus groups and findings of a survey of midwives and a survey of consumers.

The survey conclusion brings the results of the surveys together to highlight the common themes and differences.

2. Stakeholder interviews and focus groups

This section presents a summary of feedback from one-on-one meetings and the focus groups.

Meetings were held with the following service providers:

Primary

- Pasifika navigator at CPHO
- Child-birth educators – a focus group session (10 attendees) plus one-on-ones with maternity information providers
- Well child/Tamariki Ora providers – Best Care (Whakapai Hauora), Te Runanga O Raukawa, Te Waka Huia a Manawatu Hauora, Plunket
- General practitioner representatives (2 LMCs, Maternity Quality & Safety Programme rep, CPHO chair, GP)

Secondary

- Women's health service managers and midwifery and medical clinical leaders
- Clinical leaders from the paediatric, neonatal and anaesthetic services
- Sessions with the women's service medical team in August and September (covered eligibility audit, literature and survey findings)
- MidCentral Midwifery Practice Committee (MMPC)
- MidCentral Midwifery Forum in early November – eligibility audit

Focus groups with midwives

Three focus group meetings were held in May over a week, at different times to give maximum opportunity for attendance, and at different locations (MidCentral Health, Midwifery Care and Community Birth Service). Attendees were split into groups and worked on identifying benefits, concerns and characteristics of a primary birthing unit. The service model was also rated against draft evaluation criteria in two of the three groups. Twenty-two midwives and student midwives attended the sessions. The majority were LMCs. A session with the MMPC took place in July to provide another opportunity for hospital midwives to provide input.

Focus groups with consumers

The focus group method enabled attendees to discuss a birth centre in depth and their thoughts on benefits, concerns and what might make it successful. The locations for the focus groups were selected to ensure a range of perspectives. The organisation hosting the focus group put out an invitation to its members. The first focus group, at the Freyberg Teen Parent Unit, revealed that most young women did not understand what a primary birth centre was. Subsequently a stakeholder booklet was developed including visuals to provide an overview of the main features of a birth centre. This was circulated to attendees before the session started except for Te Aroha Noa which used a Facebook invitation process. Six to 12 women attended each focus group.

Focus groups were held at:

- Freyberg Teen Parent Unit
- Pahiatua Community Services Trust
- Te Aroha Noa
- Community Birth Services
- Parents Centre.

Consumers

Current service

Women shared their childbirth experiences in the focus groups. There was positive feedback and for some the experience went very well, e.g.:

Mine went really smoothly, nothing would change, didn't have any intervention, was really quick so no time for anything, was lucky with staff afterwards

Others described issues with secondary service capacity, the environment and/or the facility, policies or the care. Some women said they went home early due to restrictions on partner and family involvement, not enough support or not being able to get enough rest. The environment was described as clinical and often busy with lots of people going in and out. The pools were not deep enough. Women said staff were sometimes too busy to attend to their needs. Examples were provided of partners being sent home straight after the birth, family not being made to feel welcome and support people being refused entry when the mother was upset. Some said the hospital had a bad reputation. Childbirth educators stated the hospital was often full during hospital tours and tours were postponed on occasion. This and stories from others have contributed to an impression that there is insufficient room at the hospital. Comments included:

It is clinical / sterile. Focus is on bed, before you were in control and things were going well, then the first thing you do is hop up on the bed and ask what you can do, things go slower so you have pain relief

The feeling in the hospital is "let's just get it done", it can be hard to keep on saying no

Husband kicked out, was traumatic, baby woke up and cried all night, was the most horrible isolating experience

My baby was in hospital for 3 weeks, there was no space to stay, had to stay in a motel and get up twice in the night

Had to wait 45-60mins till bell answered. They tell you to ring them to lift the baby out for you but then they don't come

Home birth for 2 out of 3. Husband was around and part of things so able to be better support. Children were able to be there. This sort of support and involvement is possible in a birth centre

Some partners have been allowed to stay, one said the hospital was good to her partner. More La-z-boys chairs have been purchased.

Women said that a hospital was not the right place for healthy women and they desired an environment where they could relax and have the time needed to give birth, where their partner/family were welcomed and could be involved more, and where there was more support in the postnatal period.

A birth centre was seen as providing a middle ground between home birth and hospital. Some would like to home birth but are not confident to due to distance or because their partners will not support or their house is not suitable (some landlords object). Rural women described the difficulty is deciding when to go to hospital, one said how she delayed going to avoid the intervention that occurred for her first baby and nearly gave birth on the side of the road – she would have left earlier had a birth centre been available. Rural women said that there was more likelihood of having an induction if living rurally.

Women wanted intervention if it was necessary but many thought there was too much. A normal birth was desired by most, however they felt this was undermined by doctor's eagerness for action. Women talked about being scared into intervention such as an induction or not trying a VBAC because of the way doctors explained the risks to them. Some doctors gave the impression that a VBAC was very dangerous. Midwives seemed to be relying on technology more such as monitoring which "makes you worried things are going wrong".

Childbirth educators said having a caesarean is most women's great fear however is becoming commonplace, "half the last antenatal class had a caesar". The downside of intervention included problems afterwards such as difficulty getting breastfeeding established, postnatal depression and ruining future chances of having a normal birth. Comments included:

Operations are dangerous and the risk to the mother is higher, doctors need to acknowledge this

They don't take into account the complications of the interventions and the relationship that the mum is going to have with her baby and the impact that a failed birth experience might have

Women expressed concern that the risk based approach to childbirth would overly decrease the number of women that can use a birth centre e.g. some aspects of the referral guidelines and over scanning. This leads to intervention, such as inductions for big babies, and women will be ineligible for primary birthing. The risk culture also causes fear and affects women's confidence, "most women can labour well if left alone to do so". Other concerns raised were:

- Possible lack of support from the medical team; doctors are influential and their communication may affect patronage.
- Would there be enough midwife support for a birth centre? Women rely on midwives for information.
- Community fear about childbirth and lack of understanding may affect numbers. Young mums don't understand the maternity system and are vulnerable to advice which is often based on fear of what can go wrong. For some their knowledge is based on "one born every minute", and they think the hospital is safer.

Adding other services such as midwife clinics, coffee groups and antenatal classes would be an advantage.

Midwives

Benefits and concerns identified in the focus groups were used in the survey to determine those of highest priority (see p 12 and p 21). Characteristics of a successful birth centre were also identified and are listed at the end of the chapter.

Midwives saw a birth centre as a service enhancement which would allow the secondary service to focus on complex women and improve job satisfaction; there are increasing numbers of complex women. The evidence supports a birth centre and research has revealed that midwives care for women differently in hospital and are more relaxed away from the medical gaze and the focus on timeframes. Hospital staff's view of normal is different. In hospital, intervention is used because it is there e.g. CTG and epidurals; epidurals result in more intervention. There are opportunistic consults, registrars are eager to be involved, higher rates are seen when there is registrar turnover.

Hospital is not the right environment for low-risk women – can be a lack of privacy (even though well intentioned), lots of noise and activity and clinical equipment in view. This affects women's ability to relax, implants the idea of things going wrong and affects birthing hormones and progress.

Midwives were concerned about increasing defensive practice and a medicalised approach. Adverse events colour people's views and create anxiety.

There is some lack of clarity about clinical responsibility after a three way conversation; if midwives stay, who is accountable?

General Practitioners

GP stakeholders thought a birth centre would be beneficial for women. They said the evidence was clear and a home-like low tech environment was less stressful for women compared to the hospital and led to less intervention and a better start for women and babies e.g.:

Home like environment leads to relaxation, hormones where they should be and less intervention – more room for natural process which can take a long time especially for first timers

*Better birth experience results in women feeling more empowered, bonding better with baby, breastfeeding easier, decreased postnatal depression. Long term benefits enormous, breast-fed children have less illness and chronic disease
Important to avoid intervention for primips otherwise changes options for subsequent births*

Caesarean appears to be more readily available. Keeping women in a primary birthing environment avoids interrupting continuity of care. This is an impact of intervention which negatively affects women's satisfaction and increases risk. A longer length of stay would be beneficial for some women. Another advantage would be the ability to relieve the secondary capacity problem and improve care for complex women.

A concern was whether a birth centre would be affordable and the need for transfer was seen as a downside and an area that needs to work especially well. Safe timely transfer hinges on good staff and good communication and trust between the parties (e.g. theatre processes activated on phone call). Several thought that communication between the groups (LMCs, hospital midwives and medical staff) needed to improve. One suggested that the current work on communication occurring for secondary services, should include LMCs. The primary units at Horowhenua and Dannevirke were held up as examples of services that worked well. Criteria will need to be decided as there may be differing opinions of low risk e.g. VBAC. Expertise needed is midwives adept in normal birth and good emergency skills including neonatal training.

A barrier to usage is fear about childbirth. Many women are not well informed and think caesarean is safer and do not understand the implications of intervention including epidurals e.g. the increased chance of this leading to other intervention such as operative delivery. "The culture needs to change, intervention is necessary at times, shouldn't be either/or".

Other primary and community stakeholders

A theme across most groups of primary and community stakeholders (and some secondary) was the view that childbirth has become influenced by medical technology; medical intervention including pain relief has become the norm. Stakeholders believe that the focus of the hospital on what can go wrong and the view of childbirth as a medical event (only normal in retrospect) causes intervention and can do more harm than good. Many women have been conditioned that childbirth is dangerous, not helped by slanted media and organisations such as AIM (Action to Improve Maternity).

Well Child/Tamariki Ora providers relayed receiving negative feedback from mothers about their hospital experience – especially from younger mothers regarding visiting hours, lack of support and feeling judged. The hospital is not whānau inclusive e.g. people sleep in the car park. For Māori and Pasifika the support system is their family, "the hospital are uptight about having more than one or two at the birth". A birth centre would enable a more inclusive cultural approach. The ante-natal Hui at Te Aroha Noa identified concerns from women about lack of engagement and support, a birth centre may help with this by creating a hub and encourage vulnerable women to access services. Breastfeeding rates will improve if mothers are more relaxed and have more support – also more partner involvement will help.

The Pasifika navigator said in the main, women provided positive feedback about their hospital experience. Women tend to book later in pregnancy and do not use resource centres; a birth centre with midwifery clinics and pregnancy and parenting education may encourage women to access these services. However, many Pasifika women are high risk with high BMI and gestational diabetes.

Postnatal services and support are more important with the increased rate of complicated birth as women are in poorer condition to care for their baby.

Some stakeholders were concerned that a birth centre may affect birth numbers in Horowhenua, Dannevirke and Whanganui which might affect the viability of these services.

The below box are some points that have come out of research in Palmerston North involving 20 young Māori parents aged 15-24 years.

Whānau Kopepe: Young Māori parents experiences of raising a family

- Most young parent's experience or knowledge of birthing is from within their own whānau or peer group. Most of their mothers come from the generation that would have birthed in hospitals so that is what is 'expected' within the whānau. Some young parents talked about their whānau not being confident to birth elsewhere – linked to the long-lasting effects of colonisation and the medicalisation of birth where Māori have been convinced that they are not allowed nor capable of birthing themselves.
- Some of the hospital experiences included being judged by hospital staff e.g. being talked to and treated like children, not given all the information or options, not being treated with respect. For example, one partner was told to go and fill out registration details in A & E when his partner was about to push their baby out so missed the birth.
- None of the young fathers were allowed or offered to stay the night in hospital, some babies were given formula without the mothers full informed consent, some babies were bathed by staff again without the mothers full or informed consent, most were made examples of for training staff such as waking up to a number of unknown doctors discussing their case. Most just wanted to leave hospital as soon as possible and most before they were ready and breastfeeding was not yet established which resulted in many having difficulties and giving up breastfeeding as a result
- There were however some positive experiences of birthing in hospital. For some of those that did have negative experiences they indicated they would still return to hospital as they didn't know of/feel confident in any other option.
- Young Māori parents need to be treated with respect, they need good information in a format they can relate to, they need to know their rights, they need to know their options and to have the time to make their decision. Young Māori parents also wanted to have a Māori/whānau centred environment so that cultural practices such as karakia, waiata, cutting the umbilical cord, keeping the placenta etc. felt normalised.
- From most of their experiences, the hospital was not a conducive environment to enable this to happen, a primary birthing unit may enable better processes.

Source: Whānau Kopepe is a Health Research Council funded study being undertaken by Massey researcher Felicity Ware. The study looking at supports for young Māori parents and their experiences of pregnancy, birth and parenting. One hour interviews with all participants have been completed and follow up is over a two-year period. There is a Facebook web page set up for contact. <https://www.facebook.com/WhanauKopepe>

Obstetric medical team

The obstetric medical team were not convinced about the benefits of a birth centre. A sticking point was the research, the absence of randomised controlled trials and conflicting evidence. A birth centre was viewed as a good option for low-risk women who had already had a baby and also for postnatal care. Benefits identified were meeting the requirement for women's choice and providing a less clinical environment.

Concern was expressed about possible inadequate usage of a birth centre due to the high level of secondary input occurring (as shown in the eligibility audit) and lack of interest. The current rates of

intervention were attributed to complex pregnancies, older mothers and women's expectations and could be expected to increase. The UK and US have much higher rates of epidurals (40% and 90%). A question was whether the majority of women wanted a birth centre or was it driven by midwives. There is a big cohort of older women who are conservative and appear to want secondary input including epidurals. Some women are demanding caesareans. It is important to minimise intervention where possible, however the team did not think unnecessary intervention was occurring and emphasised that the goal of intervention was safety.

The eligibility audit identified possible high transfer rates (50%). This creates a two-step process, transfer is stressful and the secondary service needs to be able to respond to this.

Policies and procedures for a birth centre need to support a quality safe service; the secondary service should have input into this area. It is important there are no barriers to transfer and phoning specialists if there are issues. Boundaries need to be clear. Risk assessment is important, the team stated that sometimes guidelines were not adhered to in the district such as VBAC at home. The impression is, at times, normal birth is protected whatever the risk. The Horowhenua and Dannevirke primary units work well. CTG does not belong in a birth centre.

Reservations were expressed about the affordability of a birth centre (an expensive hotel) and the suggestion was made that the secondary service could be made more homelike like the approach taken by Finland.

Other secondary service stakeholders

Several stakeholders commented on the different focuses of a primary birth centre compared to the secondary service, the latter is focused on the highest risk. Incidents and HDC cases have resulted in more defensive practices occurring which has led to earlier intervention (most cases have involved a failure to intervene or a delay).

Ensuring that transfer processes are timely and safe was the main area of feedback. There is no paediatric flying squad service at Palmerston North Hospital, therefore transfer needs to be early enough. Staff working in a birth centre should be NLS (Newborn Life Support) trained. Improving immediate baby care such as keeping baby warm and managing low blood sugar would reduce transfers after birth. All secondary stakeholders thought that the MidCentral DHB primary units work well and there is good risk assessment/triage. A concern is possible therapeutic creep or a loosening of criteria due to the close proximity of the birth centre to the secondary service. Providing an early epidural for obese women as per the guideline may be an issue if there is late transfer.

Management

Considerations:

- The space occupied by the maternity service is tight; a primary unit would improve capacity and may also create other opportunities including elective volumes utilising the second floor beds, other services, facility improvements.
- The service is geared towards secondary women, can struggle at times to support normal birth.
- Primary/secondary boundaries are unclear e.g. for women having epidurals there are differing interpretation of Section 88 and whether epidurals are in scope of practice. Increasing numbers of LMCs don't stay which creates continuity of care issues including stress for the woman.
- Relationships between the groups are an issue, a birth centre would change dynamics.
- Opportunity to reduce primary caesarean rate, need new generation of first-time mothers who trust birthing so the tide can change.

Concerns were:

- Potential recruitment issues for midwives with midwives being attracted to the primary birthing unit (this has occurred in other areas of NZ)
- Would it be affordable
- Funding changes which may impact on the midwifery resource
- Ensuring the secondary service is resourced sufficiently including being able to respond to transfers. Provider of last resort response won't change.

Location of a birth centre

There were differing views about location, between and amongst groups of stakeholders. The main tension was between having a close location for usage and workforce relationship reasons, versus off the hospital campus to ensure a primary identity and better results.

Some woman favoured a birth centre on hospital grounds for quick transfer while others thought a community based location was important. Some midwives thought a co-located option may have better buy-in and workforce advantages (including better relationships) while others were concerned about secondary policies, medical influence and opportunistic intervention and “popping round the corner for an epidural” so thought some distance was vital. Childbirth educators preferred an off campus location; the possible issue with this was women and partners perception of the need to be close to secondary services; “women and partners seems to need a safety net these days”. The majority of the obstetric team favoured a separate birth centre to avoid feeling responsible for “what’s down the corridor”.

Factors / characteristics that would make a primary birthing unit successful

The below were identified during the focus groups with midwives.

Structure

- No consensus whether DHB owned or private or a mix
- If DHB owned some advantage with sharing policies, education and infrastructure
- Concern that it would be no different to now and benefits not realised (intervention)
- Autonomous from hospital culture

Facility

- Homelike, really good food
- Co-locate with facilities other than secondary, maybe part of IFHC
- No consensus whether on site or not, most preferred off site
- Consensus that should stand alone and not be along the corridor
- Top grade – rooms for family
- Double beds, good food/communal
- Portable pool/baths, pulls from ceiling, bean bags, pillows. Bed not occupying centre of room
- Consult rooms, Outdoor areas
- Adequate and free parking
- Good size (10 minimum)
- Separate birthing to post natal rooms but could be together – need to be home like but flexibility good
- MCIS (Badgernet) necessary

Services

- Postnatal maternity inpatients, also for >24 hours post caesarean section
- Help with breastfeeding

- Complementary services – pregnancy & parenting classes, Lactation consultant, LLL, Resource centre (information and advisory), alternative therapists, support groups, LMC room (sleep/shower)
- Midwifery clinics, education place for midwives (workshops)
- One stop shop. Could have associated services – PAFIT, WINZ etc.

Policies

- LOS – 48 hours but flexible for longer
- Partners can stay overnight
- Analgesia – Entonox, Tens, water birth, acupuncture, homeopathy, hypnotherapy
- CTG – no consensus
- Transfer – ambulance or car

Workforce

- Midwife led, no doctors
- Core midwives as employed (MECA), care assistants/cleaners, admin
- LMCs – access agreement
- Most approachable, supportive and experienced midwives (in identifying all the options for women) – chosen for their philosophy, role is different and is about supporting LMCs rather than handover
- Core staff work 12 hour shifts. Casual midwives separate from secondary
- Which is best? Rotation of staff across units or separate? If philosophy is important the latter
- Could be part of new graduate rotation
- Professional development – case review
- Advantage for maintenance of skills, in-between unit

Clinical relationships

- Colleagues have to be approachable
- Good communication important
- Open forums for midwives “to work out what this means for us”

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3. Midwife survey

Methodology

The information gained from focus groups with midwives held in May 2014 helped to inform the survey design. At these sessions midwives identified benefits and concerns related to a birth centre – these were provided in the survey for the wider group of midwives to rank and thus get a view about their relative importance. At the focus groups, some areas were identified as either contentious or needing feedback from the wider group including; LMC support for a birth centre, location of a birth centre, workforce model and collegiality issues.

The survey was designed on the Survey Monkey tool and piloted with a LMC and a dual role midwife. Changes were made and the web link was e-mailed out to midwives on Monday 30 June 2014. The survey questions are provided on p 49; mandatory questions are identified by an asterisk *.

The timeframe given for completion of the survey was just under three weeks. The initial closing date was Thursday 17 July; this was extended by a day for LMCs after feedback was received that a question asking midwives to identify their caseload was seen as inappropriate by some – this question was removed on the 16 July mailout of the survey.

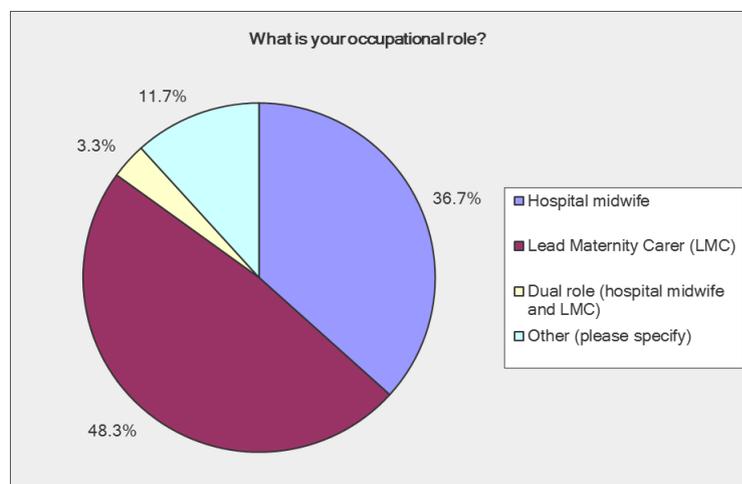
Names were required to ensure responses were unique and were also used for reminders and in a couple of cases where issues arose with the tool (the ‘skip logic’ did not work resulting in the first two respondents missing a question). Names were confidential to the project manager and not used in the analysis.

The survey was e-mailed to all midwives in the MidCentral DHB area by the PA of the Women’s Health Unit – there were 59 e-mails on the LMC list and 53 on the hospital midwife list. Names were later reviewed to give an up-to-date list in order to calculate response rates. LMCs holding an access agreement as a locum but practising outside the Palmerston/Manawatu area were excluded at this point; this involved 16 LMCs in total however two midwives (Otaki/Horowhenua area) had already submitted surveys and were therefore included – this left a total of 45 LMCs.

Two e-mail reminders were sent out, one by the local branch of the College of Midwives and a final one three days before the closing date by the PA of the Women’s Health Unit. Text reminders were also sent out to LMCs using the Mamaternity Find a Midwife spreadsheet as a resource.

Response rate by occupational role

Respondents were asked to identify their occupational role.



Those in the 'other' category were:

- Midwifery director – 1
- Hospital midwife and locum – 2
- Midwifery lecturer and LMC – 1
- Locum midwife – 1
- Third year midwifery students – 2

In order to calculate a response rate for midwives, those in the 'other' category were allocated to either hospital midwife, LMC or dual role (hospital midwife & LMC) groups as shown in Table 1 below. Midwifery students were excluded from response rate calculations as the denominator for student midwives was not known.

Table 1: Other occupational roles

Other	Number	Group allocated to
Midwifery director	1	Hospital midwife
Hospital midwife and locum	2	Dual role
Midwifery lecturer and LMC	1	Dual role
Locum midwife	1	LMC
Third year midwifery students	2	Midwifery students

Surveys completed and response rate

Almost four fifths of LMCs responded to the survey compared to about half of hospital midwives.

Table 2: Survey response rates by occupational group

Occupational group	Survey responses	Total (Denominator)	Response rate
LMCs ¹	35	45	78%
Hospital midwives ¹	28	58	48%
Total midwives	58	98	59%
Third year midwifery students	2	N/A	N/A
Grand total	60		

Note 1 – Dual role midwives were allocated to LMC and hospital midwife groups for responses and the denominator in order to calculate responses rates for each group.

Analysis

Three survey responses were deleted; two respondents completed only the background identification details and a third submitted two surveys.

Survey responses were downloaded to Excel. Survey Monkey question summary tables / graphs were used for questions with defined options. Raw data was further analysed manually by occupational group using a pivot table.

Text questions were grouped into categories of similar meaning to identify those of highest importance.

Midwife survey findings

The survey findings are presented in the form of question summaries.

Strategic fit and priority

Midwives were asked to rate how essential it is that a birth centre forms part of the strategy to achieve the aim of the MidCentral and Whanganui DHB Maternity Quality and Safety Programme (MQSP).

Table 3: Survey response – How essential is a birth centre?

The aim of the MQSP is “To enhance safety for women, babies, families and whānau and for service providers working together to create the best possible maternity service in which all mothers and babies are the focus of care, feel safe and have improved outcomes.” How essential is it that a birth centre forms part of the strategy to achieve the aim of the MQSP?									
Answer Options	1 Not essential	2	3	4	5	6	7 Imperative	Rating Average	Response Count
	0	1	2	3	3	13	36	6.29	58
<i>answered question</i>									58

The overall rating was very high at 6.29 out of a possible 7. When analysed by occupational group the ratings were:

- LMCs – 6.6
- Hospital midwives – 6.1
- Dual role (hospital midwife and LMC) – 5.0

There were 11 additional comments. Most described benefits of a birth centre such as less intervention, more normal births and freeing up secondary care. One respondent asserted that research shows birthing in hospital increases intervention and “changes the way midwives make decisions. A primary birthing experience is an important step in reducing intervention, improving both the actual birth outcome and the emotional experience for the woman and her baby.” Two midwives stated that a birth centre was either not necessary or a “nice to have.” A further respondent was concerned whether enough women would support a birth centre and also that the clearer demarcation between primary and secondary care (noting that LMCs are paid for primary care only) may result in LMCs “running for the door as soon as they have handed them over.”

Benefits

Twelve potential benefits of a birth centre were identified by participants at the midwifery focus groups; midwives were asked to rank these benefits from 1-12.

The average ratings are shown in Table 4. The top three were ‘More normal births’, ‘Family focused’ and ‘Provides choice for women.’ ‘More normal births’ was the top ranked benefit by a significant margin with 88% ranking this first or second.

Table 4: Survey response – Benefits of a birth centre

Please rank these benefits in order of importance to you.	
Answer Options	Rating Average
More normal births. The environment is more supportive of natural birth - more homelike, bed and equipment has less focus, atmosphere supports relaxation / release of birthing hormones and staying active in labour.	1.66
Family focused - partner and family are made welcome and are more involved, partner stays first night	3.66
Provides choice for women - an 'in-between' option between home and hospital	4.00
Promotes skills in normal birth (primary midwives and training interns)	6.12
Better support in the post-natal period - help with breastfeeding and transition to parenting	6.21
Creates more clarity between primary and secondary care - better working relationships	6.66
Physical separation from secondary staff and availability of interventions (e.g. CTG, epidurals, augmentation, caesareans) results in less intervention	6.67
Can incorporate Māori birthing traditions	6.91
Creates more capacity for women requiring secondary services - less pressure on service and beds	8.05
Improved job satisfaction / retention of midwives (less stress and another option to work)	8.16
Workforce flexibility - LMCs can provide casual cover for core staff	9.22
Cost savings due to less intervention	10.69
	<i>answered question</i> 58

Other benefits listed by respondents were:

- the message to the community “about the nature of birth’s place in the life of family and society” and that birth can be normal for low-risk women, such as in Dannevirke where most women (including first-timers) opt for the primary unit as a first choice
- easier access to services for women and midwives and the option of better uptake of child health care, if onsite paediatric checks weekly, hip checks, hearing screening
- gives rural women a primary birth option [in Palmerston North] – some women who would like the option of home birth don’t want to risk the long travel times if transfer is required.

One respondent stated that she did not agree with the list of benefits and that many can be achieved in the secondary care setting (mentioned were: incorporating Māori birthing traditions, making partners and family feel welcome and support in the postnatal period).

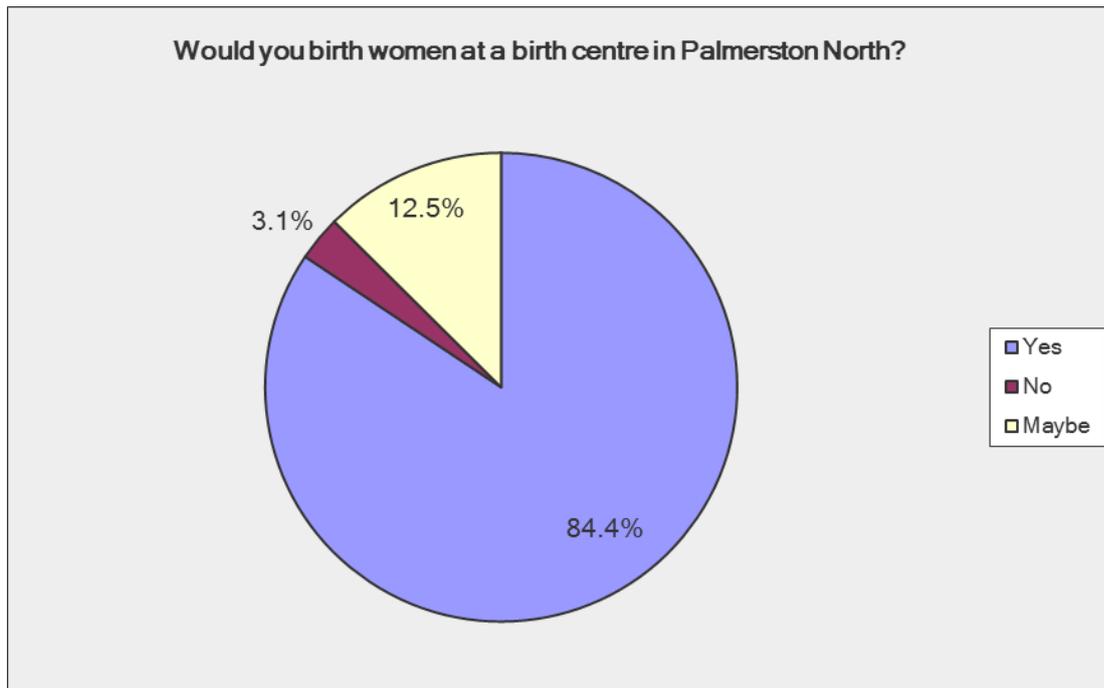
LMC support for a birth centre

LMCs and dual role midwives were asked if they would birth women at a birth centre in Palmerston North. Midwives answering ‘other’ as an occupation did not receive this question, however, had the opportunity to respond by e-mail if they had LMC or locum roles.

Thirty-five respondents answered this question (100% of LMCs). Almost all LMCs stated they would use a birth centre as follows.

- Yes – 30
- Maybe – 4
- No – 1

Figure 1: Survey response – LMC support for a birth centre



Those that answered ‘No’ or ‘Maybe’ were asked “What would make you more likely to use a birth centre?”

Factors important for those answering ‘Maybe’ were:

- a homely relaxed environment
- easy access to secondary care if needed
- being staffed by experienced midwives (this midwife stated she was still gaining experience).

One respondent stated that this was women’s choice.

The single respondent answering ‘No’ provided services for women in Otaki and stated she accessed the primary birthing unit in Levin.

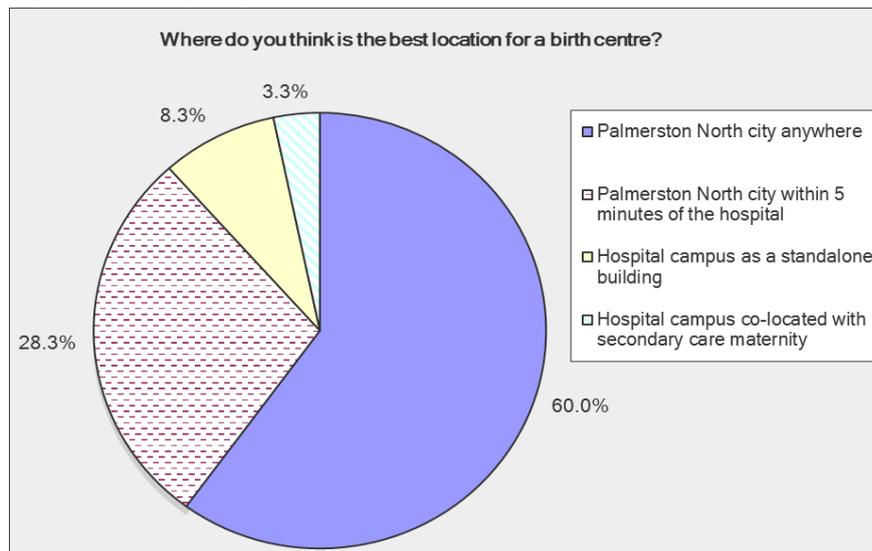
Where should a birth centre be located?

Midwives were asked to identify their preferred location for a birth centre. Table 5 and Figure 2 shows that this was overwhelmingly off the hospital campus – 88% chose “Palmerston North city anywhere” or “Palmerston North city within five minutes of the hospital.” Analysis by occupational group showed similar results; 93% of LMCs, 83% of hospital midwives, 80% of dual role and 100% of midwifery students preferred an off hospital campus location.

Table 5: Survey response – Location for a birth centre

Where do you think is the best location for a birth centre?		
Answer Options	Response Percent	Response Count
Palmerston North city anywhere	60.0%	36
Palmerston North city within 5 minutes of the hospital	28.3%	17
Hospital campus as a standalone building	8.3%	5
Hospital campus co-located with secondary care maternity	3.3%	2
<i>answered question</i>		60

Figure 2: Survey response – Location for a birth centre



Forty-six respondents provided a reason for their choice.

Palmerston North city options

Thirty-nine of the 53 respondents choosing the off hospital campus options provided a reason.

Over three quarters of reasons given (77%, n=30) were based on the principle that a clear separation between the birth centre and the secondary service was necessary for success. Locating the birth centre away from the hospital was seen as helping to create a primary identity rather than being an extension of the hospital service. This distinction was seen as necessary for women and health professionals and women would be making a conscious decision to birth away from the availability of analgesia and doctor. One respondent explained,

Part of the effectiveness of a primary unit is the non-availability of medical pain relief options, which assists women and midwives to use only non-pharmaceutical comfort measures, which keeps labour normal – an overly quick and easy transfer from on-campus cancels this out, and is likely to reduce the difference in outcomes between the primary and secondary units.

This separation was seen as helping to ensure that the birth centre was midwifery led rather than being under secondary control. It would also prevent blurring of care options such as any temptation to provide secondary type services in the birth centre if the delivery suite was full – “women requiring obstetrics should be transferred.”

Many respondents commented that the distance to the hospital from anywhere in Palmerston North was acceptable with one saying the broader city limits could be considered. Another said that locating it too close to the hospital gives the impression that primary birthing isn't safe enough to be any sort of distance from a secondary unit. Several respondents that preferred the location to be within five minutes of the hospital commented that this would be advantageous for quick transfer – one was of the view that women would feel safer.

Hospital campus options

All seven respondents provided a reason. The main themes were:

- ease of access to the secondary service
- possible increased usage by women
- staffing advantages e.g. rotation of secondary care midwives and having more staff on hand for emergencies in the primary unit.

Should the birth centre be co-located with other services?

The focus group discussions with midwives and consumers identified that there was support for co-locating the birth centre with a range of complementary services (e.g. maternity information, pregnancy and parenting classes, midwifery clinics, support groups, alternative services) for reasons of normalising the service, raising visibility and cost-effectiveness. Midwives were asked to rate the importance of the birth centre being located within a hub of services.

Table 6 shows that the majority of midwives (70%) thought it important or very important that the birth centre was located with complementary services. By occupational group the results were similar, with 80% dual role, 70% LMC, 70% hospital midwives and 50% of midwifery students (1 of 2) choosing important or very important.

Table 6: Survey response – location within a hub of services

Please rate the importance of the birth centre sitting within a hub of services.					
Answer Options	Not important at all	Somewhat important	Important	Very important	Response Count
	3	15	22	20	60
	5%	25%	37%	33%	100%
	<i>answered question</i>				60

Fourteen respondents provided additional comments. Most emphasised the positives of a hub such as normalising birth and having a central and visible place for women to come for maternity and other related services where they would become familiar with the unit and staff. Women would be more likely to use the centre for birth and this arrangement was also seen as having the potential to improve access to maternity services generally. Comments included:

It would become a 'one-stop shop' rather than working isolated from the LMCs and childbirth educators/lactation services etc.

Our society now sees birth as an event full of risk. We must help to put birth in its right place. Normal (in the main).

Labour hormones change when women enter an unfamiliar environment. As midwives, we often see women's labours slow down significantly when they arrive in hospital. If women have become comfortable and feel "at home" at the birth centre having been there for antenatal classes, yoga classes, and perhaps antenatal visits, they are likely to labour there more naturally.

Primary birthing is about community....putting a more community focus on pregnancy, birthing and parenting...a holistic service...in line with Ministry of Health primary health centres... opportunity to address some of the culturally inappropriateness that the hospital has for our Pacific Island women.

One respondent noted the importance of users having a sense of privacy and another thought that the hub should include only 'wellness' services that promote positive active birth, encourage confidence and good health and that it would be inappropriate to have medical consults or commercial ventures there.

Workforce

Preferred workforce model

In the next question respondents were asked to identify their preferred workforce model in a birth centre. Stakeholder interviews and focus groups with midwives had revealed differing opinions; some thought a rotation between the birth centre and the secondary maternity service would enable midwives to retain skills and others thought core staffing should be separate due to the different focus/philosophy in the units.

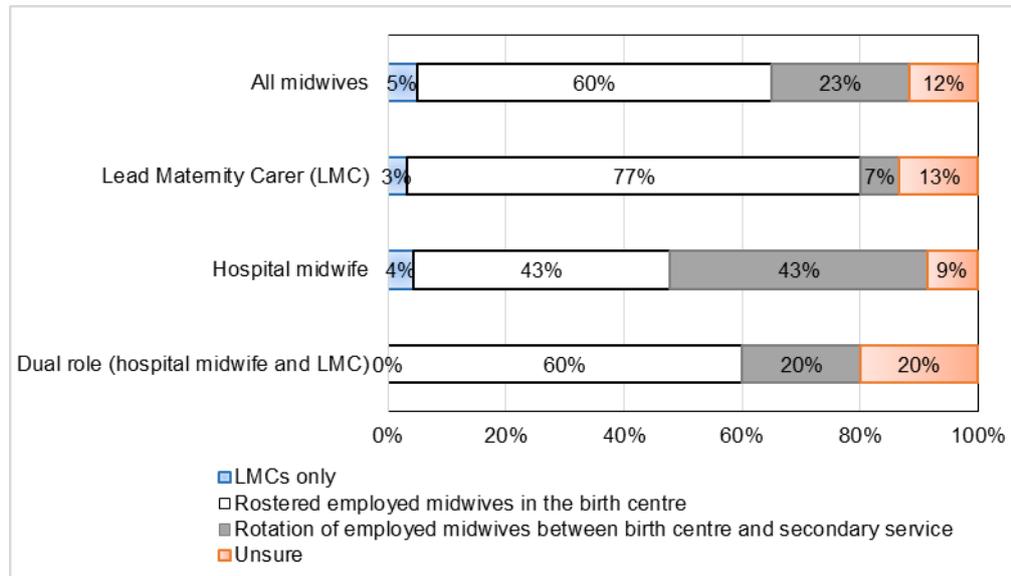
Table 7 shows that well over half of midwives preferred separate staffing in the birth centre and about one quarter chose a rotational model across the birth centre and the secondary service. One sixth were unsure.

Table 7: Survey response – Workforce model

What workforce model do you favour and why?		
Answer Options	Response Percent	Response Count
Rostered employed midwives in the birth centre	60.0%	36
Rotation of employed midwives between the birth centre and hospital maternity service	23.3%	14
Unsure	11.7%	7
LMCs only	5.0%	3
	<i>answered question</i>	60

Analysis by occupational group showed a different picture – almost half of hospital midwives preferred the option of rotation between the birth centre and the hospital maternity service compared to only 7% of LMCs (refer Figure 3 below).

Figure 3: Survey response – preferred workforce model by occupational group



Reasons for choice of workforce model

Thirty-eight respondents (63%) provided a reason for their answer. Following is a summary of reasons offered for the two main models; ‘rostered employed midwives in the birth centre’ (24 respondents commented) and ‘rotation of employed midwives between the birth centre and secondary service’ (9 respondents commented).

Rostered employed midwives in the birth centre

The majority described the necessity for a primary focus/normal birth philosophy in the birth centre or mentioned the differing philosophies and skill sets between primary and secondary (71%, n=17). One quarter thought midwives should have a choice (25%, n=6) and several commented that the role of the core midwife is different in the birth centre and focuses on support and working alongside the LMC rather than taking over care (13%, n=3).

Primary and secondary settings are within the scope of all midwives however respondents pointed out that the focus of primary and secondary is different. They emphasised the importance of core midwives in a birth centre being able to practice autonomously without the oversight of the medical team. Respondents explained.

Midwives who staff this unit must be committed to normal birth and believe in that philosophy. They must have skills to keep birth normal. Some midwives are best suited to a secondary/tertiary environment, others have their strength in primary....celebrate the difference...we need both

...it is essential that the employed midwives are confident and competent to provide midwifery emergency care without medical backup until transfer can be arranged in emergencies... ideally employed midwives should have some birth experience... Rostering secondary core staff through the unit is likely to input secondary care philosophies into the unit, which is inappropriate, and also to result in midwives who are inexperienced/unconfident/unsupportive of the primary care philosophy being part of the staffing mix. This would result in LMCs feeling less confident in the core staff supporting their births

Different from working in secondary care where there can tend to be an us/them mentality between core and LMC...in a birth centre all need to work as a team

Rotation of midwives between services

Seven of the nine respondents providing a reason were hospital midwives. Midwives saw this option as being advantageous for maintenance/extension of skills, improving relationships between midwives and adding to job satisfaction. One described recent research which found that rotation of midwives across primary and secondary settings leads to less divisiveness. Whilst hospital midwives would like to have this option available, they did not think it should be mandatory.

Comments included:

The option of spending some shifts in a birth centre may help with staff morale, recruitment and retention

We have the opportunity to learn off each other and this should be shared across the midwives...I think to have two separate non-connected rosters would cause division

It is important that midwives retain their skills e.g. cannula insertion for use in the primary setting and these have historically been lost

Some midwives were unsure about what workforce model would be best. One described the tension between the models saying,

You definitely put different hats on working in the different areas. It is great for midwives to be able to work across a wider scope in different practices, and great for the women to have access to midwives with a higher levels of skill in a primary unit in case something does goes wrong. Midwives need experience to recognise normal and abnormal to know when to refer/transfer. I think it is imperative that midwives working in a birth centre have had secondary experience, but they need to bring a primary philosophy to their practice, otherwise you will end up with unnecessary interventions

Collegial relationships

Two thirds of midwives thought there were collegial relationship issues that needed to be addressed for a birth centre to be successful. The proportion was similar across the occupational groups.

Table 8: Survey response – Collegial relationship issues

Are there collegial relationship factors that need to be addressed for a birth centre to be successful?		
Answer Options	Response Percent	Response Count
Yes	66.7%	40
No	33.3%	20
answered question		60

Summary of collegial issues

Respondents that answered yes were asked to provide some detail about the collegial relationship problem. 39 respondents provided comments which are summarised under three areas, ‘hospital midwife and LMC issues’, ‘other collegiality issues and support’ and ‘transfer from birth centre to secondary care’.

Hospital midwife and LMC issues

Over half the comments related to problems between midwives. A lack of respect, support, communication problems and understanding of other’s roles / responsibilities were common phrases. Relationships were described as being strained and a “divide between LMC and core midwives that is longstanding.”

A number of LMCs expressed feeling isolated and unsupported. One stated being shocked when midwives turned their back on her, “some midwives were great but others were rude and unhelpful” and another was concerned that if hospital staff were to rotate at a birth centre that “LMCs would continue to feel unwelcome and unsafe working in any setting other than home birth.” LMCs felt there needed to be better communication and understanding of what primary care involves and less reliance by hospital midwives on the obstetric team. Comments were not all negative, one respondent said that while the teams were divided, the current hospital team was the best she has seen for years.

Hospital midwives were more likely to think that issues were inevitable and due to different philosophies, experiences and “primary vs secondary.” One midwife stated “core midwives don’t want to supervise LMCs, when we take over care we do so completely.” Another stated “secondary care is not a drop off facility.” Two thought that a birth centre would improve relations; “fix the problem of handover” and midwives “would need to work well as a team.”

Other collegiality issues and support

Some mentioned “general collegial support” or described issues within groups or extending to other groups e.g. “core staff degrading other core staff” and “includes staff at all levels and the doctors.” Others focused on what was required in the future rather than current problems e.g. having regular meetings to iron out any differing views, the need for good communication and clear boundaries or the advantages of midwives working in the different roles to improve understanding of the other’s perspective. One referred to research findings that respectful collegial relationships are essential for a midwifery led unit to function effectively.

The necessity for secondary services to support a birth centre venture was put forward by five respondents. Doctors’ support was viewed as important, one saying that challenging and undermining the service will “affect the confidence of women accessing the service.” The suggestion was made that it would be beneficial for some doctors to work in a primary care situation.

Transfer from birth centre to secondary care

Six midwives specifically mentioned transfer with some concerned about the impact of collegial relations on transfer between the birth centre and secondary care. Good relations, timely communication and clear expectations were viewed as important. Comments included:

Need collegial support especially when transferring...there should be no problems with facilitating a speedy transfer

LMCs need support not criticism on arrival when transferring

My concern is how midwives would be treated if a transfer was to occur between the proposed unit and the hospital, from personal experience it is anything but seamless

Concerns

Ten potential concerns of a birth centre were identified by participants at the midwifery focus groups; midwives were asked to rank these concerns.

The top three were 'If DHB owned/along the corridor, benefits would not be realised', 'Would transfer be timely' and 'Initial buy-in may be low due to perceived safety concerns.'

Table 9: Survey response – Concerns about a birth centre

Please rank these concerns in order of importance to you.	
Answer Options	Rating Average
If the birth centre is DHB owned and along the corridor, then benefits would not be realised	3.02
Would transfer be timely? (processes and adequate differentiation of not normal vs normal)	4.02
Initial buy-in may be low due to perceived safety concerns from women/partners that intervention may be difficult to get	4.52
Possible issue with shifting of resources (primary to secondary) if DHB owned/managed	4.78
Less exposure to normal birth for midwives and doctors working in secondary care	5.24
Ensuring criteria is appropriate - balance between access to the birth centre and safety	5.64
Facility concerns - design may not have sufficient input / consultation or enough capacity especially if a post-natal service is provided	6.03
Possible lack of commitment to use birth centre by midwives	6.50
Secondary service midwife staffing levels may be inadequate due to recruitment and retention issues and/or reduction in staffing levels which may be insufficient for the complex caseload	7.60
Potential decrease in Levin and Dannevirke primary unit volumes	7.66
<i>answered question</i>	
58	

Respondents were asked if there were other concerns not identified. Nine respondents provided comment:

- Security services may be required in the event of violence and/or abuse
- The transfer of funding from the secondary service to fund a birth centre may result in a “poorer quality of service for the women that need it most”
- Fewer normal births in secondary services: one respondent talked about the decrease in job satisfaction while several others were critical that this had been identified as a concern with one saying that this is about having women centred care (supporting normal birth and family focused) versus doctor/facility needs focused as currently and;

“When you become a midwife in a secondary unit...that is what you are...a secondary midwife for women under the care of secondary services....this is not a reason to have primary women in a secondary care environment. We are here for women, they are not here for us”
- One commented that the concerns identified will always be a work in progress but should not stop a birth centre being created.

Critical success factors

Midwives were asked to name up to three factors/characteristics critical in making a birth centre in Palmerston North successful.

Fifty-four respondents answered this question and there were a total of 158 factors/characteristics. Table 10 provides an overview. The top six themes are discussed below.

About half (52%) commented on the **support required** for a birth centre. Support from LMCs was viewed as most crucial (43%) followed by support from users (21%) and secondary services (18%).

The **facility and environment** rated similarly with 50% mentioning. Themes included: an appealing and homelike environment, sufficient space for whānau and for fathers to stay, communal spaces e.g. “lounge with couches and toys for older siblings”, being purpose built and having ease of access – parking and “in and out for vehicles and women.”

Staffing/skills rated third at 39%. Comments related to both the birth centre and the secondary service – the underlying theme was having competent and adequate staff in both places.

Ownership/leadership also rated highly with nearly one third mentioning. Midwifery leadership and being independent of the secondary service and the DHB were the top themes.

One quarter proposed that there needed to be **adequate input into the design** of the birth centre. This included consumers and midwives, e.g.

Consult Māori, and make it extra friendly for all cultures.

The design of the centre must be well thought out with input from midwives on the ground especially those who have worked in other centres.

One fifth identified **appropriate location** as a critical success factor. A non-hospital location was viewed as important by the majority (two thirds). Three respondents stated it should be accessible or close to the hospital.

Table 10: Survey response – Critical success factors

Critical success factors for a birth centre Total number of respondents = 54	Respondents Mentioning	
	No.	%
Support is required	28	52%
Facility and environment	27	50%
Staffing/skills	21	39%
Ownership/leadership	16	30%
Input into design/establishment	13	24%
Appropriate location	11	20%
Adequate promotion	10	19%
Criteria and policies	9	17%
Woman/family focused	6	11%
Financially viable	5	9%
Hub/complementary services	4	7%
Good relationships	4	7%
Services	2	4%
Collaboration	2	4%
Total Responses	54	
No response	6	10%

Other comments

Twelve respondents provided additional comment which in the main gave support for a birth centre and encouraged action. Comments included:

We desperately need a primary unit in Palmerston North. Currently women have very limited choice. Normal women should not birth in a secondary care facility, but lots of women don't feel confident to birth at home. This will provide women with another option

Finances are what's holding this up from moving forward ... be proactive, be seen as a community that supports the best for its women

Several respondents reiterated the need for appropriate input into design, especially Māori.

One respondent stated that birthing units do work overseas when located on hospital grounds with women having the expectation they will go to the birthing unit and transfer if clinically needed.

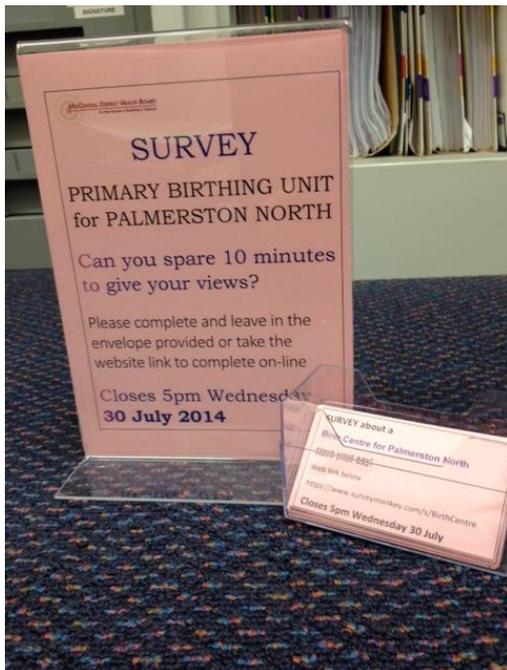
4. Consumer survey

Methodology

Over June and July 2014 focus groups were held with service providers (childbirth educators and well child/Tamariki Ora providers) and five consumer groups in different locations.¹ These focus group sessions helped to inform survey design including compiling a list of problems that a birth centre might resolve and factors/characteristics that might make a birth centre successful. These were provided in the survey as likert scale or rating questions. Several questions were duplicated from the midwife survey including preferred location for a birth centre and whether the birth centre should sit within a hub of services. The focus groups identified that many consumers had little or no understanding about a birth centre. Two pages in the survey were devoted to providing an overview including two pictures.

The survey was designed on the Survey Monkey tool and sent out to the Childbirth Educator group to pilot. Changes were made and the survey was released on 10 July. The survey web-link was distributed widely using maternity service providers and consumer organisations² with many posting on their websites and facebook pages. Hard copy surveys and business cards with the web-link were also made available to these organisations, Māori and Pasifika providers and Midwifery practices in Palmerston North. Flyers were distributed to four early childhood education centres. The survey questions are provided on page 51; mandatory questions are identified by an asterisk *.

Figure 4: Survey display stands and web-link cards



The timeframe given for completion of the survey was three weeks and the survey closed on 30 July.

Names were required to ensure responses were unique but were not used in the analysis.

¹ Freyberg Teen Parent Unit, Pahiataua Community Services Trust, Te Aroha Noa, Community Birth Services, Parents Centre.

² Community Birth Services, Mamaternity, Parents Centre, Pahiataua Resource Centre, Teen parent unit, Well child/Tamariki Ora providers, Māori providers, some early childhood centres.

Response profile

There were 541 valid responses.

The breakdown by survey type was as follows.

- Hard copy – 46 (9%)
- Web-link – 495 (91%)

The hard copy version was utilised particularly by those of Pasifika and Māori ethnicity. Almost all Pasifika respondents used hard copy (13 of 15) and 22% of Māori respondents (13 of 60).

Age

Breakdown by age showed that survey respondents were fairly similar to the Palmerston North birthing population but were slightly older – in particular there was under-representation in the age bands under 25 years and over-representation in the 25-29 years and ≥ 40 years groups. Considerable effort was made to increase the response rate of young parents through contact with organisations/groups focusing on this group – this resulted in a few additional responses.

Table 11: Survey responses by age band and comparison to Palmerston North birthing population

Age band	No. of responses	% of responses	Comparison with 2013/14 PN birthing pop
Under 20 years	16	3.0%	6.9%
20-24 years	87	16.1%	21.0%
25-29 years	172	31.8%	27.0%
30-34 years	145	26.8%	27.4%
35-39 years	77	14.2%	14.2%
40 years or over	44	8.1%	3.5%
Total	541	100.0%	100%

Ethnicity

Ethnicity analysis used four groupings: Asian, Māori, Pasifika and Other³. In comparison with the Palmerston North Hospital birthing population, Other were significantly over-represented (+16%) and the smaller ethnicities were under-represented, particularly Asian respondents who comprised only 1% of the survey population.

Table 12: Survey responses by ethnicity and comparison to Palmerston North birthing population

Age band	No. of responses	% of responses	Comparison with 2013/14 PN birthing pop
Asian	7	1.3%	8.4%
Māori	60	11.1%	18.0%
Other	459	84.8%	69.0%
Pasifika	15	2.8%	4.6%
Total	541	100.0%	100.0%

Gender, pregnancy and parenting

Almost all respondents were female:

- Female – 534 (98.7%)
- Male – 7 (1.3%)

112 respondents (21%) were pregnant.

³ Respondents choosing Other and European were combined - the breakdown was Other 6% and European 94%

The majority of respondents (88%) had children. The number of children reported were:

- None – 65 (12.0%)
- 1 or 2 – 382 (70.6%)
- 3 or more – 94 (17.4%)

Of those who had no children, 50% were pregnant and the remainder except one were less than 30 years of age.

Locality

The majority of respondents (86%) were from Palmerston North or Manawatu.

Over half (58%) of Tararua respondents were from Pahiatua. Proportions from Eketahuna, Dannevirke and Woodville were 18%, 13%, and 11% respectively. Half of Horowhenua respondents were from the Shannon/Tokomaru area and the remainder from Foxton and Levin.

Table 13: Respondent's locality

In which locality (district council area) is your address?		
Answer Options	Response Percent	Response Count
Palmerston North City	69.7%	377
Manawatu District	16.1%	87
Tararua District	7.0%	38
Horowhenua District	3.5%	19
Kapiti Coast District	0.4%	2
Other or unsure	3.3%	18
answered question		541

Analysis

Twenty-six survey responses were deleted; 17 respondents skipped out after completing the identification/demographic details and nine were from outside the MidCentral DHB area. When the latter issue was noticed (a number were from distant locations including overseas) an additional question was added to the survey for respondents choosing 'Other' for address locality asking about their past or future use of MidCentral DHB maternity services. Surveys were deleted where the answer was no or the address was outside the district before the question was added.⁴

Analysis for the question asking preferred location of a birth centre required changing from a ranking question from 1 to 4 to a single option multiple choice question. This was because many respondents completing the hard copy survey only identified one choice. A drop off in response volume from 541 to 514 occurred between the question asking whether a birth centre would be considered as an option and the question asking about the best location for a birth centre.

Survey responses were downloaded to Excel. Survey Monkey question summary tables/graphs were used for questions with defined options. Raw data was further analysed manually using a pivot table.

Text questions were grouped into categories of similar meaning to identify those of highest importance.

⁴ Four surveys from neighbouring localities (Bulls, Masterton, Marton) were not deleted

Consumer survey findings

The survey findings are presented in the form of question summaries.

Problems that a birth centre may resolve

The focus group discussions with consumers identified a number of problems with the current maternity service that a birth centre may help to resolve. Respondents were asked to indicate their level of agreement with these problems. The rating scale was: Strongly disagree = 1, Disagree = 2, Agree = 3, Strongly Agree = 4. A small proportion (range 1-7%) chose Don't know.

There was a high level of agreement with the statements. The top five problems (range 89%-96% agreement) were lack of choice, leaving the hospital too early, a need for more partner/family involvement and help after the birth. Over two thirds agreed that birth was too medicalised and the hospital was clinical and not conducive to normal birth. There was the least agreement (just over half) with the statement about inadequate privacy in hospital.

Table 14: Survey response – Problems that a birth centre may resolve

Participants at consumer focus groups talked about problems that a birth centre may help to resolve. To what extent do you agree with the following statements?		
Answer Options	Rating Average	% Agree / Strongly agree
Partners need to be involved more - they should be able to stay the first night	3.80	96%
There is a lack of choice for women in Palmerston North, there needs to be an in-between option between home and hospital	3.66	90%
There needs to be more help with breastfeeding and transition to parenting	3.59	89%
Women sometimes leave the hospital too early, either because they don't like the environment or they feel pressured to	3.57	89%
Not enough space for family/whānau and restrictive visiting hours. Needs to be more family orientated.	3.55	89%
Birth has become too medicalised and is not viewed as normal, affects woman's confidence	3.09	67%
The hospital is clinical, scary, noisy and not conducive to normal birth	2.96	69%
There is not enough privacy during labour/birth at the hospital	2.76	55%
answered question	541	
skipped question	0	

94 respondents (17%) provided additional comment in 107 subject areas. Themes (by number and percentage of respondents mentioning) were:

- Problems with the hospital facility and /or environment – 23 (24%)
- Issues with staff – 19 (20%)
- Lack of support and assistance – 15 (16%)
- The need for more partner/family involvement – 14 (15%)
- General comments in support of a birth centre – 12 (13%)
- Positive experiences in hospital 6 (6%)
- Feeling pressured to leave – 4 (4%)
- Safety factors – 4 (4%)
- Other – 10 (11%)

There was overlap in the categories, for instance respondents described how issues with the environment, lack of partner involvement or assistance led them to leave hospital before they were ready.

Hospital facility and/or environment: Mentioned most often was the noisy and clinical nature of the environment. Seven commented on rooms, the small size and difficulties sharing rooms and bathrooms just after giving birth. Shared rooms impacted on the ability of mothers to rest with visitors “interrupting or intruding on other mothers.” Birthing pools (poor design, size) and lack of birthing equipment was mentioned by three. Comments included:

Hospitals are clinical, it's hard to relax during labour because of this.

The facilities at Palmerston North's delivery suite are cramped, noisy, restricted (visiting hrs).

A group of about 15 ... spilled into corridors and made the environment uncomfortable.

I found Palmerston North Hospital had friendly enough staff, however, the tone and coldness of the environment put me off, so I chose to birth at home.

The hospital was definitely too noisy, so I went home early. I just about fainted when I left because I just wanted to get out of the place and still had low blood pressure. Partner was told to go home at 3 in the morning and he was shattered and we lived in Bulls (I was worried he would fall asleep at the wheel). [this respondent also said the care received by the hospital midwife and Feilding midwives after discharge was amazing].

The hospital has barely any recovery room, or space for others. Sharing a room with someone who has also just had a child is hard. As for myself when I gave birth I wanted to go straight home cause I wanted to be with my husband and staying in hospital felt like hell.

Issues with staff: Respondents commented on the lack of consistency of care, issues with midwives' manner and not getting help when they asked for it. Comments included:

When I asked for help with breastfeeding got told to call her back when my baby had calmed down again...can be unapproachable and hard to ask for help.

It's feels very much like they are there to do a job at the hospital, not to help you bring someone special into the world.

The constant changing of shifts for midwives, doctors and nurses at hospital meant that I never saw the same person twice, every person tried to get me to do it 'their way' and didn't listen to me so I ended up leaving without having breastfeeding established because I was so fed up...

One described the change in control once arriving at the hospital,

The hospital nurses and drs take over. Both mum to be and midwife lose their ability to make decisions

Six commented on interventions and the role of staff. One stated that some midwives use non-natural methods unnecessarily which affect labour's progress and another said the “decision to resort to caesarean is far too easy.” Several thought junior doctors were too quick to intervene, one saying that some doctors see all women on the delivery suite even if under LMC care and that registrars are under pressure to perform a certain number of caesareans per year. Other comments included:

Many of the doctors at PN hospital (especially junior ones) do not seem to understand normal physiological birth and do not see the link between their actions and interruptions to/halted progress of labour.

Birth is a once or twice lifetime experience for us consumers and not a training opportunity for a junior doctor...

One respondent was concerned about the long hours that LMCs do and proposed this should be limited to a 10 hour shift.

Lack of support and assistance: Specific gaps identified were the first night, weekend (limited staff), breastfeeding and feeling confident looking after a baby before leaving the hospital. Problems getting

breastfeeding established was cited by six respondents – three said physical issues such as tongue and lip tie were not picked up:

Definitely felt like I needed to stay longer, my milk hadn't come through like most mothers and I had no support at home to help with breastfeeding and if we are pushing the breastfeeding we need support as our family unit only includes husband with clearly no experience.

I'd decided to have him in Masterton after losing all confidence in Palmerston North hospital as you are pushed out before you're ready to leave and no advice or help is given for breastfeeding

In my case there was nothing wrong with my milk supply or my technique, my baby had tongue, lip tie and had a neck injury from the ventouse. This is why she wasn't latching but no one checked her at the hospital. By the time it got sorted it was too late and she was on formula which I was very disappointed about.

The hospital is good for those who have complications, but for first time mothers I found it hopeless. I had no idea how to bath or care for my first child and the hospital didn't help. At the time of child birth and post child birth you really need to be in a private, quiet place to bond with your baby and get well needed rest. The hospital is inadequate for providing this.

Partner/family involvement: Most of the comments (11 of the 13) specifically mentioned partners. Women wanted partners to be more involved and especially expressed feeling isolated, scared and upset when separated after the birth. The other two respondents wanted a more family oriented atmosphere including involvement of siblings [liked the picture of the Warkworth playground].

Having been awake for 3 days and 2 nights I was devastated and scared when I had to look after my newborn that first night without my husband.

The two reasons I chose to leave Palmerston North Hospital after giving birth (episiotomy with ventouse – no epidural), instead of staying overnight, was due to lack of family support overnight and lack of own bathroom.

It's ... scary having a first baby then suddenly being cut off from all family and unable to stay with my husband – which is why I left hospital straight after birth, no way was I staying on my own.

When I had my son I got up to the ward at midnight and my partner was asked to leave straight away. I was terrified and alone. This should change.

Comments in support of a birth centre: Respondents advocated for an 'in-between' option, postnatal services for high-risk women and provided general comments of support. Three described previous positive birthing experiences in birth centres and two emphasised that well women and babies should not be in a secondary care setting.

A birthing centre is an alternative place to have a 'homebirth' and a homebirth experience, especially for those who are wanting a homebirth but not confident to choose this.

Have had two hospital births and one at a birthing centre, all in different towns in NZ. While no complaints about hospital ones, birthing centre one was better experience, much better set up, nicer food with more variety, more birth choices etc.

Positive experiences in hospital: Six women described positive experiences at Palmerston North hospital. Most emphasised how all people involved including the woman played a part in this.

My experience in the delivery suite at PN hospital was very good. A medical birth is not only influenced by the environment; midwives, women (and partners) and baby influence this.

I've had very positive experiences at the hospital. The environment was fine. The midwife, other health professionals, the woman, and baby together contribute to how medicalised the birth is. Having a birthing centre would be fabulous. I have no concern at all with the hospital – but I would have opted for a birthing centre if it had been available.

The key was having my midwife as LMC whom I had got to know during the pregnancy (very different from UK experience where hospital birth was with multiple midwives I had never met before).

Feeling pressured to leave: Four women described pressure to leave before they were ready, all used the words “pushed out” or “pressured to leave” with one stating this was before breastfeeding was established.

Feeling safe in hospital: Three respondents felt safer in hospital and one birthed at hospital due to her family’s fear about home birth. The latter respondent stated a birth centre would be a “perfect middle ground ... giving me the homely feel that I wanted while putting my families fears at ease.” Two in the first group said they were first-time mothers and would be concerned about emergencies and potential delay in intervention – for one the deciding factor on using a birth centre would be distance to the hospital, the other believes first-time mothers should birth in hospital.

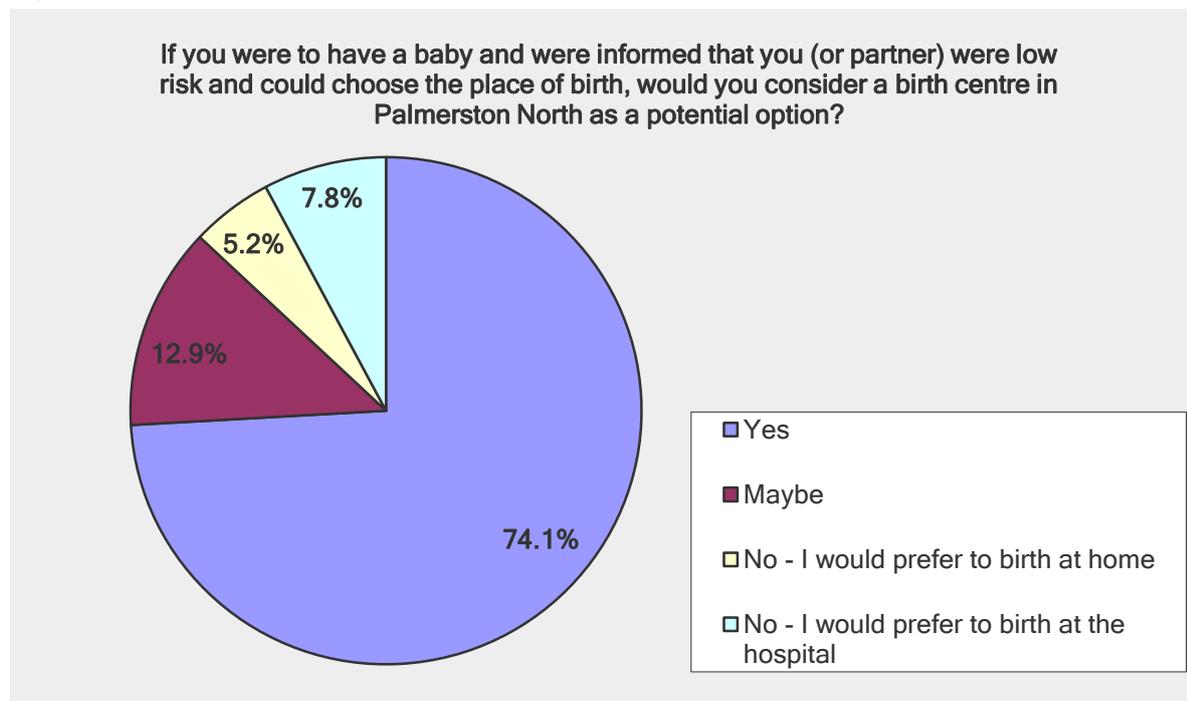
Other: There were 10 comments not fitting into the above categories including: the hospital food is not very attractive, complications can arise and reassurance would be needed re transfer, a birth centre would take some strain off the hospital ward, doctors and epidurals could be provided and an interpreter for people who speak English as a second language. One suggested that a room be provided for parents who wish to do Kangaroo Mother Care full-time with premature babies. This respondent described her difficulties doing this at Palmerston North Neonatal saying that she was not welcome in the unit and “there is no facility/space in neonates for this option.”

Support for a birth centre

Respondents were asked if they would consider a birth centre as an option if they were low risk. All 541 respondents answered this question.

There was a high level of support; three quarters of respondents said they would use a birth centre as shown in Figure 5. Numbers in each category were: Yes (401), Maybe (70), No – Hospital (42), No – Home (28).

Figure 5: Survey response – Would you consider a birth centre if low risk



The web survey used ‘skip logic’ to ask the groups answering ‘Maybe’ or ‘No-I would prefer to birth at the hospital’ the following question.

Is there anything that would make you more likely to consider a birth centre as an option?

Nearly two thirds of the group (70, 63%) answered this question; 46 of the 70 choosing ‘Maybe’ and 25 of the 42 choosing ‘No-I would prefer to birth at the hospital.’ The main categories of response identified were:

- Availability of medical/secondary services or No – 32 (45%)
- Distance to hospital and emergency services/transfer– 16 (23%)
- Seeing the birth centre and having more information – 9 (13%)

Availability of medical/secondary services: Just under half of all answers were in this category. Respondents answered either no or wanted secondary staff or services available only in secondary care (12 wanted on site doctor availability) in case it was needed. Nine wanted epidurals or more pain relief options. Comments included:

No. I want to be near doctors and drugs

A doctor, if anything went wrong a baby could die while waiting for ambulance.

If I had based my choice of location for giving birth on how uncomplicated my pregnancy was then I would have chosen a birth centre, but having to be moved to a hospital towards the end would have made the whole experience far more stressful than it was, so would definitely choose a hospital over another location for future births.

Never in a million years would I consider birthing anywhere other than a hospital because even seemingly normal pregnancies can go hideously wrong in labour with little or no warning. The closer the operating theatre the better.

Distance to hospital and emergency services/transfer: A location close to the hospital in case of an emergency and confidence in emergency/transfer arrangements might sway some people as the following examples show:

If it was located on hospital premises for very quick transfer if required to hospital delivery suite.

I would need absolute certainty that if at any time I changed my mind and wanted to go to the hospital I would be listened to.

It would depend on the services and transfer times to hospital in case of complications.

Seeing the birth centre and having more information: Some respondents would consider a birth centre if they had opportunity to “get the feel of the place” and be reassured that they would feel comfortable at the birth centre and that they would be in good hands including receiving recommendations from others. One respondent said she would strongly consider the birth centre “If it means partner can stay with the mother and newborn and family can be around for longer.”

Some respondents answered that they could not use a birth centre due to: high risk status (4); preference towards home birth (3); preference for postnatal only services (2); or may use for a second baby (1). One would be tempted if the pools were better (not the narrow baths in the hospital) and there was,

Privacy, my own midwife, children able to attend and not being rushed out of the room.

Post-natal services

The same group of respondents who answered Maybe or 'No-I would prefer to birth at the hospital' were asked:

If you (or partner) were to have a baby at Palmerston North Hospital, would you be interested in transferring to a birth centre for post-natal care?

There was strong support for this service as shown in Table 15 below.

Table 15: Survey response – utilisation of post-natal services

If you (or partner) were to have a baby at Palmerston North Hospital, would you be interested in transferring to a birth centre for post-natal care?		
Answer Options	Response Percent	Response Count
Yes	73.4%	80
No	6.4%	7
Maybe	20.2%	22
answered question		109

16 respondents provide additional comment: five answering No (1) or Maybe (4) and 11 answering Yes. Of those answering No or Maybe, for three it would depend on the service and receiving more information and two would go home. Of the remainder, seven provided comments in support of a postnatal service and four provided detail of how they thought it would solve the problem of either having to leave hospital too early or improve on care they received previously, e.g.:

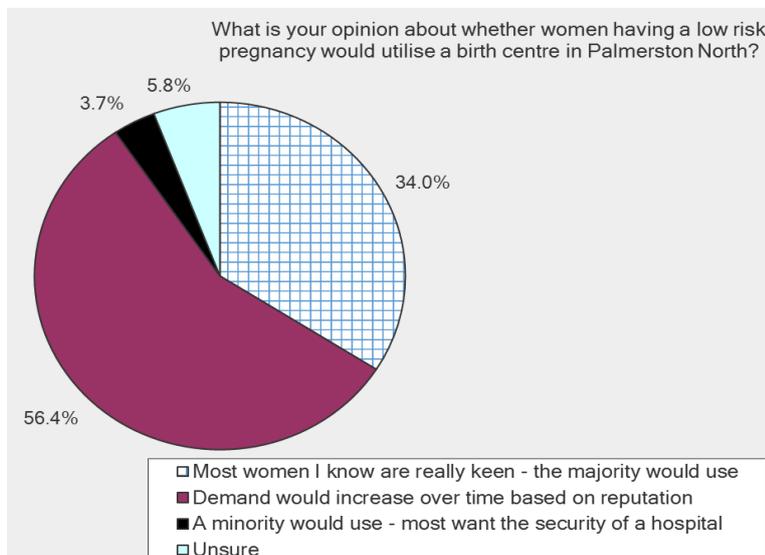
I was told that I was being lazy and needed to shower myself and shouldn't be relying on staff to pick up my crying child as I should be up and moving around when in actual fact I had a torn uterus and had a 2.5 hr op after my c section and it was harder to get up and down.

*Being at home or going home are not always best for a woman and child. I was literally *kicked out* out of PN maternity before I was happy with breast feeding. I also had depression and issues at home and being transferred to a Birthing Centre would have been perfect.*

I think this is really important, so we have time to learn what we need to learn with the support right there. I'm due soon and scared at the thought that I may be kicked out of hospital not knowing what to do.

Respondents opinion on whether birth centre would be utilised

Figure 6: Survey response – Opinion on whether women would utilise a birth centre



39 respondents provided additional comment as follows:

- A minority would use – most want the security of a hospital – 3 (8%)
- Demand would increase over time based on reputation – 25 (66%)
- Most women I know are really keen – the majority would use – 7 (18%)
- Unsure – 3 (8%)

Comments from the three respondents in the first category were related to safety and security.

The key points made by other respondents were:

- a birth centre may be more popular with women having their second baby
- midwife influence/support is important
- trust and confidence in birth centre systems is needed – this will take time
- the increased use of epidurals and fear about childbirth could hinder utilisation of a birth centre

Comments included:

I think as more people use it and talk about it, demand would increase. This is based on what I saw happen in Auckland as my friends started using Birthcare facilities.

I've only heard good things from people who have used birthing clinics around the country so based on this reputation I'm sure a lot of people would be willing to try out.

Mothers will probably be sceptical at first but I think once the reputation grows and gets around to other mums there will be an increase in use.

Women are losing sight of what comes naturally and turning to intervention for pain relief and birth. I believe a birth centre will give women more confidence to birth naturally, making birthing safer.

If we live in a society where the people begin to aspire to having natural births not in a hospital, I think a birth centre would become very popular.

Several respondents commented that women they know wanted to avoid the hospital, for instance;

The hospital has a really bad reputation for birthing and after care and most women I know would choose a different option if given a choice.

One woman described the need to have confidence that there are systems in place in the event of last minute complications saying “hospital security is a big factor for me and overrides any other comfort or privacy factors.”

Where should a birth centre be located?

514 respondents answered this question. Consumers were split in their choice of preferred location.

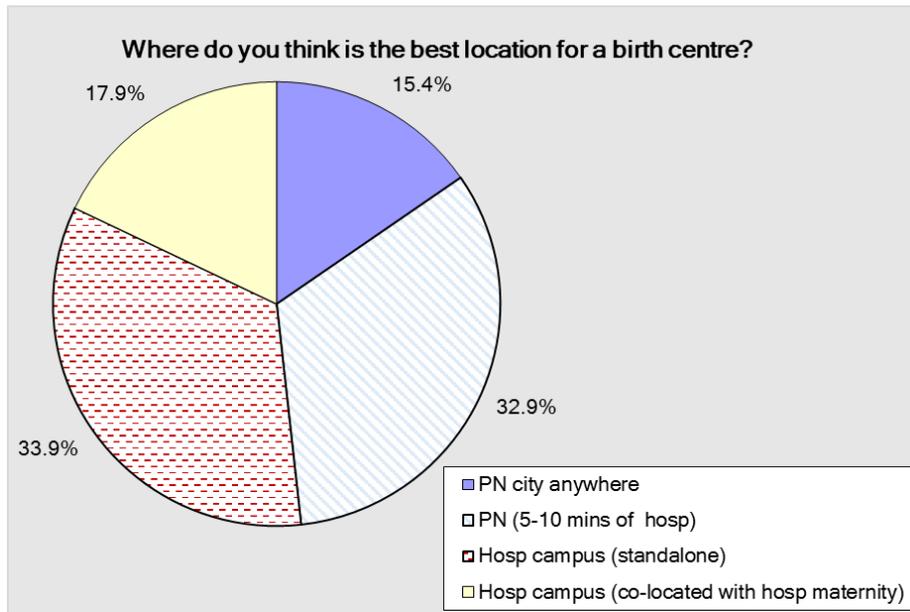
The top choices were:

- on the hospital campus as a standalone facility – 174 (34%)
- within 5-10 minutes of the hospital – 169 (33%)

The division between on-campus and off-campus options was:

- hospital campus – 52%
- Palmerston North city – 48%

Figure 7: Survey response – Location for a birth centre



Analysis by age group showed some differences as shown in Figure 8 below. Off-campus options were preferred most by 35-39 year olds (57%) and least by 20-24 year olds (36%).

Figure 8: Survey response – preferred location by age band

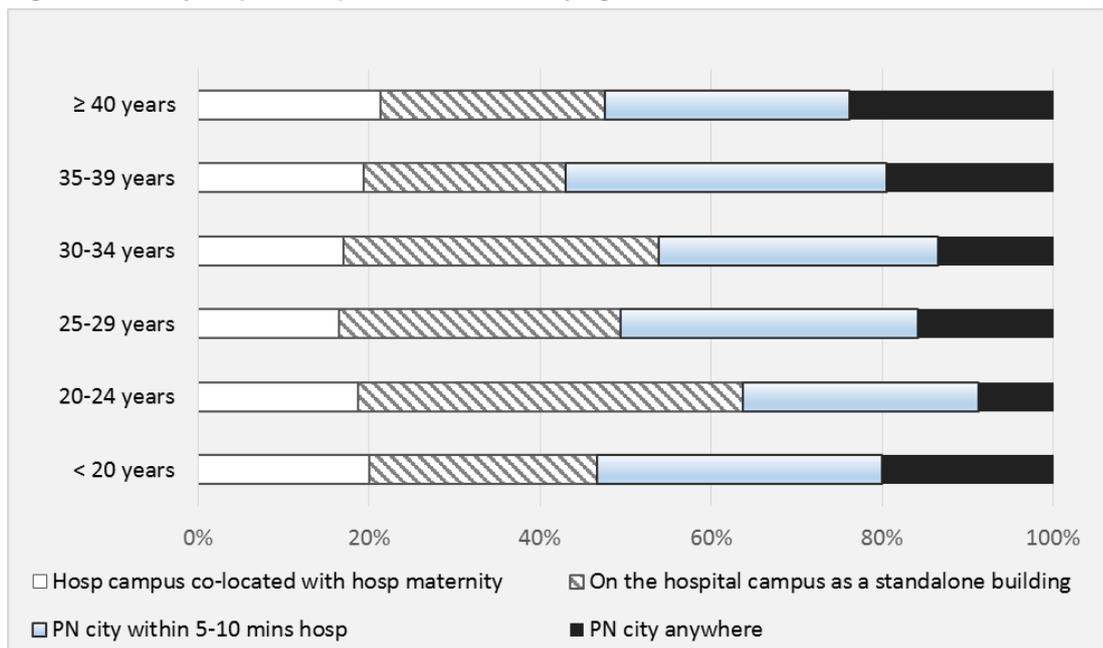
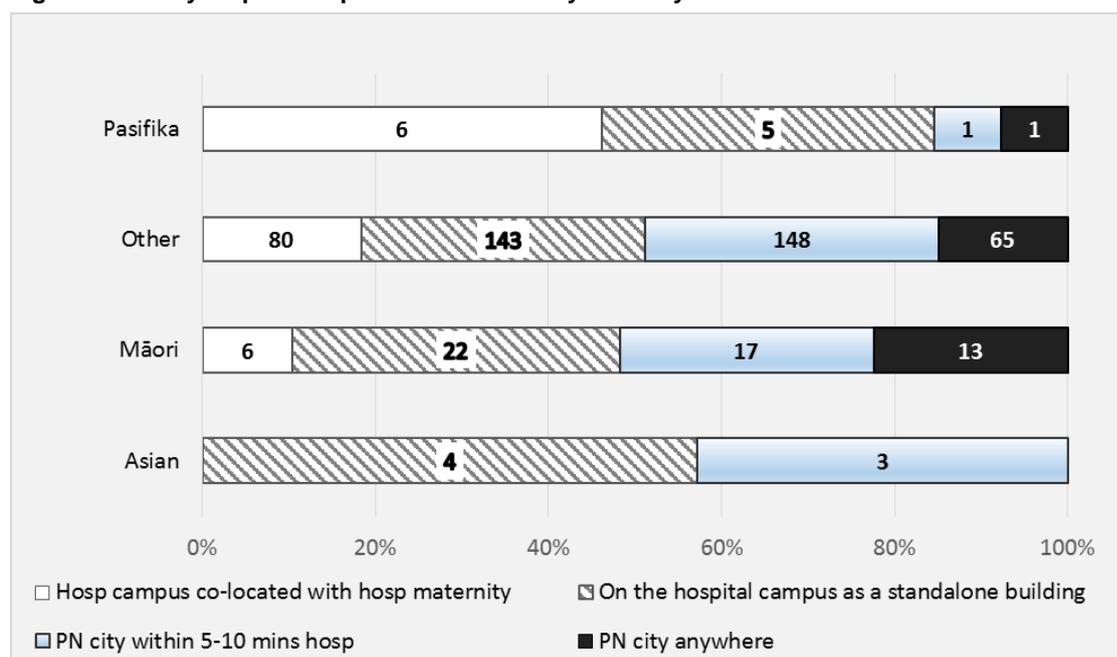


Figure 9 over the page shows the ethnicity breakdown. Off-campus options were preferred most by Māori (52%) and Other (49%). The majority of Pasifika (11 of 13) and Asian respondents (4 of 7) preferred on-campus options, however note that the overall volume of responses for these ethnicities is quite small for ethnicity analysis.

Figure 9: Survey response – preferred location by ethnicity



Should the birth centre be co-located with other services?

Consumers were asked whether there was support for co-locating the birth centre with a range of complementary services (e.g. maternity information, pregnancy and parenting classes, midwifery clinics, support groups, alternative services) for reasons of normalising the service, raising visibility and cost-effectiveness. Respondents were asked to rate the importance of the birth centre being located within a hub of services.

Table 16 shows that the majority of consumers (72%) thought it important or very important that the birth centre was located with complementary services. By age, a lower proportion of those under 20 years and between 30 and 34 years rated this as important (60% and 65% respectively). By ethnicity, a lower proportion of those of Pasifika ethnicity rated this as important (62%).

Table 16: Survey response – location within a hub of services

It Please rate the importance of the birth centre sitting within a hub of services.					
Answer Options	Not important at all	Somewhat important	Important	Very important	
	19	127	230	138	514
	3.7%	24.7%	44.7%	26.8%	100%
<i>answered question</i>					514

53 respondents provided additional comment. The main themes were:

- A hub of services is a good idea – 25 (47%)
- Separation needed between birth centre and other services – 18 (34%)
- Privacy and focus are important – 7 (13%)

A hub is a good idea: The main reasons respondents were in favour of a hub was for easy access to services, raising visibility of the birth centre, enabling women to become comfortable in the environment and connecting with the community. Maternity services were mentioned most often

(pregnancy and parenting classes, midwife appointments and lactation consultant services) but several thought the birth centre should host support groups e.g. breast feeding, postnatal depression and birth trauma. Comments included:

Helps to make normal pregnancy a normal life event, rather than something you go to hospital or the medical centre about. It puts the services in a community setting, where they belong.

Parents might come to a parenting class and then decide to go to the centre for their next birth. Current services are spread all over the town and are hard to find for first time parents, in particular in early pregnancy.

Promotes a holistic approach to care and ensures parents/whānau can access services under one roof this is particularly important toward successfully maintaining ongoing connection, engagement and a sense of belonging for whānau .

Women would know where they would be giving birth and be comfortable with their surroundings and the carers working there, very early on in their pregnancies. It would allow them to be able to visualise how they would like their birth to go and this could in turn help to relax them.

The birth centre should be separate: Respondents were concerned about the busyness, noise, distractions and lack of privacy if other services were provided at the birth centre, e.g.:

A hub would be quite busy. The whole point is for calm and privacy and time to rest and bond while supported.

I feel it is important that it has a feeling of a sacred place that is not too busy with other things than birthing.

Several suggested that this could be catered for by providing services nearby or in a different section of the building. One suggested “not too close or it may disrupt the home like feel and seem more like a business.”

Privacy and focus: Similar to the group wanting a separate birth centre, this group had concerns about privacy and thought that birthing should remain the primary focus of the venture. Several suggested that the birthing area was away from other services including having different entrances. Some had mixed feelings, e.g.:

Yes and no, providing that that the birth centre can stay as private as possible.

However the primary purpose is birthing... The umbrella is everything else

Several respondents commented that there are plenty of maternity services already in the community, one suggesting that the birthing centre “does not need to be co-located with these other services, but having information about them there is a must.” Another suggested that strong ties to women’s refuge, addiction rehab professionals and mental health professionals would be advantageous.

Critical success factors

The focus group discussions with consumers identified factors/characteristics necessary for a birth centre to be successful. Respondents were asked to rate between 1 and 7 how essential these factors are. There was a very narrow range; all were rated highly. The factors rated highest were adequate length of stay, post-natal support and involvement of family, access to birthing aids and a good transfer process.

Table 17: Survey response – factors /characteristics necessary for a birth centre to be successful

How essential do you think these factors are? Please rate on a scale of 1 to 7 with 1 being 'Not essential' and 7 being 'Imperative'	
Answer Options	Rating Average
The length of stay should be long enough to allow mothers to feel confident with feeding / caring for their baby	6.46
There should be lots of support postnatally - breastfeeding and parenting skills	6.43
There should be ready access to a range of birthing aids such as pools, balls and stools	6.29
Partners/family should feel welcome and included. Relaxed visiting hours	6.26
The transfer process needs to be efficient and seamless	6.18
Women should have their own room with an ensuite and double bed for their partner to stay over	6.08
Midwives who are keen to use the birth centre because they discuss the options with women	6.04
Adequate and free parking	6.03
Midwives working at the birth centre should have a philosophy based on normal birth	5.74
The facility should provide a home-like, relaxing and private environment to give birth. It should not look like a hospital	5.54
answered question 514	

64 respondents provided 75 additional characteristics or comments. A few reinforced success factors identified in the survey e.g. partner staying overnight, free services including parking or midwife support. The main subject areas of the responses were:

- Facility & support services – 16 (25%)
- Staff – 12 (19%)
- Clinical services – 12 (19%)
- Environment/ambience – 8 (13%)
- Secondary services – 7 (11%)

Other factors mentioned by less respondents (range 1-3) were midwifery leadership, an 'opt out' booking process, off-campus location, flexible criteria, privacy, a safe service, the use of natural products and upgrade options for additional services.

Facility and support services: 8 respondents mentioned food including large meals, healthy options, catering for food allergies/intolerances and providing facilities for women and partners to heat and store basic food. Four proposed that communal dining/lounge areas were necessary and would provide the means to meet other parents, for instance;

The birth centre should have a communal area to be able to meet other mothers and having a kitchen area so families can bring food and having an area for children for mothers who already have children when they come to meet their new siblings.

The sort of things that could be considered superfluous, but would make a big difference to some families.

The provision/ability to play music was suggested by several. Two thought that single beds or a 38medical bed would be better than a double bed.

Staff: Most respondents wanted staff to have an open-minded approach, be helpful without pushy and to be accepting of women's choices even when in conflict with midwives' views e.g.:

There should be no judgement on which option you choose [feeding method] or forcing people to choose one option over another

It is imperative that midwives working at the birth centre have a range of birthing philosophies and are prepared to work with the birthing women to ensure that the women's needs and wishes are put before the midwives own philosophy

Staff need to be open to the need for 38medicalization and transfer

Respondents mentioned the need for adequate staff including a second midwife at each birth. There were three comments about the staffing model; staff should be qualified nurses as well as midwives; staff should be non-hospital maternity staff; and staff should be linked to the secondary maternity service.

Clinical services: Respondents favoured breastfeeding assistance/lactation services (mentioned most frequently) providing postnatal services after birthing at the hospital, postnatal education on infant care, Māori related services, and counselling and support for those previously having a stillbirth. One suggested the birth centre should be able to treat babies with mild jaundice if well, feeding well and no other risk factors. Another suggested additional support for teen parents;

Practical Support that sets them up for success as parents. With non-judgemental mentors tracing the extra support.

Environment/ambiance: there was some overlap with comments about the facility and support services. Characteristics important to respondents were: a calm quiet environment, the ability to bring their own things, a less clinical experience, option to use candles and having a child and whānau friendly environment. One respondent expressed concern about partners staying;

I'm not sure how comfortable I would feel trying to sleep in a building full of strange men, especially when I'm feeling vulnerable after giving birth

Secondary services: Respondents advocated a close relationship with secondary services in order for fast handover/transfer. Three proposed more pain relief options or a doctor on site.

Concerns

Respondents were asked to describe any concerns they had about a birth centre. Three text fields were provided. Just over one third (184, 34%) answered this question and provided a total of 302 concerns.

The overwhelming concern cited by the majority was in the category of safety, emergencies and transfer.

Table 18: Survey response – Concerns about a birth centre

Please describe any concerns that you have about a birth centre Total number of respondents = 184	Respondents Mentioning	
	No.	%
Safety, emergencies and transfer	107	58%
Workforce factors	29	16%
Access and capacity	24	13%
Funding and cost to users	19	10%
Inadequate pain relief	17	9%
No concerns / good idea	15	8%
Facility and support services	13	7%
Type of services provided by the birth centre	11	6%
Communication and relationships	10	5%
Becomes a mini hospital	10	5%
Other	8	4%
Visiting hours	5	3%
Culture	5	3%
Leadership	5	3%
NA	3	2%
Total Responses	302	

The top five categories of concern are discussed below.

Safety, emergencies and transfer

107 respondents listed 122 concerns in this area (some identified more than one concern).

The themes were:

- What happens if something goes wrong?
- Will transfer to the hospital be easy/fast enough?
- Location close to the hospital
- Having no doctors on site
- Delays in midwives seeking medical input
- Emergency services for the baby

The majority of concerns raised were related to whether secondary assistance (doctors, equipment and facilities) would be available if they were needed.⁵ Some pointed out that things can go wrong very quickly. There was considerable overlap between themes in this category but speed and ease of transfer were the overriding concerns, for instance:

Complications can happen quickly during a birth, there needs to be quick access to good medical care.

⁵ 6 stated “safe” or “safety” or “as long as safe to use.”

Ease and quickness of being transferred to secondary care.

How long would transfer take to hospital if emergency arises – i.e. with me I had major haemorrhage and had to be taken to theatre to be stitched up and have blood transfusions.

If an emergency were to happen how soon would they be transferred and dealt with through the hospital, e.g. handing over to hospital staff then waiting for a theatre room.

Twenty-four respondents specifically mentioned that the location of the birth centre should be close to the hospital with most linking this to the availability of secondary care e.g.:

Location should be nearby the hospital in case of complications.

If not close to the hospital I would not be interested. I have no interest in having to transfer locations if the birth gets complicated quickly.

In case of emergencies will they be able to handle it? Being near the hospital would give mothers a peace of mind.

Eleven were concerned about the lack of medical staff at the facility:

Birth would be a concern if there were no doctors for emergency.

Some wanted to know what the plans were if secondary assistance was needed:

What would happen if the baby or mum was at risk or distressed once labour has begun but then stalls?

Or wanted reassurance that there would be access to medical assistance and back-up:

Action plan for complications.

On-call and associated obstetricians an imperative ... midwife backup by specialists needed during birthing process

My only concern would be if things went wrong women would need to be transferred to hosp fast but I'm sure that would be the case.

Ten respondents were concerned about the referral process to secondary services:

If midwives were reluctant to pass on birthing women to hosp if complications arose.

Six commented on transfer procedures and processes e.g.; “strict and adhere to best practice,” and “clear and non-controversial.” One recommended a discussion with St Johns to understand what to expect.

Four specifically mentioned emergency services for the baby after birth:

Availability of paed input for babies who are unexpectedly born unwell or with abnormalities.

Several respondents were not clear on services that would be offered, e.g:

Is there a place to have emergency c-section at the unit or do you need to get to the hospital?

Would they provide services such as surgery and stitches facilities?

Workforce factors

Mentioned in order of frequency were concerns about midwife expertise (n=9), that staff were friendly/open-minded (n=6) and adequacy of staffing levels (n=4). A few framed their concerns as questions, e.g. “what kinds of staff will be there?” Two commented on the staffing model and one was concerned about forcing unwilling midwives to be there. Comments included:

Staff need to be experienced or new midwives need active mentoring.

How equipped are staff to handle various situations?

Needs to be staffed well and run efficiently.

Access and capacity

The main theme (19 of the 24) was fear that the facility may not be large enough and women may not get in. Four wanted reassurance that a 24 hour service would be offered and one that access would not be affected by too strict criteria e.g. women expecting twins who are otherwise well. Comments included:

Not being able to secure a place there in advance – certainty of location of giving birth is important.

Capacity – how many can it serve – how do you decide who gets to use the service at any given time.

Funding and cost to users

12 respondents were concerned about cost, five did not specify any details and seven mentioned costs to users:

That a fee may be charged which would prevent lower income families from utilizing such a service.

The cost of using it vs. free hospital stay.

The remaining seven individuals were concerned that funding may not be adequate:

That it wouldn't be resourced properly, e.g. financially.

One linked funding concerns with safety, and asked if the Centre/Midwife would lose money if a woman was transferred to the hospital to deliver as she would not like to see “safety compromised over profit.”

Inadequate pain relief

Respondents were concerned that the options for pain relief maybe too limited. Five mentioned epidurals and one mentioned having gas available.

Not offering an epidural may put people off.

It may limit parents' choices especially first time parents unaware of level of pain tolerance.

Other categories

The remaining categories of concern are worth summarising as collectively these were mentioned by half the respondents answering this question. The category ‘No concerns/good idea is self-explanatory.

Facility and support services: Warm and clean, adequate security and that the design and layout is appropriate.

Type of services provided by the birth centre: postnatal services for high-risk woman, adequate length of stay, assistance with breastfeeding/baby care, other supports (interpreter, still birth, social worker/mental health).

Communication and relationships: Interface with secondary services important, several were concerned about lack of support from senior medical staff with the public and media and the potential impact on reputation. One mentioned the need for a good relationship between community, birth centre and community midwives.

Becomes like a mini hospital: if too close to the hospital or DHB run the birth centre could become an extension of the hospital.

Other: Utilisation – won't be used or lowers Levin or home birth volumes: Attitudes – need to encourage a societal fear of medical professionals/hospitals and give mothers more confidence: that it

would be too close to the hospital: may become too popular and lose its intimacy: that there would be no time limits on labour.

Visiting hours: These may be too relaxed and therefore disruptive if there are large numbers.

Culture: Whether all cultures would be catered for, whether it might be a too restrictive /controlling environment or too 'hippie like.'

Leadership: Concern about who would run the centre – two thought non-hospital leadership and one suggested a doctor should oversee it and a clear hierarchy to mediate disputes (between women or different midwifery styles),

Other comments

Eighty-four respondents (16%) answered the final question asking if there were other comments. The majority (72, 86%) made comments in favour of a birth centre.

Comments in favour of a birth centre

Just under half this group (n=33) provided comments such as “good idea,” “can’t wait,” “Palmerston North needs one,” “hope it happens in time for my next baby.” The remaining 39 gave 44 reasons why they thought a birth centre would be beneficial.

- **Provision of additional support** (12) – partner and postnatal support (breastfeeding and parenting skills). One woman attributed her postnatal depression to lack of support. One suggested a birth centre could be particularly valuable for young vulnerable women. Another proposed it was an opportunity to provide a holistic service taking into account the woman’s family/whānau and circumstances and what supports she may need once home. Another stated it could be a “powerful tool in preventing child abuse in infants- an opportunity to teach basic parenting skills to mothers AND fathers”
- **Desire to avoid hospital or a previous bad experience** (11) – three of the group said they did not want to go to hospital (one because of negative stories) and the remainder described problems they had had in hospital including lack of support, sharing a room and staff being too rushed and impersonal. Six said they left early as a result; one woman said she was asked to leave at 36 hours which she found upsetting.
- **Other birth centres** (8) – respondents had either used a birth centre or had knowledge of one. Two were considering travelling to birth centres they had used previously for the birth.
- **Normalises birth** (6) – respondents advocated de-medicalising birth and asserted that hospital is not the appropriate place to have a baby. One gave a quote, “Birth is not only about making babies, it is about making Mothers. Strong, competent, capable Mothers who trust themselves and believe in their inner strength.” (Barbara Katz Rothman)
- **Taking the pressure off secondary service** (2) – One respondent who would use a birth centre for postnatal service (previous caesareans) said that hospital is overcrowded and under a lot of strain to provide adequate care to those needing hospital births.
- **Alternative to home birth** (2) – one woman said this option would have been perfect as home-birth was her first choice but not her husband’s.
- Other reasons were a suggestion that epidurals be offered, that this was an opportunity for upskilling midwives in twins, breech births (if there was good back-up) and another suggested it would improve the economy by encouraging more women into the city.

Other

Seven respondents proffered a variety of comments. Concern that women with previous caesarean would be excluded, that such a venture needs to be for the right reason (vs cost saving or politically

motivated) and that it is unfair that low-risk woman would have better care compared to those in hospital. Two made comment on facility characteristics, one on the need for adequate space, partner support and confident staff (that instilled confidence in the woman) and the other thought that a birth centre did not need to be home-like – as long as it was family focused. One that it should be affordable and another that the funds may be better used on more postnatal support in the first two months, more GPs and free GP care during pregnancy, more hospital midwives and more training and more skin to skin which is not currently encouraged.

Staff

Five respondents made comments about staff; the need to have experienced staff and a mix of expertise e.g.; “not all midwives have a strength or experience in postnatal work.” Two thought a specialist should be on staff. One respondent who said she would have been low risk, recounted a bad experience and criticised her midwifery care. She was concerned that “the industry is becoming too focused on the wellbeing side and midwives are not taking concerns of patients seriously” and called for the birth centre to be managed and run by the right people with the right qualifications and opposing the automatic use of a birth centre by all midwives.

5. Survey conclusion

The conclusion looks at the results of the midwife and consumer survey together to see the common themes and differences.

The surveys achieved respectable response volumes; 60 for the midwife survey and 541 consumer responses. For the midwife survey a high rate was sought from LMCs in particular; this was attained with a 78% response rate.⁶ The consumer survey was circulated broadly within maternity and early childhood providers/organisations – the respondent profile was relatively close to the Palmerston North birthing population in age except slightly older. Almost all respondents were female (98.7%) and the smaller ethnicities were under-represented, particularly Asian which achieved only seven responses (1.3%). These factors need to be kept in mind when interpreting the results.

Utilisation of a birth centre

Overall the results show there is strong support for a birth centre from midwives and consumers. Midwives viewed a birth centre as a vital part of achieving the aim of the MQSP and gave a rating of 6.3 out of 7.⁷ Almost all LMCs (84%) said they would birth women at a birth centre. The remainder preferred hospital (8%), home (5%) or were undecided (13%). Three quarters of the consumer group that were undecided or preferred the hospital said they would be interested in postnatal care services.

Benefits of a birth centre

Consumer survey findings indicate considerable issues with satisfaction of maternity services at the hospital. A list of problems that a birth centre may resolve were identified by consumers in the focus groups and survey respondents agreed with most. The top problems with 89-96% agreement were:

- Partners need to be involved more – they should be able to stay the first night
- There is a lack of choice for women in Palmerston North; there needs to be an in-between option between home and hospital
- There needs to be more help with breastfeeding and transition to parenting
- Women sometimes leave the hospital too early, either because they don't like the environment or they feel pressured to
- Not enough space for family/whānau and restrictive visiting hours. Needs to be more family orientated.

Over two thirds agreed that birth was too medicalised and not viewed as normal and that the hospital was clinical and not conducive to normal birth. There was the least agreement (just over half) with the statement about inadequate privacy in hospital.

Comments provided in the consumer survey provide some context to the results in respondents own words so the reader can better understand the experience of respondents. Comments covered issues with the facility/environment such as noise, cramped space and difficulty getting rest in shared rooms, issues with staff including manner and interventions, lack of support and assistance and not feeling confident on discharge and women's distress when left alone after the birth. Positive experiences were also reflected and placed emphasis on how all people involved contributed to this.

⁶ The survey web link was e-mailed out to all LMCs on the MidCentral DHB contact list. To calculate the response rate LMCs practising outside the Palmerston/Manawatu area were excluded except for 2 in the Otaki/Horowhenua area who answered the survey. Denominator was 45 LMCs.

⁷ 1 = Not essential, 7= Imperative

The top benefits of a birth centre identified by midwives were:

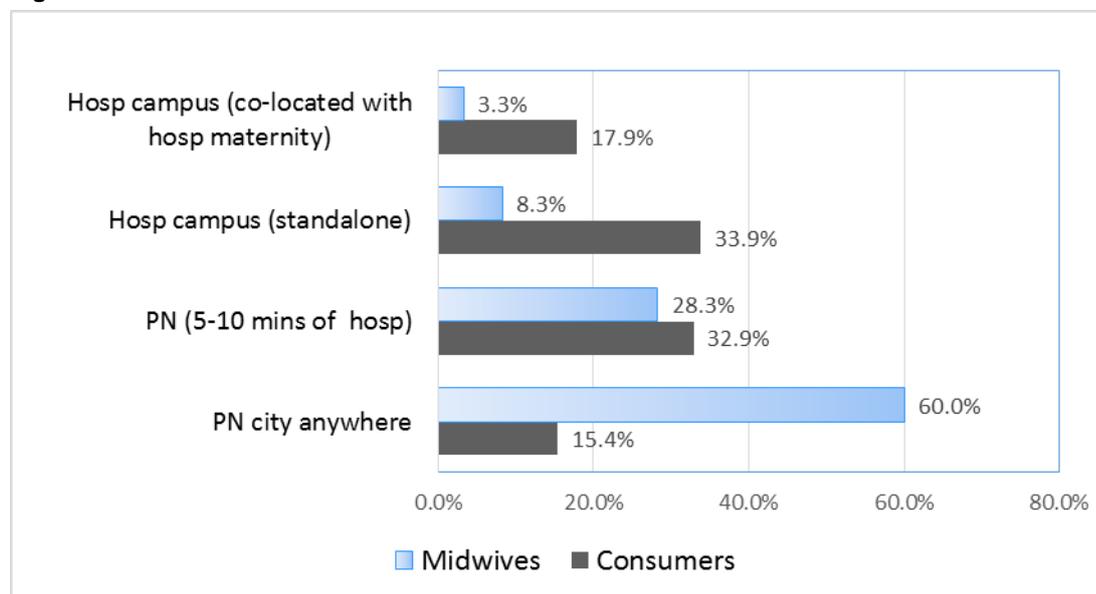
- More normal birth (88% ranked this as their first or second choice)
- Family focused – partner and family are made welcome and are more involved, partner stays first night
- Provides choice for women – an ‘in-between’ option between home and hospital.

These latter two benefits are particularly aligned to consumer priorities.

Location

Midwives and consumers had different views about preferred location as shown in Figure 10. Almost all midwives (88%) preferred off-campus locations and the majority were not concerned about distance to the hospital. Consumer preference was less definitive and was split 52/48% between on and off-campus locations. Overall, consumer responses reflected a desire to be closer to the hospital compared to midwives.

Figure 10: Preferred location for a birth centre – Midwives and consumers



Midwives preferred off-campus options in order to have a clear separation between the birth centre and the hospital and to position the birth centre as primary and midwifery led rather than an extension of the secondary service. This was seen as essential for both women and midwives and women would be making a conscious decision to birth away from epidurals and to use non-pharmacological measures which helps keep birth normal.

Relationship to other services

The majority of consumers and midwives agreed that the birth centre should be co-located with complementary services (72% and 70% respectively). The main advantages seen were easy access to services, raising visibility of the birth centre and enabling women to become familiar with the environment and staff thus affecting utilisation and also relaxation during labour. Maternity services were seen as most ideal in a hub (antenatal classes, midwife appointments and lactation services) and some thought support groups could also be located there.

Those that disagreed had concerns about the busyness, noise and lack of privacy that could result if other services were provided at the birth centre.

Workforce

There were differing views between midwives about the preferred workforce model. The majority (60%) preferred separate staffing in the birth centre versus a rotational model across the birth centre and the secondary service (23%). However, the results were quite different by occupational group; hospital midwives were equally split between these models while almost all LMCs preferred separate staffing. Supporters of a separate workforce model in a birth centre described the necessity of a primary philosophy and skill set. They explained that a core midwife in a birth centre performed a different type of role compared to the core midwife in secondary services and was focused on supporting the LMC rather than taking over care.

Those that advocated rotation saw this as being advantageous for maintenance/extension of skills, improving relationships between midwives and adding to job retention and satisfaction. Most thought there should be a choice of working environment and it was important that midwives worked where they felt comfortable.

The majority of midwives thought that collegial relationships (particularly between LMCs and hospital midwives) would need to be addressed in order for a birth centre to be successful. As well as issues with working relationships and understanding of each other's roles, concerns were expressed about the impact of collegial relations on transfer between a birth centre and the secondary service and the need to have good communication and clear expectations.

Concerns

For consumers, safety, emergencies or transfer was the top concern identified by 58% of those answering this question (response rate 34%). The main theme was whether secondary services would be available quickly if needed. This tied into location preferences, nearly one quarter of this group mentioned the need for the birth centre to be close to the hospital.

Other concerns mentioned by 9-16% of respondents were staffing factors (competent, friendly, adequate staff), ensuring the facility was large enough, financial (adequate funding and no cost to users) and pain relief options being too limited.

Midwives' top concern was that the benefits of a birth centre would not be realised if DHB owned and along the corridor. Concerns ranked second and third reflected consumers' concerns: 'Would transfer be timely?' and 'Initial buy in may be low due to perceived safety concerns from women/partners that intervention may be difficult to get.'

Consumers and midwives also identified other concerns that would be useful to consider during design and implementation of a birth centre. Some of the concerns revealed that consumer respondents had a limited understanding about a birth centre, e.g. that it would be publicly funded or that there would be no medical specialists on staff.

Success factors

Consumers were provided with a list of factors/characteristics necessary for a birth centre to be successful (developed from the focus groups). These were all rated highly. The factors rated highest were having an adequate length of stay, post-natal support and involvement of family, access to birthing aids and a good transfer process.

Having adequate support for a birth centre was the top factor identified by midwives – from LMCs, users and secondary services.

The facility, environment and support services was a high priority factor for consumers and midwives including ensuring an appealing environment, sufficient space for family and communal areas, good food (consumers) and input into design (midwives).

Staffing was another high priority factor. The theme for midwives was having competent and adequate staff across the birth centre and secondary services while for consumers it was related to the approach and manner of midwives as well as the need for adequate staff.

Other comments

Some consumer and midwife respondents provided additional comment (84 and 12 respectively). Most made comments in support of a birth centre and expressed the desire for it to happen soon. Half of the consumer group provided reasons for their support including the need for additional support and relating how it would improve on a previous experience. A number had either used a birth centre or had knowledge of one.

Appendix A – Glossary and abbreviations

Term	Description
CTG, Cardiotocographic monitoring	Form of electronic fetal monitoring which records the fetal heartbeat and the uterine contractions typically in the third trimester.
CPHO	Central Primary Health Organisation
DHB	District Health Board
HDC	Health and Disability Commissioner
IFHC	Integrated family health centre
LMC – Lead Maternity Carer	Lead Maternity Carers can be midwives, GPs with a diploma in obstetrics or obstetricians. LMCs are contracted through the Ministry of Health to provide a complete maternity service. The majority of women choose a midwife as their LMC
LOS	Length of stay
MECA	Multi-Employer Collective Agreement
VBAC, vaginal birth after caesarean'	60-80% of women with previous caesarean can have a vaginal birth. Although uncommon, the most significant risk is uterine rupture. Generally a VBAC is viewed as a 'trial of labour' and recommendations may include giving birth in a unit where immediate Caesarean section is available and monitoring.

Appendix B – Midwife survey questions

1. *What is your name?
2. *What is your occupational role?
 - Hospital midwife, Lead Maternity Carer (LMC), Dual role (hospital midwife and LMC), Other
3. *Would you birth women at a birth centre in Palmerston North?
 - Yes/No/Maybe/Not a LMC
4. *If you answered No or Maybe to the last question, what would make you more likely to use a birth centre?
5. *The aim of the MidCentral and Whanganui DHB Maternity Quality and Safety Programme (MQSP) is "To enhance safety for women, babies, families and whanau and for service providers working together to create the best possible maternity service in which all mothers and babies are the focus of care, feel safe and have improved outcomes." How essential is it that a birth centre forms part of the strategy to achieve the aim of the MQSP?
 - Please rate on a scale of 1 to 7, with 1 being 'Not essential' and 7 being 'Imperative.'
 - Box for additional comment
6. *Where do you think is the best location for a birth centre?
 - Palmerston North city anywhere
 - Palmerston North city within 5 minutes of the hospital
 - On the hospital campus as a standalone building
 - On the hospital campus co-located with the secondary care maternity service
 - Comment box - Please give a reason for your choice
7. *The focus group discussions with midwives and consumers identified that there was support for co-locating the birth centre with a range of complementary services (e.g. maternity information, pregnancy and parenting classes, midwifery clinics, support groups, alternative services) for reasons of normalising the service, raising visibility and cost-effectiveness. Please rate the importance of the birth centre sitting within a hub of services.
 - Not important at all, Somewhat important, Important, Very important
 - Box for additional comment
8. *Differing opinions have been expressed about the ideal staffing model. Some think that rotation between a birth centre and the secondary maternity service would enable midwives to retain skills. Others think that core staffing should be separate due to the different focus / philosophy in the units. What workforce model do you favour and why?
 - Rotation of employed midwives between the birth centre and hospital maternity service
 - Rostered employed midwives in the birth centre
 - LMCs only
 - Unsure
 - Comment box - Please provide the reason for your choice
9. *Are there collegial relationship factors that need to be addressed for a birth centre to be successful?
 - Yes/No

10. *If you answered Yes to the last question please provide some detail about the collegial relationship problem
11. *Participants at the midwifery focus groups identified potential benefits of a birth centre, the majority are listed below. Please rank these benefits in order of importance to you.
- More normal births. The environment is more supportive of natural birth more homelike, bed and equipment has less focus, atmosphere supports relaxation/release of birthing hormones and staying active in labour.
 - Can incorporate Māori birthing traditions
 - Workforce flexibility – LMCs can provide casual cover for core staff
 - Family focused – partner and family are made welcome and are more involved, partner stays first night
 - Better support in the postnatal period – help with breastfeeding and transition to parenting
 - Creates more clarity between primary and secondary care – better working relationships
 - Creates more capacity for women requiring secondary services – less pressure on service and beds
 - Promotes skills in normal birth (primary midwives and training interns)
 - Physical separation from secondary staff and availability of interventions (e.g. CTG, epidurals, augmentation, caesareans) results in less intervention
 - Improved job satisfaction/retention of midwives (less stress and another option to work)
 - Cost savings due to less intervention
 - Provides choice for women – an ‘inbetween’ option between home and hospital
12. Are there other important benefits that have not been listed above?
13. *Participants at the midwifery focus groups identified potential concerns about a birth centre, the majority are listed below. Please rank these concerns in order of importance to you.
- Would transfer be timely? (processes and adequate differentiation of not normal vs normal)
 - Less exposure to normal birth for midwives and doctors working in secondary care
 - Initial buy-in may be low due to perceived safety concerns from women/partners that intervention may be difficult to get
 - If the birth centre is DHB owned and along the corridor, then benefits would not be realised
 - Possible issue with shifting of resources (primary to secondary) if DHB owned/managed
 - Possible lack of commitment to use birth centre by midwives
 - Ensuring criteria is appropriate balance between access to the birth centre and safety
 - Facility concerns design may not have sufficient input / consultation or enough capacity especially if a postnatal service is provided
 - Secondary service midwife staffing levels may be inadequate due to recruitment and retention issues and/or reduction in staffing levels which may be insufficient for the complex caseload
 - Potential decrease in Levin and Dannevirke primary unit volumes
14. Are there other important concerns that have not been listed above?
15. Please name up to three factors/characteristics that you think are critical in making a birth centre in Palmerston North successful
16. Do you have any other comments?

Appendix C – Consumer survey questions

1. *What is your full name?
2. *What is the street address where you currently live?
3. *In which locality (district council area) is your address?
 - Palmerston North City, Manawatu district, Tararua district, Horowhenua district, Kapiti Coast district, Other or unsure
4. If your address is outside the MidCentral DHB area, have you used MidCentral DHB maternity services in the past or do you expect to use them in the future?
 - Yes, No, Other (please specify)
5. *What is your age?
 - Under 20 years, 20-24 years, 25-29 years, 30-34 years, 35-39 years, 40 years or over
6. *What is your ethnicity?
 - Māori, Asian, Pasifika, European, Other
7. *What is your gender?
 - Female, Male
8. *Are you currently expecting a baby?
 - Yes, No
9. *How many children do you have?
 - None, 1 or 2, 3 or more

About a birth centre

In New Zealand the options for giving birth are at home, a birth centre or a secondary / tertiary hospital. Women living in Palmerston North have the choice of home or Palmerston North Hospital (a secondary hospital).

Birth centres are run and staffed by midwives and are designed for well women who have uncomplicated pregnancies. Giving birth in a birth centre has many advantages for women and families – the environment supports keeping birth normal and there is less likelihood of interventions. Birth centres are funded by the DHB and are free to women.

Features of a birth centre are listed below followed by some images. Women with pregnancy complications and/or needing the care of specialists are advised to give birth in a secondary hospital.

Features of a birth centre	
Generally have a more relaxed and 'home-like' atmosphere than larger secondary or tertiary hospitals. Some have accessible outdoor areas.	Partners are able to stay the first night after the birth and are encouraged to be involved. There are long visiting hours for family.
Rooms are likely to be spacious and have an ensuite. The bed is not the focus in the birthing room and there are birthing pools and a range of birthing aids. Postnatal rooms may have double beds.	There is emphasis on providing support after the birth including help with breastfeeding and transition to parenting.

APPENDIX C – CONSUMER SURVEY QUESTIONS

Pain relief options include entonox, water and wheat bags. There are no epidurals or caesareans provided.	Most offer post-natal services for women birthing at the hospital.
Women are transferred if they need secondary services e.g. caesarean section (like occurs for women birthing in Dannevirke and Levin).	Birth centres can be 'standalone' or 'co-located' with other services such as pregnancy and parenting classes, midwifery clinics etc.
There is up to date resuscitation equipment and other equipment necessary if there are any problems.	Birth centres are hospitals. The facility must meet all standards applicable to hospitals and service delivery must meet quality and safety standards.

Warkworth



River Ridge East (Hamilton)



10. *Participants at consumer focus groups talked about problems that a birth centre may help to resolve. To what extent do you agree with the following statements? Strongly disagree, Disagree, Agree, Strongly agree, Don't know
- The hospital is clinical, scary, noisy and not conducive to normal birth
 - There is not enough privacy during labour/birth at the hospital
 - Partners need to be involved more - they should be able to stay the first night
 - Not enough space for family/whanau and restrictive visiting hours. Needs to be more family orientated.
 - Birth has become too medicalised and is not viewed as normal, affects woman's confidence
 - Women sometimes leave the hospital too early, either because they don't like the environment or they feel pressured to
 - There needs to be more help with breastfeeding and transition to parenting
 - There is a lack of choice for women in Palmerston North, there needs to be an in-between option between home and hospital
 - Test box - List any other problems or write additional comment
11. *If you were to have a baby and were informed that you (or partner) were low risk and could choose the place of birth, would you consider a birth centre in Palmerston North as a potential option?
- Yes
 - Maybe
 - No - I would prefer to birth at home
 - No - I would prefer to birth at the hospital
12. If you answered Maybe or No to the last question, is there anything that would make you more likely to consider a birth centre as an option?
- Text box for answer

13. *Where do you think is the best location for a birth centre? Rank the locations between 1 and 4 in order of preference using 1 for your top preference.
- Palmerston North city anywhere
 - Palmerston North city within 5 – 10 minutes of the hospital
 - On the hospital campus as a standalone building
 - On the hospital campus co-located with the secondary care maternity service
14. * If you (or partner) were to have a baby at Palmerston North Hospital, would you be interested in transferring to a birth centre for post-natal care?
- Yes, No, Maybe
 - Text box for additional comment
15. Participants at consumer focus groups identified factors/characteristics they thought were necessary for a birth centre to be successful. How essential do you think these factors are? Please rate on a scale of 1 to 7, with 1 being 'Not essential' and 7 being 'Imperative'.
- The facility should provide a home-like, relaxing and private environment to give birth. It should not look like a hospital
 - There should be ready access to a range of birthing aids such as pools, balls and stools
 - Women should have their own room with an ensuite and double bed for their partner to stay over
 - There should be lots of support postnatally - breastfeeding and parenting skills
 - Partners/family should feel welcome and included. Relaxed visiting hours
 - Adequate and free parking
 - The transfer process needs to be efficient and seamless
 - Midwives working at the birth centre should have a philosophy based on normal birth
 - The length of stay should be long enough to allow mothers to feel confident with feeding / caring for their baby
 - Midwives who are keen to use the birth centre because they discuss the options with women
 - Text box - List any other characteristics that you think are important or provide additional comment
16. *It has been suggested that the birth centre should be co-located with a range of complementary services (e.g. maternity information, pregnancy and parenting classes, midwifery clinics, support groups, alternative services) for reasons of normalising the service, raising visibility and cost-effectiveness. Please rate the importance of the birth centre sitting within a hub of services.
- Not important at all, Somewhat important, Important, Very important
 - Text box for additional comment
17. *What is your opinion about whether women having a low-risk pregnancy would utilise a birth centre in Palmerston North?
- Most women I know are really keen – the majority would use
 - Demand would increase over time based on reputation
 - A minority would use – most want the security of a hospital
 - Unsure
 - Text box for additional comment
18. Please describe any concerns you have about a birth centre
19. Do you have any other comments?