birth place lab

CHANGING CHILDBIRTH

in British Columbia

www.birthplacelab.org/
changing-childbirth-in-british-columbia

This community-based participatory action research project was originally funded by the Vancouver Foundation and Phase 2: analysis and knowledge translation activities are being funded by the Michael Smith Foundation for Health Research's Health Professional-Investigator Award. We are grateful to Perinatal Services BC for financing the analysis, staff time and community engagement activities to produce this report.

FULL REPORT

CONTENTS

ACKNOWLEDGEMENTS 3
INTRODUCTION 4
The context for maternity care in British Columbia 4
METHODS 5
Survey construction 5
Recruitment 5
Sample 6
Data considerations 7
Scale development 8
Data Analysis 9
Focus Groups 9
RESULTS 10
Sample characteristics 10
Care provider type, prenatal care and place of birth 10
Choosing a prenatal Care Provider 10
Choice of birth place 11
Choice of provider 12
Time allotted for prenatal care 12
Preferences for care 13
Decision-making during maternity care 14
Involvement in decision-making 15
Decisions about interventions and procedures 16
Respectful maternity care 17
Experiences of autonomy and respect, for selected subpopulations 18
Autonomy and respect for women with and without pregnancy complications 19
Quotes on experiences of disrespect and lack of involvement in decision-making 20
Experiences of care among vulnerable populations 22

Focus groups with vulnerable women 24
Access to Maternity Care 25
Rural Experiences 25
Knowledge of Midwifery Care 25
Changing Childbirth in BC - Open-ended responses from survey 28
Choice 28
Choice of birth place 28
Experience with Heath Care Providers 28
Support in Birth 29
Next Steps 29
REFERENCES 30
THANKS 31
FUNDERS 31

ACKNOWLEDGEMENTS

We are extremely grateful to all the people across British Columbia who took the time to share their experiences of maternity care, and in particular the community members who helped improve the survey by sharing their knowledge during the content validation process.
We are also indebted to the Vancouver Foundation, the Michael Smith Foundation for Health Research for the generous support to the Birth Place Lab that allowed the development and analysis of this project and Perinatal Services BC for support for preparing this policy report.
We are grateful to the larger team that contributed to this work: our community partners throughout BC, the multi-disciplinary Changing Childbirth in BC Steering Council, and the staff and students at the Birth Place Lab at the University of British Columbia, for their work on the development, recruitment, analysis and dissemination of this project.

Recommended citation for this report:
Changing Childbirth in British Columbia
Birth Place Lab, University of British Columbia, February 2019

To access the full report and related resources:
www.birthplacelab.org/

For support interpreting or using this report please complete the contact form at this link:
https://www.birthplacelab.org/contact-us/

Or email: birthplace.lab@ubc.ca
The authors declare that they have no conflicts of interest with regard to this report.

Birth Place Lab
E418 Shaughnessy Building,
Oak Street, Vancouver, British Columbia,
Canada, V5Z 1M9

Related Publication

Vedam S, Stoll K, McRae D, Korchinski M, Velasquez R, Wang L, Partridge S, McRae L, Elwood Martin R, Jolicoeur G & the CCinBC Steering Committee (in press). Patient-led decision making: Measuring autonomy and respect in Canadian maternity care. *Patient Education and Counseling*.

INTRODUCTION

High quality, respectful maternity care (RMC) is a global priority. In 2016, the World Health Organization (WHO) published eight standards for quality of maternal and newborn care that can be used to evaluate "the extent to which health care services provided to individuals and patient populations improve desired health outcomes and [is] safe, effective, timely, efficient, equitable and people-centred".[1] Four of the standards emphasize the judicious use of evidence-based practices alongside care that prioritizes respect, dignity, emotional support, and patient-led, informed decision-making. It is unclear whether the BC maternity care system meets these standards. Specifically:

- *Do childbearing women in Canada lead decisions around their care, do they feel pressured into accepting interventions, and do care providers respect their preferences?*
- *Does poor treatment link to adverse outcomes?*
- *Do patients who experience mental illness, poverty, or other vulnerabilities during pregnancy report different levels of access to high quality, respectful care?*

In 2009, the Canadian Maternity Experiences Survey (MES) showed higher use of obstetric interventions than evidence-based recommendations, especially among socially disadvantaged women. The Organization for Economic Co-operation and Development (OECD) ranked Canada last among 22 high resource countries on obstetric trauma.

In the last decade, there has been a shift towards using patient experiences as indicators of quality, resulting in new patient-oriented instruments that measure the impact of models of care on quality, safety and cost-effectiveness. Thus, in the ***Changing Childbirth in BC*** study we employed both conventional and community-based participatory research methods to evaluate women's experiences and preferences for care, access to care and their knowledge of maternity care options. We also assessed whether the experience of respectful, person-centred maternity care in British Columbia (BC) differs by socio-cultural factors, comorbid conditions, provider, place of birth and/or other factors.

The context for maternity care in British Columbia

Pregnant women in BC can choose from three types of providers: obstetricians, midwives, and family physicians. Most women see physicians during pregnancy in BC, but as of 2016, 21% receive prenatal and birth care from midwives[2]. Midwives were added to the register of regulated providers in BC in 1998 because of widespread community-based advocacy for inclusion. Patient-centred care was described in the 2014 British Columbia Ministry of Health's strategic plan as a key priority for the provision of healthcare[3]; yet very little is known about how women, including disadvantaged women, experience maternity care in BC. This is the first provincial study to elicit person-centred outcomes of pregnancy and childbirth. In addition, since the inclusion of midwives, there have been limited opportunities for women to evaluate their experiences of maternity care or level of access to different models of care.

METHODS

In 2013, a Vancouver Foundation grant supported The Birth Place Lab team to initiate *Women taking Charge of Changing Childbirth*, a community-based, participatory action provincial research project. The resulting mixed-methods study was designed by women of childbearing age from different cultural and socioeconomic backgrounds [4,5]. A community consultation with 1333 women determined the research questions and data collection modalities (which were an online survey and focus groups). The community members chose to explore women's preferences for care, their lived experience of maternity care, including the process of decision-making, and access to maternity care across BC.

Survey construction

A multi-stakeholder Steering Council collaborated to develop and content validate a core set of 310 survey and focus group questions. The team then supplemented the core survey tool with targeted items to capture unique aspects of care, access, potential barriers to accessing care, and preferences that were germane to lived experiences among women from three disadvantaged communities: recent immigrants and refugees, formerly incarcerated women, and those who have experienced homelessness and/or substance use. All versions were embedded into an online platform and beta and pilot-tested by community members from the target populations before distribution. Details on women-led survey construction and content validation are published elsewhere[4,5]. The Behavioural Research Ethics Board at University of British Columbia approved the study (H12-02418).

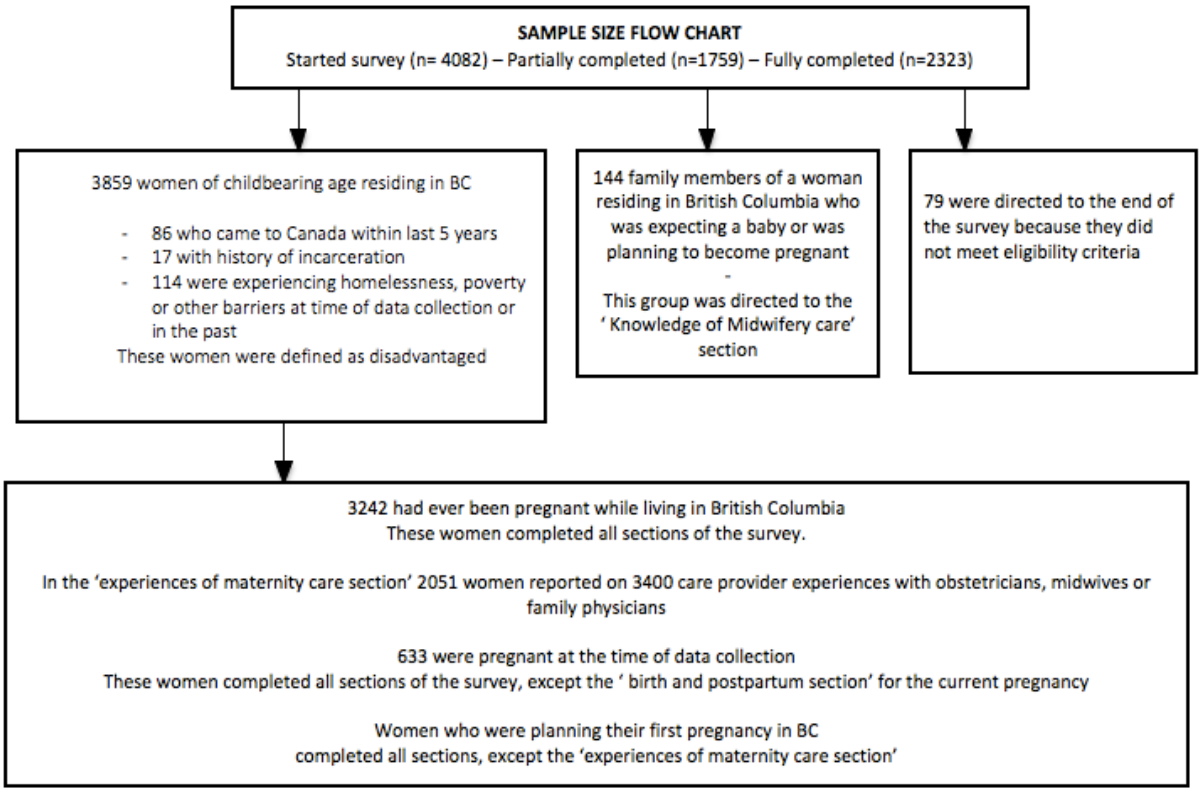
Recruitment

In 2013, community partners recruited participants through social media channels, postcards and posters at clinics, targeted invitations from settlement counselors and clinicians who served special populations, as well as snowballing via the pregnancy community and neighborhood groups, e-list-serves, local pregnancy and parenting vendors, conferences and fairs. Recruitment was robust, with over 4000 community members across all health authorities providing survey data and 1100 women volunteering to participate in focus groups (see figure 1) and provide their contact information.

To effectively manage this overwhelming response, the team built community capacity by training 33 focus group facilitators who led 20 focus groups with women in rural and urban locations (Vancouver Island, Northern BC, Interior, and the Lower Mainland), including disadvantaged women. Focus groups were planned in communities with the highest demand and the e-mail addresses that women provided at the end of the survey were used to recruit women to the groups.

Community-led analysis of focus group transcripts are underway (estimated time of completion is Summer 2019).

Figure 1: Sample size flowchart

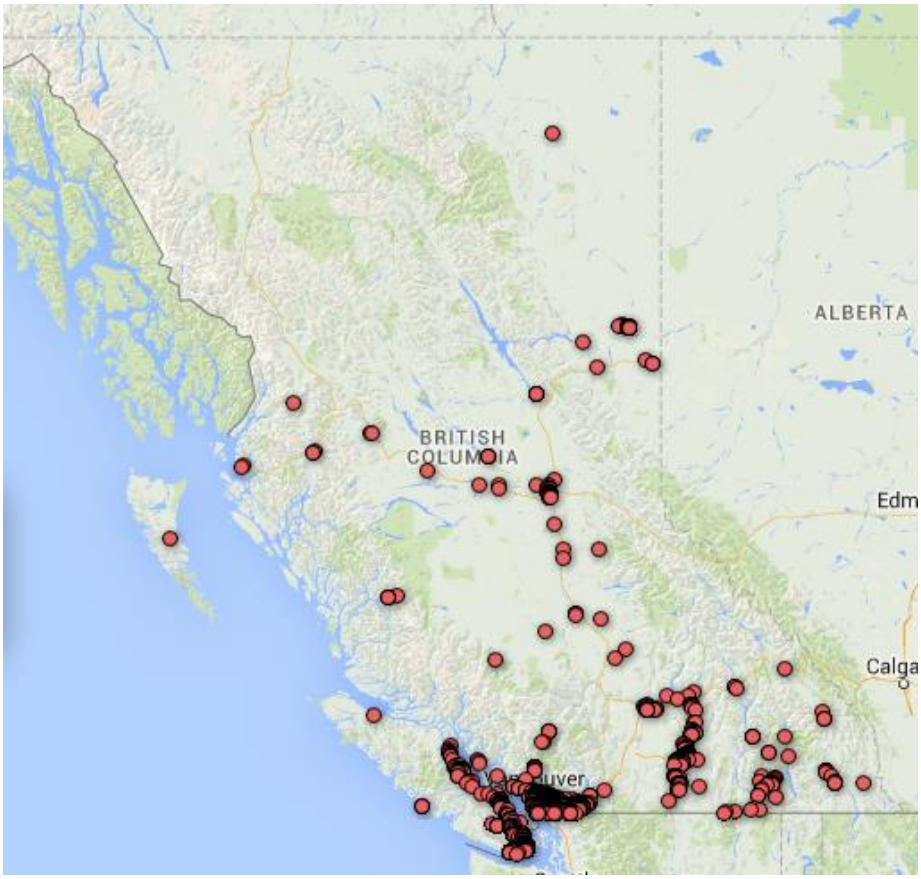


Sample

The survey was open to women who had experienced pregnancy while living in BC, their family members, as well as women residing in BC who were planning to become pregnant. Family members completed only one section of the survey (knowledge of midwifery care), and women planning pregnancy reported on their preferences for care but not experiences. Women who had given birth in BC were able to report on their experiences during up to 3 pregnancies. For each pregnancy/birth they were able to describe their interactions with up to three maternity care providers.

Women were asked to provide their postal code and the name of their community. Based on this data, we established the proportion of childbearing women who responded from different health authorities/areas of BC: 702 (28.6%) responded from Vancouver Coastal, 717 (29.3%) from Fraser, 537 (21.9%) from Vancouver Island, 360 (14.7 %) from the Interior and 135 (5.5%) from Northern Health Authority.

Figure 2: Location of respondents



Data considerations

The focus of this report is the experiences of women who have ever been pregnant while living in BC and received maternity care from obstetricians, family physicians, or midwives. In the ***Changing Childbirth in BC*** study, 2051 women completed all sections of the online survey and reported on their experiences during 3400 pregnancies. Women also answered questions about their preferences for maternity care; access to maternity care; experiences with maternity care; and knowledge of midwifery care. They provided information about their pregnancy (e.g. health status, singleton or twins), birth (mode of delivery, procedures), and the postpartum period (postpartum maternal or newborn health).

Women who were pregnant at the time of data collection provided data on all sections of the survey, except the 'birth and postpartum section' for the current pregnancy. Though not all women completed all items on the survey, over 2900 completed at least some sections of the survey (including items measuring preferences and choice) resulting in variable denominators for most analyses. Some variables such as parity and maternal age at birth could not be extrapolated from survey responses, because women reported on multiple pregnancies and we did not ask for parity or age for each pregnancy. Details on survey construction, and content validation of key findings, and reliability and validity testing, including controlling for sample characteristics, are available in recently published literature.[6,7]

Scale development

Initial analysis of survey data resulted in the development and validation of two scales that measure the degree of *Mothers' Autonomy in Decision Making (MADM)* and women's experience of respectful maternity care – the *Mothers on Respect index (MORi)* [4,5]. Higher scores indicate that women reported greater agency in decision-making and received more respectful care. Both scales are reliable measures that have been applied in middle and high resource countries to assess the quality and safety of provider-patient relationships and person-centred maternity care [8,9]. The final MADM scale and MOR index items are presented in Tables 1 and 2, and the tools are available online at www.birthplacelab.org/tools.

Table 1: Mothers' Autonomy in Decision Making (MADM) scale

Please describe your experiences with decision making during your pregnancy, labour and/or birth. (select one option for each)						
	Completely Disagree	**Strongly Disagree**	**Somewhat Disagree**	**Somewhat Agree**	**Strongly Agree**	**Completely Agree**
My doctor or midwife asked me how involved in decision making I wanted to be.	1	2	3	4	5	6
My doctor or midwife told me that there are different options for my maternity care.	1	2	3	4	5	6
My doctor or midwife explained the advantages/ disadvantages of the maternity care options.	1	2	3	4	5	6
My doctor or midwife helped me understand all the information.	1	2	3	4	5	6
I was given enough time to thoroughly consider the different care options.	1	2	3	4	5	6
I was able to choose what I considered to be the best care options.	1	2	3	4	5	6
My doctor or midwife respected my choices.	1	2	3	4	5	6
	SUM OF ALL CIRCLED ITEMS = TOTAL SCORE:					

Table 2: Mothers on Respect index

A: Overall while making decisions about my pregnancy or birth care: (select or circle one answer for each statement)

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
I felt comfortable asking questions	1	2	3	4	5	6
I felt comfortable declining care that was offered	1	2	3	4	5	6
I felt comfortable accepting the options for care that my doctor or midwife recommended	1	2	3	4	5	6
I felt pushed into accepting the options my doctor or midwife suggested	6	5	4	3	2	1
I chose the care options that I received	1	2	3	4	5	6
My personal preferences were respected	1	2	3	4	5	6
My cultural preferences were respected	1	2	3	4	5	6
	SECTION A TOTAL SCORE:					

B: During my pregnancy I felt that I was treated poorly by my doctor or midwife because of: (select or circle one answer for each statement)

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
My race, ethnicity, cultural background or language*	6	5	4	3	2	1
My sexual orientation and / or gender identity*	6	5	4	3	2	1
My type of health insurance or lack of insurance*	6	5	4	3	2	1
A difference of opinion with my caregivers about the right care for myself or my baby*	6	5	4	3	2	1
ADD ALL SCORES IN SECTION B:	SECTION B TOTAL SCORE:					

C: During my pregnancy I held back from asking questions or discussing my concerns because: (select or circle one answer for each statement)

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
My doctor or midwife seemed rushed*	6	5	4	3	2	1
I wanted maternity care that differed from what my doctor or midwife recommended*	6	5	4	3	2	1
I thought my doctor or midwife might think I was being difficult*	6	5	4	3	2	1
ADD ALL SCORES IN SECTION C:	SECTION C TOTAL SCORE:					

Data Analysis

We report on descriptive analyses in this report, i.e. medians, means and proportions. Although women completed the MADM scale and MOR index for up to three pregnancies, we only report MADM and MORi scores for one pregnancy per woman. We have also analyzed factors that are associated with women's experiences of autonomy and respect, using the full dataset (i.e. MADM and MOR scores for all pregnancies and for up to three care providers). We used mixed effects Poisson regression modelling, to control for women reporting on multiple pregnancies and providers. Findings from these analyses will be published in academic journals.

Focus Groups

Because of the low response rate of women from visible minorities and women who experience multiple barriers, we convened targeted focus groups of recent immigrants and refugees, and women who faced multiple barriers such as homelessness, or substance use, or history of incarceration. Community-led analysis of focus group transcripts is underway. A first round of coding was conducted, in which members

of each community group were selected and trained to code the data inductively. They were given training in NVIVO software and were provided with a coding framework. Some coders chose to follow the framework, and others created their own codes. Most coders added new categories that had not been elicited by researchers in the preliminary codebook, creating 15 new codes. A second cycle of coding is currently underway in order to synthesize the findings and create a more robust analysis. Thematic analysis will follow. We have integrated selected focus group quotes throughout the report, to use the voices of women to highlight quantitative findings.

RESULTS

Sample characteristics

The survey respondents were representative of the geographic and socio-economic profile of childbearing women across the province. There was a larger proportion in the sample of women who had experienced some midwifery care than reflected in provincial data. To address the issue of overrepresentation of midwifery clients, we break down results by care provider type for selected findings.

Care provider type, prenatal care and place of birth

Of 3400 primary care provider experiences, 2071 had midwives, 772 were cared for by family physicians, 557 identified obstetricians as their primary maternity provider. Of the total sample 303 (14.8%) women were pregnant at the time of data collection. Most women (1672, 81.5%) saw a single type of maternity care provider during pregnancy; the remainder (379, 18.5%) saw two or more.

Choosing a prenatal Care Provider

Women who had already experienced pregnancy (n=2942) and those planning to become pregnant (n=271) were asked how they chose/would choose a prenatal care provider, and where they got information on the available options. Information shared by friends was the most prevalent driver, and books about pregnancy and online resources were common sources of information that women referred to when choosing prenatal care providers. See a full list of responses in Table 3.

Table 3: When I was choosing my prenatal care provider I considered what I learned from:

Check all that apply:	**n=2942** n (%)	**n=271** n (%)
Friends	2127 (72.3)	226 (83.4)
Books about pregnancy and birth	1449 (49.3)	181 (66.8)
Online connections (websites, parenting forum members)	1189 (40.4)	137 (50.6)
My family doctor	1083 (36.8)	161 (59.4)
Other family members	864 (29.4)	141 (52.0)
My/my partner's previous birth experiences	834 (28.3)	--
My parent(s)	792 (26.9)	165 (60.9)
Co-workers	604 (20.5)	120 (44.3)
Other _____	396 (13.5)	33 (12.2)
Community Health Service	279 (9.5)	91 (33.6)

Having a provider who shares the same values and can meet the woman's preferences was the most important factor when choosing a maternity care provider.

> *"I think the most important part about finding a care provider is finding someone whose values are in line with yours; who wants the same thing that you do for your pregnancy and labour and delivery"*
> (Speaker 2, in May 2nd, 2014 focus group).

Half of participants preferred a female provider and half reported that the delivery hospital played a role in choosing a provider. Recommendations from health professionals and online ratings were not often reported as major factors (see Table 4).

Table 4: Factors women consider when choosing a maternity care provider.

The maternity care provider...	**Major factor** n (%)
Was a good match for what I value and want	2559 (87.7)
Is female/included female providers	1591 (54.6)
Attends births at a hospital I like	1399 (48.0)
Provided my prenatal care in a previous pregnancy	1086 (37.2)
Was recommended by a health professional	702 (24.0)
Is highly rated on websites with information about specific care providers	488 (16.7)
Was assigned to me as my maternity care provider	386 (13.3)
Had provided my well-woman (gyn) care	353 (12.1)

Response options: Major factor, minor factor, not a factor

Choice of birth place

The majority planned a hospital birth (1209, 69.8%), and 140 (8.1%) had planned a home birth but transferred to hospital. Of the 365 (21.1%) women who gave birth at home, 337 (19.4%) had a planned home birth and 28 (1.6%) an unplanned home birth. The remainder (19 women) delivered in other settings (e.g. a health centre or en route to the hospital) or checked 'Other'. Birth at home or in a birthing centre were popular options for women with previous birth experiences (see Table 5).

Table 5: “For any future births, how open would you be to giving birth?”

Respondents who have pregnancy experience	**Definitely would not want this** n (%)	**Would consider this** n (%)	**Definitely would want this** n (%)	**Not sure** n (%)
In a birth centre that is separate from a hospital	718 (28.5)	1407 (55.8)	288 (11.4)	109 (4.3)
At home	959 (38.0)	729 (28.9)	727 (28.8)	109 (4.3)
In a hospital	745 (29.6)	1142 (45.3)	561 (22.3)	71 (2.8)

Never pregnant before	**Definitely would not want this** n (%)	**Would consider this** n (%)	**Definitely would want this** n (%)	**Not sure** n (%)
In a birth centre that is separate from a hospital	70 (26.3)	175 (65.8)	14 (5.3)	7 (2.6)
At home	101 (37.8)	94 (35.2)	67 (25.1)	5 (1.9)
In a hospital	46 (17.2)	154 (57.7)	62 (23.2)	5 (1.9)

Excludes women who do not want to have any more biological children

Choice of provider

Women without prior pregnancy experiences were also very interested in home and birth centre options (see Table 5). Birthing centres are not available in BC currently, but findings from the survey show strong consumer interest in this option. Similarly, midwifery care is often difficult to access because of strong consumer demand or lack of midwifery services (see access section and the results of the thematic analysis of open-ended comments from the end of the survey).

“I did initially get a midwife but they were all booked up [agreement]. I found there was not enough midwives to go around, and I would have had to travel a really long way to get, the first I had, and this was seven years ago, my first pregnancy was longer ago and um, so I tried to get a midwife, couldn’t get one” (Speaker 4 in May 2nd, 2014 focus group).

Time allotted for prenatal care

Women under the care of physicians reported that their prenatal appointments were, on average less than 30 minutes long; 40% of physician patients reported appointments lasted less than 15 minutes, on average. The majority of midwifery clients reported that appointments lasted from 30-60 minutes. While 1 in 3 women who saw physicians found that prenatal appointments were too short, less than 2% of midwifery clients found appointments too short. Women’s perceptions about length of prenatal appointments are reported in Table 6.

Table 6: Women's perceptions about length of prenatal appointments (n=2051)

How long were your prenatal appointments, on average?	**Full sample** n (%)	**Family physician** n (%)	**OB** n (%)	**Midwife** n (%)
<15 minutes	313 (15.3)	170 (41.5)	131 (41.9)	12 (0.9)
15 – 30 minutes	781 (38.1)	206 (50.2)	145 (46.3)	430 (32.5)
30 – 60 minutes	904 (44.1)		22 (7.0)	857 (64.7)
I felt that my prenatal appointments were:				
Too long	42 (2.1)	5 (2.1)	5 (1.6)	32 (2.4)
Just right	1722 (84.1)	269 (65.6)	201 (64.2)	1252 (94.5)
Too short	240 (11.7)	125 (30.5)	92 (29.4)	23 (1.7)

Preferences for care

All women (regardless of reproductive history) were eligible to answer questions about preferences for care. Of the women who filled out the preferences section, 2723 (85.7%) had given birth in the past; 442 (13.9%) had never given birth and 12 (0.4%) had a miscarriage or fetal loss during one or more pregnancy. At the time of data collection, 572 (18.0%) were pregnant. In Table 7 we report the proportion of women who agreed or strongly agreed that the following are important for their maternity and newborn care. The top five were: (1) having a trusting relationship with the care provider, (2) having enough time to ask questions and discuss options, (3) not being separated from my baby after birth, (4) having support people present for labour and birth, and (5) leading decisions about pregnancy, birth and baby care.

Table 7: Rank-ordered responses to the question: What is most important to you for your maternity and newborn care? (n=3183)

	n (%)
Having a trusting relationship with my care provider	3140 (98.6)
Having enough time to ask questions and discuss my options	3116 (98.0)
Not being separated from my baby after birth	3083 (97.0)
Having support people of my choice present for labour and birth	3058 (96.2)
I lead the decisions about my pregnancy, birth and baby care	3007 (94.5)
Having a care provider who speaks my language	2916 (91.9)
Knowing the doctor/midwife who will care for me during my birth	2908 (91.4)
Choice of birthplace (home or hospital)	2823 (88.7)
Staying in my community for pregnancy and birth	2663 (83.9)
Having a provider who has expertise with natural methods for pain relief	2576 (80.9)
Having a provider who will do newborn care/breastfeeding support at my home	2563 (80.7)
Having no more than 4 providers care for me	2511 (79.0)
Having only one provider care for me	1766 (55.6)
Having a provider who has expertise with high-risk pregnancies	1728 (54.3)
My doctor or midwife guides the decisions	1537 (48.4)
Having access to medicines for pain relief	1365 (43.0)
Having a pain-free birth	627 (19.7)
Being cared for by my own family doctor	565 (17.8)
Being able to choose a planned caesarean	450 (14.2)

Decision-making during maternity care

When asked who usually makes decisions about pregnancy, birth and infant care, 61.7% said that they make decisions together with their partner, and 58.7% said they are the sole decision makers. Very few women said their partners or elder family members take the lead in decision-making (0.3%) (see Table 8).

Table 8: Who usually makes decisions about pregnancy, birth, and infant care? (e.g., choice of provider, types of prenatal tests, birth location, etc.) (n=2941)

Check all that apply:	n (%)
I do	1727 (58.7)
My partner takes the lead	3 (0.1)
My partner and I make the decision together	1814 (61.7)
My parents/elders lead the decisions	7 (0.2)
My partner and I make the decisions together with our elders	15 (0.5)
Other, please explain: _____	55 (1.9)

Almost all women had a strong preference for leading decisions around options for care (see Tables 8 and 9). A little less than half also highly valued the input of their provider. Only 10 participants indicated that leading decisions was not important to them.

Table 9: Women's preferences for role in decision-making (n=2051)

	n (%)
It is very important or important to me that I lead the decisions about my pregnancy, birth and baby care	1952 (95.2)
It is very important to me that I lead the decisions	1440 (70.2)
It is very important or important to me that my doctor or midwife guides the decisions	970 (47.3)
It is not very important to me that that I lead the decisions	10 (0.5)

Involvement in decision-making

When assessing the degree to which care providers involved women in decisions about their care, this study identified several gaps in the provision of person-centred maternity care. For example, 18% of women reported that their care provider did not tell them about different options for care (46% of OB patients and 5 % of midwifery clients), 19% said that their care provider did not explain the advantages/disadvantages of maternity care options (44% of OB patients and 6% of midwifery clients). One in seven women were not given enough time to thoroughly consider their options (37 % of OB patients and 4% of midwifery clients).

> *"It's my body. It's my baby. How do I want this process to happen to me. In my mind, you know, maybe I'm a little bit naïve, but women have been having babies since the beginning of time. You know, I'm not sick. Just help me through the process; I need some support. Yeah, I got it. Yeah, but so many women— Like friends of mine that just went to their family doctors, when I was talking to them about, 'Did you get offered this? Did they tell you the reason why you need to do this? Or inject the baby, or inject you? Are you okay with that?' She said, 'No-one ever asked me. They just did it.' So you've got no control over your body. Surely that's not right."* (Speaker 9, Immigrant Women focus group, April 29, 2014).

Table 10: Proportion of women who disagreed with items in the MADM scale

	Total n	n (%)
My ____ asked me how involved in decision making I wanted to be	1855	357 (19.2)
My ____told me that there are different options for my maternity care	1875	334 (17.8)
My ____explained the advantages/disadv. of the maternity care options	1854	343 (18.5)
My_____ helped me understand all the information	1925	234 (12.2)
I was given enough time to thoroughly consider the different care options	1875	266 (14.2)
I was able to choose what I considered to be the best care options	1920	222 (11.6)
My ____ respected that choice	1870	160 (8.6)

The items listed in table 10 were summed for women who completed all items of the scale (n=1705), to generate an overall scale score (MADM score). Women reporting on their experiences with decision-making with midwives had higher median MADM scores compared to women who reported on experiences with physicians (41 versus 32).

Decisions about interventions and procedures

In this sample overall, one in five women (n=368, 20.8%) had a caesarean section and 332 (18.8%) women reported that their labours were induced. Despite their reported preferences for being the lead decision maker, when asked whose idea it was to have the caesarean section, 66.9 % of them reported that a care provider recommended the procedure before or during labour. Overall, 120/1754 women (6.8 %) 'felt pressure' from a health professional to have epidural anesthesia, 277/1756 (15.8 %) felt pressured to have their labour induced, and 194/1754 (11.1%) felt pressure from a healthcare provider to have a caesarean section. When restricting this analysis to women who had an induction or caesarean section, 179/332 women (53.9 %) felt pressured to accept induction of labour and 141/368 (38.3%) reported feeling pressure to agree to caesarean surgery.

> *"I remember, the midwife was there, but the OB was saying, 'You're never gonna, if you don't let us … just take some drugs. Don't try to be a hero.' Like, I don't want to be a hero; I just want a natural … I don't feel the need to. I know I can do it. And they're like, 'Well, if you don't take any drugs, you are not going to relax and you're never going to get this kid out.' And I remember thinking, like, at that moment when I'm in intense pain and like, that was not helpful to me at all. And I remember just feeling like if I say I don't want it, I don't want it. And you can offer it to me, and that's fine. I said, 'No.' Like that whole, don't try to be a hero thing. I found that degrading." (Speaker 2, Current and Potential focus group, May 2nd, 2014).*

> *"Not only did I feel like I did not [have] the ability to speak up during my care, I felt as though I was directly disrespected by my obstetrician when I DID speak up. I was induced using cervidil. The attempted removal of the cervidil (though actually, as it turns out it had fallen out on it's own) was the single most painful thing I've ever been through, far surpassing any other part of my labour. I was literally begging the OB to STOP, and she did not even acknowledge me let alone actually stop. I felt assaulted, fearful and unsafe, and I have no doubt now that it is the thing which ultimately halted my labour completely, leading to my eventual c-section."(comment from survey)*

Women were asked whether at any time they refused to accept any care that a nurse, doctor or midwife offered to them or their baby. "Care" was defined for women as anything that might be done or given to either of you or that you were asked to do (take a test, treatment, medicine, etc.).

Of the 2051 women, 892 responded in the affirmative (45.6 %). Women who answered yes to the question were then invited to provide open-ended comments describing what they refused, why they refused it, how the staff reacted, and how they felt about it. Thematic analysis of these comments are currently underway.

Respectful maternity care

Respectful maternity care was measured by the MOR index (see Table 2) where women rated their level of agreement with 14 statements about their interactions with care providers. Overall, most women in BC reported being comfortable asking questions and accepting options that their care provider recommended. Women reporting on their experiences with respectful maternity care with midwives had similar median MORi scores as women who reported on experiences with physicians (median MORi score for midwifery clients was 14, compared with 13 for family physician and obstetrician clients, n=934). Fewer were comfortable declining care that was offered and 13% felt coerced into accepting options their care provider suggested (9.7% of midwifery clients, 19.4 % of family physician patients and 23.8% of OB patients). Poor treatment by care provider because of women's race, ethnicity, sexual orientation, gender identity or type/lack of health insurance were rare, but 8.5% of women felt that they were treated poorly because of a difference in opinion with their caregivers about the right care for themselves or their baby. Approximately one in 10 women held back questions more than once during prenatal appointments because their care provider seemed rushed.

Figure 3: Percent of women who felt coerced into accepting options their care provider suggested, stratified by provider type.

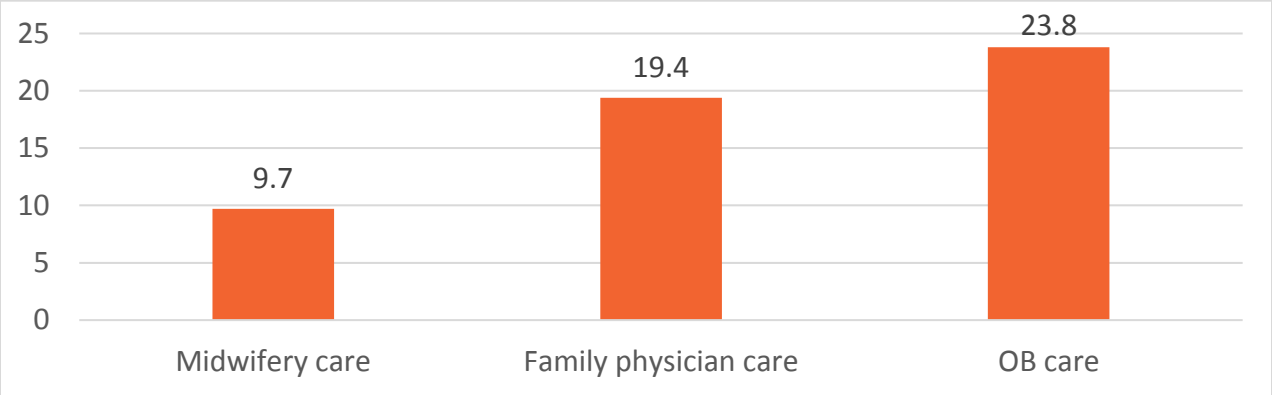
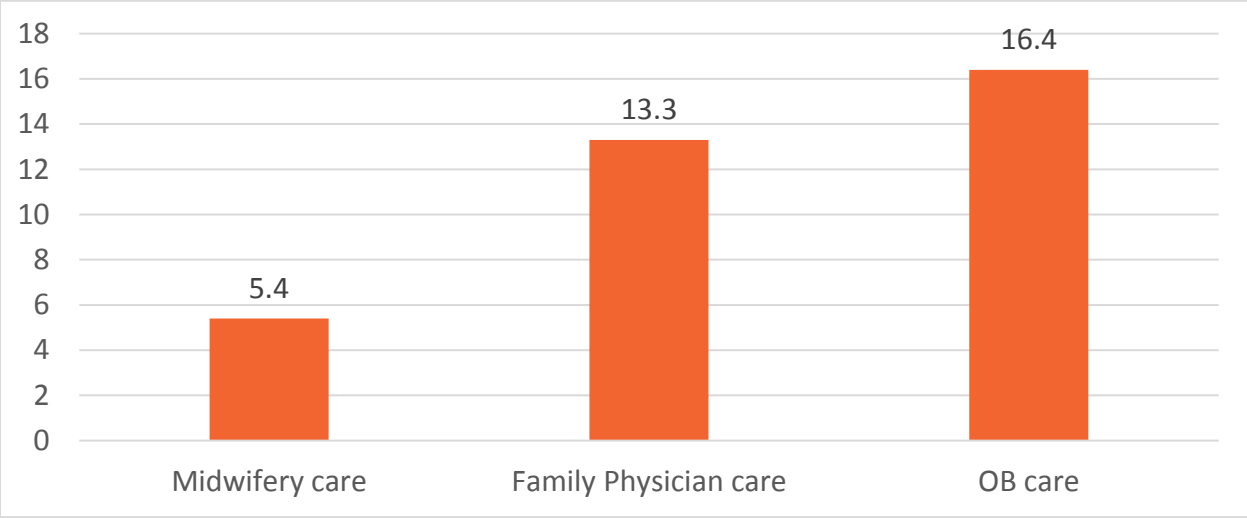


Figure 4: Percent of women who reported that they were always, often or sometimes treated poorly by their care provider because of a difference in opinion about the right care for themselves or their babies, stratified by provider type.

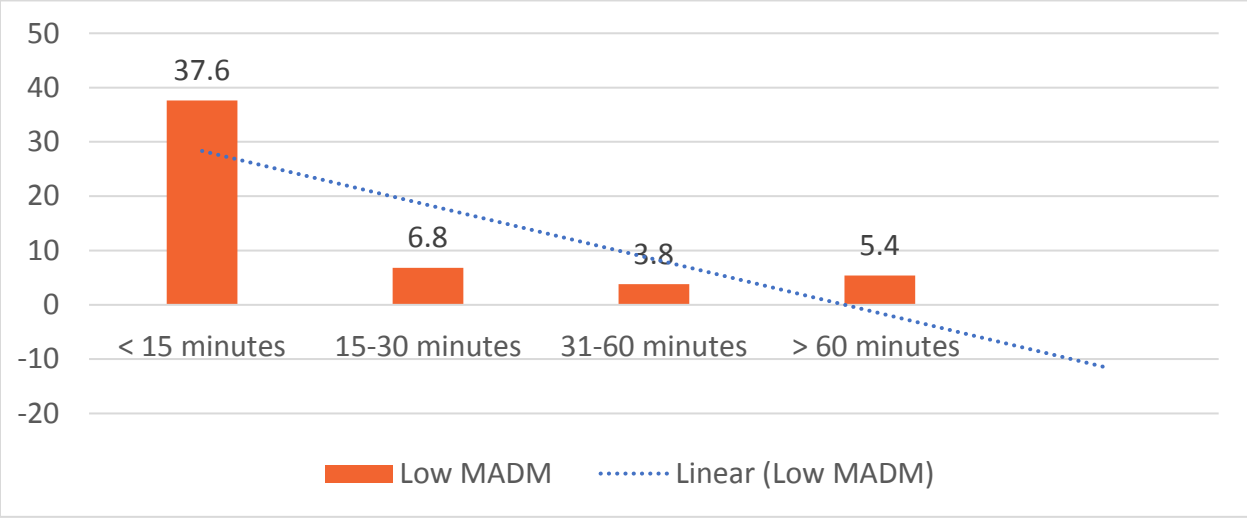


Experiences of autonomy and respect, for selected subpopulations

When examining women who scored in the bottom 10th percentile of the scores for the MADM scale and MOR index (i.e. women who reported the least autonomy and respectful care) (see Figure 3 and 4), we found some important differences in experiences of autonomy and respectful care, by socio-demographic factors, type of care provider, health status, planned place of birth and mode of birth:

- **Disadvantaged women, women without postsecondary education and women of colour were more likely to report very low scores on the MADM scale and MORi.** The same differences in experiences of autonomy and respectful care were not observed for women with low household incomes.
- **Women with medical or social risk factors were nearly twice as likely to report low autonomy and low respect, compared to women without such risk factors**. Low autonomy and respect was also more common among women who gave birth via caesarean section and those who reported that their prenatal appointments, on average, lasted less than 15 minutes (see Figure 5 for details).
- Women who reported on their experiences with physicians and gave birth at the hospital reported much lower MADM and MOR scores, compared to midwifery clients; Midwifery clients were unlikely to score in the bottom 10th percentile of the MADM scale and MOR index, regardless of planned place of birth; whereas 1 in 4 physician patients reported low autonomy and respect.
- Women who reported feeling pressured into a caesarean or induction were much more likely to report low MADM and MOR scores, whether they ended up having the procedure or not. Interventions without pressure were not linked to low respect and autonomy.
- One in seven midwifery clients planned a home birth but were transferred to hospital and reported very low scores on the MOR index.

Figure 5: Low autonomy scores, by average length of prenatal appointments.

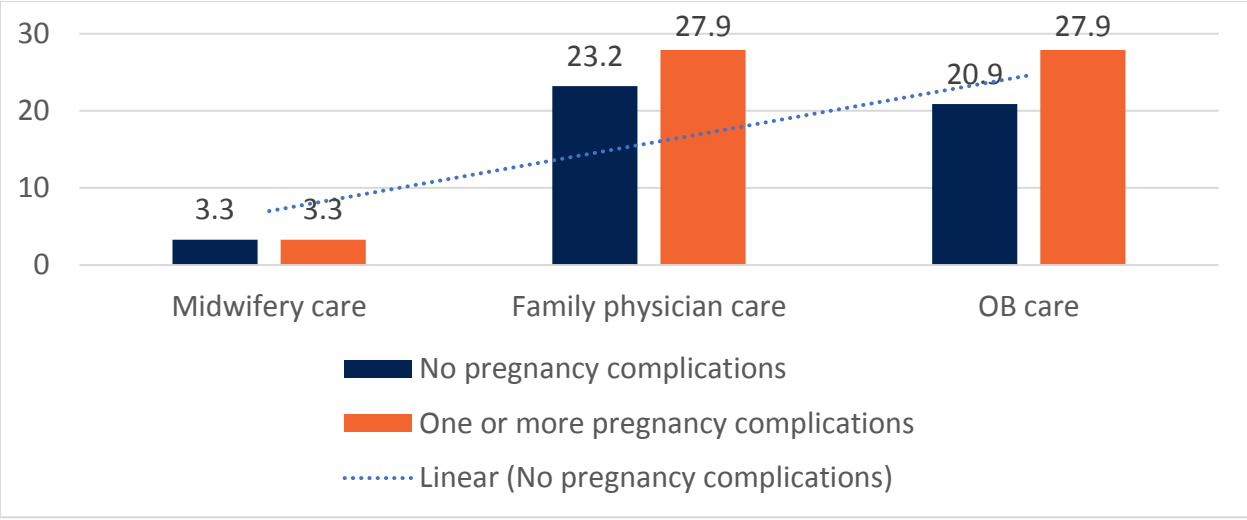


Short prenatal appointment (< 15 minutes) were linked to women's diminished ability to make autonomous decisions about their care.

Autonomy and respect for women with and without pregnancy complications

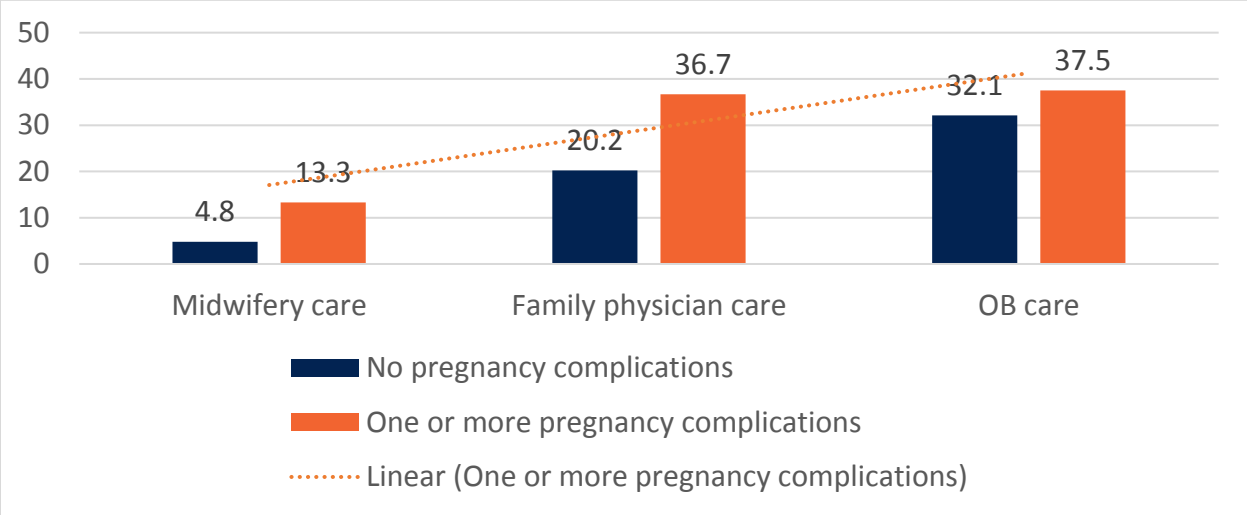
Midwifery clients were unlikely to report low autonomy scores and experiences of autonomy among midwifery clients did not differ for women with versus without one or more complication. Women who reported about their experiences with physicians and had one or more pregnancy complications were more likely to report lack of involvement in decision-making.

Figure 6: Proportion of women with low autonomy scores, stratified by presence of pregnancy complications (yes/no) and type of care provider



When we assessed the relationship between respectful maternity care for women with pregnancy complications, we found that midwifery clients were the least likely to report disrespectful care provider behaviours or communication. However, women with complications were more likely to report disrespectful experiences and encounters with care providers, irrespective of type of provider.

Figure 7: Proportion of women with low respect scores, stratified by presence of pregnancy complications (yes/no) and type of care provider



Quotes on experiences of disrespect and lack of involvement in decision-making

"Compared to my home birth, I felt very out-of-control of my treatment in the hospital. The room was packed (even though I had delivered my baby in the parking lot, and all that was left was stitching), the doctor spoke to nurses and students in the room as if I wasn't there. I found the hospital experience very uncomfortable."

"[…] Most of the experience of dealing with doctors and hospitals, I just felt shuffled around and bewildered. Doctors rarely took more than a few seconds to explain anything, and then seemed disdainful if I asked what they deemed a stupid question, or if I failed to know something they thought I should have known. Nearly every doctor I dealt with seemed to convey the attitude that I was wasting their time. Communication problems throughout the system between doctor's office, hospital, lab, and departments were constant. More than once a mistake in relaying information caused major inconvenience and stress. [….]. *The only positive part of the whole experience was the care and understanding given by nurses. They were the ones who took the time to answer our questions, speak to us as if we were humans. I am very grateful for the nurses I encountered."*

"The doctor who attended the birth was someone who I had never met or heard of. The midwife failed to inform me that she worked with other care providers in a different office. This doctor was rushed and condescending. My calls were not returned by the midwife for over a week following discharge from the hospital with my baby. The public heath office did not call me because I had a midwife. There was very little support offered in the hospital and at home. There was also no screening done for postpartum depression even though I was at a high risk for it. It is still a daily problem almost 5 years later. The

events surrounding my daughter's birth made it the worst weeks of my life. I was made to feel that I had no say in what happened to my body or my care once I entered the hospital. I hope that there is better system of communication in place now."

"What was missing in my care overall or baby's care? -I needed more after birth care. -I needed more support probably because I have a variety of diagnoses and have a disability. Needed financial help for eating better, fruits/veggies, and vitamins. There were major issues in our care with my second child AFTER we got transferred to the nearest hospital with a NICU. The care at the hospital was horrendous. I am still affected by it 4 years later. No nurses, no Drs, no pain management, treated like a young child, no area for support person. A big issue is that once you are transferred you are no longer under the care of your midwife or Dr at the new hospital because of "privileges". […] They didn't believe me when I said that my body metabolizes medication somehow very quickly, and after a first dose it won't work very well. I was treated like a drug addict… I got a bad uterine infection after the Drs at said hospital didn't take out staples and I had to get my midwife to come take them out (overgrown with skin) 6 days later. It was a really really bad experience. I was very ill as well, and there were so many visitors late at night and no health assistant/people to help control or enforce rules."

"I forgot to say that there was an OB involved in my care once I went post dates (42weeks) and he was horrible. My midwife had to step into a supportive role with my care and it was terrible. He totally took over and forced me to do things I didn't want to.

He even broke my water without discussing it or asking me or telling me what he was doing."

The midwife who attended my birth, upon arrival said, "We have a problem!" which set the tone for the rest of the day. She kept trying to go home because I was not in 'active' enough labour, and when she was there, she kept telling my husband that I should just get an epidural because she didn't think I could give birth naturally. When I had inhaled too much oxygen from the oxygen mask, she was asking me what my problem was. When the baby was born she did not wait to cut the cord or ask us if we wanted to see the placenta, and when I needed stitches she had to call the OBGYN to do it (the same one who told us we should just go home). Lastly, when she came for a post-natal visit, she told me I should seek professional help for my needle phobia (implying that everything that happened was my fault)."

The strong desire for continuity and known providers was described by several respondentsMany of the responses that described negative experiences with midwives were related to a lack of connection with a specific attending midwife, often because the team was too big. This quote captures that feeling: "*loved my midwifery care from 3 of the 4 providers in the group. However, for my labour I was with the one provider I did not care for. She did not respect my wishes to come to my home nor was she in the room at all for support. I felt abandoned by her."*

Another respondent described a similar perspective: "*It might be of interest to you to inquire about birth experiences involving multiple midwives (planned or unplanned) and how this had an effect on pre or postnatal care. It was VERY important to me to have my chosen midwife for my prenatal, birth, and postnatal care. Unfortunately, an emergency removed her from my birth experience and I was passed on to her partner, whom I had only met one time."*

Experiences of care among vulnerable populations

Women with a history of incarceration, substance use, poverty, mental illness and/or homelessness made important recommendations to improve quality of care.

"Mental illness and pregnancy was poorly understood by my midwives. This is an area where everybody says we have little training, please address this knowledge and experience gap. Also, there was a poor working relationship between my midwives and the psychiatrist which resulted in the worst possible outcome for me and my child-me ending in hospital for three months and her in foster care for 6 months".

"Giving birth is a unique experience for each woman that requires a wide spectrum of care and non-judgment. Services for women facing poverty and sexual abuse issues are important. Emphasis on resources available after the newborn stage including what's next for mom and couple therapy, post partum issues for the father, and how and when to leave an abusive relationship would be helpful."

"Having a child in an urban area can be surprisingly isolating. Some women cannot leave the house to access programs offered by the health unit. Be it anxiety issues or sleep deprivation that prevents driving or lack of community support. Doulas sponsored by the government for low income families (postpartum) is needed. Online services and information through midwife websites would be very helpful. Financial education about EI, how moms cannot apply for student loans etc how to keep women economically sound (even if married) would be helpful".

"I was separated from my baby during my blood patch procedure, and my baby was not returned to me afterwards. Even though my baby was perfectly healthy, and I was cleared to return to my room, my son was said to be on a 'feeding schedule', and not returned for several hours. I had nightmares and anxiety as a result."

"Trauma and sexual abuse was triggered during birth. More screening and education is needed in this area. Severe postpartum needs to be taken extremely seriously. I was suicidal and not taken seriously until I hurt myself and was very ill. I wish more awareness and screening was mandatory."

"I think many women work at minimum wage jobs and are not aware that Midwife care is available to them, but think they are stuck with the cheapest, most "efficient" options available, and that even if it's not what they want, at least they are getting care. At the time of my pregnancy I was hugely unsupported and uninformed. I was 20 years old and under the poverty line. I felt disrespected for this."

"[I] was 19 [years old. The] doctor didn't listen to anything I said."

Table 11: Lowest MADM and MORi scores, by socio-demographic characteristics, maternity care provider, place of birth and mode of birth (n=2051)

	Bottom 10th percentile MADM %	Bottom 10th percentile MOR-i %
Disadvantaged status		
Yes	15.2	12.0
No	9.3	9.2
Family income < 30 k		
Yes	10.4	5.9
No	8.2	7.7
Women of colour [1]		
Yes	10.2	13.8
No	8.4	9.8
No postsecondary education		
Yes	12.8	11.3
No	8.1	7.5
One or more medical or social risk factor during pregnancy		
Yes	14.7	18.8
No	8.7	7.7
Maternity care provider and planned place of birth		
GP- planned hospital birth	24.2	18.9
OB - planned hospital birth	22.3	26.7
MW- planned hospital birth	3.1	4.7
MW – planned home birth	2.8	6.8
Average length of prenatal appointments		
< 15 minutes	37.6	35.6
15-30 minutes	6.8	7.9
31-60 minutes	3.8	3.5
Mode of delivery		
Vaginal birth	9.7	8.6
Caesarean birth	11.2	13.0
Pressure to have intervention		
Pressure to have CS, and had CS	20.0	30.3
Pressure to have CS, but did not have CS	34.1	22.6
No pressure to have CS, but had CS	9.2	5.6
Pressure to have induction, and had induction	21.5	26.7
Pressure to have induction, did not have induction	26.3	30.4
No pressure to have induction, but had induction	5.7	12.7
Transferred from home to hospital		
Yes	6.5	15.0

1.Includes all women who did not identify as White.

Focus groups with vulnerable women

Women from diverse socio-economic and cultural backgrounds participated in 20 focus groups across the province (n=133). Nine of the focus groups were attended by women from vulnerable populations. In the following section we report some preliminary results. Negative maternity care experiences reported included: Feeling treated in an impersonal/condescending manner "like a number on a list", receiving fragmented maternity care & false information and feeling lonely, disregarded, & abandoned by care providers.

Newcomers to Canada struggled with language, financial & cultural barriers, making it difficult to navigate our maternity care system & access culturally congruent care.

> *"It would have helped if I got more resources, if I had more options because I was like okay, this is the only gynecology I know and she said 'I can't guarantee that I'll be there when you, you deliver your baby,' so I would just prefer if she had more options, if I can be referred to another one who can guarantee to be there at this time, or at least if I had a doctor with me in the delivery room because actually I was scared, because I don't know how good nurses are here. I'm new to this country, or at that time I was new to this country, and I don't know, maybe, in my country a nurse can't deliver a baby actually, it should be a doctor, so and he's available all the time until you get your baby delivered so I was like: 'Why I'm left alone like this, why there is nobody there in the room, only the nurse?' Then I saw the doctor only five minutes before the baby's out. So I didn't have any resources, I didn't have any support, I didn't have any options, just like going through the process like a number, not like treating a human being, so actually that was a very bad experience* (Speaker 6, Immigrant women focus group, April 29, 2014).

Marginalized and immigrant women experienced higher rates of discrimination/ disrespect during pregnancies.

> *"[Y]es you are treated differently uh, especially, well because I wear a hijab so it's definitely something that I'm not born and raised here but as soon as I open my mouth and then they see and they hear I can speak perfect English almost, they start treating me a little bit better that's the only thing. But at the very first point as soon as they see you "Oh my god, she's a terrorist" so it's just the experience is usually really horrible, usually but then when you start talking and having a good sense of humour, people start um, uh, easing up um so yeah*" (Speaker 3, Immigrant women focus group, April 29, 2014).

Vulnerable/immigrant women had lack of information about maternity care options, including types of providers & birth settings.

> *"I went to walk in clinic, they saw that I'm pregnant, then they referred me to where the low income people must go. So they referred me to other doctors. So I went there, then they started to see me often. Then later on, they refer me to BC Children's Hospital. So I didn't choose myself. They choose for me where to go because of my financial status"* (Speaker 1, Immigrant Women focus group, April 4, 2015).

Immigrant and refugee women appeared to have little knowledge about midwifery care in B.C. They did not know if their services were covered by MSP, where midwives work/deliver babies, or differences in models of care between practitioner types. There was hesitant speculation that midwives practice more natural birthing methods, collaborate with doctors, help in breastfeeding and supplying maternal education and attend low risk pregnancies. Participants felt that more education/information was needed

for immigrant women regarding midwifery care. The women also discussed midwifery from the context of standard perinatal practices in their home county which included exclusive hospital births.

Access to Maternity Care

One in five women struggled to find a doctor or midwife to care for them during pregnancy. A higher proportion of women from vulnerable populations reported difficulties accessing midwifery care (37.1%) or finding a doctor during pregnancy (31.3%). Of women with previous childbirth experiences, 21.9%encountered difficulties finding a doctor during pregnancy and 21.2% encountered difficulties finding a midwife during pregnancy.

The most common reasons were: no midwife in community (135 women), no doctor who delivers babies in community or doctor not accepting new patients (245 women), midwife not accepting new patients (160 women), pregnancy deemed high risk (35 women), distance to services (67 women), cost (27 women), other (247 women).

Fifty-eight women said they had to travel more than 60 minutes to access maternity care during labour. Forty-four women travelled outside their community to have a home birth (at a hotel or a friend's home). Thirty-three women who had not given birth before said they would travel outside the community to have a home birth.

Rural Experiences

In response to the open-ended question at the end of the survey '*Is there anything else that you would like to add? Or is there anything important that we forgot to ask?*, many participants described experiences in remote places. They identified how this had an impact on their choice of care providers and choice of birth place. Comments were also made about the cost (financial, and in terms of time) of relocation. This quote reveals some of the struggles families in rural locations face in giving birth:

> "*I think that there is a problem in BC, and perhaps other provinces, for birthing options in rural areas. During my last pregnancy and labour, I spent 7 nights in hotels waiting for my labour to begin as I live 2 hours away from a community that offers birthing services. It makes it extremely stressful to relax into labour when you knew there is a long drive ahead with the possibility of having a baby on the road, road conditions (snow and construction). I did not receive compensation for my hotel visits plus meals. I wonder how a woman with no or low income affords to feel comfortable? Or how do they travel 2 hours without a vehicle?"*

Another participant described traveling out of her community to give birth as the hardest thing she's had to do. One comment underscores a reoccurring theme for people living in smaller communities: "*Our current system, specifically in more remote regions, is severely lacking in this regard. A pregnant woman should never feel "lucky" to have "at least" found a doctor"*.

Knowledge of Midwifery Care

Women and family members were asked to indicate whether they agreed, disagreed or were unsure about the accuracy of a list of 24 statements about midwives.
Results were analyzed for four groups: 1) full sample (n=2296), 2) subsample of disadvantaged women (n=88), 3) childbearing women without previous midwifery experience (n=416), and 4) childbearing women without previous midwifery experience, who said would not have a midwife in a future pregnancy and would not recommend one to family or friends (n=211.) To summarize the findings, we report the top five knowledge gaps (as indicated by the proportion of unsure responses) and the top five misperceptions

about midwives (as indicated by the proportion of people who disagreed with a correct statement or agreed with an incorrect statement).

Group 1 (full sample) top five knowledge gaps:
One in five people did not know that midwives do women's health exams, one in six did not know that midwives can order medicines during pregnancy and that prenatal appointments with midwives usually last 30-60 minutes. One in ten were unsure about whether midwives only care for women without health problems.

Group 1 (full sample) top five misperceptions:
One in five people disagreed that midwives use medicine to promote comfort and progress in labour, one in six disagreed that midwives do women's health exams, 12.3 % disagreed that midwives can order medicine during pregnancy, 7.5 % agreed that midwives work *under* doctors, and 5.8 % agreed that midwives only care for women with no health problems. Midwives' ability to order medicines (to promote comfort in labour etc.), and do women's health exams were also common areas of misperception and lack of knowledge, as was the average length of midwifery visits.

Group 2:
Disadvantaged/vulnerable women reported similar knowledge gaps. The statements that vulnerable respondents were more frequently mistaken on, included: 1. Midwives use medicine to promote comfort and progress in labour (23.4 % disagreed), 2. Midwives do women's health exams (19.5 % disagreed), 3. Midwives can order medicine during pregnancy, (16.9 % disagreed) 4. Midwives work under doctors (16.9 % agreed), and 5. Midwives can treat some pregnancy and birth problems (9.1 % disagreed). Areas where both misperception and knowledge gaps exist included the way that midwives practice with other maternity care providers. For example, 1 in 5 vulnerable women were unsure whether midwives consult with OBs when complications arise.

Group 3:
Included responses from women with no previous midwifery care experiences. Knowledge gaps and misperceptions about midwives were more prevalent in women with no personal experience of care by a midwife. The top five knowledge gaps were: 1. A midwife office visit is usually 30 to 60 minutes long (43.0%), 2. Midwives do women's health exams (41.8%), 3. Midwives can order medicine during pregnancy (30.0%), 4. Midwives use medicine to promote comfort and progress in labour (27.9%). And 5. Midwives provide newborn care up to 8 weeks postpartum (20.2%). The statements that the respondents were more frequently mistaken on, demonstrating the top five misperceptions, included: 1. Midwives do women's health exams (26.7 % disagreed), 2. Midwives use medicine to promote comfort and progress in labour (25.7 % disagreed), 3. Midwives can order medicine during pregnancy (21.4 % disagreed), 4. Midwives work under doctors (12.5 % agreed), and 5. Midwives only care for women with no health problems (9.1 % agreed).

Group 4:
Included women with no previous midwifery care experiences and who would not have midwives care for future pregnancies and would not recommend a midwife to families or friends. In this group knowledge gaps about midwifery were especially prevalent.

Table 12: Group 4 and Group 5 knowledge of midwifery. *Group 4 — No previous MW experience and would not have MW for future and would not recommend one (n=211)*

Top 5 Knowledge gaps (number and % of unsure responses)	
A midwife office visit is usually 30-60 minutes long	106 (50.2)
Midwives do women's health exams	102 (48.3)
Midwives can order medicines during pregnancy	75 (35.5)
Midwives use medicine to promote comfort and progress in labour	67 (31.8)
Midwives care for the baby after the birth for 6-8 weeks	55 (26.1)
Top 5 Misperceptions (number and % of inaccurate responses)	
Midwives do women's health exams	59 (28.0)
Midwives use medicine to promote comfort and progress in labour	58 (27.5)
Midwives can order medicines during pregnancy	56 (26.5)
Midwives work under doctors	32 (15.2)
Midwives only care for women with no health problems	19 (9.0)

Open-ended responses (of women in group 4):
Some open-ended responses to "please describe what a midwife is and/or does" were quite accurate.

> "[A midwife is} *A medical professional with … experience in advising and assisting women (and their partners) through pregnancy, labour and post-delivery. An advocate for a labouring woman's right to choose where and how she delivers a child (location of birth, pain management, etc.)*"

The responses that were inaccurate referred mostly to the scope of midwifery care. For, example, a number of responses indicated that midwives do not use medication in pregnancy and/or in labour and that midwives cannot manage emergencies. However, midwives in fact are able to prescribe certain medications and manage some common obstetrical emergencies. Some inaccurate responses are highlighted below:

> "*They help to deliver babies in and out of homes and hospitals. They tend to lean towards pain med free deliveries. I don't think they can give you pain meds. They will facilitate transport, etc if there are emergency health problems. Right?"*

> "*Attends birth and delivers babies, and offers prenatal care. Acts in place of doctor in deliveries of healthy babies, but limited in scope because cannot prescribe medication, do medical procedures or have access to resources available to doctors*."

Changing Childbirth in BC - Open-ended responses from survey

Participants had the opportunity to provide comments in many sections of the survey. Our team comprised of community members and researchers is in the process of thematically analyzing these comments as well as rich qualitative data from 20 population-specific focus groups from across the province. Included in the current report is a summary of responses to the last survey question: *Is there anything else that you would like to add? Or is there anything important that we forgot to ask?* Feedback in this section of the ***Changing Childbirth in BC*** survey was wide-ranging. Nonetheless certain themes do stand out, particularly as they relate to choice, respect and the significance of support in birth.

Choice

Many participants wrote about the importance of and barriers to accessing the care provider of their choice, including: lack of information about options, a shortage of midwives in the province, and a lack of options in rural locations. On the short supply of midwives one participant emphasized: *"I love midwifery care and wish there was more available to women. It saddens me that many women who wish to have a midwife and/or home birth are unable to do so because of lack of midwives in the community."*

Some respondents also mentioned the role that health care providers play in decision making; many noted that their health care providers (and in some cases, family members) did not support their decision to access midwifery care. As one respondent explained: *"My own family doctor was very unreceptive to my choosing a midwife for my last pregnancy, insisting I'd be giving birth unmedicated and at home that a hospital birth wasn't an option, etc. He is extremely critical, dismissive, and ill-informed regarding midwives."*

Choice of birth place

Many respondents wrote about choice of birth place (including homebirth), drawing specific attention to the absence of birth centres in the province. This quote points to the benefits of these desired spaces: *"I would LOVE for midwives to truly offer an alternative to the typical doctor/hospital birth by having Birthing houses, staffed by both midwives, nurses and doulas with medical equipment on hand, but out of sight. This would provide a comfortable, supportive environment for those who wish for a home birth but are not in a situation to have one. This would free up space in hospitals for more critical patients and saving money."*

Experience with Heath Care Providers

Participants wrote about positive experiences with doctors. The main reasons they chose to birth with doctor (including obstetricians and family doctors) was either because they believe these health care providers as especially skilled, or because they had a pre-existing relationship. The negative experiences people shared about their doctors were when they did not feel supported, or connected, and importantly did not feel they were given enough time.

More participants wrote about their experience with midwives. An overall positive sentiment was echoed in 47 similar responses*: "I would like to say that the care I received under my midwife was outstanding. I am so happy that I was under their care. My husband and I have a happy and healthy baby girl, born*

naturally. That is entirely in thanks to them. I hope that the BC Healthcare system furthers support for midwifery." Aspects that facilitated a positive experience for clients included the fact that midwives advocated for their choices, and that clients and their families/partners were involved in decision making. Others described a positive experience with midwifery care because of the support they received (in labour and postpartum), the time they were given, the respect they felt and the personal connection they had with their midwives. Negative experiences with midwives centred on times when they felt there were too many midwives working in one clinic and that they did not have a strong connection with one in particular.

Support in Birth

Many comments were made about the importance of support during birth. This came up in respondents' comments about why they valued **midwives**, but also in the repeated mention of doulas. One enthusiastic comment read: "*The best part of my labour/birth experience was my doula. And the baby. But also the doula*." Many emphasized that doulas should be funded or part of care offered by MSP. Others highlighted the aspect of support as the reason they had a positive birth experience with midwives: *"I cannot underscore the psycho/emotional/social importance of my midwife for the duration of my pregnancy, birth, post-natal period. She provided a 'safe' space for discussion and a 'safe' space for the birth of my daughter. The freedom to choose and to overcome basic fears resulted, in my opinion, in a very positive birth outcome and birth experience."*

Next Steps

The Birth Place Lab is currently continuing analysis of the qualitative component of the study with our community partners. We will develop Knowledge Translation strategies for dissemination of the findings in partnership with community members to ensure that the important stories from families in BC are heard. We have worked with our community partners to identify some policy recommendations from the survey results, available in the executive summary.

For more information about this and other projects, please visit: https://www.birthplacelab.org/

REFERENCES

1. WHO. *Standards for Improving Quality of Maternal and Newborn Care in Health Facilities*.; 2016.
2. PSBC. *Midwifery Report Deliveries in BC*.; 2014. www.perinatalservicesbc.ca. Accessed July 30, 2017.
3. British Columbia Ministry of Health. *Setting Priorities for the B.C. Health System*.; 2014. http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf.
4. Vedam S, Stoll K, Martin K, et al. The Mother's Autonomy in Decision Making (MADM) scale: Patient-led development and psychometric testing of a new instrument to evaluate experience of maternity care. Kumar S, ed. *PLoS One*. 2017;12(2):e0171804. doi:10.1371/journal.pone.0171804
5. Vedam S, Stoll K, Rubashkin N, et al. The Mothers on Respect (MOR) index: measuring quality, safety, and human rights in childbirth. *SSM - Popul Heal*. 2017;3:201-210. doi:10.1016/j.ssmph.2017.01.005
6. Vedam S, Stoll K, Martin K, et al. The Mother's autonomy in decision making (MADM) scale: Patient-led development and psychometric testing of a new instrument to evaluate experience of maternity care. *PLoS One*. 2017;12(2). doi:10.1371/journal.pone.0171804
7. Baji P, Rubashkin N, Szebik I, Stoll K, Vedam S. Informal cash payments for birth in Hungary: Are women paying to secure a known provider, respect, or quality of care? *Soc Sci Med*. 2017. doi:10.1016/j.socscimed.2017.07.015
8. Baji P, Rubashkin N, Szebik I, Stoll K, Vedam S. Informal cash payments for birth in Hungary: Are women paying to secure a known provider, respect, or quality of care? *Soc Sci Med*. 2017;189. doi:10.1016/j.socscimed.2017.07.015
9. Vedam (Conference Paper) S, Stoll K, Monroe S, et al. *The Giving Voice to Mothers Study: Measuring Respectful Maternity Care in North America.* Toronto, Canada; 2017.

THANKS

We would like to acknowledge the staff and leadership of our community partners for their unwavering commitment to supporting this complex and diverse group of women to tell their stories. We are grateful to academic colleagues from several UBC Departments including Education, Family Practice, Public Health, Obstetrics, and Midwifery, and the Women's Health Research Institute for providing training and support for the community as they engage in all steps of the research process. Thanks to our students: Julia de Montigny and Julie Bowser for their contributions.
The project would not have been possible without the persistence and perseverance of the members of the Steering Council, including work group leaders Lorna McRae, Mo Korchinski, Anna Tashlykova, Raquel Velasquez, and Nora Timmerman who liaised with community members. We thank all the community members and partners who facilitated focus groups.
Most of all we thank the women and families of British Columbia who participated in the study.

FUNDERS

Vancouver Foundation - https://www.vancouverfoundation.ca/
This survey and focus groups were supported by operating grant #UNR12-0701 for the provincial community-based participatory *Changing Childbirth in BC* study.

The lead of the Birth Place Lab, Saraswathi Vedam, is supported by a Michael Smith Foundation for Health Research- Health Professional Investigator Award. MSFHR supports the qualitative analysis and knowledge translation activities of the *Changing Childbirth in BC* project.

Perinatal Services BC funded the creation of this report.

The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.