“The Birth Home of dreams”

A Case study about a co-design process of a Birth Home

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Master’s Thesis

September 2019

Double Degree Programme

Master’s Degree Programme in Health Care and Social Services Development and Management

Study Field: Social Services, Health and Sport

Master’s Degree Programme in Health Management

Carinthia University of Applied Sciences

School of Health Sciences and Social Work

Health Management

JAMK University of Applied Sciences

School of Health and Social Studies

Health Care and Social Services Development and Management

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A case study about a co-design process of a Birth Home

Submitted in partial fulfilment of the requirements of the academic degree

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At Jyväskylä, September 2019

CARINTHIA UNIVERSITY OF APPLIED SCIENCES | FACHHOCHSCHULE KÄRNTEN

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Description

Author(s)	Type of publication	Date
Ikonen, Jenni	Master's thesis	23.08.2019
		Language of publication: English
	Number of pages: 93	Permission for web publication: x

Title of publication

The Birth Home of dreams

A case study about a co-design process of a Birth Home

Master's Degree Programme in Health Care and Social Services Development and Management, Master's Degree Programme in Health Management

Tutor(s)

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Assigned by

Abstract

In social and health services, the customer's role is changing from a passive service user to an active service designer. In Finland, the big reform in social and health care services has brought a pressure to renew social and health care services, and this has helped the progress of customer oriented services. Co-design is a method that enables service design with the customers.

This case study was conducted by using co-design and participatory action research. The object of this case study was to co-design a visionary birth home with its potential customers and personnel. The data for this study was collected in two workshops by using participatory methods.

The results of the participatory methods with the most common expressions concerning the birth home of dreams were related to the services given before the birth, family centeredness, the use of water in the birth, safety, the use of time, mental coaching, the use of space, naturalness, home-likeness, visuality, individuality, peacefulness, nature, congeniality, the nearness of the hospital and professionalism. Co-design was found to be a useful method in designing social and health care services. The workshops produced voluminous amounts of beneficial material. The added value of co-design in designing social and health care services are the opinions and thoughts of the service users that are taken along to the design of the services

Keywords/tags (subjects)

Co-design, customer oriented approach, participatory methods, birth home

Miscellaneous

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Kuvailulehti

Tekijä	Julkaisun laji	Date
Ikonen, Jenni	Opinnäytetyö, ylempi AMK	23.8.2019
		Language of publication: English
	Number of pages 93	Verkkojulkaisulupa myönnetty:

Työn nimi
"Unelmien synnytyskoti" – Tapaustutkimus synnytyskodin yhteiskehittämisestä

Tutkinto-ohjelma:
Kätilö (YAMK): Sosiaali- ja terveysalan kehittäminen ja johtaminen

Työn ohjaajat
Klein, Regina & Mäkelä, Tapio

Toimeksiantaja

Tiivistelmä

Sosiaali- ja terveydenhuollossa asiakkaan rooli on muuttumassa passiivisesta palvelujen käyttäjästä aktiiviseksi palvelun suunnittelijaksi. Suomessa sote-uudistuksen mukanaan tuoma paine uudistaa sosiaali- ja terveyspalveluita on edistänyt palvelujen asiakaslähtöistä ajattelua. Yhteiskehittäminen on menetelmä, joka mahdollistaa palvelun kehittämisen yhdessä asiakkaan kanssa.

Tämä tapaustutkimus tehtiin yhteiskehittämisen ja osallistuvan toimintatutkimuksen avulla. Tapaustutkimuksen aiheena oli kuvitteellisen synnytyskodin yhteiskehittäminen potentiaalisten asiakkaiden ja henkilökunnan kanssa. Tutkimuksen aineisto kerättiin kahdessa työpajassa osallistavia menetelmiä hyödyntäen.

Osallistavien menetelmien tuloksissa unelmien synnytyskotiin liittyen useimmiten toistuvat ilmaisut liittyivät ennen synnytystä annettaviin palveluihin, perhekeskeisyyteen, veden käyttöön synnytyksessä, turvallisuuteen, ajankäyttöön, henkiseen valmentautumiseen, tilankäyttöön, luonnollisuuteen, kodinomaisuuteen, kauneuteen, yksilöllisyyteen, rauhallisuuteen, luontoon, saman henkisyyteen, sairaalan läheisyyteen ja ammattitaitoon. Yhteiskehittäminen todettiin hyödylliseksi menetelmäksi sosiaali- ja terveyspalveluita suunniteltaessa. Työpajat tuottivat runsaasti hyödyllistä materiaalia. Yhteiskehittämisen tuoma lisäarvo palvelujen suunnittelemisessa on palvelun käyttäjien mielipiteiden ja ajatusten mukaan saaminen palvelujen suunnitteluun.

Keywords/tags (subjects)
yhteiskehittäminen, asiakaslähtöisyys, osallistavat menetelmät, synnytyskoti

Miscellaneous

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1 The need for a change

This Master's thesis is a case study for co-designing a visionary birth home with its potential customers and personnel. This case study uses the qualitative approach of the participatory action research (PAR). The design process of this case study was done collaboratively with potential birth home customers and personnel by using the process of co-design and creative participatory methods.

In 2017, according to the perinatal statistics, 50 854 children were born in Finland, and 99.5 % of them were born in hospitals. The remaining 0.5 % were born at home or on the way to the hospital. The number of home births increased by 50% during the years 2014-2015 and by 34 % from 2016 to 2017 (Ennakkotieto: Perinataalitilasto – synnyttäjät, synnytykset ja vastasyntyneet 2016; THL 2018.) Since the 19th century, births have moved from homes to hospitals in Finland. By the end of the 19th century, over 90% of births happened at home, in 1930 2/3 of births happened outside of hospital and in the beginning of 1950 almost 60% gave birth in hospitals. (Paananen 2009, 22). Finland is going through a vast reform in social and health care at the moment, and it can be seen in maternity care as well. A large number of the small and more organic birth units have been closed down, and births are centered to big hospitals in big cities. At the same time, new, private and midwife-led pregnancy services are opening at an increasing rate. There are many different kinds of services available from breastfeeding counseling to a variety of mentoring services according to birth and parenthood. However there are still no other places to give birth besides hospital and home (only in some cases). In a country where almost all the women give birth in hospitals, there seems to be a need for choice.

A birth home is a birthplace between hospital and home. The reason to co-design a birth home was fully personal. In Finland, almost all the women give birth in hospitals. There is a lack of birth home culture and a wider perspective to birth giving. As a mother and a midwife, I have experience in births, how they are taken care of and how they could be taken care of. In my perspective, there should be

more options to choose from, for example, when talking about the birthplace. In an Austrian survey (Luegmair, Zenzmaier, Oblasser &König-Bachmann 2018) about "satisfaction with care in the birth place" with 539 participants that had given birth within five years, one of the findings was "the desire for more midwifery-led care". In another study about "The influences on women who choose publicly-funded homebirth in Australia (Catling, Dahlen & Homer 2014) one conclusion was the flexibility of the service to permit women to choose their birthplace at any time during pregnancy was appreciated. In the same study an implication for service was made: "Service managers and health professionals need to acknowledge the importance of place of birth choice for women". It is important for women to be able to choose the place of birth and to have midwives, the people who are educated for it, in charge of it.

There has been more and more discussion about the customer participation in the service development. The customer oriented thinking means organizing the services from the customer point of view together with the customer not only for the customer. For the social and health care services to be producing what is needed the producing of the services necessitates the participation of the service users to the development of the services. For the real development of the customer orientation instead of talking about it the customers and their needs should be returned to the center of the service production. (Virtanen, Suoheimo, Lamminmäki, Ahonen & Suokas 2011, 12; 36). The main objective of this case study was to co-design a visionary birth home and the services in there collaboratively with the potential customers and personnel. In this research the term personnel refers to midwives. The focus was on the outcome of the creative workshops rather than the process itself. The core idea was to study whether co-design would be a useful method in designing social and health care services together with the customers.

The idea and motivation for this innovation process came originally from my personal will to extend my professional health care and social service skills into the commercial area. I and my sister have been dreaming of having our own birth home, something that would be an alternative for hospitals. We are both midwives, and we

share the same thoughts and worries about the medicalization of the birth culture and about childbirths going too far away from a normal physiological birth, and we want to do something about it. I have degrees in social services, nursing, midwifery and sexology. At the beginning of my Master studies, the business class that I was attending gave me the will to test the Business Model Canvas for creating a business model. At the same time, learning about the methods of the Lean Launchpad strengthened my idea of co-designing the business model together with potential customers through co-design, agile development and by using innovative methods. This was the plan at first, but further on, I decided not to make a business plan but rather fully concentrate on the co-design process of the birth home. The more I studied managing health care and social services, the clearer it was to me that I wanted to hear the voices of the people who could be using these particular services. The main point in this Master's thesis is the collaborative design process and its outcome. I think that the best way to consider the customer point of view in the social and health care services is when the potential customers are participating already in the creation stage of the services and helping to co-design them. This is why I wanted the customers to take part in the creation process and see what a birth home of dreams would be like when asked from them.

Similar research about co-designing a birth home could not be found. There are studies about co-design and about birth homes but not a study that combines these two. Co-design has been used in research about computer programming, teaching and service design, for example. Studies concerning birth homes are mostly about the risks or benefits of birth homes versus hospitals. In WHO's new (2018) guidelines on intrapartum care, a great deal of attention is paid to the childbirth experience and the factors that influence on it. It is said that because of the growing possibilities to monitor and regulate the physiological process of labour and birth, the medicalization of the process has increased. However it is now understood that this approach "may undermine a woman's own capability in giving birth and could negatively impact her experience of what should normally be a positive, life-changing experience" (WHO 2018). In the UN Global Strategy for Women's, Children's and Adolescents' Health the existing and new recommendations are brought together.

There are clinical recommendations for a safe labour and childbirth but also recommendations concerning the psychological and emotional needs of women including the choice of the place of birth. It is recommended for women to give birth in a place that besides being safe allows them "to have a sense of control through involvement in decision making and which leaves them with a sense of personal achievement" (UN 2019).

2 The changing role of a customer – from passive actor to active actor

In this chapter, the theoretical basis of this research is presented. It begins with the explanation of the background and then continues with the theories of co-design and design thinking that are the basis for new kind of service design. The research questions are also presented in this chapter.

2.1 Background

There are many different choices for places to give birth, and the popularity of them varies in different countries. In Europe, the most common way to give birth is in hospital. Even the hospitals can have multiple choices, like in England where there are units that work alongside a hospital's maternity ward and independent units which do not work alongside a maternity ward. In Israel, the hospitals have delivery rooms and 11 of the 16 hospitals also have "dedicated delivery rooms for natural birth". The opposite choice for giving birth in hospital is the choice to give birth at home. The possibility for this option varies greatly between countries. In Europe, the country with the highest home birth percentage is the Netherlands (16 % in 2016). One of the biggest reasons for it is the maternity policy of the Dutch government that "views pregnancy and childbirth as a natural physiological process and not as a medical procedure" and it uses several measures, like money, for example to

encourage the women to give birth at home. The state pays for the home birth and if the mother wants to give birth in hospital and there is no medical reason for it, she is required to participate to the costs. In comparison, in 2012 in the UK, 2 % of the births were home births. In Finland, the home births are not supported by any policies. If the mother wants to give birth at home, she has to find the midwife herself and take care its costs. (Simon & Becker 2018)

The third option for a birth-place is a birth home which is a place for low risk birth givers. A birth home is a Midwife-led unit (MLU) that can have many different names. In English, the terms birth center, birth centre, birthing house, maternity home, out-of-hospital maternity unit, community birthing home all mean the same. It is a birthplace between hospital and home that is led by midwives, and it takes care of low risk pregnancies, and supports normal births. It is situated in a homelike environment. The main idea of a birth home is to minimize the medical interventions and to let the woman to be in the center of the care. (About the GoodBirth Network n.d) It is common in the developed countries that in addition to the hospitals, women have an option to give birth in the birth homes or at home. The countries with the most birth homes are Australia, the United States of America, England and the Netherlands (Simon & Becker 2018, 2-17). The birth homes are quite new choices over hospital births, and home births and the need for birth homes is increasing. The motives for setting up birth homes vary. In Australia the motive is the expansion of the birth options, in the USA the need to reduce the cost of the birth by reducing the number of the medical procedures performed during birth and in some parts of Canada to find a nice choice to home birth. The core idea behind the birth homes is that pregnancy and childbirth are natural physiological processes and therefore the medical intervention is not needed. (Simon & Becker 2018, 2-17)

In Jane Sandall's article (2015) "Place of Birth in Europe" it is told how "the national policies and guidelines can support choice in place of birth". There is an example of England where the maternity policy has supported the choice of the place of birth, and some guidelines are given for low risk and high risk pregnancies. It is common at the moment all around in Europe that the user choice is supported but at the same time maternity units are closed down resulting in reducing the user choice especially

in the rural areas. It is stated in the article that the maternity services and the choices available to women vary greatly throughout Europe.

Tekes is a Finnish funding agency for innovations. It is a “publicly funded expert organisation that finances research, development and innovation in Finland” (Tekes n.d.) Tekes offers versatile information about innovations, and in 2011, they published a “Travel guide for customer orientated development of social and health care services”. In this publication, the customer’s role in service development is discussed. In Finland, the need to reform social and health care services has hastened the development of customer orientation. More customer-oriented procedures can increase the impact of care, the cost efficiency of the services and the satisfaction of the customers and the employees. The customer needs and expectations are growing and varying all the time, and a stronger ability to respond to them is needed. In Finland, the public, private and third sector all provide social and health care services, and they have been doing it quite independently. The development of customer orientation lowers the boundaries between the different sectors and brings them together. (Virtanen et al. 2011, 8-9)

The customers have become empowered policy makers according to the services they use. They are no longer satisfied with vapid treatments or a malfunctioning service and as a result the malfunctioning services will die as the well-functioning services will thrive. This is all happening because of social media and their customer’ networks that have given the well-functioning organizations the possibility to stand out from their competitors through reviews and networks. The service culture has changed. The customers are moving away from the products and private ownerships to the world of services and innovative ownerships. For example, it is self-evident for us nowadays that when we buy a phone, we will get a full product-/service system with it. The old kind of brand culture is no longer working, and new kind of interaction with the customer is needed. The global market and network culture furnish the customers with real-time information. Anybody can be a policy maker. (Ahonen 2018, 12)

Including the customer in the service development can be “information giving” when the service users are integrated to the design process of the services and their thoughts and ideas are listened to. The difficulties in describing people’s needs and thoughts can sometimes be difficult as well as understanding their future needs. Another choice is to approach the customers in their own environment. A so-called “third space” is constructed where the service users and service producers can meet and go through the service process by benefitting from the experiences and expertise from both sides. Whatever the style in co-designing the services, interaction is the key point. (Virtanen et al. 2011, 36)

It is also good to distinguish between the customer centered and customer orientated approaches. There is a significant difference in practice. When the development process or design process is customer centered, the customers’ needs and wishes are taken into account and the customers might be even heard concerning the design process. However the customers are not the initiative power of the development process nor do they have the chance to decide the final way of producing the service. Instead in the customer orientated development process the client can also be the initiative power of the development process. In the best case possible, the customer can be within the process from the beginning to the end and their ideas and innovations can be used fully. In Finland, the customer role in the development of the services has not been greatly emphasized. The studies show, however, that the involvement of the customers to the development of the services can have many benefits. The costs can be better managed, and the services can better respond to the needs of the individuals or the communities. It also gives the possibility to define the relationships between the service producers and the service users, and it changes the statutory position and the responsibility. (Virtanen et al. 2011, 36-37; Leemann & Hämäläinen 2016, 586-592)

In this research, the core idea since the very beginning was to involve the customers in the design process of the birth home. This co-design process is customer orientated because the potential birth home customers and midwives participate in the design process from the very beginning of the process. The co-design process was conducted in two workshops. The first workshop was for the potential birth

home customers, and the second workshop for the potential midwives working there. The midwives continued from the first workshop ended, and the idea was to obtain the professional views from them and possibly additions and different points of view for the co-design process.

2.2 Co-design and Design thinking

This research is based on co-design that is the name for the collaborative design approach used in Northern Europe for nearly 50 years. Co-creation is a term often used synonymously with co-design. They are both terms of participatory design, and according to some experts, their meaning is the same and according to some others, they differ from each other. There are different opinions about the level of the participation in the process and the time of it. Participatory design was developed in the 1970s by engaging the workers in the development process of industrial production. In addition to the industrial environment, it was also used primarily in education. The first experiences of co-design were user-centered so that the product users were observed or interviewed about the product that was designed. This approach was more popular in the US and it was called user-centered design. Since then, the user has not been in a passive role but more and more active and participating in the creation process already from the early stages of design. The Scandinavians developed the participatory approach where the user is seen as a partner, and nowadays the two approaches are coming closer to each other all the time. (Sanders & Stappers 2008, 5-9.)

Co-design brings the designers and the people not trained in the design process together. It can be used in many different fields, but when it comes to the issues of health and wellness, the people involved as health care professionals, families or patients are the experts of their own experiences. Therefore, they are the ones that can provide invaluable information about the services and give solutions on how to improve them or design new ones. The main idea of co-design as well as the

participatory approach is that we are not designing for people but we are designing with them. (Sanders, Singh & Braun 2018)

Sanders and Stappers present the figure below in their article (2008) “Co-creation and the new landscapes of design”. It explains the classical roles of users, researchers, and designers in the design process (on the left) and how they are merging in the co-designing process (on the right). In the classical user-centered design process the user has a passive role. The researcher is the active one who brings all the knowledge; the knowledge that already exists and the knowledge that comes through research. The researcher informs the designer about the knowledge (usually in the passive form of a report) and the designer adds technology and creativity to form ideas etc. However when we are talking about the right side of the figure, the co-design process, the roles are mixed up. In co-design “the user” is seen as “the expert of his/her experience” and he/she has a great role in bringing the knowledge, generating ideas and eventually developing concepts for the research. The researcher’s job is to support this work by providing tools for ideation and expression. The researcher and the designer are collaborating on the ideation tools to enhance the design process. The researcher and the designer might even be the same person.

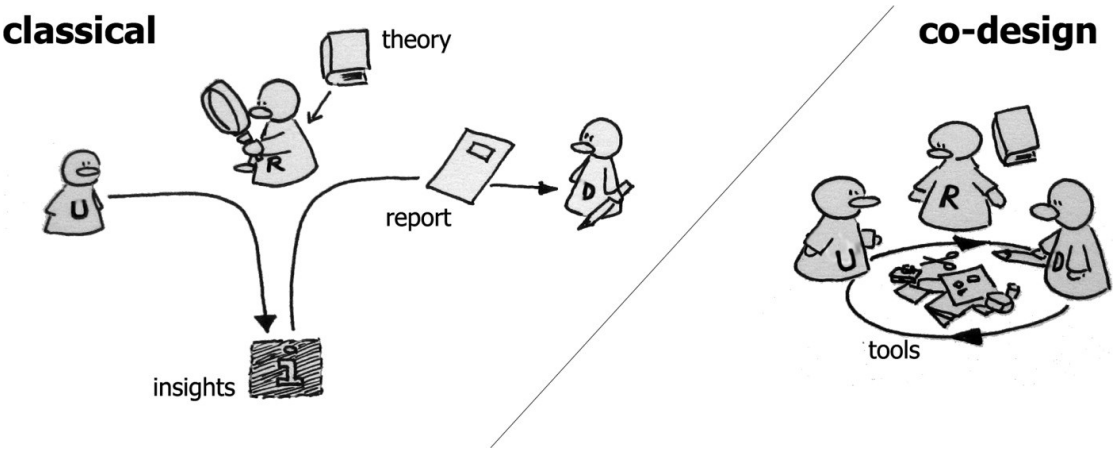

Figure 1: The classical design process and the co-design process (Sanders & Stappers 2008)

There are at least four levels of creativity in people and their lives. They are: doing, adapting, making and creating. **Doing** is the most basic level of creativity. It means "getting something done" like exercising or organizing at home. The skill and amount of interest required for doing are minimal. The "consumer ready" products and services that are offered to us today satisfy this level. In terms of cooking, this level would mean buying a microwave meal and preparing the meal. (Sanders & Stappers 2008; Sanders 2006)

The second level of creativity is **adapting**. The motivation behind it is "to make something of one's own". It can mean, for example, personalizing an object or adapting a product so that it fits one's needs better. Compared to doing, more interest and higher level of skills are needed in adapting. People use adaptive creativity when our surroundings or the products and services we use do not completely fit our needs. In terms of cooking this would mean adding an extra ingredient to a ready-made meal to make it special. (Sanders & Stappers 2008; Sanders 2006)

The third level of creativity is **making.** It means using hand and mind to make something new, something that did not exist before. It is usually done with the help of some guidance such as a pattern or a recipe. Many hobbies fit into this category of creativity because it requires a genuine interest and earlier experience. In terms of cooking, this level would be making a meal by using recipes. The fourth and most advanced level of creativity is **creating**. The motivation behind it is innovation and expression. It requires passion and high skills. Compared to the making, in creating, there is no plan or pattern and raw materials are used. In terms of cooking, this level would be making a recipe while cooking and improvising while doing it because of a missing ingredient. We develop our way from doing to adapting and through making to creating over time and through experience. People differ in these levels and can be in all of them at the same time but in different life sector. (Sanders & Stappers 2008; Sanders 2006)

Here they are presented in the figure below the same way as in the article of Sanders & Stappers (2008).

Level	Type	Motivated by	Purpose	Example
1	Doing	Productivity	"Getting something done"	Select/buy and prepare a microwave meal
2	Adapting	Appropriation	"Make things my own"	Adding extra ingredient to a ready-made meal
3	Making	Asserting my ability or skill	"Make with my own hands"	Cooking with a recipe
4	Creating	Inspiration	"Express my creativity"	Making a recipe while cooking

Figure 2. The levels of creativity by Sanders & Stappers (2008)

Depending on the level of expertise and creativity, it is possible for the "users" to become co-designers, meaning that they have the co-design role through the design process. In this study, the co-design process described above was used. The idea was to design a birth home by using the method of the co-design process. There were two workshops of which the first one was attended by potential customers of the birth home and the second one by potential personnel of the birth home which in this case were midwives. The workshops included different creative participatory methods that were the "ideation & expression tools" helping in the design process. In this study, the researcher was also the designer.

In WHO's Health 2020 –policy framework the aim is to "significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centered health systems that are universal, equitable, sustainable and of high quality". The term "people-centered health systems" can mean many things but using the model of co-design is "people-centered" and letting the service users say what they want and need is the future of designing services, including social and health care services. All along this has been one of the main reasons for doing this kind of thesis and co-design process that I have been doing. I wanted to hear the opinions of the customer/personnel and start designing the concept from their perspective.

People commonly think that design means making things pretty and that the designers will start their designing job after the product has been engineered or the idea has been given to them from somewhere else. This is still sometimes the reality in some organizations but more and more over the last decades the innovation process called design thinking has started to arise. (Traitler, Coleman & Hofmann 2015, 23-24.) The technological innovation and the wonders it has produced have changed our lives and will continue doing so. At the same time, we are fighting to resolve the growing waste and pollution problem and the technological innovations alone will not be able to solve it. Design thinking could be the new approach to innovation and finding solutions to problems like this. Something that brings the design and innovation for everybody, something that lines the natural world and peoples needs. (Brown 2010, 2.) Tim Brown (2010, 2-3) represents a good example of this when the Japanese bicycle company Shimano asked help from his design and innovation company in finding out why the American bike riding habits change from childhood to adulthood so strongly. 90 % of Americans rode bikes as kids and only 10 % of them when adults. The positive biking experiences as children were analyzed as well as the negative associations as adults and they were aligned. So, instead of just approving the technological facts the new bike designs included human factors to the design process.

Not long ago when talking about design, it mostly meant designing a physical product. These days design can focus on consumer experience, services, production

processes etc. In all this design, thinking is needed. Design thinking focuses on creating human centered products and services in a human way. It means working closely with the clients and customers so that the needs of the people consuming a product or a service are addressed. It lets people to be intuitive and construct ideas that are functional and have emotional meaning. It is rather a system of overlapping spaces than a sequence of orderly steps. The three spaces are inspiration, ideation and implementation. Inspiration being the problem or the opportunity that makes us search the solutions, ideation the developing process itself and implementation the part where the project leads from the project stage into people's lives. The different spaces do not necessarily follow each other in this order, the projects may go back through inspiration, ideation and implementation many times, as the project team brightens its ideas and finds new directions. While design thinkers go back and forth through these spaces they use a framework of three intersecting "constraints" that are "feasibility" (what can be done), "viability" (what you can do successfully within a business) and "desirability" (what people want). In his article "Change by design" (2010) Brown tells an example of how these constraints were used successfully when designing the new "Nintendo Wii" game console. Instead of the designers' common focus on graphics and consoles, the design thinkers focused on "how to make video games more appealing to wider market". (Brown 2010, 2-3; Brown & Wyatt 2010, 32-33.)

"How people actually use things" is the focus of design thinking. That means observing people and what they are and are not doing. According to Brown (2010) design thinking uses the same ethnographic observational techniques like in anthropology and by using them practical solutions are created. The thinking process of design thinking goes through different phases. "Divergent thinking" means going through choices and making more of them. "Convergent thinking" means going through your options and picking the best one. In "Analysis", the patterns are broken down and in "Synthesis" reassembled by going back and forth, analyzing, evaluating and examining it in practice and possibly starting from the beginning. Design thinking uses multiple methods while doing this innovation process such as drawing, role-

playing, mind-mapping, basic prototyping, storytelling, acting etc. Basically it can be anything that helps the innovation process. (Brown 2010, 2-4)

Through service design, we can make services that are considered from many different angles based on various needs. Understanding the customer, the needs and wishes have to be well understood before any services can be created. Services that give real added value to the customer. Co-designing together with the different stakeholders openly and equally so that everybody can share their thoughts. Doing the co-design iteratively until the result is satisfying. Using visual and creative work methods to make designing more controlled, easy and successful. Service design fits well in designing social and health care services because they have a lot in common. Both service design and social and health care services aim in creating the best possible experience to the customer by making the kind of service and service environment where the customer enjoys himself and where his needs are addressed. Both are based on the values of equal cowork that is creative, intuitive, systematic and goal-directed. (Ahonen 2007, 36-38; 66)

3 Birth home

In Finland, the childbirths have moved from saunas to hospitals. Because of the medicalization of the births and the high education level of the midwifes, Finland has become one of the world tops when talking about maternity care. The birth mortality rate in Finland is one of the lowest in the world. However, there is not really any other choice for the birth place than the hospital. The Finnish birth givers commonly think that the bigger the hospital is, the safer it is. A common thought is that Finnish health care is very high-level and the level of care is the same in every hospital. The birth givers are not used to comparing different nursing models or procedure statistics. In Finland since the 1970's the midwife education has included the education of a qualified nurse and since then the part of the non-institutional care was almost completely removed from the education and the midwives have been educated exclusively for hospitals. (Kätilöliitto n.d.)

The popularity of the small midwife-led-units (MLU) have rapidly grown during the last 15 years. The MLU's can be called birth homes, birth centers, or many other names. Common for all of them is that they are small, independent units, run by midwives and usually situated in natural surroundings and quite near the hospital. An MLU can also be situated inside the hospital. It is very common that the maternity care happens in the birth home meaning that already during pregnancy the birth home and the staff becomes familiar to the mother and the same midwives that take care the mother during the pregnancy take also care of the birth. The birth homes are usually designed to be very home like in the interior and the atmosphere is relaxed and easy-going. The birth homes keep birth orientation classes but all the clinical procedures like ultrasounds and blood tests are done in hospitals or at doctor appointments. Usually the birth homes work in cooperation with the hospitals and they have an advising doctor. (Bebes N.d., The Midwifery Birth center 2016)

In birth homes, there is a strong understanding of the connection between the birth environment and the course of the birth. There is typically 2-3 different birth rooms in a birth home and they are decorated beautifully. It is common to have a bath tub in the room and many equipment to use during the labour like mattresses physio balls, ropes etc. Mothers are encouraged to move around and to keep moving. All the clinical equipment possibly needed in the birth is near when needed but otherwise out of sight. The staff uses regular clothes as well as the birth giver. The birth home does not want to resemble clinical atmosphere or hospital in any ways and the birth giver is a customer not a patient. The mental preparation is known to have a strong impact on the birth and the course of it. The birth homes rely on the normal physiological birth. This means that the epidurals are not used and usually no other medical pain relievers either. Usually the mothers who come to give birth in the birth homes know about the normal physiological birth and they trust the ability of their body to go through the birth without the medicine. The birth homes use water in many forms in births and the water births are also common in them. The family, doula or the close friends of the birth giver can attend the birth in birth homes. (Bebes, N.d., The Midwifery Birth center 2016)

The most important reason why the birth givers choose the birth home as the birth place is usually the midwife model that is also called woman centered model. It means that the birth giver is in the center of her birth and her needs are accounted. The birth is emphasized as a social family event. In the midwife birth model the unnecessary procedures like vaginal examination and rupture of the fetal membranes are avoided. The course of the birth is not intervened. There is a trust that the woman's body will do it's job if the mother is given the peace to give birth. For example the birth is not hurried with the use of oxytocin and the electrical monitoring of the baby's heart rate is not used. When the baby is born there is no rush in cutting the umbilical cord. The mother gets the baby in her arms right away and the breastfeeding can begin. The baby is not taken away from the mother, all the necessary procedures are done in mother's bed. After a nutritious meal and about four hours time the family can leave the birth home to go home. (Bebes, N.d.)

According to many different studies when the mother is in good health and the pregnancy has been evaluated normal, giving birth in birth home is as safe as in the hospital. In Finland there is no birth home culture and therefore no possibility to give birth in a small home-like unit at the moment. However the woman centered model of birth giving is getting more popular all over the world at the moment so it is only a matter of time for Finland also to join this culture.

4 How to put co-creation into research practise?

This research is a case study on a single case of co-designing a visionary birth home with its potential customers and personnel. This case study follows the methodological theory of participatory action research (PAR) as an overall approach to reach the customers. The next chapters explain how the co-creation was implemented with the approaches of case study and participatory action research. Moreover, the theories or methods of agile development, innovation management and the Delphi method are presented. They all include information that has been important in the planning of this case study and the implementation of it. The last

chapter presents the creative innovation tools used for data collection in the workshops, the participative methods.

4.1 Putting co-creation into practise: A case study

People have always been interested in cases, stories, events, especially when they include something exciting, new and different. The word case is used when we talk about a person, a group of people, a community, an institute, an event or a broader phenomenon. A case usually differs from others in some ways, positively or negatively but it can also be an everyday event. Researchers have been fascinated about cases as well and, for instance, the anthropologists, sociologists, psychologists and education theorists have conducted case studies. When talking about cases in research, we are interested in action in a certain environment, a chain of events, and action in some particular case, a school class for example. In case studies, the objectives and implementation differ, but the common feature is obtaining versatile information in multiple ways about the case being studied. There is no solid definition of a case study. It is typically a qualitative research strategy that can sometimes be used also together with quantitative methods. The opinions on and definitions of case studies vary according to the field of science and era. The following sentence about case study can be found in many books and articles about case studies: *" The case study is not itself a research method, but researchers select methods of data collection and analysis that will generate material suitable for case studies…"* (Syrjälä L., 1994, 10-11 & Piekkari R. & Welch C. 2011, 183-185.) Robert Yin (2002, 4), who has popularized and legitimized case study as a scientific research strategy describes case study like this:

> *"A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident."*

This means that case study is used, for example, when the contextual conditions are needed to take into consideration and when in an experiment the context has to be divorced from the phenomenon. Yin says that since the phenomenon and context are not always distinguishable in real-life situations, the case study is an *"all-*

encompassing method – with the logic of design incorporating specific approaches to data collection and to data analysis." Yin(2002, 3-9)

According to one of the case study pioneers, Robert E. Stake (1995, 4), one of the most important questions in making a case study is "what can we learn from the case?" Characteristic for a case study is that we want to clarify something that is not yet known but it needs to be illuminated. "How" and "why" are the typical questions that case study answers to. The aim is to gain understanding about the case and the context being researched. (Laine, Bamberg, & Jokinen 2007, 10.)

There are several types of case studies. Case studies can be exploratory, descriptive or explanatory depending on the conditions of the case. The conditions can mean the type of the research question, the extent of control that the researcher has over the actual events and the degree of focus on contemporary events. When the research question is a "what"-question, it can be exploratory or explanatory depending on the type of the question. When the goal is to develop relevant hypotheses and suggestions for further research the study is exploratory. The "how" and "why" – questions are usually explanatory studies. Direct observation and systematic interviews are sources of evidence that are typical for case studies. The strength of a case study comes from its ability to handle a large variety of evidence. (Yin 2002, 3-9)

The typical critics about case studies concern the lack of rigor. It is said that too many times the researcher has been too careless and has allowed ambiguous evidence or partial views to influence the findings and conclusions. The researcher must work hard to report all the evidence and remember the partial views, and this can even affect the use of research strategies and other factore. Another concern about case studies is that they provide little foundation that could be scientifically generalized. One common complaint refers to the time that it takes and to the too massive results although it is said that this has changed lately. (Yin 2002, 9-10)

4.2 Putting co-creation into practise: Participatory Action Research

Participatory action research (PAR) is a research method that uses research information for developing and changing practice and produces information about the practical life at the same time. This means that there are two sides, that both benefit the research process. The researcher obtains practical information for testing and developing theoretical concepts, and the practical actor receives help for solving a problem or developing a product. PAR is interventing with the true world and examining the influence of the intervention. It has originated from the research of poor communities and the ways in which they could understand the reasons for their oppression. It has encouraged the communities to become active for a change. (Baum, McDougall & Smith 2006; Tiainen et al. 2015)

There are many ways to participate. One can vote, make position papers, statements, remarks and participate in different working committees. The different ways to participate can be interpreted according to their level of affection. Sherry R. Arnsteins (1969) “The ladder of participation” is a classic of the participation theories that were created to help interpretation. The ladder of participation demonstrates the connection that the different level of participation have to affection and decision making. The purpose of the ladder is to help to analyse participation and its level. The higher up the ladder we reach, the more power and possibilities to influence we have. The two lowest steps are called manipulation and therapy, and they form the level of nonparticipation. These steps occur mean that people are not told everything and they are made to believe that they are participating for some reason. In the middle of the ladder there is the “tokenism”-level that include informing, consultation and placation. They are the steps that have the smallest amount of participation. The highest level of participation is the citizen power including the steps of partnership, delegated power and citizen control. On this level the power is divided between the citizens and the authorities as a result of a discussion. (Arnstein 1969)

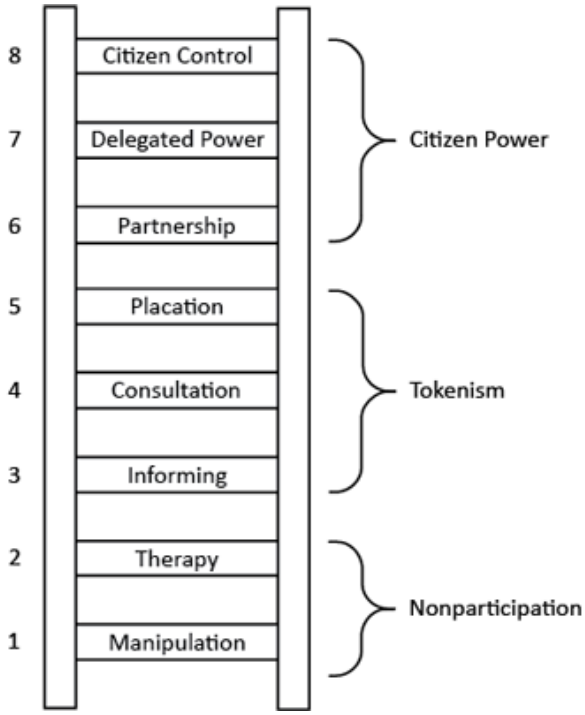

Figure 3: The ladder of participation (Arnstein 1969)

The target and the substance of participatory action research can be almost anything connected to human life (Kuula 2006). It begins when there is a problem or a challenge that needs to be solved. Interaction between the researcher and the participants of the research is essential. The researcher is an active influencer and actor who has knowledge of the subject being researched. The researcher has to have a clear understanding of the contextual actors of the subject. In PAR the researcher is an expert and a researcher at the same time. (Toikko & Rantanen 2009, 118; 124)

The participatory action research moves ahead like a spiral including the phases of diagnosing, planning, action, evaluation and learning. According to Susman & Evered (1978) the cycle phases are:

1. Diagnosing
2. Action planning
3. Action taking
4. Evaluating
5. Specifying learning

Phase 1. ”Diagnosing” consists of the identification of the problems and the causes to them. At this phase the researcher and the participants together formulate a working hypothesis to be used in the action research cycle. The expertise of the participants is used for mapping the situation, they describe the problem and the researcher brings relevant, researched data to the discussion. Phase two ”Action planning” means the specifying of the kind of action used to solve the problem, to improve the situation. The action research is usually iterative with multiple cycles so deciding only the first step is needed at this point. Again, relevant data is used to help the participants. The third phase is ”action taking” which means implementing the action planning phase. It might include expertise outside the target organization. The fourth phase is ”Evaluation”. It includes the defining of the evaluation criteria and self evaluation. The criteria is usually defined, when planning the action. The data is gathered and evaluated. The 5th and last phase is “learning” which means documenting and summing up the action research cycle. How did it go, what was the outcome of it and what information did we get. According to the research, it is important to test researched data in a practical situation and possibly find new problems, concepts and models.

Figure 4: The cyclical, iterative process of participatory action research by Susman & Evered (1978)

PAR is bound to a particular place; it diagnoses a problem and aims to solve it in the same circumstances. It is self-critical research that the participants do to achieve more reasonable or more efficient functions in their work place for example. PAR has been criticized for focusing to one problem in one context that makes it difficult or impossible to be generalised. Other reasons for critics have been for example the researcher's too big impact to the research, the reliability of the results and the unclear line between research activity and manipulation according to the researcher. Collaboration and active participation are important factors of the participatory action research. It is also practical, meaning that the focus of the research is in the activity of the target organization and the problem/case under development in there. The process of PAR is flexible and allows changes during the process. The idea in the cyclical process of PAR is to do little changes along the way to let the development happen little by little. The reflection of the activity and the impact of it is an essential character of PAR. Through the reflection we can get results that are not achievable with any other method. It is typical for PAR to have 2-3 cycles. Each cycle includes a specified problem solution which is part of the original problem. Cycles are done until the aimed change or goal is achieved. (Tiainen et al. 2015)

There are three different process models of PAR: iterative, linear and reflective. In the iterative model the recognition of the problem and the action alternate until the solution is found. The linear process model focuses on the testing and reflection of single intervention. The reflective model researches human operations, the connections between different operation models aiming to find solutions to them. (Tiainen et al. 2015) In this research the iterative cycle was used.

4.3 Putting co-creation into practise: The co-design process

This co-design process had its beginning in the DDP Programme's winter school in Austria that I was attending spring 2016. There we had a class of creative writing and the first ideas of our Master thesis subjects were discussed. The original idea was to make a business plan or co-design a place called "house of women" that would give

social and health care services to girls and women of all ages including, day care, immigrants nursing home and a birth home. After winter school the exposé was written and approved and the planning of the actual research began. Like mentioned before the first idea was to make a business plan. First a business plan about the house of women which then transferred to the business plan of a birth home which was transferred to a co-design process of a birth home. Spring 2017 the workshops were kept and with the workshops the reality was also something different than the original idea. The first idea was to have 2-3 workshops with potential customers but after more researching was done it became clear that the other workshop would have the professionals as the participants. Here the theories or methods of agile development, innovation management and Delphi method are explained. They formed the information needed to design these workshops and to perform them.

4.3.1 Agile Development

Agile development was originally developed for programming but it is nowadays used also for designing or enhancing products and services. The agile development includes customers in the development process and gives them an active role. With the customer feedback and reflection, the product is iteratively developed and this leads to a more satisfying outcome. (Dingsoyr, Nerur, Balijepally & Moe 2012, 1214.)

The agile development has been popular over the last two decades. In the 1980's the software development started using iterative and interactive methods like James Martin's Rapid Application Development that gave the basis for the rise of the three most important agile methods: Extreme Programming, DSDM and Scrum. Year 2001 the agile method pioneers gathered together and wrote the statements and principles of the methods. It is called "Manifesto for Agile Development". (Lankhorst 2012.)

Manifesto for Agile Development

We are uncovering better ways of developing software by doing it and helping others do it. Through this work we have come to value:

- Individuals and interactions over processes and tools
- Working software over comprehensive documentation
- Customer collaboration over contract negotiation
- Responding to change over following a plan

That is, while there is value in the items on the right, we value the items on the left more.

Figure 5: Manifesto for agile development. (Lankhorst 2012)

Although Agile development or Agile or Agility was originated and evolved in the software engineering community these principles can be easily used in any kind of development process and dynamic environment. Customers these days ask for different services rather than just the product itself but the level of professionalism in developing services rarely matches the level of expertise in the product development in the organization. This is where agility steps in. It is the capacity to deal with changing conditions and surroundings and adapting to it. The change is seen as a positive force. (Lankhorst 2012, 2; Moreira 2013, 2.) The focal point of agile development is to deliver customer value. Value is what the customer gets from the product or service when their needs are met. Customer value can only be defined by the customer and with respect to a specific product/service or both. It is also affected by time and cost which makes it elusive. It means that it is not stable, it has to be continually adapted. The things we like today and find valuable might not be the things we like and find valuable tomorrow. This is why agile development is important because with its iterative continually adapting nature the customer needs can be met. (Moreira 2013, 7-10.)

4.3.2 Innovation management

Management is activity that is needed to achieve a goal. It is activity that achieves, targets and benefits through contribution and collaboration. There are several management theories, paradigms that change through times and trends. Innovation

management is one of them and a possible one to be “the management theory” of the beginning of the 20th century. (Seeck 2009, 36-40)

Thinking of the word “innovation” makes you think of a new idea, product or a service. There are different meanings on innovation but common in all of them is that it means something new. It is said that innovation has “novelty value” which means that it can and has to be differentiated from improvement. It brings a solution to a problem or descends from a new combination of technologies and their contexts that already exist. The other aim or reason for innovation is benefit. The companies always want to benefit from the new products or services they make. The important aspect of an innovation is that it has to create value for the customer as well as profit the producer. Business models or organizational arrangements can also be innovations like the new technologies, products and services. (Kettunen, Ilomäki & Kalliokoski 2008, 5-7, 30-31)

It is said that all successful companies are based on innovation. Like said before it can mean innovation in products, services, business models or paradigms. How are innovations managed though? It is impossible to have a single concept that could be successfully copied from one company to another. Different companies with different cultures and strategies make it challenging for a common innovation process. All innovative companies have similar actors for innovation culture that are communication, collaboration, trust, freedom, learning, entrepreneurship, risk tolerance and innovation as a company value. (Apilo, Taskinen & Salkari 2007, 33-36) Sometimes the difference between business management and innovation management is very small. They both concentrate in future wanting growth and profits to happen. Where business management concerns the future looks and the way to get there the innovation management can help in specifying the future objects and in finding the way. It is essential to “step outside the box” and to see beyond the businesses that are already there although innovation management should not be a separate thing either. In fact it has been noticed that the stronger the connection between innovation process and companies other processes and functions, the more successful the outcome of the innovation process. For

innovations to be born creativity, chaos, overlapping functions, data transmission and failures have to be connected to company's other processes and systematic procedures. The different phases of innovation need different management. For example in the beginning of an innovation process innovation leadership is needed in the form of providing favourable circumstances and supporting people and their ideas. In the end of an innovation process management is needed again. Innovation management is not a work of a single manager neither a subject of a singular unit like research & development. It covers whole company and therefore needs a separate system, a strategy. (Kettunen, Ilomäki & Kalliokoski 2008, 34-44; Apilo & Taskinen 2006, 19-20)

4.3.4 Analyzing the Participatory action research: The Delphi method

The Delphi method refers to the ancient Greek oracle place called Delphi where the high priestess Pythia answered the people's questions about the future. As a research method, the Delphi method has same kind of interest to predict the future, to find the answers to the problem in hand. It is a method that allows each member of a group to develop the collective conclusion when staying at individual level at the same time. As the conclusion of the group develops the members keep checking their position and perception of the situation gradually and at the same time they can make proposals for correction and modification. The final solution is a conclusion that each member is aware of. (Anttila 2007.)

The Delphi method begins with the gathering of the expert panel. The experts do not have to be academically advanced, it is sufficient if they are in a way or another interested and acquainted of the topic. It is also important to have a group whose expertise supplement each other so that the topic or problem on hand could be as versatile and realistic as possible. The Delphi method aspires to present predictions about the future based on experts different aspects. The aim is to get the essential information crystallized. The three typical aspects of the Delphi method are: the anonymity, iteration and the feedback. (Savela & Hakulinen 2007.) In this research

the experts were the potential customers and the potential personnel of the visionary birth home. The first workshop consisted of the potential customers and the second workshop the personnel. In the second workshop the work and the results of the first workshop was presented and they continued working from where the first workshop ended. The Delphi method is also a method of analysis since it "forces" the researcher to do some analysis between the iteration cycles. That was the case also in this study.

4.3.5 Triangulation

Combining different methods, data sources, theories or investigators in a research to get multiple aspects is called triangulation. Triangulation is often used to gain a deeper understanding of a phenomenon. There can be data source triangulation, theory triangulation, method triangulation or analyst triangulation and any combinations of these. Data triangulation means using multiple data (interviews, statistics, surveys, different times etc.) or data sources (comparing people for example doctors, patients, family). It is typical for a case study. Theory triangulation uses multiple theories or sciences to explain phenomena. Method triangulation means the use of multiple methods. There are features of method triangulation in case studies because multiple data needs multiple methods for data gathering and analyzing. The use of method triangulation gives a more comprehensive image of the subject than the use of one method. Therefore, it can also approve the reliability of the research. Sometimes quantitative and qualitative research methods are combined in a triangulation. Analyst triangulation means having multiple analyst to understand multiple ways of seeing the data. Normally these 4 main types of triangulation are known. There can also be analysis triangulation if multiple methods of analysis are used or multi triangulation when many different types of triangulation are used. (Denzin, N. 1978; Kananen, J. 2013; Saaranen-Kauppinen A. & Puusniekka A. 2006) In this study, the data triangulation was present because multiple data was collected and it happened in two different times. There was also theory and method triangulation in this case study.

4.4. The co-creative participative methods to co-design innovative birth home

Participatory research and the methods it uses means planning and doing the research process with the people whose life and actions are under study. In participatory research, science and practice come closer to each other, interact and make an understanding of each other. Because of the creative character of participatory research and the individuality and self-determination of the research partners this research style cannot have a single methodological approach. Usually, in practice the research uses many different participatory research strategies. (Bergold & Thomas, 2012) In this study the expression “participative methods” refers to the creative tools of ideation that has been used in the two workshops where all ten data to this study was collected.

Finland is going through a vast reform in social and health care system at the moment. One of the key projects for the ministry of social affairs and health is to make the social and health services customer orientated (STM 2016). The customer no longer is considered as a passive service user but as an active person with different needs and roles. (Keronen 2013). By using the agile and participatory methods, the customer can become part of the service design process and create the kinds of services that would serve her in the best manner. In WHO’s Health 2020 – policy framework the aim is to “significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centered health systems that are universal, equitable, sustainable and of high quality”. I wanted this birth home project to be a “people-centered health system” since the very beginning. The data in this research was gathered by using participative methods in the workshops. The participative methods used were brainstorming, creative writing and learning café.

4.4.1 Starting the co-creative Participative Action Research: Brainstorming + Creative writing

Alex F. Osborn published the book ”Applied Imagination” in 1953 where he presented first time the problem-solving technique called brainstorming. Since that it has been widely used in many different kind of situations and nowadays is a well-known creativity technique used to collect ideas. Alex F. Osborn had an advertising company where he encouraged the workers to “think up” which was the precursor of brainstorming. He was interested in creative thinking theories and the aspects of them can be seen in his four brainstorming rules. The rules are:

1) Create as many ideas as possible. Quantity over quality.
2) No criticizing.
3) Wild ideas are welcome.
4) Ideas can be combined and improved

Osborn designed brainstorming to happen in a group of 5-12 people and the rules and techniques were taught to the participants by a facilitator. Brainstorming became very popular In US and after 5 years of publishing the “Applied Imagination” it was used in 80% of all the large companies. Since then it became a focus of research and several studies were made comparing for example the productivity of individual brainstorming and group brainstorming. Some of the studies did not see brainstorming as effective and it started getting bad reputation in academic environment. Some later review of 50 studies (Isaksen 1998) revealed brainstorming as the most studied creative technique and at the same time the least understood one. World famous company owners like Bill Gates and Steve Jobs are known to have used brainstorming in Microsoft and Apple “in their own way”. Bill Gates used more the individual brainstorming model during his “think weeks” when he took a week off and spend it alone in a cottage going through his workers ideas. Steve Jobs was more loyal to the original idea but he also made his own style of it and focused more on the quality of the ideas rather than quantity. Today one of the innovation leaders in the world, the design company IDEO uses brainstorming daily and they follow most of Alex Osborn’s ideas. (Besant 2016, 1-7.)

In this study brainstorming was used in the beginning of both workshops. A picture of a house was drawn to a flip chart and it was told to represent birth center. The group was encouraged to tell what words or expressions came to their minds from the word “birth home” (in Finnish synnytyskoti-birth home) and the answers were written to the flip chart.

The sprint writing is an exercise of creative writing technics that I got familiar with in my double degree programme studies. In winter school in Austria I attended a class of creative writing and this exercise was one that we did. In this exercise the idea is to write at least 10 sentences that each begin the same way. As fast as possible and without thinking to much you write the endings to the sentences. The idea is that when you don’t think you might end up writing about something that is eventually a good and usable idea. In the creative writing class we were trying to come up with ideas and topics for our thesis’s. Each sentence started with “If I could I would write about…”. I liked this exercise a lot and since winter school I wanted to use it in the data gathering of my thesis. In this study the sentence began with words “If I could I would give birth (or be a support person) in a birth home that/where… or ”If I could I would work in a birth home that/where…” depending on the workshop.

4.4.2 Implementing the co-creative participatory action research: The Learning café

Learning café is a method used for learning and innovating. It is a collaborative method for discussion, creating and transmitting knowledge. The discussion is important: explaining different opinions and finding a mutual understanding. (Savolainen, H. 2017.) Various names are used for learning cafés depending on the context. Strategy café, creative café, leadership café or many times world café in English is based on the idea that people already have the knowledge and creativity needed to find the answers for a particular question and together we are more than alone. (The world café community 2015.)

Learning café happens in small groups where the participants are divided into small coffee table groups of 4-5 members in each. Each table has their own topic that they talk and make notes about. The table has a table cloth or a large paper that can be used for making notes or the highlights of the conversation. The group in each table chooses a table host among them who remains at the table during the whole time. The group can decide whether the host or all of them are making the notes. Each table has their own subjects or questions to answer to and each coffee table round lasts 20-30 minutes. The host welcomes the new coffee table members and briefly informs them about the prior conversation and the key insights of it. (The world café community 2015.) In this research the workshops included learning cafes with two coffee tables and two topics. Both tables chose a host from their group that stayed in the same table all the time.

5 The co-design process of an innovative birth home

In this chapter the iterative co-design process of the birth home is explained. It describes how the workshops were planned and implemented in two phases: first workshop 1 and then workshop 2. The work that was done between the two workshops is presented as well. In the first subchapter the objective and the research questions are explained.

5.1 The research questions

The main purpose of this study was to co-design a visionary birth home together with the potential customers and personnel of the birth home. The overall objective was to study if co-design would be a useful method in designing social and health care services. Co-design is an example of the new service design culture. The main research question was: HOW CAN CO-DESIGN BE USED IN DESIGNING SOCIAL AND HEALTH CARE SERVICES?

- What is the added value of co-design in designing social and health care services?
- How does the data produced by co-design differ between service users and professionals?

The philosophical background of this study is in constructivism where the core idea is that knowledge is not transferred but constructed and that knowledge is the result of the interpretation of reality. It means that we are all different and have different knowledge and experiences, and when we are learning, we are constructing on top of what already is in our knowledge already. Subjective experiences become objective knowledge through social interaction. All the models, plans, diagrams, products and information systems are constructed. It means that they are not found, they are invented and developed. (Lukka 2001)

5.2 The planning of the workshops

It was clear from the very beginning of this research process that the data collection had to be creative and include the potential customers to some extent. In the Master studies of social and health care management and development, we had classes and courses about service design, innovation management and co-creation, for example. The classes gave me the knowledge and idea to do my Master thesis in collaboration with the potential customers and personnel and co-design the visionary birth home. Another reason for taking along the customers to the research process was the fact that there were no birth homes in Finland at the time, only one that functioned by renting the space. For me, it was important to hear and see what kind of birth home people would want and what the services in the birth home would be like when we ask the people potentially using it. I have also been used to collaboration and participative methods to some extent because of my degree in social studies, and that might be one reason why this kind of functional way of working appeals to me.

The core idea was to be as creative as possible and to find multiple answers for the research question “How can co-design be used to design social and health services?” Literature about participation and different participative methods was studied, and the planning of the workshops began. The participative methods chosen for the workshops were Brainstorming, Creative writing and Learning Café. They are called methods later on in the text. In the beginning, the idea was to have 2-3 workshops containing the potential customers of the visionary birth home. Later on, when becoming acquainted with the Delphi method, it proceeded to the idea of having potential customers in the first workshop and professionals (midwives) in the second workshop. Both workshops were video taped for potential later use and the group work conversations were videotaped or voice recorded. All the participants in the both workshops were Finnish, and all the discussions and exercises done in the workshops were in Finnish. My own role in the workshops was to be a facilitator and to guide the exercises so that everybody would understand what they were asked to do. I did not take part in the participative methods.

5.3 The first workshop: doing and harvesting

The planning of the workshops began with the search of a place/environment that would be good for creative working. The place needed to have separate rooms or sufficient space for separate coffee tables for one participative method, hopefully technical equipment, kitchen and a toilet. After some searching, a perfect place was found in Tehy trade union’s office in Turku. They offered their meeting rooms for use free of charge. When the place and dates for the two workshops were agreed the gathering of the suitable participants began. The participants of the first workshop were gathered from two pregnancy orientated Facebook groups called “Raskaana Varsinais-Suomessa” and “Aktiivinen synnytys”. An advertisement about the on-coming workshop was published in the Facebook groups. Some of the participants were also my family and friends. The Facebook group “Raskaana Varsinais-Suomessa” is a group for pregnant families and the people giving services for

pregnant families in South-West Finland. The Facebook group “Aktiivinen Synnytys” is a large Facebook group for everyone interested in the active birth culture.

The first workshop was held in April 2017. It was attended by seven potential birth home customers. In the beginning of the workshop, I shortly introduced myself and told about my professional background as well as this thesis and the idea behind it. I told the participants that the idea was to be as creative as possible and to let the ideas flow and that hopefully all the ideas and thoughts were told out loud and there was no need to filter them. Coffee was served, and I encouraged the participants to walk around and have more coffee during the workshop, and be as relaxed as possible.

Then the creative part began. The first participative method was brainstorming. I drew a house on a flip chart and asked the group to tell any words or impressions that came to their mind with the word “birth home”. After this exercise, I told the group some facts about birth homes. I had prepared a PowerPoint -show about birth homes in case somebody did not know what the concept “birth home” meant since there were no birth homes in Finland. When planning the first workshop, I did some thinking about the order of the participative methods and whether to show the PowerPoint-slide show before or after the first method. I ended up doing it in this order because I wanted the first participative method, the brainstorming, not to be influenced by any information given in advance.

The second method was a kind of “Creative writing” method where everyone was given the same beginning of a sentence: “If I could I would give birth (or be a support person) in a birth center that/where…” The group was asked to write approximately ten sentences that would begin with the same example sentence. They were also told to do it as quickly as possible so that their “minds would flow” and no hard thinking was needed since there were no right or wrong answers.

The third participative method was a Learning Café. The group was divided in two different coffee tables that had their own topic. Both tables had a host who was the

"secretary" who wrote down the main ideas of the discussions in the group. The group decided themselves who the host would be in that group. The discussions went on for about 15-20 minutes and after that the group changed the tables. The hosts stayed all the time at the same table and explained the new group what the topic was and what the earlier group had produced and then the second group continued from that. The topic in the first table was: "Birth home of your dreams – What's in it?" and the topic of second table was: "If the birth home of your dreams existed, what advantage could it have? Could there be any disadvantages?". When the groups had finished the discussions, the results of the two groups were presented to everybody by the hosts.

5.4 The analysis after the first workshop

There was one week in between the two workshops. The second workshop was designed after the experience of the first workshop. When planning the first workshops, it was decided that if something went wrong in the first workshop, for example if some exercise would not work somehow or give any data then it would be changed to something else. Luckily this was not the case because everything worked out very well in the first workshop and the amount of the data produced in it was satisfying. All the participants were active and took part in the conversation After the first workshop the second workshop was designed with the experience of the first workshop in mind. The second workshop was designed to follow the same order and exercises as the first one. The only difference would be that before each exercise the output of the same exercise of the first workshop was shown or explained to the participants of the second workshop.

The output of the first participative method, the Brainstorming, was in a paper of a flip chart and that was planned to be shown and explained to the participants of the second workshop before they began to do their Brainstorming exercise. A small analysis of the second method, the sprint writing was done where the sentences of the sprint writing were transformed into one word/impression and entered to a

program that calculated the incidence of the words/impressions. The program made a graph in which the most common words/impressions were written in greater font size than the more uncommon ones. The same PowerPoint-slide show about the birth homes was decided to be shown in the second workshop as well. The output of third method was decided to be explained to the second workshop and the idea was that they would continue from where the first workshop had left.

5.5 The second workshop

The second workshop had six participants that were midwifery students and teachers from Turku Polytechnic school and professional midwives working in Turku university hospital. The students that attended the workshop were nearly graduated and the midwifery teachers were also midwives. The participants were gathered through a Facebook invitation. Like in the first workshop coffee was served and in the beginning I shortly introduced myself and told about my vocational background as well as this thesis and the idea behind it. I told the participants about the idea of creativity and that they would be allowed to dream now because we were designing a visionary birth home and even if they would know that something could not be possible because of a particular law or a rule, they would not let it stop the flow of ideas. The first participative method was the Brainstorming, and the participants were shown the work of the first workshop before they started their brainstorming.

The second participative method, the Creative writing, had small analysis done between the two workshops and the results of it was explained to the participants of the second workshop. According to the first workshop the most common aspects of the birth home were family centeredness (perhekeskeisyys in Finnish, n=5), individuality (yksilöllisyys, n=5), security (turvallisuus, n=4) and professionalism (ammattitaito, n=4). This graph of the answers of the first workshop was shown to the midwives attending the second workshop.

Figure 6: The results of the Creative writing method of the first workshop/The mean time analysis

After seeing the results of the potential customers of the birth home, the midwives did the second participative method, the sprint writing. The third participative method, the Learning Café included the results of the two individual coffee tables in the first workshop. The results were explained to the midwives and they added some aspects to it. The participants of the both workshops were very talkative and participative. There were times when the groups just started talking and the exercise had to be stopped. I tried to stay in my “designer” or “facilitator” role and tried not to talk so much that I would normally do so that the outcome of the participative methods would not be affected. This facilitator’s role was not very easy all the time because I was asked questions about birth giving, especially in the first workshop.

6 The results of the co-creative workshops

In this chapter, the results are presented according to the participative methods used in the workshops. The results are shown one method at a time in the same order as they were conducted in the workshops. The data produced in the workshops was documented, interpreted and analyzed by using thematic analysis. Thematic analysis is a commonly used qualitative data analysis method that can be used in different frameworks. Its purpose is to identify patterns of meaning in the research data that answer to the research question. (Tuomi & Sarajärvi 2013, 91-93) As the workshops were held in Finnish, first all the data collected from the workshops had to be translated to English first.

6.1 The results of the first participative method: Brainstorming

The first exercise, the brain storming, was done in the same way in both workshops. A sketch of a house was drawn on the flip chart and the participants were asked to brainstorm anything that came to their mind from the concept “birth home/synnytyskoti”. The first workshop that consisted of potential customers of a birth home produced 28 expressions. Thematic analysis was used in the analysis of this exercise. First, all the 28 expressions were grouped into smaller groups that would have an applicable title to them. Three groups were made and they were “descriptive adjectives”, “expressions of action/function” and “expressions of physical surroundings”. The biggest group was the “descriptive adjectives” with twelve expressions. They were safe, warm, homelike, family centered, soft, individual, open, informative, no need to fear, friendly, threshold and peaceful. The group of “expressions of action/function” had eight expressions that were: maternity clinic, same midwife all the time, coach, continuity, sincere considered encounter, 24 h, always a comforting word, rush can’t be seen. The third group “ expressions of physical surroundings” also had eight expressions that were: near home, near hospital, soft big gloomy rooms, rocking chair, normal bed, beautiful bed sheets, something other than white, an own room for the family.

Descriptive adjectives	**Expressions of action/function**	**Expressions of physical surroundings**
safe	maternity clinic	near home
warm	same midwife all the time	near hospital
homelike	coach	soft big gloomy rooms
family centered	continuity	rocking chair
soft	sincere, considered encounter	normal bed
individual	24 h	beautiful bed sheets
open	always a comforting word	something other than white
informative	rush can't be seen	an own room for the family
no need to fear		
friendly		
threshold		
peaceful		

Table 1: The results of the brain storming method of the first workshop

The second workshop that consisted of midwives as participants was shown the results of the first workshop, and after that they did the same brainstorming exercise. They produced 17 expressions that were mostly concepts (16). They were: freedom, choice, family, peace, feeling of security, control, naturality, tenderness, stagnation, one's own wishes, responsibility, decision making, atmosphere, forethought, satisfaction, preparation. One of them was an expression describing function: midwife's possibilities of analgesia.

Nouns	**Expressions of action/function**
freedom	midwife's possibilities of analgesia
choice	

family	
peace	
feeling of security	
control	
naturality	
tenderness	
stagnation	
one's own wishes	
responsibility	
decision making	
atmosphere	
forethought	
satisfaction	
preparation	

Table 2: The results of the brainstorming method in the second workshop

6.2 The results of the second participative method: Creative writing

The second participative method used was a creative writing exercise, a kind of a sprint writing exercise, where the participants were advised to complete ten sentences as quickly as possible. Each of the sentences started with the same words. The method was the same in both workshops; only the beginning of the sentence was modified to better match the participants' possible role in the birth home. In the first workshop, where the participants were potential customers of the birth home, each sentence started with the words **"If I could I would give birth or work as a support person in a birth home where…".** Each participant wrote five to ten sentences. First, the sentences were translated to English and a table was formed (Appendix 1). In the table, there are numbers on top that represent the participants and below each participant are the results (the endings of the sentences) of the creative writing.

In the second workshop, where the participants were midwives the beginning of the sprint writing sentence was modified into the version **"If I could I would work as a midwife in a birth home that has/where…".** They wrote 10-15 sentences. The sentences were translated into English and written in a table (Appendix 2).

6.3 The results of the third participative method: The Learning Café

The third participative method used in the workshops was the Learning café where the participants were seated at two coffee tables. Each coffee table had their own topic and after 15-20 minutes, the participants changed from one table to the other and continued working on where the first group had finished. The topic at table 1 was **"What is in the birth home of your dreams?"** and the topic in table 2 was **"If the birth home of the dreams existed, what would be the advantage of it? Could there be any disadvantages?".** The participants started talking about the topic, and each table had a host whose job was to write down the conclusions of the conversations. The host stayed at the table when the participants changed and reported the work of the earlier group to the new group. The discussions were videotaped and voice recorded. This is how it was done in the first workshop. In the second workshop, where the participants were professionals, the results of the first workshop were presented and (as in the Delphi method) after that the participants discussed them and added some expressions to them.

6.3.1 The results of coffee table No. 1

The coffee table with the question "What is in the birth home of your dreams?" produced the expressions shown below in the first workshop. The expressions were translated from Finnish to English, and the translation was done to resemble the original expression as much as possible. The expressions written in blue are the results of the second group that after the changing of the tables continued working on the topic.

soundproof rooms	background music	big home-a-like rooms
light	big bed	ropes to hang about
stools	a tub	a gymnastic ball
room for the whole family	a shower	a birth stimulation room where you can practice and test all the birth equipment
nature sounds, musical instruments	rehearsing the birth beforehand	good food, delicacies, healthy and empowering food
a midwife/doula is present throughout the birth	a better ring bells system (than in the hospitals)	good possibilities to get some fresh air, surrounded by beautiful nature, park where you can walk
medical readiness (not visible though)	professional, capable midwives	The 2nd group: to be able to stay right away at the birth home (especially the first timers)
the experiences of the first time birth givers are important	mentally important to encounter the birth giver "the right way/well"	the doors are always open
"there are no stupid questions" –attitude	the mental encounter is most important -> brings safety	Mother is the main person in her birth

Table 3: The results of the learning café method of table 1 in the first workshop

In the second workshop, the professionals commented on the results of the first workshop and continued where the first workshop participants had left. The table

below presents what they wanted to add to the work done by the previous workshop.

birth orientation/birth coaching	maternity clinic	the place is familiar beforehand, staff met	led by midwives
deep orientation to the birth already during pregnancy so that the pelvis/stomach area is in optimal shape according the forthcoming birth + accompanied by the partner	teaching the concrete things for the partner to do during the labour (like pushing the acupuncture spots) -> helps to be at home longer	"we need to get away from the thought that everything is going to go to hell" (like the common idea is about the home births)	a place to meet: different peer groups (breast feeding etc.)
No ring bell system	A work partner		concrete things (the weight of the pelvis)
personnel resources adequate -> time with the family	the hopes and wishes of the family known beforehand because familiar midwife	less filing the report, more attentively present	the possibility to file the report by mobile or in the room

Figure 10: The result of the learning café method of table 1 in the second workshop

Besides that there was a discussion about some of the results of the first workshop. The participants of the second workshop really liked the idea that the responsibility about the after care would be given to the midwives and not the mother herself like

is the current situation in Finland. Meaning that the midwives would contact the families in every case. It was said “it would help to know that the midwife is going to call tomorrow morning when you have been awake with the crying baby all night long”.

On top of this, the first workshop also thought of ideas about the services that the birth home could give besides the birthing service itself. Here they are listed below.

the mother –child clinic (the health care and the monitoring during and after pregnancy)
the services after birth/post-partum services: breastfeed support, home visits, the mental and physiological rehabilitation of the mother
recognising the fears and nursing it + caring the postpartum depression
peer groups
“low doorstep” to contact right after the birth
The midwives would contact the birth giver after the birth (like for one week)
The “after care” also for others than the first timers + other services
Going home according to mother’s own knowledge, (not after 2 days)

Table 4: The result of the learning café method of table one, the services in the birth home

6.3.2 The results of the coffee table No. 2

The coffee table number 2 had the topic: ”If the birth home of the dreams existed, what would be the advantage of it? Could there be any disadvantages?” The results of the coffee table discussions in the first workshop are presented below. The first table is about the advantages of a birth home.

Less interference - no stupor from medicine - interfering	Supports physiological birth	home-a-like environment, more pleasant for the family	home-a-like environment -> the secure feeling → the more secure	no “fear of the white jacket”

adds interference			birth	
More individual care	Familiar midwives	midwife is acquainted with the birth giver	the possible fears and wishes according the birth are handled already beforehand	softer ways to help/interfere the birth
a secure feeling and a secure environment help to forward the birth and the recovery from it	the less interference to the birth the faster the recovery from the birth	the family can be with the mother	the emphasis is on the prevention of the emergency situations	A positive birth experience increases the birth rates
a change of attitude towards birth - naturality of the birth - pregnancy is not a sickness	more open, more dialogical	continuity, the familiar same staff	the more likely positive/successed birth experience	empowering birth

Table 5: The results of the learning café method of table 2 in the first workshop, the advantages of the birth home

These results were represented to the participants of the second workshop, the professionals. They added the following expressions to it.

A more sensible way to work for a midwife -> The sensibleness, permanence and gratitude of the work
When the midwife is familiar the mother's trust is is possibly bigger
A lot of expertise about non-medical analgesia
Yoga, relaxation

Table 6: The added results of the learning café method of table 2 in the second workshop

Here are the results of the disadvantages of the birth home according to the discussions in the learning café method in coffee table 2.

In the emergency situations the help is more far away
The lack of readiness for emergency caesarean section which at worst can lead to baby's death
the possible transfer to the hospital
does it increase the expenses or the inequality -> who gets to give birth in a birth home
the clearing of the finances (confusing law)
who is responsible if something happens?

Table 7: The results of the learning café method of the table 2 in the first workshop, the disadvantages of the birth home

7 The analysis in this case study

The data produced by a study can be analyzed in various ways. The main principle is to choose an analysis method that brings out the answer to the research question. In a qualitative study the analysis is usually difficult. There are many options and no strict rules guiding the choice. The qualitative studies can be analyzed by using statistical techniques but the most typical methods for analysis are thematic analysis, content analysis, discourse analysis and conversation analysis. (Hirsjärvi &co. 2010; 224-225) The term ”analysis” sounds fancier than it actually is in reality. In empirical study the analysis refers to the careful reading of the data, organising of the data and mostly thinking about what is in the data and how it can be shown. The analysis can mean the grouping the data according to different themes or subjects. The main idea is to make something understandable from what most of the times is very coloured and large material. Through the analysis, the information value of the data is added. The material is condensed and interpreted and the researcher is in constant dialogue between the theory, empiricism and his own thinking. In the end, the researcher should have something more than just the material in its original form. It is said that

when talking about qualitative research something “arises” from the material, from the data. But it does not happen by itself, it only happens when the researcher thinks and talks to the data and seeks answers to the question: “what is in the data that connects it to the research problem?”. (Saaranen-Kauppinen & Puusniekka 2006)

7.1 The analysis of the first participative method: Brainstorming

The results of the first participative method used in the two workshops differ from each other in the amount and the quality of the expressions produced. The first workshop produced 28 expressions and the second workshop 17 expressions. The expressions in the first workshop were divided into “describing adjectives”, “expressions of action/function” and “expressions of physical surroundings” of which the first group of describing adjectives was the largest. The second workshop produced mostly nouns that were conceptual impressions. The results of the potential customers of the first workshop were more versatile than the results of the midwives in the second workshop.

7.2 The analysis of the second participative method: Creative writing

The analysis of the creative writing was done according to thematic analysis. After the sentences were written to the tables performed in the attachments (Attachment 1-2) began the coding of them. The similar kind of sentences or sentences meaning the same thing were grouped under a headline that would describe the sentences in that particular group. Five main themes was found. They were SURROUNDINGS, STAFF, FAMILY, ATMOSPHERE and BIRTH (Appendix 3).

In the “SURROUNDINGS”-group are the sentences that describe the physical grounds of the birth home. Examples of the sentences describing the surroundings are:
“If I could I would give birth or work as a support person in a birth home where…

…it smells good, not like medicine

…is some other system than a ring bell for the staff

“If I could I would work as a midwife in a birth home where…

…water in all forms is used for relaxation

…the access to hospital would be quick (when needed)

The “ STAFF”-group consists of sentences that describe the staff of the birth home or the ways they are working. Examples of the sentences in this group are:

“If I could I would give birth or work as a support person in a birth home where…

…you always get an answer to your question and there are no stupid questions

…you get good individual service

“If I could I would work as a midwife in a birth home where…

…the staff resources are adequate

… I could carry out midwifery from my own professionalism – not from hospital rules

The “FAMILY”-group consists of sentences describing the families possibilities to attend the birth or the way they are considered. Examples of the sentences in this group are:

“If I could I would give birth or work as a support person in a birth home where…

…family is in the middle

…whole family is welcome

“If I could I would work as a midwife in a birth home where…

…the children would be welcome to participate the birth

…the family would be known beforehand

The “ATMOSPHERE”-group consists of sentences that describe the different aspects of atmosphere. Examples of the sentences in this group are:

“If I could I would give birth or work as a support person in a birth home where…

…is safe

…is gentle and peaceful

“If I could I would work as a midwife in a birth home where…

…is safe

… the work atmosphere would be compassionate and open

The “BIRTH”-group consists of sentences describing the birth itself. Examples of the sentences in this group are:

“If I could I would give birth or work as a support person in a birth home where…

… the birth is natural (no concentration on what can go wrong)

…the birth is given time

“If I could I would work as a midwife in a birth home where…

… the birth givers would have prepared for the birth

…would be time

After dividing the sentences into the groups of SURROUNDINGS, STAFF, FAMILY, ATMOSPHERE and BIRTH, the frequency of them was calculated. There were sentences that could have been in two or three groups. For example the sentence “where all the hard and difficult parts according the birth and puerperium are told” could be in the group of “STAFF “or “BIRTH” but it is in the group of “BIRTH”. The “BIRTH”-group was the last one formed. In the beginning all the sentences were in the group “STAFF”. There were so many sentences in it that it needed to be divided into two groups. All the sentences including some comments about birth were transferred to the group ”BIRTH”. Both groups include sentences concerning the work of the staff but the sentences concerning the birth were transferred to the group “BIRTH”.

In the first workshop the total result was 63 sentences of which 1/3 of were sentences concerning the surroundings of a birth home. The sentences were about the actual building of a birth home and the interior of it as well as the equipment in there and the distance from hospital. 15 of the sentences were concerning the birth. There were sentences about the individuality of the birth giver, about the work methods of the midwives during the birth and the birth itself. The third largest group with 11 sentences concerned the staff of the birth home. The sentences about the staff were mostly about the professionalism of the staff and the work of the staff.

There were nine sentences concerning atmosphere and seven sentences concerning family.

In the second workshop the total result was 69 sentences of which almost 1/3 of were sentences concerning the birth. The sentences were mostly about the midwife's work during the birth. The second largest group with 17 sentences was the group concerning the surroundings of the birth home and like in the first workshop it included sentences about the physical building, the interior, the equipment in it and the distance to the hospital. The third largest group with 16 sentences was the group concerning the atmosphere of the birth home. The second smallest group with 11 sentences was the group with the sentences concerning the staff. The sentences were about collegiality and professionalism. The smallest group with six sentences was the group with the sentences concerning the family.

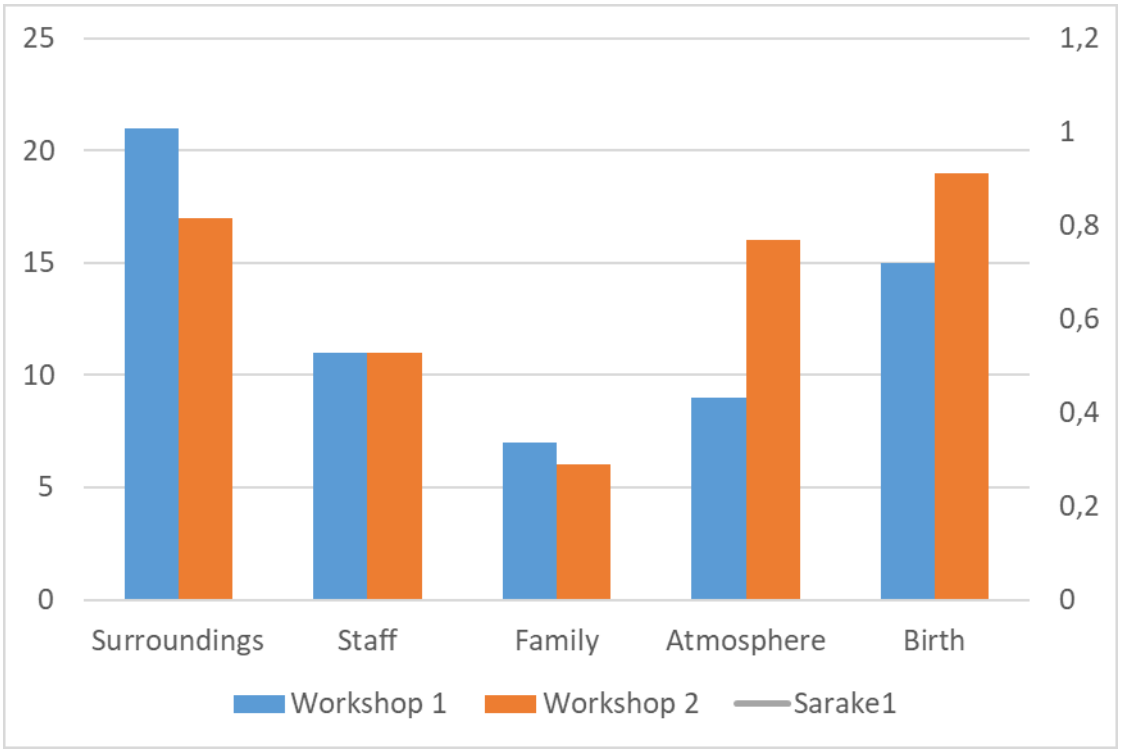

Figure 7: The results of the second participative method: the Creative writing

7.3 The analysis of the third Participative method: The Learning Café

After translating, the impressions from Finnish to English started the coding of them according to the thematic analysis. Different themes were found and they were given different colours. They were building, equipment, atmosphere, service and policy. In the "building" group are all the impressions concerning the birth home building itself or the size of it. The "equipment" group includes the impressions concerning the different things needed or helpful equipment in the birth. The group "atmosphere" has impressions that deal with attitude and different aspects affecting the atmosphere. In the "service" group are all the impressions that had something to do with the work of the midwives in the birth home or the service given in there. In the group, "policy" are the impressions that describe the procedures in the birth home. The impressions written in blue are from the second round of the learning café.

soundproof rooms BUILDING	background music EQUIPMENT	big home-a-like rooms BUILDING
light BUILDING/EQUIPMENT	big bed EQUIPMENT	ropes to hang about EQUIPMENT
stools EQUIPMENT	a tub EQUIPMENT	a gymnastic ball EQUIPMENT
room for the whole family BUILDING/ATMOSPHERE	a shower EQUIPMENT	a birth stimulation room where you can practice and test all the birth equipment BUILDING/EQUIPMENT
nature sounds, musical instruments EQUIPMENT	rehearsing the birth beforehand SERVICE	good food, delicacies, healthy and empowering food EQUIPMENT/SERVICE
a midwife/doula is present throughout the birth POLICY	a better ring bell system (than in the hospitals) EQUIPMENT	good possibilities to get some fresh air, surrounded by beautiful nature, park where you can walk

		BUILDING
medical readiness (not visible though) EQUIPMENT/SERVICE	professional, capable midwives SERVICE	The 2nd group: to be able to stay right away at the birth home (especially the first timers) POLICY
the experiences of the first time birth givers are important ATMOSPHERE	mentally important to encounter the birth giver "the right way/well" ATMOSPHERE/SERVICE	the doors are always open ATMOSPHERE
"there are no stupid questions" –attitude ATMOSPHERE	the mental encounter is most important -> brings safety ATMOSPHERE/SERVICE	Mother is the main person in her birth POLICY/ATMOSPHERE

Table 8: The analysis of the Learning Café method table 1 in the 1st workshop

The same coding was done to the impressions produced by the midwives in the second workshop. Here they are in a table.

birth orientation/birth coaching SERVICE	maternity clinic SERVICE	the place is familiar beforehand, staff met POLICY	led by midwives POLICY
deep orientation to the birth already during pregnancy so that the pelvis/stomach area is in optimal shape	teaching the concrete things for the partner to do during the labour (like pushing the acupuncture spots)	"we need to get away from the thought that everything is going to go to hell" (like the common idea	a place to meet: different peer groups (breast feeding etc.) SERVICE

according the forthcoming birth + accompanied by the partner POLICY	-> helps to be at home longer SERVICE	is about the home births) ATMOSPHERE	
No ring bell system POLICY	A work partner POLICY	the possibility to file the report by mobile or in the room EQUIPMENT	concrete things (the weight of the pelvis) SERVICE
personnel resources adequate -> time with the family POLICY	the hopes and wishes of the family are known beforehand because of a familiar midwife POLICY	less filing the report, more attentively present POLICY	

Table 9: The analysis of the learning café method in the second workshop

After the coding and colouring of the impressions was done they were organized in a table (Attachment 5) according to the group they belonged to. All the results of the learning café exercise's coffee table no. 1: "what is in the birth home of your dreams ?" are presented in the table. The impressions are written in black, blue and red according to the coffee table conversation that produced them. The impressions in black are from the first workshop and from the first group in the coffee table, the impressions in blue are from the first workshop and the second group in the coffee table and the impressions in red are from the second workshop.

7.4 Analysis of all the results

After analysing all the three participative methods on their own, a summary of all the results was needed. The data produced by the workshops was so massive that it was quite difficult to analyse. When continuously going through the results it was found that the different exercises produced some exactly same or similar results. By calculating the prevalence of the same or similar results, the 16 most common results were found. In the order of most popular result to the least popular result, the 16 categories were: Beforehand, Family-centeredness, Water, Safety, Time, Mental coaching, Spacious, Naturalness, Homelike, Beauty, Individuality, Peaceful, Nature, Congeniality, Near hospital and Professionalism. There were many impressions concerning the services and happenings before the actual birth like birth orientation/birth coaching forming the biggest category “Beforehand”. The category of “Family-centeredness” was the second most common. It includes impressions about the families of the birth giver and how the whole family should be considered and served at the time of the birth. The third largest category was “Water” that includes all the impressions about the shower, tub and water birth possibilities. The category “Security” includes impressions about being safe and the impressions concerning the midwife’s chances to be with the family or the possibility to stay in the birth home as long as needed are under the “Time”-category. The category “Mental coaching” includes impressions about the mental aspects of the birth giving and the category “Spacious” about the size of the rooms or the building itself. The category “Naturalness” includes impressions concerning the natural physiological birth, the atmosphere and the policies of the birth home. The impressions describing the cosiness of the birth home are in the category “Homelike” and the impressions concerning the beauty or the visuality of the interior design are under the category “Visuality”. The category “Individuality” includes the impressions concerning the individuality of the birth giver and the impressions concerning the peaceful atmosphere are in the category “Peaceful”. There were quite many impressions about the location of the birth home or the possibility to walk in a beautiful park and they are all in the category of “Nature”. In the “Congeniality” category are the impressions concerning the congeniality between colleagues and between the

customers and the midwives. The category “Near hospital” includes the impressions concerning the location of the birth home and the category “Professionalism” the professionalism of the personnel. The categories are presented in the figure below.

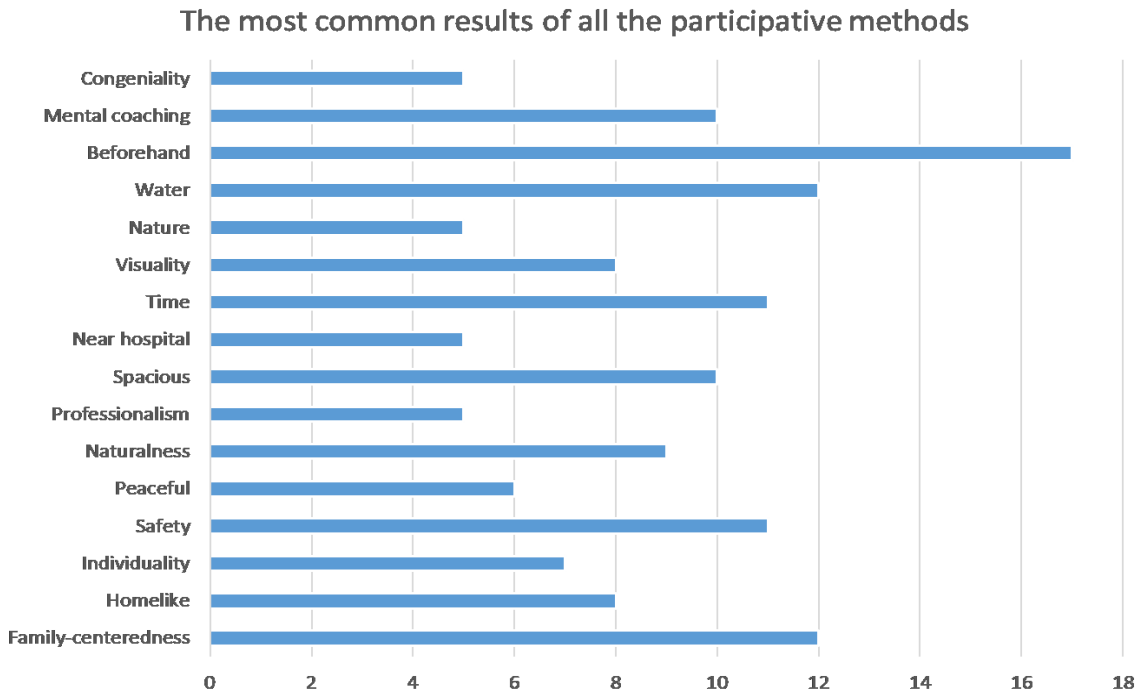

Figure 8: The most common results of all the participative methods

According to these results there seems to be a strong need for maternal services during pregnancy, before the actual birth happens. The social and health services have gone through financial cuts and many of the cuts have been made to these kind of services. The amount of times the maternity clinic nurse/midwife meets the pregnant family before the birth has come down as well as the number of birth coaching meetings. The birth services are wanted and needed for the whole family and the possibility for the family to be around when the birth happens is seen important. Water in its all forms is wanted as a pain relief and the possibility to give birth in water is wanted. Both the potential customers and the midwives want to have time to be as much with the family as needed. Many different aspects about time was given in the results. The birth givers wanted to feel safe and the midwives wanted to give them the secure feeling. Mental coaching was wanted before and during the birth giving. The building of the birth home should be big in size with big, homelike and beautiful rooms and situated in a beautiful and peaceful landscape

near the hospital. The personnel working there would be professional and congenial. That would birth home of dreams be like.

7.5 Reliability, validity and ethical issues

There are many ways to evaluate the reliability of a research. Basically it means the repeatability of the measurements. There are many statistical ways to measure reliability in quantitative studies but in qualitative studies it is usually the accuracy of the researcher that makes it reliable or not. The accurate explanations of how the research was performed, what were the circumstances and the places where the data was collected. The classification of the data in the analysis phase is important and the justification of the interpretation about the results. The validity means the ability of the method or a meter to measure exactly what is supposed to be measured. The reality is not always, what it was thought to be. For example, the questions in the questionnaires can be understood differentially than designed. The core things in qualitative studies are the descriptions about the people, the places and the happenings. The validity is then the match between the description and the interpretation of it that the researcher makes. Does it match it, is it valid? The validity can be defined by using triangulation. (Hirsjärvi et al. 2010; 231-233)
In this study, the different phases of the study were explained keeping the accuracy in mind. The triangulation was also used in this study to define the validity of it.

The Helsinki declaration is a collection of all the ethical principles that have to be considered in all medical research all around the world. It was originally approved in a meeting of WMA (The World Medical Association) in Helsinki 1964. The ethical principles are guiding all medical research associated with human beings including identifiable human based material information identifiable to subject. It is addressed primarily to doctors but WMA encourages also others dealing with human medical research to adhere these principles. It has been renewed many times and the current version includes 37 principles. There are common principles and principles

concerning the risks in research, principles about vulnerable groups and individuals and principles about privacy and reliability for example. (Lääkäriliitto 2019)

According to the Finnish national board on research integrity TENK, the ethical pre-evaluation in human sciences has to be done by following their guidelines. The principles are divided in three sections concerning a) the respect of the self-determination of the examinees, b) the avoidance of injury and c) privacy and confidentiality. The respect of the self-determination of the examinees include aspects of voluntarism, the self-determination and the age limits to it and the informing of the examinees. The avoidance of injury means avoidance of the mental distress and avoidance of economic or social hindrance. The principles of privacy and confidentiality include aspects of protecting the data and the confidentiality of it as well as the preservation and the elimination of the data. It also includes information about the privacy of the examinees according to the research publications. (TENK n.d.)

In this study all the examinees were volunteers, meaning that their participation to this study happened if they wanted to. All the examinees in this study were over the age of 18. In the beginning of both the workshops the examinees were given information about this study and about their anonymity throughout the whole process. The names of the workshop participants were known only for the researcher and all the material they produced in the workshops was done anonymously. The participants were told that the video material and voice recordings were to be demolished when the research was completed. The e-mail addresses and phone numbers of the participants were collected to researcher's use only in case something needed to be asked after the workshops. The participants also wanted to get the final report to their e-mails.

8 Listening the experts of their experience

This study was about co-designing a visionary birth home with potential customers and personnel. The research question was: “How co-design can be used in designing social and health care services?”. According to the results and experiences from this study it can be said that co-design can very well be used in designing social and health care services. One of the main conclusions of this study is the added value co-design gives when designing services. Usually when a new service or design is designed or the already existing services are developed it is done inside the same organisation or then an advertising agency is used to help with the design. When using co-design, the service users whether they are customers or personnel are not just only asked what they want but they are brought to the core of the development process themselves and they can design the services and products themselves.

Sanders and Stappers (2008) have mentioned that

> *“the service users can become part of the design process as expert of their experience but in order to be able to take this role they must be given appropriate tools for expressing themselves”.*

In this study the participative methods (brain storming, creative writing and learning café) were “the appropriate tools” helping in the design process. These three methods used in the co-design process worked very well and made it possible for everyone in the workshop to take part to the design process. Co-design is said to have three different benefits: benefits for the service design project itself, benefits for the service’s users and benefits for the organizations involved. (Steen & co. 2011) Based on the experiences from this case study these all benefits occurred. It is clear that the design project benefitted from the co-design approach by simply having “the experts of their experience” taken along. The ideas of the service users or customers were better and more original and had a lot user value. The service users benefit usually come from getting better fitting services as the end product and therefore they get more satisfaction. In this study the benefits for the service users can be seen as the informative value that the results of the co-design process bring to the Finnish birth culture. There was not any organisations involved since the whole process was fully visionary and the birth home designed imaginary. However if this Thesis can be

seen as an organization then the third benefit is also true. Altogether this co-design produced an innovation in a form of an imaginary birth home. The results of this co-design process can possibly help the design of birth services in future. Because this study was a qualitative study the results can not be generalised. The results are bound to the context where they happened and it cannot be known if the similar kind of research setting would produce same kind of results or not. The creative co-design process with the people participating in it is always a unique setting and the results fit into that unique setting only.

The data gathering in his study was done in the workshops that had the potential customers as the service users and the potential personnel, the midwives designing the visionary birth home. One of the sub-research questions was: ”How does the data produced by co-design differ between customers and professionals?” The both groups produced many similar answers in the workshops but some differences was found. For example in the first participative exercise, the brain storming, the potential customers produced many different kinds of impressions about the birth home whereas the midwives went straight into concepts. The group of the midwives was also more talkative and the conversations got very deep into the professional things and the evaluation of the current birth culture etc. The original idea was to have the potential customers first to do the co-design process and then the midwives to add their professionalism to it. This turned out to be a very reasonable and productive way to co-design a birth home. The customers brought out the opinions of the service users in what they would want as birth givers and the midwives completed their answers with the professional opinions about the policies and equipment needed for example. This combination with the customers and professionals was successful and can be recommended to anyone wanting to use co-design for designing a service or a product.

The Fair Deal forum (2016) constituted the principles of co-design that are inclusive, respectful, participative, iterative and outcomes focused. **Inclusive** means having the representatives from the co-design project utilising the feedback and advice from the people that are “the experts in the field”. **Respectful** means seeing the participants

as experts and valuing their input. **Participative** comes from the overall approach that includes conversations and activities where new meanings based on expertise are generated. The **iterative** cycle is characteristic to co-design, meaning the continuous testing and evaluation of the ideas and solutions. Co-design can be used to create, redesign or evaluate services, systems or products. It pursues an outcome or series of outcomes and that makes it **outcomes focused**. From the experience of this case study and the co-design process it has performed these principles are all true and accurate. The workshops were quite easy to plan and to perform. The participants were clearly enthusiastic about the topic and willing to give their time to something they felt important. There was intensive conversations in both of the workshops and the atmosphere was very creative.

Yin (2002) said that one common complaint about case studies is that the amount of material they produce is too massive. It is also said, that the analysis of the qualitative research can be difficult. (Kauppinen-Saaranen &Puusniekka 2006) From the experience of this case study, it can be said, that it is all true. The two workshops with the three participative exercises in each produced so much information that it made the analysis very hard. It was almost impossible to handle the material because the material collected from the workshops was so large. On top of the three exercises there was intensive conversations going on in between and during the participative methods. Because of the videotaping and voice recording of the workshops the material from the conversations could have been used as a material to this study also but since the material from the three exercises was so vast already there was no possibility to take along all the spoken material. If I would do this kind of co-design process again, with the knowledge that I have now, I would plan the workshops differently so that the material produced by them would not be so large. These things could not be foreseen and like said before; case studies usually produce a lot of material.

The different exercises performed in the workshops produced a lot of exactly same or similar answers and in this case that was the salvation because in the end it was possible to find 16 categories or aspects that the birth home of dreams would have.

The findings of this study are in line with the studies concerning birth homes or the reasons for people to use birth homes. A review by Hodnett, Downe & Walsh (2012) evaluated the effects on labour and birth outcomes in an alternative institutional birth setting compared with care in a conventional hospital labour ward. It involved 11,795 women and the results were that the alternative settings were associated with "reduced likelihood of medical interventions, increased likelihood of spontaneous vaginal birth, increased maternal satisfaction and greater likelihood of continued breastfeeding one to two months postpartum with no apparent risks to mother or baby." There was also an implication made by the same study saying, that "pregnant women should be informed that the hospital birth centers are associated with lower rates of medical interventions during labour and birth and higher levels of satisfaction, without increasing risk to themselves or their babies." Another implication was made to the decision-makers that if they wish to decrease the rates of medical interventions for women with normal pregnancies they should consider developing birthing units with policies and practices to support normal labour and birth. In another study by Dutch Birth Center (2016) researching the experiences of women who planned birth in a birth center compared to alternative planned places of birth the key findings were that the women who chose the planned birth in a birth center had significantly better experiences than the women who planned to give birth in a hospital under supervision of an obstetrician.
In a study of Rooks & co. about the outcomes of care in birth centers with 11, 814 women the conclusion was that:

> *"birth centers offer a safe and acceptable alternative to hospital confinement for selected pregnant women, particularly those who have previously had children, and that such care leads to relatively few cesarean sections".*

The study was done already 30 years ago in USA. There the birth home/birth center culture has been strong for a long time already and it seems that the discussion and the studies about the birth home that they did already 30 years ago has just started over here.

Like mentioned many times before it was important for me since the very beginning that my Master Thesis would be somehow participative and include workshops with

people working together. Performing this kind of participative action research has not been the easiest kind I would say but it sure has taught me many things about managing a process and the co-design itself. Overall it was very interesting to hear what the potential customers and personnel think and if they would get to decide what would the birth home be like.

The workshops were performed quite much in the way they were planned. There was some technical problems that made it impossible to have videotapes from both of the rooms where the creative working took part and that's why some part of the creative work was only voice recorded. Luckily the videotapes where there to only help the final analysis and report writing process if needed. And because of some long breaks in the writing process they were very useful in fact. No other problems occurred with the workshops. The people were actually more talkative and enthusiastic about the topic and the creative working that I had though beforehand. If this topic would be re-started with the knowledge from this process I would include some evaluation about the co-design process itself to it. Perhaps a questionnaire for the participants or then interviews to get the real opinions in measurable form. There was some conversations about the co-design process afterwards with some of the participants and the overall opinions were positive about the method.

9 Literature

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Appendices

Appendix 1: The results of the sprint writing exercise in the first workshop

Participant	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6	No. 7
1st sentence	is always professional staff	family is met as an individual	is music in the background	the experts of the birth (midwife and doula) are helping me	is safe	the customer and her needs are encountered	is skilled professionals
2nd	you get good food	family is in the middle	is freedom to move around	is a tub	is gentle and peaceful	are big rooms and a lot of space	help is near when needed (hospital)
3rd	you always get an answer to your question and there are no stupid questions	the surroundings are home-a-like and beautiful	is good food	is room for the whole family. Whole family can be accompanied	is a professional midwife	you get good individual service	is clean and organised -> confidence
4th	you are not left alone	the rights and the thoughts of the birth giver are	the birth is natural (no concentration on what can go	are many different non-medical ways to relief pain	whole family is welcome	the facts are told like the fact that it hurts to give birth	is safe

		conside red	wrong)	and they can be used			
5th	peacef ul music is played/ is quiet (howev er a person wants)	is a possibili ty to a water birth as well	the individu ality is taken into account	is a big room	the birth giver is seen as an individual and she is genuinely encounter ed	the whole family gets service	the individu al and her needs are taken into account
6th	you can keep your baby with you all the time	there is no routine interferi ng to the birth/ the birth itself is interfer ed as little as possible	high to the ceiling	is beautif ul nature (the sea!) nearby	the mother is encourage d to find her own, natural resources for the birth	is a safe, home-a-like atmosphe re	
7th	smells good, not like medici ne	the birth is given time	water in all forms is used for relaxatio n	is a sauna	support and help is offered at the birth	the focus is in the mental coaching	
8th	the whole family can be with the baby at least very soon	the physiol ogic birth is support ed	is a lot of time before and after the birth	are ways to help the baby, like oxygen or light therapy	staff is open-minded and the birth giver is listened	where all the hard and difficult parts according the birth and puerperiu m are told	

	after the birth						
9th		the active birth is supported	is beautiful bed sheet and duvets	is friendly people	is a tub, a hammock, gloomy/sunshine, birds are singing, fresh…	you get help	
10th		the mother is in the main role of her birth and the expert of it	is some other system than a “ring bell” for the staff	is a connection to hospital	you could open the window and walk in the garden	the birth givers are focused on other things than pain and epidural, eg. they are comprehensively interested in the birth giving and their own role in it	

Appendix 2: The results of the sprint writing exercise in the second workshop

Participant	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
Sentences	is warm and peaceful atmosphere	the staff resources are adequate	beautiful home-a-like interior/furniture	is safe	I could carry out midwifery from my own professionalism – not from hospital rules	would be time for the family
2	is a tub and a possibility to water births	the midwife would have time	is a tub	is near	I would get collegial support when needed	the birth giver/family is supported to use their own resources
3	is led by midwives	the family would be known beforehand	are rooms for the whole family	is time and freedom	would be peaceful and time to be with only one birth giver at a time	the natural analgesia is used a lot
4	are no “traditional” rooms	the birth givers would have prepared for the birth	colleagues are congenial	is a respectful atmosphere	the birth would always be a miracle, not a medicalized happening	water could be used as pain relief -> tub
5	is enough equipment/tools to be used	would be time to go through	is no awful hospital clothes (neither	is a lot of space	the children would be welcome	you could give birth in what position

	for everyone (liana, gymnastic ball, birth stool etc.)	family's wishes	the worker nor the birth giver)		to participat e the birth	you want to (stool etc.)
6	is a customer centered/f amily centered atmosphe re	the colleague s would be experien ced	is a possibility to the puerperiu m	is a lot of birth givers/cust omers	I could furnish the way I want	you could give birth to water
7	the midwife doesn't give birth but helps in the birth giving	the work atmosph ere would be compassi onate and open	is a trust between the midwife and the family	is a fine setting	would have a tub in each room	the midwives/ doctors would be congenial
8	is beautiful and big but practical rooms	the access to hospital would be quick (when needed)	is natural analgesia in use	working would be fun	would not be a leader but equality	the safety is considered but also the family's birth experience
9	is a home-a-like atmosphe re	would be a warm atmosph ere	is no rush in the natural familiariza tion of the newborn and the family	would be time	where the birth giver could come for a visit already before the birth giving	would be room to move around, also to be outside
10	are professio nal and congenial midwives at work	despite everythin g the mothers would trust the midwives about when the	is no "laying in the bed" positions used in the 3rd phase of the birth	I can fulfill myself	all services attached to birth, pregnanc y and puerperiu m would be	the whole family could attend if they wish to

		birth should be interfered (meaning going to the hospital)			offered	
11	has soft values -> birth is a natural happening		is a possibility to a normal housework	would be nice customers		is a pleasant surrounding
12	is birth training for families					is an easy access to hospital when needed
13						the midwife would have the possibility to fulfill herself (in the terms of the family) -> the midwives would have the possibility to educate themselves for different methods for example
14						coaches the families to the birth
15						the families are met

						during the pregnancy already -> a place to meet, possibility to a conversation etc.

Appendix 3: The coding of the results of the creative writing exercise in the first workshop

Participants	1	2	3	4	5	6	7
Sentences	is always professional staff STAFF	family is met as an individual FAMILY	is music in the background SURROUNDINGS	the experts of the birth (midwife and doula) are helping me STAFF	is safe ATMOSPHERE	the customer and her needs are encountered STAFF	is skilled professionals STAFF
2	you get good food SURROUNDINGS	family is in the middle FAMILY	is freedom to move around BIRTH	is a tub SURROUNDINGS	is gentle and peaceful ATMOSPHERE	are big rooms and a lot of space SURROUNDINGS	help is near when needed (hospital) SURROUNDINGS
3	you always get an answer to your question and there are no stupid questions STAFF	the surroundings are home-a-like and beautiful SURROUNDINGS	is good food SURROUNDINGS	is room for the whole family. Whole family can be accompanied FAMILY	is a professional midwife STAFF	you get good individual service STAFF	is clean and organised -> confidence SURROUNDINGS
4	you are not left alone ATMOSPHERE	the rights and the thoughts of the birth giver are	the birth is natural (no concentration on what	are many different non-medical ways to relief	whole family is welcome FAMILY	the facts are told like the fact that it hurts to give birth	is safe ATMOSPHERE

		considered BIRTH	can go wrong) BIRTH	pain and they can be used BIRTH		BIRTH	
5	peaceful music is played/is quiet (however a person wants) SURROUNDINGS	is a possibility to a water birth as well SURROUNDINGS	the individuality is taken into account ATMOSPHERE	is a big room SURROUNDINGS	the birth giver is seen as an individual and she is genuinely encountered ATMOSPHERE	the whole family gets service FAMILY	the individual and her needs are taken into account ATMOSPHERE
6	you can keep your baby with you all the time BIRTH	there is no routine interfering to the birth/ the birth itself is interfered as little as possible BIRTH	high to the ceiling SURROUNDINGS	is beautiful nature (the sea!) nearby SURROUNDINGS	the mother is encouraged to find her own, natural resources for the birth BIRTH	is a safe, home-a-like atmosphere ATMOSPHERE	
7	smells good, not like medicine SURROUNDINGS	the birth is given time BIRTH	water in all forms is used for relaxation SURROUNDINGS	is a sauna SURROUNDINGS	support and help is offered at the birth STAFF	the focus is in the mental coaching STAFF	
8	the whole family can be with the baby at least very soon	the physiologic birth is supported BIRTH	is a lot of time before and after the birth BIRTH	are ways to help the baby, like oxygen or light therapy BIRTH	staff is open-minded and the birth giver is listened STAFF	where all the hard and difficult parts according the birth and puerperi	

	after the birth FAMILY					um are told BIRTH	
9		the active birth is supported BIRTH	is beautiful bed sheet and duvets SURROUNDINGS	is friendly people STAFF	is a tub, a hammock, gloomy/sunshine, birds are singing, fresh… SURROUNDINGS	you get help ATMOSPHERE	
10		the mother is in the main role of her birth and the expert of it BIRTH	is some other system than a "ring bell" for the staff SURROUNDINGS	is a connection to hospital SURROUNDINGS	you could open the window and walk in the garden SURROUNDINGS	the birth givers are focused on other things than pain and epidural, eg. they are comprehensively interested in the birth giving and their own role in it BIRTH	

Appendix 4: The coding of the results of the creative writing exercise in the second workshop

Participants	1	2	3	4	5	6
Sentences	is warm and peaceful atmosphere ATMOSPHERE	the staff resources are adequate STAFF	beautiful home-a-like interior/furniture SURROUNDINGS	is safe ATMOSPHERE	I could carry out midwifery from my own professionalism – not from hospital rules STAFF	would be time for the family FAMILY
2	is a tub and a possibility to water births SURROUNDINGS	the midwife would have time BIRTH	is a tub SURROUNDINGS	is near SURROUNDINGS	I would get collegial support when needed STAFF	the birth giver/family is supported to use their own resources BIRTH
3	is led by midwives STAFF	the family would be known beforehand FAMILY	are rooms for the whole family FAMILY	is time and freedom ATMOSPHERE	would be peaceful and time to be with only one birth giver at a time ATMOSPHERE	the natural analgesia is used a lot BIRTH
4	are no “traditional” rooms SURROUNDINGS	the birth givers would have prepared for the birth BIRTH	colleagues are congenial STAFF	is a respectful atmosphere ATMOSPHERE	the birth would always be a miracle, not a medicalized happening BIRTH	water could be used as pain relief -> tub SURROUNDINGS
5	is enough	would be	is no awful	is a lot of	the	you could

	equipment/tools to be used for everyone (liana, gymnastic ball, birth stool etc.) SURROUNDINGS	time to go through family's wishes FAMILY	hospital clothes (neither the worker nor the birth giver) STAFF	space SURROUNDINGS	children would be welcome to participate the birth FAMILY	give birth in what position you want to (stool etc.) BIRTH
6	is a customer centered/ family centered atmosphere ATMOSPHERE	the colleagues would be experienced STAFF	is a possibility to the puerperium BIRTH	is a lot of birth givers/customers ATMOSPHERE	I could furnish the way I want SURROUNDINGS	you could give birth to water SURROUNDINGS
7	the midwife doesn't give birth but helps in the birth giving BIRTH	the work atmosphere would be compassionate and open ATMOSPHERE	is a trust between the midwife and the family ATMOSPHERE	is a fine setting SURROUNDINGS	would have a tub in each room SURROUNDINGS	the midwives/ doctors would be congenial STAFF
8	is beautiful and big but practical rooms SURROUNDINGS	the access to hospital would be quick (when needed) SURROUNDINGS	is natural analgesia in use BIRTH	working would be fun ATMOSPHERE	would not be a leader but equality STAFF	the safety is considered but also the family's birth experience ATMOSPHERE
9	is a home-a-like atmosphere ATMOSPHERE	would be a warm atmosphere ATMOSPHERE	is no rush in the natural familiarization of the newborn and the family	would be time BIRTH	where the birth giver could come for a visit already before the birth	would be room to move around, also to be outside SURROUNDINGS

			BIRTH		giving BIRTH	
10	are professional and congenial midwives at work STAFF	despite everything the mothers would trust the midwives about when the birth should be interfered (meaning going to the hospital) BIRTH	is no "laying in the bed" positions used in the 3rd phase of the birth BIRTH	I can fulfill myself ATMOSPHERE	all services attached to birth, pregnancy and puerperium would be offered BIRTH	the whole family could attend if they wish to FAMILY
11	has soft values -> birth is a natural happening ATMOSPHERE		is a possibility to a normal housework BIRTH	would be nice customers ATMOSPHERE		is a pleasant surrounding SURROUNDINGS
12	is birth training for families BIRTH					is an easy access to hospital when needed SURROUNDINGS
13						the midwife would have the possibility to fulfill herself (in the terms of the family)-> the midwives would have the possibility

						to educate themselves for different methods for example STAFF
14						coaches the families to the birth BIRTH
15						the families are met during the pregnancy already -> a place to meet, possibility to a conversation etc. BIRTH

Appendix 5: The coded results of the learning café method table no. 1

BUILDING	EQUIPMENT	ATMOSPHERE	SERVICE	POLICY
soundproof rooms	background music	room for the whole family	rehearsing the birth beforehand	a midwife/doula is present throughout the birth
big home-a-like rooms	big bed	the experiences of the first time birth givers are important	good food, delicacies, healthy and empowering food	to be able to stay right away at the birth home (especially the first timers)
light	ropes to hang about	mentally important to encounter the birth giver "the right way/well"	medical readiness (not visible though)	Mother is the main person in her birth
room for the whole family	stools	the doors are always open	professional, capable midwives	the place is familiar beforehand, staff met

a birth stimulation room where you can practice and test all the birth equipment	a tub	"there are no stupid questions" – attitude	mentally important to encounter the birth giver "the right way/well"	led by midwives
good possibilities to get some fresh air, surrounded by beautiful nature, park where you can walk	a gymnastic ball	the mental encounter is most important -> brings safety	the mental encounter is most important -> brings safety	deep orientation to the birth already during pregnancy so that the pelvis/stomach area is in optimal shape according the forthcoming birth + accompanied by the partner
	a shower	Mother is the main person in her birth	birth orientation/birth coaching	No ring bell system

	a birth stimulation room where you can practice and test all the birth equipment	"we need to get away from the thought that everything is going to go to hell" (like the common idea is about the home births)	maternity clinic	A work partner
	nature sounds, musical instruments		teaching the concrete things for the partner to do during the labour (like pushing the acupuncture spots) -> helps to be at home longer	personnel resources adequate -> time with the family
	good food, delicacies, healthy and empowering food		a place to meet: different peer groups (breast feeding etc.)	the hopes and wishes of the family are known beforehand because of a familiar midwife

	a better ring bell system (than in the hospitals)		concrete things (the weight of the pelvis)	less filing the report, more attentively present
	medical readiness (not visible though)			
	the possibility to file the report by mobile or in the room			