A MODEL FOR MIDWIVES TOWARDS THE FACILITATION OF CHILDBIRTH-CHOICES AMONG WOMEN IN SELECTED PUBLIC HEALTHCARE FACILITIES IN NAMIBIA

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DECLARATION

I, Sarah Mlambo, declare hereby that this study, '**A model for midwives towards the facilitation of childbirth-choices among women in selected public healthcare facilities in Namibia'** is a true reflection of my own research, and that this work or part thereof, has not been submitted for a degree in any other institution of higher learning.

Signature 

ABSTRACT

The facilitation of childbirth-choices is the epitome in rendering patient centred care to ensure that women make informed decisions regarding their care. The rights of women in ensuring decision making and affording women choices regarding childbirth types is critical for the emotional wellbeing of the women and positive birth experiences. In the public healthcare institutions in Namibia, women have no choices but rather have assumed choices and as such they receive no or little information on childbirth types. The objectives of the study were encapsulated in four phases which were: identification and analysis of concepts (Phase one); define, classify and conceptualise concepts as a basis of model development [Phase two]; developing, describing and evaluating the model (Phase three), and developing and describing the guidelines for the model (Phase four).

A mixed method approach with a convergent parallel design was used in the study. In Phase one of the study a scoping review was adopted to identify the best practices in the facilitation of childbirth-choices, whereas the qualitative approach with purposive sampling was adopted for the experiences of midwives and women. In addition, a quantitative approach with stratification was applied to identify the different childbirth types in the selected healthcare facilities. Ethical clearance was accorded by the University of Namibia Research Ethics Committee, Ministry of Health and Social Services, the selected healthcare facilities and the sampled research participants. Four participating hospitals, 1446 maternal files, 10 midwives, 12 women and 30 articles formed the sample for the study. Qualitative data were analysed through the six steps proposed by Creswell, and quantitative data were analysed through Statistical Package for the Social Sciences (version 26).

The study results were merged (Phase one and two) and they corroborated well together in the discussion of the facilitation of childbirth-choices. In the study, the results showed that facilitation is a process to be done timely and women need to be accorded some reasonable time to decide. In the scoping review, results showed that the facilitation of childbirth-choices should include shared decision making, patient centred care, the implementation of protocols and guidelines at all levels, informed consent or choice and the giving of unbiased information. The experiences of midwives in this study echoed barriers in the facilitation of childbirth-choices as they expressed the shortages of staff, timing of information, information sharing as well as cultural influences. Furthermore, midwives shared a lack of provision for childbirth-choices as the rights of women were not observed and a lack of women centred care despite protocols and guidelines hence, they are not adhered to. In addition, women in this study

affirmed that they have inadequate information of the childbirth types and they were unsure and or surprised that they had choices, and lacked shared decision making and childbirth-choices. The women also indicated that the timing of the information was late or impromptu, thereby making informed decisions difficult. Moreover, antenatal attendance in this study was 96.7%, with childbirth distribution showcasing vaginal birth 76% and caesarean section 24%. Of the 24% of caesarean sections performed, 10.44% was attributed to repeat caesarean section and 4.77% to foetal distress.

In conclusion, a model was developed and described (Phase three) based on the study findings to help in the facilitation of childbirth-choices among women. The developed model was evaluated following the considerations by Fawcett. Guidelines to operationalise the model (Phase four) were developed guided by the study results and best practices. Facilitation is of paramount importance in ensuring that women are involved in the decision making when they have accurate information and with that, they will be able to make informed choices. The right to information and the autonomy of women should not be infringed as this yields positive childbirth experiences. Midwives have the mandate to treat each woman individually hence woman centred care will be attained. Further studies need to be conducted in the private sector as well.

Key words: facilitation; childbirth-choices; woman centred care; decision making

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DEDICATION

I dedicate this work to my beloved parents Mrs Amelia Machimbirike and the late Mr Zebediah Plaas Machimbirike and my son ANENYASHA whose eleven days on earth I hold dear to my heart – love you always.

ABBREVIATIONS

ANC:	Antenatal care
FIGO:	Confederation of Gynaecologists and Obstetricians
ICM:	International Confederation of Midwives
IOL:	Induction of Labour
NAMAF:	Namibia Medical Aid Fund
MoHSS:	Ministry of Health and Social Services
RMC:	Respectful maternity care
SDG:	Sustainable Development Goals
UNAM:	University of Namibia
UREC:	University of Namibia Research Ethics Committee
VBAC:	Vaginal Birth after Caesarean Section
WHO	World Health Organisation

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CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 INTRODUCTION AND RATIONALE OF THE STUDY

Childbirth remains the epitome of happiness for a woman when the experiences are positive. Childbirth is defined as the process of giving birth to a child (Sellers, 2018), and the autonomy to choose the mode of childbirth that is best for a woman after having received adequate information from midwives is significant as this leads to an informed decision. The World Health Organisation (WHO) (2018) emphasises the need for health care professionals to understand and promote woman centred care. In addition, WHO (2018) advocates for the woman to be equipped with health information pertaining to childbirth as the woman tends to have a sense of control in decision making hence in this way the psychological and emotional needs of the woman are met. This study focused on the development of a model for midwives for the facilitation of childbirth-choices for women in Namibia to make informed childbirth-choices through information giving by midwives.

There are four different types of childbirth (the first two are available as choices and the last three in emergency situations), and these include vaginal delivery (inclusive of natural birth, vaginal birth after caesarean section (VBAC) and induction of labour (IOL)), caesarean section (childbirth type may be done by choice or in emergencies), vacuum extraction and forceps delivery (Sellers, 2018). The study paid particular attention to the vaginal birth and caesarean section as women can choose either as their childbirth type. Furthermore, a plethora of reasons for childbirth-choices are recorded in literature and they include but are not limited to tochophobia, litigation factors, previous caesarean section, obstetric complications, inadequate or insufficient health education on birthing choices and preference on the part of the women to name a few (Maswime & Masukume, 2017; Mlambo, 2018).

Childbirth facilitation in view of the rises in the caesarean section rates globally has been a cause of concern in the health sector, particularly to the WHO (WHO, 2018) and the International Confederation of Midwives (ICM) (2018), thereby necessitating the need to understand the childbirth-choices women make and their facilitation. The WHO stands by the notion that it is not the rates that matter if the caesarean section are done due to medical indications, as evidence shows that the caesarean section rates that are above 10% in low-risk pregnancies have no significance in the decrease of feto-maternal morbidity and mortality (WHO, 2015). Hence, it is of paramount importance to ensure that women are equipped with information for them to make informed decisions on the mode of childbirth that they undergo.

The above reasons have been motivated and some of them argued by health professionals and women in different studies which then makes it fundamental for midwives to have adequate knowledge to guide their patients in the facilitation of childbirth types for women (Chen & Hancock, 2012; Gallagher et al., 2012; Mlambo, 2018). The facilitation of childbirth-choices warrants midwives to be abreast of the socio-cultural environment that they find themselves in as it has an influence in the decisions that the women make.

1.2 BACKGROUND OF THE RESEARCH PROBLEM

Childbirth-choices, especially caesarean section birth, remain a health problem worldwide pertaining to the outcome of the childbirth type undertaken; however, the question which arises is that do the women have enough information and facilitation for them to decide on a childbirth type in the public sector. The WHO recommendations are that caesarean section rates should be between 10 – 15 % in low-risk pregnancies and any rates higher have proven not to be of any benefit to the mortality and morbidity rates (WHO, 2015). A study conducted in Europe on the choices of childbirth found that there is a wide range of between 14.8% - 52.2% of all births which were caesarean section and 0.5% - 16.4% were vaginal or instrument deliveries in 2010 (Macfarlane et al., 2015). The above statistics show that in the developed countries

(specifically Europe in this case), the numbers of caesarean section have become more than vaginal birth for different reasons, thereby necessitating the need for an inquiry and understanding on how the facilitation for childbirth-choices is conducted. In addition, another major factor contributing to the increasing rates of caesarean section are the overuse of IOL for women, electronic monitoring of the foetal heart rate in labour resulting in poor interpretations of the progress and the graph readings, and ultimately the women are subjected to caesarean section (Ahmad et al., 2018).

The principle of autonomy on the part of the women to make choices and beneficence on the part of midwives to give health information to the women for them to make informed choices remains a critical question with regards to ethics (Nieuwenhuijze & Low, 2013). Furthermore, the Federation of Obstetricians and Gynaecologists (FIGO, 2014), states that it is the right of the women to be treated individually by midwives who are skilled and knowledgeable to give the right information and facilitate childbirth-choices for the women to have a positive birth experience. According to Ahmad et al. (2018), some women choose caesarean section because of fear of pain from the labour itself and episiotomy or lacerations that are associated with normal childbirth, and this usually deters them from having a vaginal birth as they may perceive that they will not make it past the pain hence making their childbirth experience not memorable. According to Mlambo's (2018) study within the Namibian context, midwives had a differing perspective in that they stated that the women are more fearful of pain because of inadequate information during ANC, the birth attendant and the companion who is available during childbirth.

In Africa, childbirth-choices are perpetuated by several factors including the health professionals present, access to type of childbirth, information deficit and cost to name a few (Mlambo, 2018; Naanyu, Baliddawa, Koech, Karfakis & Nyagoha, 2018). When the childbirth-choice facilitation in nulliparous women is done with the best and most sound reasoning, it also

helps reduce fear and doubt in future pregnancies due to past experiences (Hassanzadeh, Abbas-Alizadeh, Meedya, Mohammad-Alizadeh-Charandabi & Mirghafourvand, 2020; Slade, Balling, Sheen & Houghton, 2019). Furthermore, a plethora of reasons for childbirth-choices are recorded in literature and they include but are not limited to tochophobia, litigation factors, previous caesarean sections, obstetric complications, inadequate or insufficient health education on birthing choices and preference on the part of the women to name a few (Hassanzadeh et al., 2020; Mlambo, 2018). Studies have been done to assess childbirth-choices and it is evident that in African countries some women are not within reach of the caesarean section when one is needed hence the inequalities in that the caesarean section rates in some instances are on the rise, particularly in the private sector where affordability is out of the question (Maswime & Masukume, 2017; Mlambo, 2018). These inequalities have been raised as a concern by the WHO in that the unnecessary caesarean section have a negative economic impact on health as the procedure is costly compared to a vaginal birth (Gibbons, Belizan, Lauer, Betran, Merialdi & Althabe, 2010). The WHO (2018) describes respectful maternity care as providing dignity, privacy and confidentiality to all women, thereby enabling them to make informed choices pertaining to labour and childbirth. In addition, informed choices and decision making are influenced by effective communication from midwives attending to them (WHO, 2018).

Contextualising the study further, Namibia is an upper middle-income economy, and it has differences between the public and private health care systems. Like other countries worldwide, Namibia has high caesarean section rates, with the private sector averaging 73% between 2012 and 2015 (Namibia Medical Aid Fund (NAMAF), 2015). However, the public sector has a caesarean section rate of 14.7% as of 2017 (Mackenzie, 2017). The differences in the private and public sector therefore makes one to raise questions on how midwives in state facilities facilitate childbirth-choices among women under their care. Childbirth-choice facilitation plays

an integral part in future pregnancies and how women relate to others, and the WHO has emphasised on the need to facilitate childbirth-choices to women as a means of having a safe and memorable experience (WHO, 2018). Childbirth affects the mental and physical status of a woman and having supportive midwives who guide women by giving them adequate information is an issue of critical concern (Slade et al., 2019; Wigert, Nilsson, Dencker, Begley, Jangsten, Spardin, Mollberg & Patel, 2019), hence the need for the present study. However, it is the right of the woman according to the rights of childbearing women (White Ribbon Alliance, 2011, Windau-Melmer, 2013) and the ICM's standpoint, to have fair and equitable information regarding childbirth-choices (ICM, 2018).

1.3 CONTEXT OF THE STUDY

Namibia is an upper-middle-income country that is in Southern Africa and is part of sub-Saharan Africa. The study was conducted in four selected public hospitals of which three were intermediate hospitals and one a national referral. The specific hospitals that were part of this study were Hospital A which is the national referral hospital for specialised healthcare services, Hospital B, Hospital C and Hospital D. Public hospitals mainly cater for the Namibian community that does not have medical aid insurance, meaning that they are entitled to pay a reduced fee for acquiring a booking card. Hospital A and Hospital B are in Windhoek the capital city of Namibia under the Khomas region. Hospital A became operational in 1984 while Hospital B was incepted first in 1973. Hospital C located in the Kavango region was built in 1973 and Hospital D is in the Oshana region in the Northern part of the country and became operational in 1966. The participating hospitals have various departments which include maternity department (premature unit, post-natal ward, labour ward, ANC clinic, theatre), outpatients, accident and emergency (casualty), operating theatres and X-Ray among other departments. The study included the three different regions, Khomas, Kavango and Oshana for a wider representation of the Namibian context.

1.4 STATEMENT OF THE PROBLEM

The problem to be investigated is womens choice of childbirth in the public sector of Namibia. In Namibia it seems women have more "assumed choices" in the public sector while in the private sector women are "spoilt for choice" with regards to childbirth (Mlambo, 2018). Discrepancies in the caesarean birth averaging 73% between 2012 and 2015 (NAMAF), 2015) in the private sector and 14.7% in the public sector (Mackenzie, 2017).

Women's choices in childbirth are constrained by a paucity of resources and the domineering medical personnel that alter the autonomy of women in the choices of childbirth (Feeley & Thompson, 2016). However, there is paucity of empirical evidence within the Namibian context that can provide direction and contextually specific solutions to the present challenges, to address Polit and Beck's (2021) call for the need for increased, small and local research that solves immediate problems. Globally Respectful Maternity Care continues to be advocated for as it has a direct relationship with positive childbirth experiences (Hajizadeh, Vaezi, Meedya, Charandabi & Mirghafourvand, 2020).

According to Stirling, Vanbeisien and McDougall (2018), "incomplete, inaccurate, biased or unavailable patient education resources and lack of opportunity for pregnant patients to have meaningful conversations with their healthcare providers about their individual care" (p. 13) is a major setback when women are being facilitated with childbirth choices. Initiating the facilitation of childbirth-choices early in pregnancy gives the woman some time to weigh the options and for the healthcare provider to clear any misconceptions relating to childbirth types (Ahmad et al., 2018; Hastings-Tolsma, Nolte & Temane, 2018; Loke, Davies & Li, 2015; Mlambo, 2021), yet this is a largely un-investigated area of concern in Namibia. This is despite the fact that childbirth-choice facilitation plays an integral part in future pregnancies and how women relate to others (Yuill, McCourt, Cheyne, et al., 2020) and the WHO has emphasised

on the need of facilitating childbirth-choices to women as a means of having a safe and memorable experience (WHO, 2018). Childbirth affects the mental and physical status of a woman and having supportive midwives who guide women by giving them adequate information is an issue of critical concern (CIMS, 2013, Yuill, et al., 2020), hence the need for the current study. Health information is the right of the woman according to the Universal rights for childbearing women (White Ribbon Alliance, 2011, Windau-Melmer, 2013) and the ICM's standpoint is for women to have fair and equitable information regarding childbirth-choices (ICM, 2017).

Despite the efforts by the MoHSS of Namibia through the Patient charter (MoHSS, nd) which states that communication and information should be provided openly and honestly being clear, comprehensive and understandable when dealing with clients, there is still no specific model for midwives to follow. Therefore, the problem that was investigated in the present study encompasses the fact that the researcher (who is a Midwife and Midwifery lecturer), observed during clinical allocations that some women had no idea that they had a choice with regards to the mode of childbirth as they were not informed about any of the available options. As such, some women ended up with emergency caesarean section with no prior information having been provided, which can be a shocking and uncomfortable experience. The role of the midwie is to empower women with health information regarding childbirth-choices and this is a process that begins from prenatal education (ICM, 2018; MoHSS, nd; Republic of Namibia, 2014; WHO, 2018). Health education empowers women to make the right and informed decisions. The primary caregivers of the woman have the mandate to ensure that evidenced-based information is is given to women and their families (Mlambo, 2018). This problem is heightened by the fact that there is currently a paucity of empirical knowledge in terms of childbirth facilitation in public facilities by midwives, particularly in the Namibian context. Moreover, compounding this challenge is the fact that there is no existing midwifery choice

facilitation model in the MoHSS (except the Patient charter (MoHSS, nd) which is broad and not specific to maternity) to guide midwives when facilitating childbirth choices and the current study sought to provide the highly needed data and empirical findings to fill up this knowledge gap.

1.5 AIM OF THE STUDY

The aim of this study was to develop a model for midwives towards the facilitation of childbirth-choices among women in public healthcare facilities in Namibia.

1.6 OBJECTIVES OF THE STUDY

The objectives of this study were to:

- Identify and analyse concepts as a basis of developing a model for midwives in Namibia to facilitate childbirth-choices among women in public healthcare facilities [**Phase one**]
  - Explore and describe the best practices of the facilitation of childbirth-choices for women by midwives in public healthcare facilities
  - Analyse different childbirth types, and the reasons for the use if any in public healthcare facilities
  - Explore and describe the experiences of midwives in facilitating childbirth-choices in public healthcare facilities
  - Explore and describe the experiences of childbirth-choice facilitation among women in public healthcare facilities
- Construction of relationships of concepts and statement for development of a model for midwives in Namibia to facilitate childbirth-choices among women in public healthcare [**Phase two**]
- Develop, describe and evaluate the model for midwives for the facilitation of childbirth-choices among women [**Phase three]**

- Develop and describe guidelines for operationalising the model for midwives for the facilitation of childbirth-choices among women **[Phase four]**

1.7 SIGNIFICANCE OF THE STUDY

The study provides evidence-based knowledge for Namibia for the country to have adequate research-based information on the facilitation of childbirth-choices among women during their reproductive ages. The model developed in this study is aimed to be a guiding tool for midwives involved in rendering care to women needing the facilitation of childbirth choices. The model may also serve as a guide to the MoHSS, hence the possible improvement in the facilitation of childbirth choices. The study will be significant if adopted for all women being facilitated in public healthcare facilities as they will be equipped with information regarding childbirth types and accordance of childbirth-choices. Furthermore, the model strengthens the independent function of the midwife in the public healthcare facilities as primary caregivers of pregnant women. Finally, the researcher gained some more insights on the facilitation of childbirth-choices among women and the development of the model as a research skill.

1.8 DELIMITATIONS

Delimitations are boundaries that the researcher identifies in terms of the population and the context under study (Creswell & Poth, 2018). The study was conducted at Hospital A, Hospital B, Hospital C and Hospital D in the Khomas, Kavango and Oshana regions. The study analysed and described the different childbirth types in the settings as well as explored the experiences of women and midwives in facilitation of childbirth-choices. The researcher chose public sector as midwives are the primary caregivers in this setting as opposed to the private sector (Mlambo, 2018).

1.9 PARADIGM PERSPECTIVE

A paradigmatic perspective is a world view and a basic set of beliefs that guides actions in research including specific methods of structuring reality in a discipline (Polit & Beck, 2021).

This study adopted a pragmatic world view, which incorporated mixed methods as both quantitative and qualitative methods helped in understanding the phenomenon under research. Furthermore, pragmatism is not centred on one type of philosophical perspective and reality but rather engages both assumptions to be able to draw conclusions (Creswell & Creswell, 2018). Best practices helped in clarifying the ideal situation in the facilitation of childbirth-choices, whereas the experiences of women and midwives helped with the in-depth data of how facilitation was conducted, and these followed the constructivism world view. Finally, the different childbirth types displayed the number of women who birthed during the period under study (April 2018 to March 2019) and the reasons for the childbirth type if any. The findings of the study were merged, and central concepts were identified as a basis for developing a model for midwives for the facilitation of childbirth-choices among women.

1.9.1 Ontological assumption

Ontological assumptions refer to the nature of reality meaning the researchers assumptions on the phenomenon and in qualitative research is that the reality is subjective (Crotty, 2003). In this study, the reality of women attending ANC is to get information during their pregnancy is an assumption of how the ANC information giving should entail. Ontology seeks to understand what the nature of reality is (Crotty, 2003). The researcher sought to understand the reality in facilitation of childbirth-choices by conducting fieldwork and gather experiences of women and midwives alike in childbirth-choice facilitation in the context under study. Based on the observations made by the researcher in clinical practice, women birth without having been given information on different types for childbirth based on the high risk or low risk criterion used in the hospital setting.

1.9.2 Epistemological assumption

This refers to the relationship between the researcher and the phenomenon that is under study (Creswell & Creswell, 2018). The study was undertaken as the researcher is a midwife and

understanding more of the phenomenon of how women are facilitated with childbirth-choices was paramount. The background portrayed the disparities in the private and the public sector rates of childbirth types, thereby raising the question whether the women in the public sector have a choice, and if they have sufficient information to decide. The study used one on one interviews with women who were facilitated for their childbirth type and from the midwives that facilitated women to obtain subjective views of pregnant women and midwives regarding childbirth-choices. Epistemology seeks to understand the subjective part of the phenomenon (Creswell & Creswell, 2018).

1.9.3 Methodological assumption

Methodological assumptions refer to the ways the researcher used to obtain knowledge pertaining to the phenomenon (Creswell & Creswell, 2018). The aim is to link the methodology chosen and the outcomes that are desired (Crotty, 2022). The study adopted a mixed method approach to gather knowledge on the facilitation of childbirth-choices among women. The researcher chose this approach as it offers quantifiable evidence on the data of women that have birthed with different types of childbirth and if they attended ANC, as well as the experiences of both midwives and women in facilitating and being facilitated regarding childbirth-choices. A scoping review was also undertaken to identify the ideal situation in facilitating childbirth-choices. The desired outcome in this study is for women to have positive childbirth experiences hence, best practice sets the evidence while the experiences of women help identify what women want and midwives' experiences help identify any challenges in delivering what women want.

1.9.4 Axiological assumption

Axiological assumptions seek to understand the value or aim of the research and the role of the researcher in the process of research (Creswell & Creswell, 2018; Polit & Beck, 2021). The researcher as a midwife and an educator sought to understand the phenomenon and to apply

the findings in practice. Following the research undertaking, the researcher may apply the results in practice, education and share the results with policy makers. Ethical principles where upheld by the researcher based on the Declaration of Helsinki and all the participants were not coerced into participating in the study. When analysing the study results the researcher avoided influencing the results by immersing in the data collected to analyse it objectively (Creswell & Creswell 2018).

1.9.5 Rhetorical assumption

Rhetorical assumption refers to the structure of the paper and the reality through the eyes of the research participants (Creswell & Creswell, 2018). Rhetorical assumptions appraise the results to be told from the research participants' viewpoint (Polit & Beck, 2021) hence the study adopted a scoping review and a qualitative approach for the sub-objectives of the experiences of women and midwives. A pragmatic worldview was adopted, reality was identified through the eyes of the participants as well as the quantifiable data for the childbirth type and the best practices of facilitation of childbirth choices. The researcher analysed the truths from the viewpoints of the research participants where concepts are analysed, and relationships identified which was elaborated in Chapter seven.

1.10 THEORETICAL BASIS OF THE STUDY

Research needs or depends on theories that have been tested and in this context of aiming for model development, it is imperative to include theoretical reasoning as a drawing board (Grove & Gray 2018). The researcher incorporated the Theory generation (Chinn & Kramer, 2018), Inter-professional Shared Decision-Making model (IP-SDM) (Legare, Stacey & IP Team, 2010) and the Nursing Process Theory (Orlando, 1961). The researcher applied the first theory to guide theory generation through the objectives of the study which were presented in four phases as illustrated in Table 1.1. The IP-SDM (Legare et al., 2010) and the Nursing Process (Orlando, 1961) were incooperated in the study as the former has broadness in the process of

facilitation and inclusivity of the different actors while the latter is known to the context under study and was part of the training as a guiding principle in caring for patients hence, the quality of the model will be enhanced.

1.10.1 Theory generation (Chinn & Krammer, 2018)

The study adopted Chinn and Krammer (2018) for the main objectives of the study which were presented in Four Phases as illustrated in Table 1.1. Findings from the study were the building blocks for the model development for midwives to facilitate childbirth-choices among women. A conceptual framework was also developed in Phase two of the study (Figure 7.1), which also helped in the development of the model for midwives.

Table 1.1 Steps for theory generation in model development

Phase	Step	Application Chapter
1 1.1 1.2	Analysis of concepts Identification of concepts Definition and classification of concepts	7
2	Construction of the relationship statement	7
3	Description and evaluation of the model	8
4	Description for the guidelines for operationalising	8

1.10.2 The Inter-professional Shared Decision Making (IP-SDM) (2010)

The IP-SDM model entails several actors that are critical for shared decisions pertaining to the health of the patient. The actors in this model are as follows; patient, initiator of the SDM process, decision coach, family members or significant others and health care professionals (Legare et al., 2010). In the present study, the actors included the pregnant woman, family member, midwives and medical doctors as implemented, illustrated and described in Chapter seven (Table7.7). Women do not operate in isolation and the views and advice they receive from the family play a crucial role. In the current study, the initiator of the SDM process, the decision coach and healthcare professional refer to the midwife.

The SDM process includes the following: the decision to be made, information exchange, values or preferences, feasibility, preferred choice, actual choice, implementation, outcomes

and the time taken for the process (Legare et al., 2010). The researcher included the process as it is a decision making for childbirth-choices through facilitation from midwives which entails more of the process. It important to note that before women make a decision, some information is needed and this information needs to be availed from the beginning of the facilitation and should continue until the woman gives birth (WHO, 2015).

According to the IP-SDM, the environment refers to the patient and family context and the IP team context (Legare et al., 2010). The environment entails the social norms, organisational routines and institutional structure in which the patient finds themselves in. Table 1.1 illustrates the application of the IP-SDM model as adopted in this study, but further explained following analysis in Table 7.6. In this study, the environment was represented by the external and internal environments (Table 1.1). The family and patient context in this study are represented by the external environment which is further represented by the community and family. Furthermore, the IP team context is represented in this study by the internal environment which is the healthcare facilities and these are characterised by organisational structure, policies and guidelines and resources (Table 7.6).

Table 1.2 Application of the IP-SDM model (Legare et al., 2010)

Elements	**Application**
Actors	Pregnant woman Family members Midwives, nurses, doctors
Environment	External environment (community) Internal environment (healthcare facilities) -
Process	Following the identification of the actors and the environment the facilitation of childbirth-choices is enhanced as it becomes woman-centred which is well articulated in table 7.6

1.10.3 The Nursing process theory (Orlando, 1961)

The Nursing process consists of five steps which include assessment, diagnoses, planning, implementation and evaluation in the course of nursing interventions. The Nursing process is described as a systematic guide to client centred care (Toney-Butler & Thayers, 2021). The Nursing process will further be described in Chapter Seven under development, description and evaluation of the model. In research, it is imperative to conduct an assessment before

implementation as this helps the researcher to identify gaps in knowledge (Wight, Wimbush, Jepson & Doi, 2015). The assessment stage requires critical thinking (Toney-Butler & Thayer, 2021) and midwives ought to assess the environment and the woman as there is interconnection to get to the correct diagnoses as there is an interconnection between women and their environment to get the correct diagnosis. Diagnoses follows the ascertainment of the health problem at hand, and in this study, diagnoses of the actors and environment were carried out (Table 7.7). Planning of the identified challenges or needs to ensure the implementation of specific goals was described in Table 7.7. Evaluation takes place to identify the effectiveness of the intervention that has been made and, in this study, the pregnant women were evaluated for their knowledge of childbirth choices and their experienced challenges and dynamics.

Table 1.3 Application of the Nursing process theory (Orlando, 1961)

Element	Application to the study
Assessment	Assessment of the actors and the environment and how they affect the facilitation of childbirth-choices. The actors are assessed in terms of their responsibilities, knowledge and roles in facilitation of childbirth-choices. The environment in the study context will assess the internal and the external environments as illustrated in Table 7.7.
Diagnosis	Diagnosis of the childbirth-choices, woman centred care, protocols and guidelines, rights of women as well as any barriers affecting the facilitation of childbirth-choices which is further elaborated following the analysis of the research objectives.
Planning	Planning of activities that enable the evidenced based way of facilitation of childbirth-choices and identifying the roles of the actors in each activity.
Implementation	Application of the activities to ensure the goal of childbirth choice facilitation is met.
Evaluation	Evaluating the outcome of the facilitation of childbirth-choices.

1.11 RESEARCH METHODOLOGY

In the current chapter, the methodology is described in brief, with regards to how the researcher managed the data. The methodology is described under the following subheadings: research design, population, sampling and sample, inclusion criteria, data collection tools, pre-testing, data quality, trustworthiness, data collection and analysis according to each objective of the study. The methodology of this study is further discussed in depth in Chapter Three of this study.

1.11.1 Research approach and design

The current study followed a mixed methods approach which helps researchers to maximise the strengths of quantitative and qualitative approaches (Creswell & Creswell, 2018; Grove &

Gray 2018). Within the mixed method approach, the researcher followed a convergent parallel design as proposed by Creswell (2014) who affirms the design in meeting the demands of the mixed methods approach. A convergent parallel design allowed the researcher to collect and analyse data (qualitative and quantitative) concurrently which was then followed by merging the results in Table 6.5 and the interpretation thereof. The study adopted Chinn and Krammer (2018) to guide the research thus adopting the four phases in Theory Generation namely, identification and analysis of concepts (Phase one), define, classify and conceptualise concepts as a basis of model development [Phase two], develop, describe and evaluate the model (Phase three) and develop guidelines to operationalize the model (Phase 4).

1.11.1.1 Phase one: Identification and analysis of concepts

The study identified two main concepts which were facilitation and childbirth-choices that were critical in coming up with the conceptual framework (Figure 7.1), model (Figure 8.1) as well as the guidelines (Chapter eight) for the model. The identified and analysed concepts were derived and synthesised from four sub objectives described fully in Chapter three of the study and summarised as follow:

- *Explore and describe the best practices on the facilitation of childbirth-choices for women by midwives in public healthcare facilities. [Phase one]*

A scoping review was utilised for the study to appreciate the best practices on the facilitation of childbirth-choices among women guided by the framework proposed by Arksey and O'Marley (2005). The researcher chose original published articles from 2015 to 2020. The researcher chose the period as nursing is dynamic and research continues to evolve for there to be care that facilitates women centred care (O'Brien, Butler & Casey, 2017). The researcher adopted purposive sampling by going through the research articles that met the inclusion criteria. The research articles that were included (30) used the key words ''facilitation of

childbirth-choices among pregnant women'' and they were also in English. The researcher adopted the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) flow chart which includes the identification of relevant articles, screening for the articles, eligibility of identified articles and included articles in the scoping review (Moher, Liberati, Tetzlaff & Altman, 2009).

- Explore and describe the experiences of midwives in facilitating childbirth-choices in public healthcare facilities [Phase one]

A qualitative approach with an exploratory design for in-depth appreciation of the phenomenon was adopted. One on one in-depth interviews were conducted with midwives from the selected public healthcare facilities. Purposive sampling made the researcher focus on the population that had rich data and for this study it was the midwives working in the antenatal wards and labour wards at the time of the research. A semi-structured interview guide (Appendix F; pg 282) was used to collect data and saturation was achieved by 10 midwives.

- Explore and describe the experiences of childbirth-choice facilitation among women in public healthcare facilities [Phase one]

The objective assumed a qualitative approach with an exploratory design. Purposive sampling was used in this objective and a semi-structured interview guide (Appendix F; pg 282) was utilised to collect the data. One on one in-depth interviews were conducted until the sample size was determined by data saturation with a total of 12 women.

- Analyse different childbirth **types and reasons** if any in public healthcare facilities [Phase one]

The study adopted a quantitative approach with a descriptive design to identify the different childbirth types and the reasons for the chosen type if any. The population was made up of maternity files of women who birthed at Hospital A, Hospital B, Hospital C and Hospital D

between April 2018 and March 2019. A total sample of 1446 maternity files were included using a check list. The researcher used the Statistical Package for Social Sciences (SPSS) version 26.

1.11.1.2 Phase two: Define, classify and conceptualise concepts as a basis of model development

Phase two was guided by the IP-SDM model (Legare et al., 2010) and the Nursing Process (Orlando, 1961) as a departure for conceptualising and the development of a conceptual framework. The relationship statement stems out of the concepts identified and linked towards a phenomenon (Chinn & Kramer 2018). From the concepts derived from Phase one, the researcher defined them to get meaning and linkages and through the guiding theories a conceptual framework materialised and is discussed in-depth in Chapter seven of the current study.

1.11.1.3 Phase three: Development, description and evaluation of model

The model for midwives developed in this study was guided by the IP-SDM model (Legare et al., 2010) and the Nursing Process (Orlando, 1961) and the conceptual framework developed in Phase two. The description of the model is detailed according to the six steps in quality intervention development. The steps followed were defining and understanding the problem and its causes, clarifying which causal or contextual factors are malleable and have the greatest effect of change, identifying how to bring about change, identifying how to deliver the change mechanism, testing and refining on a small scale and collecting sufficient evidence on effectiveness so as to justify rigorous evaluation or implementation. Description and evaluation are further discussed in Chapter Seven and Eight of the study.

1.11.1.4 Phase four: Development of guidelines for operationalising

For the model to be operational, guidelines need to be in place to guide the midwives in adopting and making use of the model. The guidelines focused on the aims of the three phases in the model and the activities thereof to be implemented in the respective phases. The guidelines are further discussed in Chapter Nine of the study.

Table 1.4 Summary of the methodology applied in Phase one of the study

	PHASE ONE			
Research objectives	1 Explore and describe the best practices on the facilitation of childbirth-choices for women by midwives in public healthcare facilities in Namibia	2 Explore and describe the experiences of midwives in facilitating childbirth-choices in public healthcare facilities in Namibia	3 Explore and describe the experiences of childbirth-choice facilitation among women in public healthcare facilities in Namibia [Phase one]	4 Analyse different childbirth types and reasons if any in public healthcare facilities in Namibia
Approach & design	Scoping review	Qualitative ▪ Exploratory, ▪ descriptive	Qualitative ▪ Exploratory, ▪ Descriptive	Quantitative ▪ Descriptive
Population	Published research articles from January 2015 to December 2019 on the facilitation of childbirth-choices among women	Midwives in the maternity department at Hospital A, Hospital B, Hospital C and Hospital D)	Women who birthed between the April 2018 and March 2019 financial year at Hospital A, Hospital B, Hospital C and Hospital D	Maternal registers between the April 2018 and March 2019 financial year at Hospital A, Hospital B, Hospital C and Hospital D
Sampling method Sample size	Inclusion and exclusion criteria 30 articles	Purposive 10 midwives	Purposive 12 women	Stratified simple random sampling 1446 maternity files
Data collection	Scoping review framework (Arksey & O'Malley, 2005; PRISMA)	Individual interviews	Individual interviews	Checklist
Data analysis	Thematic analysis	Creswell (2014) 6 steps of data analysis	Creswell (2014) 6 steps of data analysis	Statistical analysis with SPSS version 26
Data quality	Methodological rigor	Trustworthiness (credibility, dependability, transferability & confirmability)	Trustworthiness (credibility, dependability, transferability & confirmability)	Validity and reliability

1.12 ETHICAL CONSIDERATIONS

Research ethics are the core of any research that involves humans as participants. Research ethicaesarean section are guided by the Declaration of Helsinki of 1964 as reviewed in 2013 (World Medical Association, 2017). Ethical guidelines helped guide the researcher to make decisions that are morally justified as well as evaluating the morality of actions (Grove, Burns & Gray, 2013). The researcher sought ethical approval to conduct the research from the ethics committee of the University of Namibia (Appendix A; pg 266), MoHSS (Appendix B; pg 267), as well as from the selected public healthcare facilities (Appendix C; pg 270), and informed and verbal consent were sought from the research participants (Appendix D; pg 274). Within the study the researcher adhered to the following core ethical principles namely, informed consent, beneficence, justice and respect which are well elaborated in Chapter three of this study.

1.13 DEFINITION OF CONCEPTS

The concepts defined are derived from the tittle of the study "The development of a midwife facilitation of childbirth-choices by women in selected public healthcare facilities in Namibia and are described as follow:

1.13.1 Model:

According to Grove et al. (2017), a model is a symbolic description of reality, which helps to structure the way a situation may be viewed. The study sought to develop a model for midwives to enhance the facilitation of childbirth-choices among women. The developed model is structured in three phases namely initiation phase, facilitation phase and the outcome phase as illustrated in Figure 8.1.

1.13.2 Midwives:

Refers to a person registered as such in terms of section 64 of the Nursing Act of Namibia (Republic of Namibia, 2004). This study refers to a midwife as such, and as the one facilitating childbirth-choices among pregnant women whom in the context under study is also a nurse-midwife. A model for midwives was developed in this study for the facilitation of childbirth-choices among women in public healthcare facilities.

1.13.3 Facilitation:

This is defined as the act of helping individuals to deal with a process to reach an agreement (Oxford Dictionary, n.d). Facilitation in this study refers to the healthcare professionals interacting and guiding women who are under their care through the process of childbirth-choices. Guidelines to operationalize (Chapter eight) the model for midwives to facilitate childbirth-choices were developed with activities that were guided by the findings of the study.

1.13.4 Childbirth:

This is defined as the process of giving birth to a baby (Martin, 2005). The ICM defines childbirth as the normal physiological process that does not require medicalisation unless there is a presence of pathology (ICM, 2014). In the present study the term was used to refer to vaginal birth and caesarean section as the facilitation should not differ but should be accorded to all pregnant women by giving unbiased information on childbirth.

1.13.5 Choices:

This is defined as an act or possibility of choosing between or among several options at a given time (Oxford Dictionary). In this study, the concept choice was used in relation to the childbirth types that are available for selection, which are caesarean section and vaginal birth.

1.13.6 Childbirth-choices:

According to the Universal rights of childbearing women (White Ribbon Alliance, 2011; Windau-Melmer, 2013), childbirth-choices are described as the right of women to make informed decisions on the mode of childbirth they need based on the information given on different types (Windau-Melmer, 2013). In the current study, the definition was adopted as such in that woman have the autonomy of deciding the best childbirth type based on the unbiased information received from midwives regarding childbirth.

1.13.7 Women:

According to the Oxford Dictionary, women are defined as adult human females. In this study, women refer to women who were facilitated during pregnancy and childbirth regarding the childbirth-choice.

1.13.8 Public healthcare facilities:

According to WHO (2016), these are hospitals or primary healthcare centres where people receive care for their health issues. In this study, healthcare facilities refer to the selected public hospitals that offer ANC to women and their families for them to make childbirth-choices. The selected public healthcare facilities for the realisation of the study undertaking were Hospital A, Hospital B, Hospital C and Hospital D.

1.14 PRESENTATION OF THE CHAPTERS

This research dissertation comprises of nine chapters that are briefly described below:

Chapter One: This chapter discusses the introduction and background of the study for enabling the understanding of the study phenomenon. The chapter, furthermore, discusses the statement of the problem which is the facilitation of childbirth-choices in the quest for understanding the way women make decisions of childbirth types as communicated to women during antenatal care. The significance of the study is to promote women centred care when facilitating

childbirth-choice types through the developed model. Ethical considerations are presented as the basis of the research and the study followed and was guided mainly by respect for persons, principle of beneficence, principle of justice and anonymity and confidentiality.

Chapter Two: The chapter reviews relevant literature that is available in the interest of the phenomenon that is the facilitation of childbirth choices. The reviewed literature focusses on the best practices as this is the basis of nursing research as it is evidenced based (Grove & Gray 2018). The rights of childbearing women are also discussed as they are incorporated in the facilitation of childbirth choices.

Chapter Three: The chapter presents the methodologies that were used in the study. The study adopted a mixed methods research approach with a convergent design.

Chapter Four: Best practices are described in this chapter following a scoping review that was conducted. The analysis of the searched literature and the themes derived are discussed in detail. The chapter plays a critical role in identifying the best practices of the facilitation of childbirth-choices worldwide, and that could also be applicable to the context under study, that is, Namibia.

Chapter Five: The chapter presents the quantitative objective of the different childbirth types and their reasons, if any, in the public hospitals under study. The objective sought to identify as well if women attend ANC before birth, which was meant to elicit the phenomenon understudy with regards to childbirth-choice facilitation among women.

Chapter Six: Chapter Six presents and discusses the qualitative data objectives of the experiences of midwives facilitating childbirth-choice and experiences of being facilitated during pregnancy among women. This chapter is divided into two sections (Section A and Section B) representing the experiences of midwives and women on the facilitation of childbirth-choices respectively. The chapter ends with merging the quantitative and qualitative

data to ensure that the converging of the data is understood as the basis and foundation of model development.

Chapter Seven: The chapter defines the concepts that emerged following the analysis of data for the reader to understand the basis of the study results. Following concept definition, the researcher classified and constructed relationships of the concepts and the statement that were identified in the study. The chapter was critical as it formed the basis of model development to cater for the study's core aim the proposed structures for the model for midwives for facilitation were presented.

Chapter Eight: Chapter eight presents the model for midwives for the facilitation of childbirth-choices and its description thereof. The purpose of this chapter is to focus on the evaluation of the model to ascertain how usable it will be in practice. Furthermore, for the model to be operational, guidelines needed to be in place and this is the purpose of the chapter. The guidelines are discussed according to the different phases of the model that was developed in Chapter seven. In addition, the model review also guided the guidelines for the model to be operational.

Chapter Nine: Chapter nine concludes the study by describing the findings according to the research objectives and demonstrating how the study answered them. Recommendations that emanated from the study are also included in this chapter for further (future) research and to the participating hospitals and policy makers. Like any other study, limitations are bound to exist hence the limitations of this study are presented in this chapter. A model was developed in this study and its contribution to the body of knowledge is explained.

1.15 CHAPTER SUMMARY

Chapter one introduced the research to the reader through presenting an overview of the research. The background, statement of the problem, purpose of the study, research objectives,

and methodology of the research under study were discussed. In addition, the ethical principles that the study followed were also introduced. The following chapter discusses the reviewed literature for the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter one gave an overview and introduction of the study. This section of literature review focusses on the history of childbirth from a global, African and Namibian context; the legal perspective on childbirth, best practices of childbirth; the roles of stakeholders; experiences of women with facilitation and the effects of facilitation of childbirth-choices. The rationale of this focus was to understand the history and identify any relations with current practice in cognisance with the woman as an autonomous being in childbirth-choices. It is important to understand the best practices of other contexts in relation to the international standards according to the ICM, WHO and any other relevant bodies in the context of the phenomenon, thereby elucidating the gap in the context under study.

2.2 BACKGROUND OF CHILDBIRTH

The aim of this section is to provide some background of childbirth by specifically explaining physiological birth as midwives are key role players in advocating and supporting women. Childbirth is defined as the normal physiological process that does not require medicalisation unless there is a presence of pathology (ICM, 2014, Sellers, 2018). Women remain autonomous beings that make their own decisions regarding choice in childbirth based on experience, information given and preferences (Regan, McElroy & Moore, 2013). Historically, childbirth has unquestionably been viewed as a natural physiological process and vaginal birth has been the undoubted mode of childbirth (Loke et al., 2015). Loke et al. (2015) further proffer that historically vaginal delivery was not a choice, but the norm and women anticipated this childbirth mode. The notion for vaginal birth as the physiological way of bringing a child into the world is supported by the WHO (2018) and ICM (2018), through the midwifery led care

initiative which encourages the facilitation of normal physiological childbirth for all low-risk women. However, in respect of the above, this does not mean that women should not receive information about other childbirth types as there may be women who can end up with complications which may result in a change of childbirth type. Hence, women need to be adequately informed of the different types of childbirth types in order for any unanticipated changes (ICM, 2018), thus creating a more involved environment for the women (Preis et al., 2018).

Normal childbirth has benefits that pertain to the woman and the baby. According to Walana et al. (2017), post-delivery recovery was considered swift where normal vaginal delivery was the mode of childbirth, thus making it one of the benefits that women in Ghana identified with. Childbirth transitions most women from womanhood to motherhood and the need to bond with the baby soon after birth, making vaginal birth having an advantage of early bonding (Fenaroli, Molgora, Dorado, Svelato, Gesi, Molidoro, Saita & Ragusa, 2019; Sellers, 2018). Vaginal birth furthermore carries better chances for early initiation of breastfeeding, women also can care for their babies early with no difficulties of pain and positioning (Sellers, 2018; Walana et al., 2017).

Natural childbirth has positive impacts on the woman and family as it facilitates quick recovery hence promotion of bonding of the mother and her baby (Fenaroli et al., 2019). Medicalisation of childbirth has been noted to decrease the satisfaction and experiences of women with regards to childbirth hence, midwives as the primary caregivers of low-risk women have the mandate to advocate for vaginal birth and support women as this improves positive childbirth experiences (Olza, Leahy-Warren, Benyamini, Kazmierczak, Karlsdottir, Spyridou, Crespo-Mirasol, Takacs, Hall, Murphy, Jonsdottir, Downe & Nieuwenhuijze, 2018). On the other hand, a negative childbirth experience may lead to negative psychological distress and post partum depression which will interfere in the bond of the mother, baby and family (Fenaroli et al.,

2019, WHO, 2018). Healthcare providers inclusive of midwives need to understand the emotional aspects that are attached to childbirth and be able to facilitate and support the emotional as well as the psychosocial needs of women (Olza et al., 2018; Macfarlane et al., 2015).

A positive birth experience is created by midwives when women feel heard and seen by the healthcare providers hence involving women in decision making and their care for birth is very critical (Henriksen, Grimsrud, Schei & Lukasse, 2017, White Ribbon Alliance, 2011; Windau-Melmer, 2013). Furthermore, a positive birth experience rests in the womans trust in their ability to give birth and having a safe and supportive person at birth (Bell & Anderson, 2016).

Caesarean section childbirth is defined as an operative procedure that the woman undergoes, and the baby is birthed abdominally (Sellers, 2018). Unlike physiological childbirth, caesarean section childbirth is mostly planned, and the woman does not go into labour before the procedure can be performed. There is a myriad of reasons why women opt to have caesarean childbirth which include tokophobia, convenience and maternal requests (Mlambo, 2018). Caesarean section can be a life-saving procedure for both the mother and the infant in cases of emergency maternal and foetal emergencies which may include but not limited to the following: obstructed labour, pre-eclampsia with severe features or eclampsia, and foetal distress to mention a few (Childbirth Connection, 2014).

The WHO emphasises that the rates of caesarean sections are not of importance if the reasons are medically motivated and do not lead to unnecessary caesarean sections (WHO, 2016). Women are reported to prefer the caesarean section childbirth mode especially those who fear childbirth or going into labour (Slade et al, 2019; Wigert et al., 2020). This has been a major determinant on the escalating rates of caesarean sections (WHO, 2016; ICM, 2015, FIGO, 2014). According to Kotaska (2015), women prefer the caesarean section childbirth mode as

they believe that urinary stress incontinence later in life likely escalates in women who had a natural or vaginal delivery.

Childbirth choices and facilitation determine the birth type of women and they are influenced by different factors in different contexts. For women to make childbirth choices, there needs to be different childbirth types being offered to them, hence facilitation from the healthcare professionals plays an important role (Loke et al., 2015). Globally, there is an outcry on the discrepancies between vaginal birth and caesarean section deliveries between public sector institutions and private sector institutions and midwives and doctors as the primary caregivers and therefore as the major role players can account for this (FIGO, 2014; ICM, 2016, WHO, 2017). Therefore, there is a need according to ICM (2016) and WHO (2017), to understand the phenomenon as to why there are differences among public and private health institutions and in this way, it will be possible to formulate guidelines and models for the implementation of and encouragement of the normal physiology of birth that emanates from a better understanding and advocacy by all the parties involved.

In Namibian private healthcare sector, normal deliveries, and caesarean section rates in 2014 were 26% and 74% respectively, and in the public sector normal deliveries and caesarean section rates fluctuated from 88% and 12% (2012) to 85.1% and 14.9% respectively (2016) (NAMAF, 2015; Mackenzie, 2017). Childbirth-choice facilitation in Namibia is the phenomenon to be understood in the present study as evidenced by the significant differences in the percentages of childbirth types across the healthcare facilities, with the aim of addressing the problem of choice facilitation.

2.3 LEGAL PERSPECTIVE ON CHILDBIRTH

Litigation factors have been written in literature as a driving cause for the rise in the caesarean sections as at times some health professionals pre-empt complications (Lokugamage &

Pathberiya, 2017) though this might as well not be really the case as some women purport not having enough information on childbirth-choices which may also result in legal implications (Mlambo, 2018). According to Zamani-Alavijeh, Shahry, Kalhori and Araban (2018), in a study conducted in Iran, the WHO (2015) and ICM have a mandate to protect women from the medicalisation of birth as it is unethical on the part of the healthcare professionals. Therefore, health professionals need to understand that litigation factors are double faceted as women with vaginal delivery or caesarean section can litigate on the grounds of not having had adequate information on a birthing choice.

The scope of practice (Republic of Namibia, 2014) is described as the services given by qualified health professionals who are as well competent and permitted to undertake duties with patients under their care (ICM, 2014; Republic of Namibia, 2014). The scope of practice (Republic of Namibia, 2014) of the midwife according to the Republic of Namibia affirms that midwives ought to provide assistance, and medical care to patient … including the scientifically based physical, psychological, social, educational … relating to a patient in the course of pregnancy.

According to the Patient charter (MoHSS, nd) of Namibia, patients need to be given information for them to make a choice regarding their health. Childbirth is also not different and hence midwives need to include women in shared decision making for them to make confident and evidenced based decisions (Women's Global Network for Reproductive Rights, 2018; Mlambo, 2018; WHO; 2015; WHO, 2017). The Robson Classification (WHO, 2017) was brought about to strive and reduce the caesarean section rates for non-medical reasons by use of the ten categories that include nulliparous women who had single or more caesarean section with malpresentations or women with multiple pregnancies with a previous uterine scar or women with single pregnancies with malpresantations and how they fit into having a repeat caesarean section or a trial of scar. The Robson Classification sought to reduce the number of

first time or recurrent caesarean sections with no medical indications. It is however unclear in the Namibian context if heath practitioners are familiar with it.

According to Human Rights in Childbirth (Windau-Melmer, 2013), birthing women are not objects to be processed, but rather human beings and equal citizens with full claims upon healthcare and human rights. Based on the above, women in maternity are not excluded from the human rights accorded to all human beings and as such, they are entitled to make informed decisions based on the facilitation provided for them to make the choice they regard to be appropriate for them. Of the seven Universal rights of childbearing women the current research dwelt mainly on only two of them which are "right to information, informed consent and refusal and respect of her choices and preferences, including the right to her choice of companionship during maternity care …" and "right to liberty, autonomy and self-determination and freedom from coercion" (White Ribbon Alliance, 2011; Windau-Melmer, 2013).

The scope of practice (Republic of Namibia, 2014), Patient charter (MoHSS, nd) and the Universal rights of childbearing women (White Ribbon Alliance, 2011; Windau-Melmer, 2013) echo the importance of information giving to women to ensure informed decisions. Many scholars affirm the importance of health information giving for successful decision making (Mohamed & Fouly, 2016; Munro, Janssen, Corbett, Wilcox, Bansback & Kornelsen, 2017; Nascimento, Arantes, de-Souza, Contrera & Sales, 2015; Newnham, McKeller & Pincombe, 2017). The above confirm that midwives have the mandate to operate within the confines of their boundaries as well as including women and their families as indicated thereby curbing the fear of litigation as informed decisions would have been made.

2.4 BEST PRACTICES ON CHILDBIRTH-CHOICES

According to the WHO and the ICM, women need to be respected when they are being cared for and it is the women's right to be given the privilege to make decisions regarding their

wellbeing (WHO, 2018; ICM, 2018). Owning the birth experience means that the woman is involved in the final decision in the childbirth type to be undertaken whereas if women believe that the decision for their childbirth was made by the healthcare professionals, this has an impact on psychological ownership on the part of the women (Henriksen et al., 2017; Olza et al., 2018). Therefore, it is important to involve women in their care as this gives women positive experiences pertaining to the birth experience and outcome (Bell & Anderson, 2016); WHO, 2018). It is important for every woman to be treated individually and by so doing high quality and patient centred care in maternity and obstetrics is achieved with the woman being the epitome of the care (Mohamed & Fouly, 2016). Women centred care is spearheaded by adequate information for the women to make informed decisions regarding their care and the childbirth type of their choice (MoHSS, nd; Republic of Namibia, 2014). Furthermore, information given to women needs to be evidence based as scanty information being provided to women may result in unjustified negative attitudes towards a childbirth type (FIGO, 2014; Mohamed & Fouly, 2016).

In addition, a study conducted in the United States of America by Regan et al. (2013) supports the importance of the health information given to women as something that is vital to decide with regards to childbirth type. Regan et al. (2013) proffer that there are some expectations by the women when they attend antenatal care visits where they are to receive information from the healthcare providers, but it was not the case for one of the participants who verbalised that physical examination was done and yet if they did not ask questions nothing else was mentioned to them (Regan et al., 2013). The above is a violation of the right to information as stated in the Sustainable Developmental Goals (SDGs) (3) which states that there is a need to "ensure universal access to sexual and reproductive health care services including family planning, information and education and the integration of reproductive health…" (United Nations High Commissioner for Refugees UNHCR, 2017). The third SDG stipulates that all

women need access to information, and it is the mandate of healthcare professionals to disseminate evidenced based information so that women can make informed decisions regarding childbirth as part of reproductive health (UNHCR, 2017).

Furthermore, a study conducted in South Africa echoed similar results in light of women desiring to be involved in the decision making regarding the mode of childbirth (Hastings-Tolsma et al., 2018). The study goes on to describe the needs of women as wanting to "feel wanted, secure and not alone" as demonstrated through the actions by the midwives that are taking care of them in the facilities. As a result of poor shared decision making, women expressed no confidence in the midwives in the public sector and because of financial constraints, some women do not afford the private midwives that are said to offer more individualised care and also include women in decision making (Hastings-Tolsma et al., 2018; Mlambo, 2018; Maswime & Masukume, 2017). Women believe that they are autonomous beings and, in this regard, they ought to be identified as such and healthcare professionals including midwives owe it to them by awarding them the right to be able to decide the mode of childbirth (Loke et al., 2015). The above emphasises the need to involve women at each step of the decision-making process to facilitate a memorable childbirth experience.

Privacy in facilitation also goes hand in hand with woman led care as women have a right to be identified and managed in privacy. In South Africa, the issue of privacy arose in the public sector as many of the public hospitals do not have the luxury of according privacy during childbirth (Hastings-Tolsma et al., 2018). Privacy in the above context saw women having to be in one room with other expectant women during childbirth, thereby making it difficult and impossible for them to have birth partners, and some birth partners were even sent away as they were not permitted to be there. Privacy is a fundamental right which enables women to feel valued during childbirth and this gives them the satisfaction of being worthy (Mlambo, 2018). Resultantly, women opt for caesarean section as they can be accorded the privacy they need

and the possibility of having the presence of a partner during childbirth. Midwives and other health providers need to maintain the confidentiality of patients' information as a way of ensuring that other women in labour do not stumble on information that should not be theirs. In the South African study under discussion, women expressed a concern that midwives speak in vernacular as they perceive that the other women do not understand what they would be saying, thereby uttering confidential information pertaining to the other women hence resultantly breeching the woman's privacy (Hastings-Tolsma et al., 2018).

Women centred care is interlinked with informed decision making which puts the women at the centre when making decisions regarding childbirth (Daemers et al., 2017). In order to achieve informed decision making, women need to be equipped with information. According to Loke et al. (2015), women strongly identify their choice of mode of childbirth with the advice that they receive from the healthcare professionals. This furthermore is supported by Loke et al., (2015), who state that there is great influence from other women, as well as from midwives and doctors on the childbirth mode that they choose. On the contrary, in a study conducted in Ghana, only 1% of the respondents had their childbirth-choice influenced by healthcare providers (Walana, Acquah, Vicar, Muhiba, Dedume, Mashoud, Kolbilla, Yabasin, Kampo, & Ziem, 2017). With reference to the aforesaid, women have perceived trust on the healthcare providers to give them advice that is not flawed for women to make informed decisions. Influence on decisions by healthcare professionals also becomes questionable as they have the mandate to offer evidenced based advice to the women under their care (Walana et al., 2017).

Shared decision making in childbirth-choices may be described as a right for every woman under the care of midwives on any other health professional as this encourages patient led care and participation regarding their health (Nieuwenhuize & Low, 2013). The WHO (2018) supports the notion of women being autonomous and them having a part in the decision for their childbirth type which can help the women psychologically, and this further has an impact

on the childbirth experience that the woman has. However, depending on the contextual background of the women, some may not be able to participate in shared decision making if they do not have a health-related background or when the cultural aspect of an individual plays a role (Nieuwenhuize & Low, 2013; Preis et al., 2018). It is, however, the role of the midwife or health professional facilitating childbirth-choices to be able to provide as much information to the woman weather or not they will use the information hence ensuring best practices (Nieuwenhuize & Low, 2013; WHO, 2018).

According to Chen, Tenhunen, Torkki, Peltokorpi, Heinonen, Lillrank and Stefanovic (2018), shared decision making is influenced by a myriad of factors which are important in respectful maternity care a model that is evidenced based for positive outcomes. The factors as described by Chen, McKellar and Pincombe (2017), include women's values, women's preferences, the values, expertise and understanding from research on the part of the care giver, which is of utmost importance when women make decisions. Basing on the above, women need facilitators during pregnancy who will guide them through childbirth facilitation by giving them knowledge for them to make informed decisions (Hajizadeh et al., 2020). Furthermore, the result of evidenced based facilitation of childbirth-choices empowers women and, in this way, respectful maternity care is recognised and practiced (ICM, 2018; WHO, 2018). Information giving to women includes the pros and cons of the childbirth type to women so that they are informed when they have to make a decision which will affect them, hence this will result in woman centred or led care as advocated for by ICM and the WHO (ICM, 2018; WHO, 2018).

Guideline implementation is a necessity in facilitating the best practices in any setting and this includes strategies to identify the perceptions of healthcare providers on childbirth choices. The understanding of this phenomenon helps policy makers to formulate guidelines that recognise the healthcare provider, thus ensuring that the information that they will provide for the women is evidenced based (Diamond-Brown, 2018).

Considering the above, the healthcare providers have a mandate to identify and incorporate the value of women and their preferences when it comes to the childbirth types (MoHSS, nd; Republic of Namibia, 2014; Preis et al, 2018). Childbirth experience is positively influenced by the fact that the woman feels responsible for the decision made for the childbirth type hence encouraging autonomous decisions for the woman (Bell & Anderson, 2016; Hajizade et al., 2020).

2.5 ROLES OF STAKEHOLDERS IN CHILDBIRTH

The role of midwives is to empower women with health information regarding childbirth-choices and this is a process that begins from prenatal education (ICM, 2018; WHO, 2018). Health education empowers women to make the right and informed decisions. The primary caregivers of the woman in private settings (doctors or private midwives) or in the public sector (midwives) have the mandate to ensure that evidence-based information is given to women during pre and antenatal care (Mlambo, 2018).

Midwives, according to the WHO (2015), are encouraged and motivated to use the Safe Childbirth checklist to ensure that women have the safest and most memorable childbirth experience. The checklist denotes that the midwife has a role of pausing and checking the wellbeing of the women under their care from admission until their discharge. The purpose of the checklist on admission is to ensure that any complications that are evident may be treated and further problems avoided (WHO, 2015). The facilitation of childbirth among women does not only mean normal childbirth as midwives need to be able to identify complications and refer women accordingly so that they can be helped, thereby saving both the mother and the baby. In addition, choice is a critical aspect in maternity services and to achieve this, the midwives facilitate childbirth by giving health information (Nieuwenhuijze & Low, 2013) to the woman on the types of childbirth modes which are available as well as their advantages and disadvantages to ensure that the women are empowered (National Health Survey, 2017).

Furthermore, midwives are required to have competencies inclusive of offering information to women and their support system pertaining to normal pregnancy and childbirth (ICM, 2018). Considering the above, evidence-based information needs to be given to the women for them to be able to have a choice of the best childbirth type. Quality improvement is needed with regards to maternal and new-born care, and this includes the role of the midwife in giving sufficient information regarding the childbirth types that are available to women (ICM, 2017, Repuplic of Namibia, 2014). Furthermore, childbirth facilitation does not solely identify with first pregnancies, but with each pregnancy that the women have, health professionals should be willing to give information regarding childbirth (Konheim-Kalkstein et al., 2017). Konheim-Kalkstein et al. (2017) further state that facilitation includes and is not limited to discussing VBAC with the women as a childbirth type to consider after one caesarean section birth. The above views demonstrate that midwives or health professionals are mandated to inform women on all the possible childbirth types that are available to them.

Clinicians are not effectively communicating with women on the possible childbirth types they may take for the women to make informed decisions on the modes of childbirth they can opt for or may possibly have even if they had not planned for it (Stirling et al., 2018). Decision making entails the women comprehending the information on the different childbirth types that a woman may be subjected to when the time for birth arrives and women may only make the informed decision if they have relevant evidenced based information (Bernstein, Matalon-Grazi & Rosenn, 2012). Without any doubt, information giving to women will lead to women led care and thus making them a part of the health care that they receive.

2.6 EXPERIENCES AMONG WOMEN ON CHILDBIRTH FACILITATION

Experiences are pivotal in research as they help researchers to understand a phenomenon from the perspective of those who have lived it and hence an in-depth understanding is achieved (Grove & Gray 2018). In a Swedish study to ascertain whether women preferred one type of

childbirth over another, it was shown that most women preferred normal physiology to happen in the absence of any complications (Gunnervick, Josefsson, Sydsjo & Sydsjo, 2010).

Firstly, choices that are made at a given time are likely influenced by previous choices which were made (Fenaroli et al., 2019) and this links with the experiences that women may have had personally or may have helped others in making decisions. It is thus important that women have positive childbirth experiences for them to refer to a positive birth outcome (WHO, 2018).

According to Konheim-Kalkstein, Kirk, Berish and Galotti (2017), childbirth has a positive impact on experience if there is a sense of ownership in the decision making leading to the final choice as the women will identify with the decision of becoming a woman and a mother. Childbirth has been identified as the beginning of motherhood and for a woman to be able to be involved in making that decision, this also yields positive experiences for the woman (Yuill et al., 2020). In addition, the first experience of motherhood has an influence on the consecutive childbirths as they will desire a better one or may be fearful of childbirth (Fenaroli et al., 2019). Furthermore, Nilsson, van Limbeek, Vehvilainen-Julkunen and Lundgren (2015), emphasise the importance or need for health professionals to counsel women in helping them to let go of a previous disappointing childbirth experience as this may have a negative notion on the pregnancy that will be underway. This therefore provides evidence that with each pregnancy, women desire to experience childbirth differently and healthcare providers need to individually facilitate each childbirth for different women.

Childbirth facilitation entails the ethical aspects on the part of the healthcare professionals and each woman desires to be treated with respect and dignity for them to feel safe with the health professional (WHO, 2018). Respect and dignity may only be achieved through the health professionals communicating professionally with the women to ensure that women open up about their past experiences in-order for midwives to be able to be supportive and ensuring

adequate information for women under their care (Bell & Anderson, 2020; Fenaroli et al., 2019). Effective communication ensures the confidentiality of personal information between the health professional and the woman thereby resulting in positive childbirth facilitation experiences for the woman (Stirling et al., 2018). Furthermore, Konheim-Kalkstein et al. (2017) state that the feeling of ownership of childbirth manifests from feeling responsible for communicating with health professionals for the positive childbirth that they experience. Hence, effective communication facilitates positive childbirth experiences thus ensuring the respect and dignity for each woman.

2.6.1 Cultural practices and influences on childbirth

In a study conducted in Iran on the preferences of women regarding childbirth, it was found that the beliefs of women had a great influence on the way they would make their choice (Zamani-Alavijeh et al., 2018). Considering the above, it is worth noting that midwives and other health professionals need to understand the beliefs and culture of the woman under their care for them to be sensitive and at the same time facilitate childbirth experiences for the women more successfully and ethically. Loke et al. (2015) concur with the above scholars that beliefs play an integral role in the decision making with regards to the childbirth choice. The rising cases of caesarean sections globally could be attributed to the notion that women believe that caesarean delivery is a safer option for childbirth and those women who have this perception will opt for a caesarean section (Loke et al., 2015). It is therefore worth noting that midwives and other healthcare providers need to identify and enquire about the beliefs of the women when they come for antenatal care as ultimately the women have to choose a childbirth type.

In addition, Hsu, Liao and Hwang (2008, as cited in Loke, et al., 2015) state that in China there are cultures that believe that the time of birth for a child has great significance in the fate and destiny for each individual, and resultantly beliefs and culture have an effect on the childbirth

choice for the women. Of note is that in the year of the dragon, there are a lot of childbirth and this may influence the decisions the women make in order for the birth to be in the same year. As such, midwives and healthcare providers are encouraged to familiarise themselves with the culture of the society in which they operate for them to be a strong support when facilitating childbirth-choices in different communities they are working in (Preis, Gozlan, Dan & Benyamini, 2018). Nieuwenhuijze and Low (2013), furthermore, concur that woman with no autonomous decision making in their cultures may find it very difficult to find themselves in situations that warrant them to make decisions. Therefore, midwives need to establish rapport with women for them to be conversational and to open up in order for them to confide in the midwife, thereby affording the midwives the opportunity to offer evidenced based and relevant information to the woman during the facilitation of childbirth choices (Grigg, Tracy, Daellenbach, Kensington & Schmied, 2014; Nascimento, Arantes, de-Souza, Contrera & Sales, 2015)

2.7 THE EFFECTS OF CHILDBIRTH FACILITATION

The effects of childbirth facilitation include and are not limited to positive and negative experiences for women, the economic impacts on the health systems and the integrity of the health profession. The primary reason for facilitation in childbirth is to ensure that all women relate with positive childbirth experiences, and this will result in good ethical and professional attributes to the facilitators.

2.7.1 Effects of childbirth facilitation on the woman and future pregnancies

Childbirth facilitation affects the women directly after the whole process is over and this can be both positive and negative. If women have positive childbirth facilitation from skilled midwives, it means that they will be able to re-live the experiences with joy and appreciation, and this only happens if they are not affected emotionally and physically (FIGO, 2014, WHO, 2018). Midwives taking care of women during pregnancy have a mandate to give women

adequate professional information for informed decisions to be made and this will help even in future pregnancies as adequate information and the action taken have a bearing on future choices and actions (Grigg et al., 2014; WHO, 2016). When the facilitation in nullipara women is done with the best and most sound reasoning, it also helps to reduce fear and doubt in future pregnancies due to past experiences (Hassanzadeh et al., 2020; Slade et al., 2019).

In addition, when childbirth is well-facilitated, women will believe that they are responsible for the outcome as they would have been involved all the way up to the end (Konheim-Kalkstein et al., 2017). Midwives' professional training encourages to advocate for the physiological type of birthing as they believe in the natural way of giving birth (ICM, 2018), but not excluding the high-risk pregnancies that will need obstetric care and some women ending with a caesarean childbirth out of necessity (ICM, 2018). Midwives acknowledge the presence of pathology in some women and they are trained to identify them and when that happens they can refer women accordingly (Mlambo, 2018; Republic of Namibia, 2014). However, doctors being fearful of litigation, are more likely to recommend caesarean delivery for women be it nullipara or the multipara (Cheng, Snowden, Handler, Tager, Hubbard & Caughey, 2014; Mlambo, 2018) and this will, as a result, inflate the number of caesarean section childbirths. As earlier stated, not all women may deliver through the normal physiological way, but efforts need to be made by health professionals to uphold beneficence to ensure that women are autonomous in their decisions.

Trevathan and Rosenberg (2014) argue that the effects of surgical childbirth primarily affect the woman and infant, and this can also affect future generations. The scholars (Dehingia et al., 2020; Griggs et al., 2014; Trevathan & Rosenberg, 2014) further argue that women are connected to a line of generations and their history, whether positive or negative, will likely have an impact on the generations to come as human beings often identify with their predecessors. It is therefore imperative for midwives to have the background of the women

under their care during facilitation to correct myths and give advice that is evidence based (Lee, Ayers & Holden, 2016).

2.7.2 Effects of childbirth facilitation on antenatal care and education

In a study conducted in South Africa, there is evidence of misinformation as a woman was quoted saying, "I was told after my baby was born that l could not breastfeed my baby …. I have HIV. But if I didn't breastfeed everyone would know I had HIV. I did anyway ... I saw the sangoma (traditional healer) who helped me" (Hastings-Tolsma et al., 2018, p.46). The above clearly depicts a negative effect if facilitation is assumed and not conducted. There is therefore, a need for healthcare providers to offer women evidenced-based information that will enable them to make informed decisions. The above is supported by a study which was conducted in Pakistan which found that errors or loopholes in antenatal surveillance and an ineffective referral system are possible causes of an increase in the caesarean section rates (Ahmad et al., 2018). There is surely a gap if the healthcare professional is unsure of the information she has to give to the woman in terms of childbirth-choices and this leads to negative outcomes when the women decide without receiving professional information.

In addition to misinformed education, the healthcare system may present challenges or barriers that will affect the facilitation that needs to be provided to women and their families regarding childbirth choices. According to Stirling et al. (2018, p. 23), these barriers include but are not limited to "incomplete, inaccurate, biased or unavailable patient education resources and lack of opportunity for pregnant patients to have meaningful conversations with their health care providers about their individual care" which is a major setback when women are being facilitated with childbirth choices. Stirling et al. (2018) further proffer that women need to be equipped with all the information pertaining to the different childbirth modes that are available to them, and to ensuring that the pros and cons of the modes of childbirth are clearly given for

a healthcare provider to be satisfied that the woman will make informed decisions based on evidenced based information.

In another study in South Africa, women expressed that they did not have enough time with healthcare professionals during antenatal visits (Hastings-Tolsma et al., 2018). Some of the women expressed that there was no information giving during the visits hence it was either what the woman new superficially or what the health care provider advised (Hastings-Tolsma et al., 2018). According to the informed decision making by Stirling et al. (2018), pregnancy with no complication is carried for nine months hence giving ample time for healthcare providers to facilitate sound and informed decision making for women under their care. Stirling et al. (2018), furthermore affirms that it takes time and most women require a longer period for them to be able to make a rational decision hence it is logical to say that the facilitation of childbirth-choices should be initiated at the beginning of antenatal care. Initiating the facilitation of childbirth-choices early gives the woman time to weigh the options and for the healthcare provider to clear any misconceptions relating to childbirth modes (Ahmad et al., 2018; Hastings-Tolsma et al., 2018; Loke et al., 2015).

2.7.3 Financial effects of childbirth facilitation

Childbirth facilitation has a financial impact which can have negative consequences for the woman and the healthcare delivery system. Women's decisions for childbirth may be influenced by finances in the sense that despite negative birth experiences with the first childbirth, women will be forced to undergo normal childbirth resulting from low socio-economic statuses as there is evidence that caesarean sections are much costlier than the physiological birth mode (Khumukcham, Singh, Kaur, Gupta & Kumar, 2015; Loke et al., 2017). Furthermore, Khmukcham et al. (2015) proffer that women will deliver in public healthcare facilities because of their socio-economic status.

The above is supported by the Africa Progress Panel (2010), which states that in Africa financial constraints result in women who need the caesarean childbirth mode not receiving it while women within the private sector pay dearly for an elective caesarean section with no medical indication (Maswime & Masukume, 2017; Mlambo, 2018). The differences in cost between the caesarean and the physiological mode of childbirth is also evident in other countries globally including low and middle-income countries, with the caesarean section mode of childbirth being the most prevalent in the private sector (Maswime & Masukume, 2017; Stirling et al., 2018). In addition, there was a significant increase in the utilisation of the private sector among women with increased education and socio-economic status in India (Alcock, Das, More, Hate, More, Pantvaidya, Osrin, & Houweling, 2015). Namibia is also not exempt from such disparities as the private sector is accessed more by women who have a better socio-economic status and as such, they have medical aid facilities which allow them to access the private healthcare sector (Mlambo, 2018).

Childbirth facilitation allows women to have birth partners or doulas who are supportive of the women during labour. This is particularly so for those who have tokophobia as the available literature has indicated that tokophobia is the most driving force behind the accelerating rates of caesarean sections. Companionship during childbirth has a direct impact on the financial side as there is likely to be a reduction in unnecessary and risky caesarean sections (Trevathan & Rosenberg, 2014). On the contrary, in the public sector, women may not have the luxury of engaging a doula to be with them in labour but allowing women to have birth partners is significant in helping the women cope with childbirth (Khumukcham et al., 2015).

2.8 CHAPTER SUMMARY

The chapter reviewed the relevant literature in terms of the phenomenon under study. It is worth noting that the successful facilitation of women with regards to the birthing process requires that midwives understand the importance of facilitation and that all women, regardless of

parity, are entitled to facilitation from skilled midwives. The roles of the midwives in the facilitation was reviewed in this chapter which also saw the chapter presenting reviewed literature on vaginal birth and caesarean section. the research gap identified through the confirmed steady increase in caesarean section rates and a decline in vaginal birth with 24% and 76% respectively in the current study. The scope of practice (Republic of Namibia, 2014), Patient charter (MoHSS, nd) and the Universal Rights of Childbearing women (White Ribbon alliance, 2011) are broad in guiding childbirth-choice facilitation therefore the justification of the research problem as well as the purpose of developing a model for midwives for the facilitation of childbirth-choices. The next chapter focuses on the methodology adopted and implemented in the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter two presented the literature review relevant for the study phenomenon. This chapter focusses on the research methodology that was applied in this study. The presentation of the chapter is according to the phases of the research and the objectives of the study. Merging of the data and the reasoning behind the selected methodology are explained in detail in this chapter. The chapter also provides a detailed description on the analysis of data and the ethics followed in this study.

3.2 RESEARCH PROCESS

Research process encapsulates how a researcher undertook the study in detail to allow the reader and future research to have an appreciation of how the study was conducted (Grove & Gray 2018). The research process will be discussed inclusive of the research approach used in the study as well as the research design followed thereof. In addition, the populations identified to suit to answer the research question and the sample that was used in the study is described. Analysis of the study results which is critical in identifying the results and trends in the selected population is explained. Furthermore, ethical considerations are explained to give the reader the information on how the research participants were treated during the research in accordance to the Declaration of Helsinki (1964).

3.2.1 Research approach

A research approach refers to the blueprint that the researcher follows when conducting a study (Creswell, 2014; Grove & Gray 2018). The nature of the research problem guides the researcher to the ideal research approach to utilise (Creswell, 2014). The research sought to develop a model for midwives for the facilitation of childbirth-choices among women, hence understanding the best practices through, the proportion of the childbirth types, the experiences

of midwives in facilitating and the experiences of women in being facilitated helped the researcher to develop a model that in cooperated all the findings. Research approaches help the researcher to minimise factors that may interfere with the validity of the study being undertaken (Grove & Gray 2018). As such the current study followed a mixed method approach to maximise the validity of the study findings, hence increasing the probability of the study results to be a true reflection of reality (Creswell, 2014). Utilising the mixed methods approach enabled the researcher to maximise and utilise the strengths that are attributed to qualitative and quantitative approaches in one study (Grove & Gray 2018).

3.2.1.1 Qualitative approach

The experiences of life are described in qualitative approaches through the people that are involved (Grove & Gray 2018). The researcher collects data from persons who are within the setting of the research phenomenon to hear the information from their point of view (Creswell & Creswell, 2018). The current study utilised the qualitative approach to understand how women were facilitated for childbirth-choices when they were pregnant in ANC. The analysis of the data inductively builds from the particular to the general themes that emerge (Creswell & Creswell, 2018).

3.2.1.2 Quantitative approach

The approach focusses analysing data from assumptions and test the theories deductively (Creswell, 2014). A quantitative inquiry was utilised in this study to analyse the different childbirth type proportion in the public healthcare facilities as well as the characteristics of the women in the different categories. The researcher gathers information from existing documents or literature to identify the relationship among variables (Creswell, 2014; Grove & Gray 2018).

3.2.2 Research design

A research design is an inquiry that directs the researcher specifically within the chosen approach in research (Creswell, 2014). In other literatures designs are also referred to as strategies that researchers adopt to answer a research question which is specific to a research approach identified (Creswell & Creswell, 2018).

3.2.2.1 Convergent parallel design

The design is one among three within the mixed methods approach that collects data simultaneously as well as the data analysis thereafter merging the findings (Creswell, 2014). The researcher adopted this design as it facilitated the simultaneously collection of data among the four different data sets (articles, maternal files, midwives and women). The design is well illustrated in Figure 3.1 as adopted from Creswell (2014).

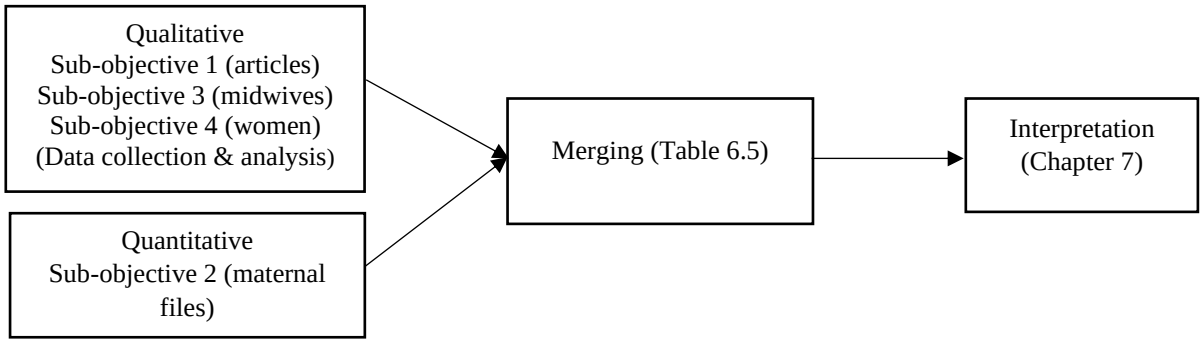

Figure 3.1 Convergent parallel design (Adopted from (Creswell, 2014)

3.3 IDENTIFICATION AND ANALYSIS OF CONCEPTS [Phase one]

The purpose of the study was to develop a model for midwives in public healthcare facilities to aid in the facilitation of childbirth-choices among pregnant women under their care. For the purpose to be realised, the researcher had to identify the concepts through study objectives.

3.3.1 Sub-objective 1: Explore and describe the best practices on the facilitation of childbirth-choices for women by midwives in public healthcare facilities- A scoping review

3.3.1.1 Design

The objective incorporated the scoping review framework by Arksey and O'Malley (2005) in order to guide the review. A scoping review seeks to identify research gaps and also aims to identify the extent of the evidence which is available in research (Peters, Godfrey, Khalil, Mclnerney, Parker, & Soares, 2015). The researcher chose a scoping review as this helps to bring depth and articulation on the best practices of facilitation of childbirth-choices as found in literature.

3.3.1.2 Population

Population refers to the elements that are to be included in a sample criterion in research (Grove, et al., 2013). The population of this objective was published articles which met the criterion of childbirth-choice facilitation among women. The articles were searched from electronic platforms that included EBSCOHOST (Pubmed, Medline), HINARI, Cochrane, SAGE journals, Science Direct and Google scholar. The aim of the search was to identify published works that represent and are evidenced-based in the facilitation of childbirth-choices among women. A total of 5345 articles were identified during the search from the different databases and electronic platforms.

3.3.1.3 Sample and sampling

The representation of a whole population is referred to as a sample (Grove et al., 2017). Furthermore, for a researcher to have a sample, a specific criterion needs to be followed to select the sample from the population in order for the population to be represented. The study objective followed purposive sampling which is a criterion under the non-probability sampling technique (Grove & Gray 2018). Purposive sampling aims to include the population that is rich in data for the phenomenon that is under study, hence the researcher aimed for the selection of a sample which is rich in information with regards to the phenomenon under study. The sample

for the scoping review comprised of 30 peer reviewed published articles that met the inclusion criterion.

Inclusion criteria

The researcher developed an inclusion/exclusion criterion as guided by the objective of the study to ensure an accurate selection of relevant studies/articles.

Inclusion criteria

The following was the inclusion criteria:

- Only articles written in English
- Original primary studies published between 2015 and 2020 as this is new evidence and thus could provide evidenced based practice. Nursing is an evolving profession and research is being continually carried out to ensure evidenced-based practices.
- Studies reporting evidence on the facilitation of childbirth-choices and informed consent globally
- Evidence of facilitation of childbirth-choices among women by healthcare providers
- Studies reporting evidence of strategies to facilitate childbirth-choices among women in hospitals

Exclusion criteria

The following studies were excluded:

- Articles without an abstract were excluded, as the procedure for selecting articles primarily involved reviewing the abstracts
- Letters to the editor and short editorials were also excluded

3.3.1.4 Instrument for data collection

The study objective was guided by the PRISMA flow chart (Figure 3.1) and the data extraction tool (Table 3.1) which included categories such as the name of the authors, year of publication, design, sample size and study aim.

Table 3.1 Data extraction tool

Code	Article details (References, Tittle, Vol No.)	Methodology and design	Population	Sample size	Study aim/ purpose	Summary of study results	Country of research

3.3.1.5 Procedure for data collection

The scoping review followed the five stages in the scoping review framework which included: identification of the research question, identification of relevant studies, selecting studies, charting data, and collating, summarising and reporting results (Arksey & O'Malley, 2005) as further discussed below:

Step 1: Identification of the research question

The research question for the scoping review was: What studies have been conducted on the facilitation of childbirth-choices worldwide?"

Step 2: Identifying relevant studies

Three steps were followed in screening the studies and the process was assisted by a Subject Librarian from the University of Namibia. Initially the researcher (SM) conducted a title screening in the electronic platforms (EBSCOHOST (MEDLINE, PubMed), HINARI, SAGE journals, Science Direct, Cochrane and Google scholar) and the eligible studies were uploaded onto a spreadsheet. All duplicates were noted and removed. The researcher then shared the final spreadsheet with the second independent reviewer (TS) who screened the abstracts of the retrieved articles as guided by the inclusion/exclusion criteria. The results of this process were reported using the adapted Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Figure 3.2) (Cleaver & Nixon 2014; Moher et al., 2009).

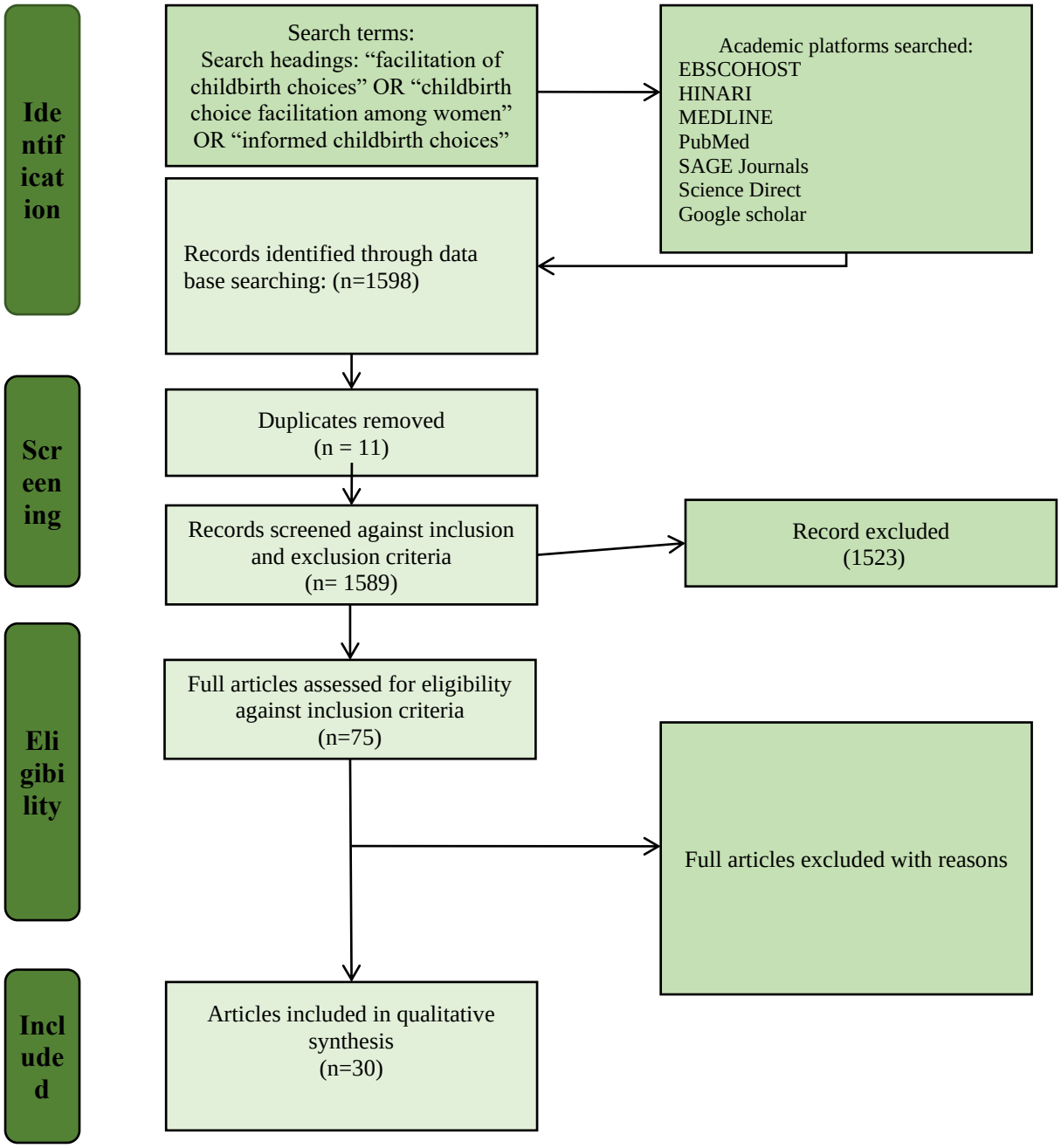

Figure 3.2 PRISMA flow chart (Moher, Liberati, Tetzlaff & Altman, 2009)

Step 3: Selecting studies

The researcher selected studies that were published between 2015 and 2020 to ensure that the best practices worldwide are identified from recent literature.

Step 4: Charting the data

The selected published articles were presented in tabular format as per the data extraction tool in Table 3.1. Charting of data is further presented and discussed in Chapter four of this study (Table 4.1).

Stage 5: Collating, summarising and reporting results

The results of the data collected from the published articles were tabulated on the data extraction tool (Table 4.1) and on the flow chart (Figure 4.1) for the analysis and discussion of the study data.

3.3.1.6 Data analysis

Data analysis was done qualitatively to come up with major themes that refer to the facilitation of childbirth-choices among women. Themes were identified (Table 4.2) through immersing in the data to identify the key concepts and these are described in-depth in Chapter four of this study.

3.3.1.6.1 Presentation of the data

The data presentation for the scoping review was done with the use of tables (Table 4.1; Table 4.2; Table 4.3 and Figure 4.1) and narratives where direct quotes were used in the discussion. Themes (Table 4.2) were also identified from the qualitative scoping review analysis to describe the best practices.

3.3.1.6.2 Methodological rigor

Methodological rigor is defined as the way in identifying confidence in the research findings (Creswell, 2014; Grove & Gray 2018). The review was conducted by the researcher and two reviewers as it is mandatory for reviews to have at least two primary reviewers (Peters et al., 2015). The researcher following the search of the literature consulted with the supervisor and an independent researcher to identify and strengthen the scoping review process. The

researcher read and re-read the identified articles to ensure that they answered the best practices for the facilitation of childbirth-choices among women.

3.3.2 Sub-objective 2: Analyse different childbirth types and reasons if any in public healthcare facilities

3.3.2.1 Design

To explore this objective, the study adopted a quantitative descriptive design to generalise the different childbirth types. A quantitative approach targets large groups to be researched about and allows for the generalisation of the results in a particular context (Botma et al., 2016). Furthermore, descriptive designs aim at providing a clear picture of situations as they occur, and they may also aid in identifying problems with current practices (Grove & Gray 2018).

3.3.2.2 Population

Population is the entire group that the researcher is interested in (Grove et al., 2017). The researcher in this objective used maternal hospital registers from April 2018 to March 2019 as the population for this specific research objective. The total population for the selected hospitals was as follows: Hospital A (4782), Hospital B (7400), Hospital D (7437) and Hospital C (5066). The researcher chose this population as this would allow the generalisation of the results as all the four healthcare facilities are representative of the referral hospitals in Namibia.

3.3.2.3 Sample and sampling

The researcher adopted a stratified simple random sampling method as it allowed the entire population to be divided into strata (Creswell & Creswell, 2018) according to the hospitals and the type of childbirth. Stratification enabled the researcher to ensure that the population is represented fairly, thus allowing the generalisation of the results (Grove & Gray 2018). The researcher stratified the sample as represented in Table 3.1:

Table 3.2 Samples for the different facilities and childbirth types

Health facility	N (total population)	n (sample)	Vaginal Birth	n(sample)	Caesarean section	n(sample)
Hospital A	4782	356	3283	245	1484	111
Hospital B	7400	366	6251	310	1114	56
Hospital D	7437	366	5042	248	2390	118
Hospital C	5066	358	4116	293	902	65

The researcher initially calculated the sample from each stratum to get the sample that would be representative of the entire population using Yamane's (1967) formula as follows: $n = \frac{N}{1+N(e)^2}$, of which n represents the sample and N represents the entire population under study, whereas (e) resembles the P value of 0.05 was be assumed. The formula has a 95% confidence level. Following stratification, to ensure that each stratum of the childbirth type is represented the researcher applied the following: $\frac{strata}{total\ population} \times sample\ size$. Strata represents the total population type of childbirth, total population represents the total births at the selected hospital, and the sample size represents the hospital sample size. The process of stratification has a significant reduction of the sampling error hence ensuring greater representation of the populations and also reducing the data collection timeframe and the costs of the study (Grove & Gray 2018). Following disproportionate stratification which does not represent 50% of the strata (Grove & Gray 2018), the researcher randomly selected maternal files totalling 1446 that fit the inclusion criteria as stated below. The random selection was done through collection of every 5th file that met the criteria.

Inclusion criteria

The inclusion criteria were as follows:

- all the maternal files that were complete with the information that the research aimed at; and
- state patients as noted on the maternal files.

3.3.2.4 Instrument for data collection

Data collection tools are described as the instruments that are used to gather the data that will answer the research question (Grove & Gray 2018). For the purpose of this research objective, the researcher incorporated available literature to formulate the checklist that was utilised. The checklist (Appendix E; pg 280) comprised of closed-ended questions including the demographic characteristics of the women, that is, age, parity, gravid, and employment status. The check list also included the childbirth type, reasons for the childbirth type if any and any complications during pregnancy.

3.3.2.5 Procedure for data collection

The five questions for data collection according to Grove et al. (2013) were followed which are; who, where, when, how, and what? The researcher, following ethical clearance, travelled to the selected public healthcare facilities to gather data. The researcher began the data collection at HospitaL A, where the pilot test was done. The data was collected following the dates as follows: Hospital A - February 2020, Hospital D - 9 to 13 March 2020, Hospital C - 16 to 20 March 2020 and Hospital B – May to June 2020. The maternity files were accessed from the maternity departments of the hospitals through the help of the matrons of the units and the administration clerks. The files were packed according to the months of each financial year, which made the accessibility easier. The researcher randomly selected every 5^{th} file for the vaginal birth and caesarean section which met the criteria until the sample size for each stratum was achieved. The researcher used the checklist to tick the variables needed and the researcher did all this within a private room that was provided by the different facilities, and this was done during the office hours.

3.3.2.6 Data analysis

Data analysis is aimed at reducing, organising and giving meaning to the data (Grove & Gray 2018). The checklist was first coded to ensure entering data in the software which was then followed by data cleaning. The researcher made use of the statistical analysis approach for the descriptive statistics. The results for sub-objective four was attained using SPSS (version 26).

3.3.2.7 Presentation of the data

Data for sub-objective four were presented in tables and graphs to illuminate the different childbirth types and reasons, if any, in the selected healthcare facilities in Namibia. The data were presented and discussed as provided for in Chapter five of this study.

3.3.2.8 Data quality

Data quality in quantitative studies is tested using two major concepts which are validity and reliability (Grove & Gray 2018). Validity refers to the extent to which the instrument used in the research reflects the subject being examined (Grove & Gray 2018).

Validity

According to Grove et al., (2013), validity refers to the extent to which the instrument measures what was intended to be measured. The study included content, face and construct validity.

Content validity - In the present research, the formulation of the checklist was based and guided by the literature to solicit the different childbirth types that women had in the different selected public hospitals. Content validity was ensured by the researcher through reviewing literature and getting feedback from the research supervisors. In addition, the researcher ensured content validity by including all major elements that would answer the objective of the different childbirth-choices and their reasons if any. The scoping review helped to strengthen the variables in the checklist as the sample characteristics were identified through the scoping. The checklist was as well pre-tested to check the variables were applicable to the context under study as well.

Face validity - The check list looked valid and gave the appearance of being able to measure what was intended hence face validity was assured. The checklist comprised of terms that are used and acquainted with the midwifery profession. Face validity is a more informal and subjective assessment done to check if the content answers the question to the phenomenon (Grove & Gray, 2018).

Construct validity – Construct validity seeks to identify if the instrument measure the concept it is intended to measure (Grove & Gray, 2018). In the current study the checklist focussed on childbirth in the participating public hospitals and the research sought to understand how facilitation of childbirth-choices is conducted in the public sector. The different childbirth types identified in the research helped in ensuring that childbirth-facilitation is understood or answered in terms of the data availed. The variables in the checklist were tailor made to ensure that the phenomenon of childbirth-choice facilitatoion is answered.

Reliability

The reliability of a study refers to how consistent the instrument measures what it intended to measure (Grove & Gray 2018). The researcher, prior to collecting data, engaged in a pre-test to ensure that the checklist had significant variables to answer the research question. The pre-test was undertaken at one of the selected hospitals to ensure that there is consistency in the data collection and to determine if what the questionnaire would measure in the final study was the same (Grove & Gray 2018). The files used in the pre- test were not included in the final sample of the study and were from the financial year April 2017 – March 2018. Following the pre-test, the researcher made changes as some variables were adjusted to suit the data collection and to answer the research question.

3.3.3 Sub-objective 3: Explore and describe the experiences of midwives in facilitating childbirth-choices in public healthcare facilities

3.3.3.1 Design

The objective followed a qualitative approach with an exploratory descriptive design. A qualitative approach uses words that are provided by the research participants; hence it uses inductive reasoning (Grove & Gray 2018). The researcher chose a qualitative research approach as it added the voices of the midwives regarding their experiences in facilitating childbirth-choices. An exploratory descriptive design was aimed at describing the phenomenon at hand and promoting understanding as well (Grove & Gray 2018).

3.3.3.2 Population

Population refers to the entire group that the researcher is interested in to gather data to answer the research phenomenon (Grove & Gray 2018). The population for the objective was midwives in the maternity department that were working in the ANC department at the time of the data collection. A total of 26 midwives were working in the ANC departments at the time of the data collection.

3.3.3.4 Sample and sampling

The selection of research participants for the study to answer the phenomenon is referred to as sampling and the sample refers to the research participants that are selected to represent the population in the research (Grove & Gray 2018). The research objective followed a purposive or judgemental sampling technique to identify participants that have knowledge on the study phenomenon. The research participants were purposively selected based on having attended ANC more than four times during pregnancy. The sample for this objective was determined by data saturation. A total of 10 midwives were interviewed and they formed the sample for the objective.

Inclusion criteria

The sample comprised of midwives having worked in the ANC department for six months and onwards as they would have experienced and had exposure to the phenomenon under study.

3.3.3.5 Instrument for data collection

The researcher made use of a semi structured interview guide (Appendix F; pg 282) to collect data from participating midwives through individual in-depth interviews. The interview guide was formulated based on the literature available to the researcher that was congruent with the phenomenon under study. The interview guide was divided into two sections: Section A where demographic data was asked, and Section B carried the main question, "What are your experiences in facilitating childbirth-choices among women?" Section B was also followed by possible probes that the researcher could use in the interviews. The researcher made use of the voice recorder as an instrument to capture the audio input of the interviewees.

3.3.3.6 Procedure for data collection

The researcher was guided by the data collection process as described by Creswell and Poth (2018) with regards to what, how, who, where and when the data were collected. The researcher used a semi-structured interview guide to gather data through individual in-depth interviews. The interviews were recorded using an audio recorder to capture the interviews. The researcher conducted some interviews in a private room at the convenience of the research participants. However, the data collection was interrupted due to the Covid-19 pandemic and the outstanding interviews were conducted telephonically due to the lockdown regulations in place. The information leaflet was shared with the research participants through email and text message for them to go through and give consent. Data were collected between March and June 2020.

3.3.3.7 Data analysis of sub-objective two and three

Data analysis refers to the reduction, organising and giving of meaning to the data collected (Grove & Gray 2018). In qualitative research, data analysis refers to the process of examining

the data collected and interpreting it with the goal of eliciting meaning, getting an understanding, and developing knowledge (Grove & Gray 2018). Data analysis was done following the six steps by Creswell (2014), as discussed below.

Step 1: Prepare and organise data

The researcher collected the data using an audio recorder and made some field notes to capture the mannerisms and expressions that the research participants would display that were beneficial to the study. The researcher transcribed all data verbatim following intensive listening of the audio recordings to ensure the accuracy of the transcriptions.

Step 2: Exploration and coding of data

The researcher got immersed in the data by repeatedly reading through the transcriptions to familiarise more with the data and to make meaning of the data set. The researcher made use of coding using a colour coded mechanism to ensure that all the phrases that had the same idea would be grouped together.

Step 3: Coding to build description and themes

Once the initial coding was complete, the researcher went through all the transcripts and grouped similar codes together to obtain larger groups of themes and subthemes. The grouped themes were in line with the research objective pertaining to how midwives facilitate childbirth-choices among women.

Step 4: Represent and report qualitative findings

Themes and sub-themes were reported and discussed in relation to the phenomenon under study with substantiated verbatim extracts of the midwives from the interviews. The themes and subthemes were also presented in tabular form at the beginning of Chapter six (Section A and B).

Step 5: Interpret findings

The themes and subthemes generated from the coding process were presented and discussed in narrative passages. The use of literature was also incorporated to ensure that the evidence was

substantiated or disputed as different contexts overlap. The researcher by so doing drew deductions that were used to write the final report where conclusions were drawn and recommendations identified.

Step 6: Validate accuracy of the findings

The researcher transcribed the recordings single-handily which ensured that the content and the medical terminology were also not altered. The researcher was in constant communication with the research supervisor and co-supervisor during the writing process which enabled significant input from the academic supervisor.

3.3.3.8 Presentation of the data

Data were presented in Chapter six (Section A and B) using tables for the demographic information and narrative passages were also used for the main themes that were identified from the data. The discussion of the findings was also displayed in Chapter six (Section A and B) and relevant literature was used to control and discuss the findings of the study.

3.3.3.9 Trustworthiness of sub-objectives two and three

Data quality in qualitative studies is termed as trustworthiness. The trustworthiness of sub-objective three and four was ensured by following the four principles as described by Lincoln and Guba (1985), namely, credibility, transferability, confirmability and dependability.

Credibility

Credibility refers to the congruence the research findings have with the reality (Lincoln & Guba, 1985). Credibility in this study was ensured by having in-depth one on one interviews coupled with prolonged engagement with the research participants hence giving them the platform to air their experiences of facilitating women in childbirth. Indepth interviews and prolonged engagement was ensured by the researcher spending more time with research participants during the interview sessions and time spent in each interview ranged from 45 minutes to and hour. Time spent with participants ensured the researcher took note and

understood the women and midwives. The use of an audio recorder made it credible as the information was made available to the supervisors at their request to verify the information given. The researcher bracketed own assumptions as this was important so that the views of the midwives and women could be portrayed as they are in Chapter Six of this study. Bracketing was ensured through transcribing verbatim the interviews of the women. The reseasearcher ensured listening to the interviewees and asked questions based on the experiences of the women rather than what is known to the researcher. Bracketing was ensured during the interviews as well as on transcription and analysis of the study findings.

Transferability

The extent to which work can be transferred to other settings is referred to as transferability (Lincoln & Guba, 1985). In qualitative research, there are two important aspects to consider when ensuring transferability and they include, contextual boundaries of the given study findings and the closeness the research participants have with the setting under study (Grove & Gray 2018). Transferability was increased by the researcher in that the midwives that participated in the research are the primary caregivers in the public healthcare facilities where women are facilitated for childbirth-choices, hence they were able to enlighten the study with regards to how facilitation is done in their facilities. In addition, the selected public hospitals that were chosen for this study are a representation of Namibia as they are the national referral hospitals.

Confirmability

Confirmability is the extent to which the work may be attributed to the research participants and not the researcher's assumptions (Lincoln & Guba, 1985). To ensure the confirmability of the research, the researcher made use of verbatim extracts in the final report when the results were presented and discussed. In addition, the recording of the interviews and later transcribing the interviews, all point to the data being able to be confirmed that it was relevant and indeed

researched. Member checking was not applied in this study due to the Covid 19 regulations as well as the different locations in which the participants were located. The researcher ensured listening to the audio recordings again and again to capture the correct information.

Dependability

The dependability of a study is based upon its ability to be repeated by other researchers in any other different context (Lincoln & Guba, 1985). The researcher demonstrated the in-depth methodology that was used for the objective of the study and hence future researchers can follow the research process and the results of the studies may be more meaningfully compared.

3.3.4 Sub-objective 4: Explore and describe the experiences of childbirth-choice facilitation among women in public healthcare facilities

3.3.4.1 Design

A qualitative exploratory design was chosen as it enhances an in-depth appreciation of data (Grove & Gray 2018) as the researcher could interact with women who had attended antenatal care at the public healthcare facilities under study. Exploratory research seeks to gain an understanding on the phenomenon under study (Grove & Gray 2018). The design was appropriate for this study as it gives in-depth data pertaining to the experiences of women from their own perspective.

3.3.4.2 Population

The population of this study objective comprised of women who had given birth during the financial year under study, that is, from April 2018 to March 2019. The purpose of choosing the specific population was because the maternal files that were reviewed were of the same time. The total number of women was as follows, according to the health facilities; Hospital A with 4782, Hospital B with 6946, Hospital D with 7437 and Hospital C with 5066.

3.3.4.3 Sample and sampling

Purposive sampling technique was adopted for this research objective. Purposive sampling enhanced the data richness as the researcher identified the participants that had given birth during the period under study. The researcher identified the research participants through the maternal files that hence identifying the participants that were rich in the phenomenon under study. The sample size for this objective was 12 women who were determined by data saturation as this research objective specifically entailed the use of qualitative approach. Data saturation is described as a situation whereby no new data is obtained or where there is some repetition of data as the researcher interviews research participants (Botma, Greef, Mulaudzi & Wright, 2016).

Inclusion criteria

The objective included women who had attended antenatal care at least once at the public health facility.

Exclusion criteria

The women who presented for birth at health facilities without booking or antenatal care, as well as women who had stillbirths were excluded. The former was excluded as facilitation had not been done as they did not attend and the latter due to emotional distress that the experience may have had on the woman.

3.3.4.4 Instrument for data collection

The study used a semi-structured interview guide (Appendix F; pg 282) to conduct one on one in-depth interviews. The interview guide had two sections: Section A which requested for the respondents' demographic data, for example age, gravid, parity, childbirth type and reason if any; then Section B had the main question, 'what are your experiences of childbirth-choice facilitation from midwives in the healthcare facility?' In addition, probes were included to gain

more insights into the facilitation experience when the participant did not address the phenomenon under study. The instrument was developed using literature and the critical knowledge from the research supervisors.

3.3.4.5 Procedure for data collection

The objective built upon the document review of the maternal files as the researcher obtained the contact details from the files. The researcher contacted the prospective research participants by telephone and gave each of them a brief background on the purpose of the study and following the conversations and them agreeing, the researcher would meet the research participants. On meeting the participants, information about the research was given for them in the form of information leaflets for them to read and ask any questions they may have. Some of the participants received the information leaflet and informed the researcher that they would think about it and get back to the researcher, but some did not get back to the researcher. In the Northern part of the country, the researcher had a challenge of some floods in the area which prevented the physical accessibility of some of the prospective research participants and as a result, the researcher obtained verbal informed consent from participants who were keen to participate. Telephonic interviews at the convenience of the participants were conducted and these were recorded with an audio recorder. The researcher conducted the interviews single handedly. Due to the Covid-19 pandemic, the researcher also used telephonic interviews with some of the participating women as lockdown measures were in place. Despite the challenges, the researcher managed to obtain rich data until data saturation.

3.3.4.6 Presentation of the data

The data for sub-objective three are presented in Chapter six (Section B) using tables for the demographic information and narrative passages are used for the main themes and subthemes that were identified from the data. The discussion of the findings is also presented in Chapter

six (Section B) and literature was used to control and discuss the findings of sub-objective three.

3.3.5 Merging of the findings

Merging of the results was a critical aspect to show the relationships that were identified in the different objectives of the study in phase one. Researchers merge quantitative and qualitative study findings for complementing the reasoning strategies as they each have their own weaknesses. The researcher presented the best practices results as a basis of leading the discussion of the quantitative and the qualitative discussion, to help in the discussion of the results, and thus showing the relationships between the two research strategies. The data for this study were collected concurrently thereby making it a concurrent design (Creswell, 2014). Making use of the concurrent design helped in informing the researcher while collecting data to confirm some of the findings and to probe more where relevant in qualitative data (Creswell & Creswell, 2018).

3.3.6 Analysis and definition of concepts

An analysis of concepts was implemented through the rigorous process of data analysis so as to identify the concepts. Concept analysis is explained in detail in Chapters four, five and six where the data analyses for the identified objectives are done. Concept analysis is aimed at defining attributes of a phenomenon and thus representing categories of information (Walker & Avant 2011). Furthermore, Walker and Avant (2011) posit that concept analysis helps at improving communication and in this study, it is communication in practice, hence the study aimed at developing a model for midwives in the facilitation of childbirth-choices to enhance and inform practice.

The definition of concepts (Chapter seven) is useful as this is done through making use of dictionaries, thesaurus and available literature for the identified concept (Grove & Gray 2018). The aim of defining concepts is to ensure their applicability in the study and the concept under

study as well (Walker & Avant, 2011). The researcher included the definitions of the concepts in the study, including the discussion of the results with the control of literature.

3.4 Define, classify and conceptualise concepts as a basis of model development [Phase two]

Relationship construction was paramount in this study as concepts were derived from four objectives with the aim of informing practice on the facilitation of childbirth-choices in selected public hospitals in Namibia. Relationships were drawn from the analysis of the four objectives in phase one when merged to help with the description of the main concepts and to pave way for model development (Grove & Gray 2018; Walker & Avant, 2011). There was need in the merging of the findings to identify the major concepts that would be informative to practice (Walker & Avant, 2011).

3.5 Development, description and evaluation of model [Phase three]

The aim of the study was to develop a model for midwives in the facilitation of childbirth-choices among women in public healthcare facilities. To attain the development of the model goal, the researcher identified concepts through objectives, the analysis of concepts and the merging of the data to have sound and informative data for practice. All the critical attributes of the concepts identified were required to develop the model as they are the ones that help with the development through the use of the conceptual framework as well as the relevant literature to develop the model and also the description of the model.

3.6 Development and description of guidelines [Phase 4]

For the developed model to be fully functional, there needs to be guidelines that are in line with the policies of the institutions where the model will be operationalised. The researcher developed guidelines for the three phases by stating the aims and the activities thereof in the phase. The activities were also derived from the concepts that were identified during the analysis of the study objectives.

3.7 REASONING STRATEGIES

Reasoning refers to the processing and organising of ideas aimed at concluding a phenomenon in a research study (Grove & Gray, 2018). For this study, the researcher adopted the following reasoning strategies to process the data and conclude the findings of the study; inductive, deductive, synthesis, derivation, analysis, inferences, bracketing, reflexivity, and flexibility.

3.7.1 Inductive reasoning

Inductive reasoning derives from the specific to the general in research (Grove & Gray 2018). The research made observations through the qualitative objective that focused on the scoping review for best practices with regards to the experiences of women and midwives on facilitation, and this was also observed through in-depth interviews. Inductive reasoning also identifies patterns in the observations that have been made to move towards theories or generalisation (Grove & Gray, 2018).

3.7.2 Deductive reasoning

Deductive reasoning refers to the reasoning from the general to the specific (Grove & Gray 2018). Deductive reasoning was applied through the quantitative approach of identifying the different childbirth types in the selected public hospitals. The childbirth types are forms of general knowledge and the rates have also been researched, but the current researcher sought to understand the specifics on the childbirth types that women underwent in the selected public healthcare settings in Namibia.

3.7.3 Synthesis

Synthesis in research helps the researcher and the readers to have a complete picture of what is known and what is unknown in research (Creswell & Poth, 2018). The researcher carried out a scoping review to identify the best practices that inform the facilitation of childbirth choices. Secondly, the experiences of midwives whilst facilitating and the women being facilitated were

also sought to seek clarity on what is being done in the healthcare settings. Finally, the researcher analysed the different childbirth types in the facilities and all this was done to enable the synthesis of data. Hence, the researcher synthesised what is known through the best practices and childbirth types and how facilitation takes place through the midwives and women.

3.7.4 Analysis

Clarifying and refining concepts is materialised through analysis (Walker & Avant, 2011), as this is useful in the presence of existing theoretical literature. The research examined the best practices through a scoping review, and in midwifery facilitation is a common phenomenon although the researcher needed to identify the gaps in the facilitation of childbirth-choices in reference to the ideal. The merging of findings assisted in the identification through an analysis of the recurring concepts that answered the research objective of facilitation of childbirth-choices.

3.7.5 Inferences

Inferences refer to inductive reasoning, thus moving from the specific to the general (Grove & Gray 2018). The study implored inferences in phase one, sub-objective four, by analysing the different childbirth types and their reasons in the selected public healthcare facilities. The results of the childbirth types were then made generalisable to the larger population of women in Namibia.

3.7.6 Bracketing

Bracketing is used in qualitative research in the quest of putting aside what is known about the phenomenon understudy (Grove & Gray 2018) and thus allowing the found data to give information that is not distorted or biased (Creswell & Creswell, 2018). The study implored a mixed method approach hence qualitative methods were utilised to explore the experiences of

midwives and women in facilitation. The researcher as a midwife bracketed her own knowledge and experiences to ensure that the results were credible. Bracketing was enhanced by the researcher through exploring the experiences of women and midwives, analysis of the data through coding and emergence of themes as well as giving voice to the research participants interviews through the derived themes (Creswell & Creswell, 2018).

3.7.7 Triangulation

Triangulation is defined as making use of multiple techniques when collecting and interpreting data in a study phenomenon (Creswell & Creswell, 2018; Grove & Gray 2018). The study phenomenon was childbirth-choice facilitation among women and the study accumulated data from different data sets, and that is through literature, women, midwives and the maternity files. The different data sets brought a variety of data which were then merged to make meanings and relationships identifiable to address the research question.

3.8 ETHICAL CONSIDERATIONS

The study followed ethical procedures as the study involved human participants and confidential information in the maternal files as well as healthcare facility statistics. The ethical considerations are discussed in detail in this section.

3.8.1 Permission and ethical clearance process

Research ethics are the core of any research that involves humans as participants. Research ethics are guided by the Declaration of Helsinki of 1964 as reviewed in 2013 (World Medical Association, 2017). Ethical guidelines help and guide the researcher to make decisions that are morally justified as well as evaluating the morality of actions (Grove & Gray 2018). The researcher sought ethical approval to conduct the research from the ethics committee of the University of Namibia, the Ministry of Health and Social Services, the selected public healthcare facilities and informed consent from the research participants. The ethical principles

that guided this research were; beneficence and non-maleficence, respect for persons, and fair treatment.

3.8.1.1 University of Namibia Research Ethicaesarean section Committee (UREC)

Following the approval of the research proposal by the faculty, the researcher applied for ethical approval from the UREC in May 2019. The approval was granted in November 2019 (Appendix A; pg 266). Upon receiving ethical clearance from UNAM, the researcher applied for ethical clearance from the MoHSS on the 10th of December 2019.

3.8.1.2 MoHSS

Ethical clearance was applied for on the 10th of December 2019 and the researcher received comments on the 24th of January 2020, worked on them and re-submitted. Ethical clearance from the MoHSS was then received on the 5th of February 2020 (Appendix B; pg 267).

3.8.1.3 Institutions

The researcher sought for clearance at the selected healthcare facilities concurrently at Hospital A, Hospital B, Hospital C and Hospital D. The researcher got approvals from the institutions on the dates as follows; at Hospital A - 27 February 2020, Hospital B - 28 February 2020, Hospital C - 20 February 2020, and Hospital D (26 February 2020). The approvals from the participating hospitals are attached as Appendix C (pg 270).

3.8.2 Principle of respect for participants

Participants in any given research have the rights both legal and human. Voluntariness is emphasised in the respect for persons (Jacobsen, 2017). Voluntary informed consent includes the ability of the research participant being able to give legal capacity to give consent. In this study the right to full disclosure and right to self determination/autonomy was upheld. Respect

for persons refers to the rights of the individual whether to participate without fear of being penalised (Botma et al., 2016).

The right to full disclosure

Prior to giving the voluntary consent, the participant must be furnished with truthful information about the research under study for the consent to be regarded as informed (Grove & Gray 2018). In this research, telephonic communication preceded the process as the researcher obtained the telephone numbers from the maternal records that formed part of the research population. The researcher explained to the research participants the purpose of the study when being considered for the research. Benefits that were not direct (improvements of childbirth-choices and positive bitrth experiences) were also explained to the prospective participants. A follow up with an appointment was done and the researcher provided the prospective participants with an information leaflet for them to read through and ask questions and this was done to participants engaged before the lockdown was enforced during the Covid 19 pandemic (Appendix D; pg 274).

The right to self determination/autonomy

The researcher informed the participants that they are free to withdraw at any time during thrthe study should they wish to not participate and will not be hheld against them. In addition, participants following the full disclosures of information signed voluntarily an informed consent. Participants where not cohesed into participating in the research. In the present study, the researcher ensured respect for persons by ensuring that an information leaflet with all the reasons for conducting the research was given to the participant prior to the consent and subsequently the signing of the informed consent. The research participants were respected by the researcher by answering any questions they had pertaining to the research. The researcher applied the principle of respect as well when prospective research participants refused to

participate as the participants were not coerced or asked why they did not want to partake anymore as it was their decision.

3.8.3 Principle of beneficence

Beneficence refers to the researcher being good in terms of actions, conduct and approach while always carrying out the research process (Pera & van Tonder, 2011). The researcher in this study was upheld through freedom of harm and the competence of the researcher.

Freedom from harm

In this study, the researcher upheld beneficence by making sure that all the appointments that the research participants agreed to were adhered to. The researcher made sure not to double book the participants at the same time and ensured that the interviews were in the confines of the time that was stipulated, which was 30 to 45 minutes, to exclude discomfort. The researcher only obtained information that was directed to answer the study questions.

Competence of the researcher

The researcher holds a Master's degree in nursing science hence was competent in carrying out the research project.

3.8.4 Principle of justice

Fair selection and treatment of research participants refers to the principle of justice (Grove & Gray 2018). The participants are also entitled to the information giving for them to understand how the information they give would be used (Botma et al., 2016). The present research purposively selected research participants through the qualitative approach that fit into the inclusion criteria without any unfair selection. Women that commuted to the researcher in the areas not familiar to the researcher were refunded their transport money. Transport costs were mainly catered for in the settings where the researcher had no fixed abode.

3.8.5 Anonymity and confidentiality

Grove and Gray (2018) emphasises the importance of confidentiality and anonymity for the research participants for participants not to be identified in any presentation of findings.

Anonymity

Data for the research was coded in that the research participants would not be identified in the presentation of data. The participating hospitals were also anonymised as well as the maternal records were not identified together with the research participants but rather coded.

Confidentiality

The checklists and transcribed interviews were filed and kept in a lockable cupboard which is only accessible by the researcher. The audio recordings were also stored on a computer that is encrypted and the recorder locked up. The checklists, informed consent forms and the transcriptions will be shredded after five years following the completion of the study.

3.9 CHAPTER SUMMARY

The chapter presented the research methodology that the study followed. The methodology was discussed to allow the reader to understand the phenomenon under study and how it was carried out. The research ethicaesarean section that guided the research were also presented in this chapter. Chapter four presents and discusses the scoping review of the first objective in Phase one of the best practices of childbirth-choice facilitation.

CHAPTER FOUR

RESULTS AND PRESENTATION OF THE BEST PRACTICES IN CHILDBIRTH-CHOICE FACILITATION: A SCOPING REVIEW

4.1 INTRODUCTION

Chapter three detailed the methodology that was used in the current study together with the ethical considerations that were followed. The aim of this chapter is to present and discuss the findings of the scoping review on the exploration of the best practices on the facilitation of childbirth-choices among women. The aim of the scoping review was to explore and describe the existing research that has been done on the facilitation of childbirth-choices among women in the world.

4.2 RESULTS OF THE SCOPING REVIEW

The scoping review process yielded a total of 1598 sources of evidenced based articles, guidelines, dissertations, etc. from different electronic databases and websites as indicated in Figure 4.1 below. The electronic databases used in this study were hosted by the University of Namibia library. A total of 1523 articles were excluded based on the title and the abstract as some had no abstract or the article was not relevant for the childbirth-choice facilitation literature. A total of 75 potential articles in terms of relevance were selected for further evaluation during the scoping review, 45 articles were excluded based on the full text scrutiny by the researcher, of which 11 were duplicates and 34 were not on childbirth facilitation. Resultantly, a total of 30 (Figure 4.1) evidence-based articles that fit in the inclusion criterion on the facilitation of childbirth-choices were included for the scoping review to elicit the best practices in facilitation. The results were presented with the guidance of the PRISMA-ScR (Tricco et al., 2018).

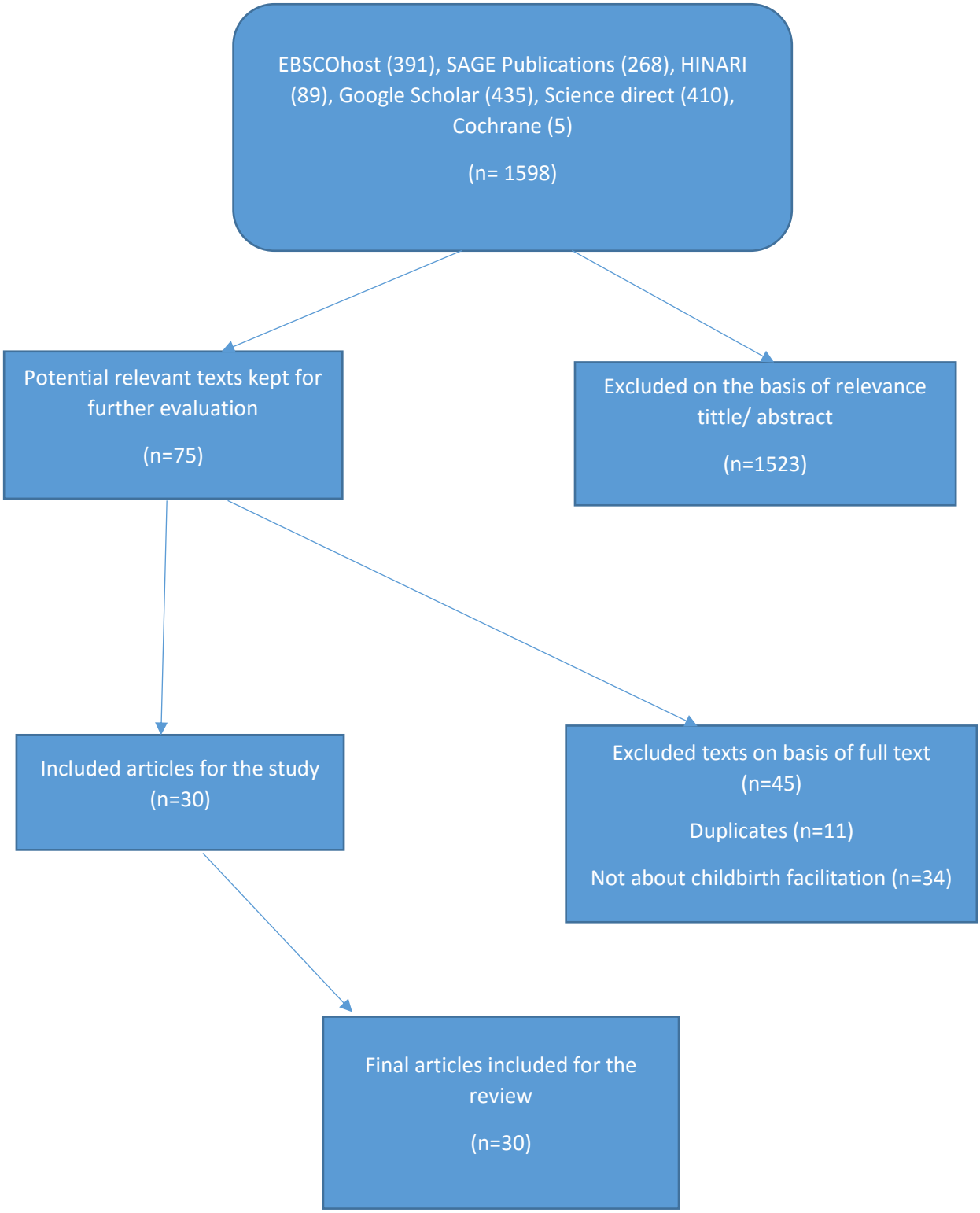

Figure 4.1 PRISMA flow chart (Adapted from Moher et al., 2009)

4.3 SCOPING REVIEW SAMPLE CHARACTERISTICS

The researcher followed a rigorous process to select articles that were relatable and evidence-based to the facilitation of childbirth-choices among women. Table 4.1 portrays the characteristics that were identified from the articles. The methodology used in the articles varied widely and this helped in ensuring that the facilitation from different articles were examined and depicted in various methodologies. The articles comprised of qualitative, observational, quantitative, mixed methods and a scoping review as discussed below.

Table 4.1 Data extraction tool (Sample characteristics)

Code	Article details (References, Tittle, Vol No.)	Methodology and design	Population	Sample size	Study aim/ purpose	Summary of study results	Country of research
A1	Attanasio, L. B., Kozhimannil, K. B., & Kjerulff, K. H. 2018. Factors influencing women's perceptions of shared decision making during labour and delivery: Results from a large-scale cohort study of first childbirth. *Patient Education and Counselling, 101, 1130*-1136. https://doi.org/10.1016/j.pec.2018.01.002	Quantitative	Women with first singleton baby	3006	To examine correlation of shared decision making during labour and delivery	Women from marginalised social groups were less likely to report shared decision making	USA
A2	Benyamini, Y., Molcho, M. L., Dan, U., Gozlan, M., & Preis, H. 2017. Women's attitudes towards the medicalization of childbirth and their associations with planned and actual modes of birth. *Women and Birth, 30*, 424-430. https://dx.doi.org/10.1016/j.wombi.2017.03.007	Quantitative observational study	Parous women	836	To assess attitudes towards the medicalization of childbirth	Women who were younger and less educated had more positive attitudes towards the medicalisation of birth	Israel
A3	Borrelli, S. E., Walsh, D., & Spiby, H. 2018. First-time mothers 'expectations of the unknown territory of childbirth: Uncertainties, coping strategies and 'going with the flow'. *Midwifery,63*,39-45 https://doi.org/10.1016/j.midw.2018.04.022	Qualitative	Primi-gravid women in the 3rd trimester	14	To explore the expectations of first time mothers of labour and birth	Women identified labour as an unknown territory, waiting for the unknown and just going with the flow	England
A4	Boz, I., Teskereci, G., & Akman, G. 2016. How did you choose a mode of birth? Experiences of nulliparous women from Turkey. *Women and Birth, 29,359*-367. http://dx.doi.org/10.1016/j.wombi.2016.01.005	Qualitative phenomenological	nulliparous women	29	To obtain in-depth experiences of nulliparous women during decision making	Women's experiences included getting confused and also making a decision one way or the other	Turkey
A5	Bringedal, H., & Aune, I. 2019. Able to choose? Women's thoughts and experiences regarding informed choices during birth. *Midwifery, 77,123*-129.	Qualitative	women 4-6 weeks post birth	10	To gain deeper understanding of women's thoughts on	The resources that women have and their coping abilities influenced how they retrieved information	Norway

	https://doi.org/10.1016/j.midw.2019.07.007				informed choices during childbirth		
A6	Butler, M. M. 2017. Exploring the strategies that midwives in British Columbia use to promote normal birth. *BMC Pregnancy and Childbirth,17*:168 http://creativecommons.org/licences/by/4.0/ DOI 10.1186/s12884-017-1323-7	Interpretive phenomenology	experienced midwives	14	To explore strategies midwives use to promote normal birth	Key themes included working with women from early pregnancy and informing choice	British Columbia
A7	Chen, M., McKellar, L., & Pincombe, J. 2017.Influences on vaginal birth after caesarean section: qualitative study of Taiwanese women. *Women and Birth, 30, e132*-e139. http://dx.doi.org/10.1016/j.wombi.2016.10.009	Interpretive descriptive methodology	women with a previous C/S and were currently pregnant	29	To explore factors affecting women's decision making regarding vaginal birth after C/S	Past experiences with childbirth and also the contemplation of the childbirth process	Taiwan
A8	Coates, D., Thirukumar, P., & Henry A. 2020. Making shared decisions in relation to planned caesarean sections: What are we up to? *Patient Education and Counseling, 103, 1176*-1190. https://doi.org/10.1016/j.pec.2019.12.001	Mixed method including Scoping review	studies included, women and clinicians	34; 9750; 3313	To map available literature in relation to shared decision making	Women in this study reported limited shared decision making and a lack of information needed to make the decision	Scoping review
A9	Cutajar, L., & Cyna, A, M. 2018. Antenatal education for childbirth-epidural analgesia. *Midwifery, 64, 48*-52. https://doi.org/10.1016/j.midw.2018.04.024	Observational study	childbirth educators	3	To identify the way information is described and presented during ANC	Language structures and timeframe during information giving varied between educators	Australia
A10	Davis, D., Homer, C, S., Clack, D., & Turkman, S. 2020. Choosing vaginal birth after caesarean section: Motivating factors. *Midwifery,88* ,1002766. https://doi.org/10.1016/j.midw.2020.102766	Qualitative descriptive	women with previous C/S birth	18	To examine factors that motivate women with previous C/S birth to opt for vaginal birth	Women individualised information in order to make decisions as they weighed the pros and cons	Australia

A11	Diamond-Brown, L. 2018. It can be challenging, it can be scary, it can be gratifying: Obstetricians' narratives of negotiating patient choice, clinical experience, and standards of care in decision-making. *Social Science & Medicine, 205,* 48-54. https://doi.org/10.1016/j.socaesarean sectioncimed.2018.04.002	Qualitative	self-selected obstetricians	50	To examine perceptions of standards of care and patient centred care in decision making	Most obstetricians feel they have the authority to interpret the appropriateness of standards and the choice of the patient on case to case basis	USA
A12	Feeley, C., & Thomson, G. 2016. Tension and conflicts in 'choice': 'women's' experiences of free birthing in the UK. *Midwifery, 41,* 16-21. http://dx.doi.org/10.1016/j.midw.2016.07.014	Qualitative	women	10	To explore why women choose to free birth in the UK	Violation of rights highlights the conflicts women faced from maternity care systems	United Kingdom
A13	Hallam, J., Howard, C., Locke, A., & Thomas, M. 2018. Empowering women through the positive birth movement. *Journal of Gender Studies, 28:3, 330*-341. https://doi.org/10.1080/09589236.2018.1469972	Qualitative	women	6	To explore the role that positive birth movement may have on women in tackling negative birth experiences	Lack of support and information during pregnancy	UK
A14	Happel-Parkins, A., & Azim, K, A. 2016. At pains to consent: A narrative inquiry into women's attempts of natural childbirth. *Women and Birth, 29,310*-320. http://dx.doi.org/10.1016/j.wombi.2015.11.004	Qualitative narrative inquiry	women	6	To understand and contextualise childbirth experiences of first time mothers	Benefits and limitations of pre-labour self-education	USA
A15	Hinton, L., Dumelow, C., Rowe, R., & Hallowell, J. 2018. Birthplace choices: What are the information needs of women when choosing where to give birth in England? A qualitative study using online and face to face focus groups. *BMC Pregnancy and Childbirth,18*:12 http://creativecommons.org/licences/by/4.0/	Qualitative focus groups	women in their last trimester	69	Aimed to provide evidence on women's experiences of choice and decision making	Women had different sources of information to make decisions and also needed information throughout pregnancy to make sound decisions	UK

	DOI 10.1186/s12884-017-1601-4						
A16	Homer, C. S. E., Watts, N. P., Petrovska, K., Sjostedt, C. M., & Bisits, A. 2015. Women's experiences of planning a vaginal breech birth in Australia. *BMC Pregnancy& Childbirth, 15:89.* DOI 10.1186/s12884-015-0521-4	Qualitative	women	22	To explore the experiences and decision making process of women who sought a vaginal breech birth	Reacting to a loss of choice and control, wanting information that is trustworthy	Australia
A17	Lee, S., Ayers, S., & Holden, D. 2016. How women with high risk pregnancies perceive interactions with healthcare professionals when discussing place of birth: A qualitative study. *Midwifery, 38, 42*-48. http://dx.doi.org/10.1016/j.midw.2016.03.009	Qualitative	high risk pregnant women	26	To examine differences and similarities between women planning to give birth at home or in a hospital	Women planning hospital births were less likely to question advice from health professionals	UK
A18	Loke, A. Y., Davies, L., & Li, S. 2015. Factors influencing the decision that women make on their mode of delivery: the Health Belief Model. *BMC Health Services Research,15:*274 http://creativecommons.org/licences/by/4.0 DOI 10.1186/s12913-015-0931-z	Quantitative cross-sectional study	women	319	To identify the factors influencing the decision that women make on their mode of delivery	22.9% preferred C/S as they were concerned of advanced age labour pain and perineum tearing. Perceived benefits severity and cues to action of C/S influenced the decision of either mode of birth	China
A19	Mohamed, S. L., & Fouly, H. 2016. Women's Preferences for Mode of Delivery in Upper and Lower Egypt: A Comparative Study. *Best practice & Experiences of women* https://www.researchgate.net/publication/301942893	Cross sectional comparative study	women	368	To determine women's preferences regarding mode of delivery	Previous mode of birth, preferred birth for next, maternal factors and responsibility for decision influenced decision making	Egypt

A20	Mselle, L. T., Kohi, T. W., & Dol, J. 2018. Barriers and facilitators to humanizing birth care in Tanzania: findings from semi-structured interviews with midwives and obstetricians. *Reproductive Health, 15:137.* https://doi.org/10.1186/s12978-018-0583-7	Qualitative	midwives and obstetricians	6; 2	To explore perceptions and practices of skilled health personnel on humanising birth care in Tanzania by identifying current barriers and facilitators	Institutional norms and practices prohibited family involvement during the birth process	Tanzania
A21	Munro, S., Janssen, P., Corbett, K., Wilcox, E., Bansback, N., & Kornelsen, J. 2017. Seeking control in the midst of uncertainty: Women's experiences of choosing mode of birth after caesarean. *Women and Birth, 30,129*-136. http://dx.doi.org/10.1016/j.wombi.2016.10.005	Qualitative	women	23	To explore attitudes towards and experiences with decision making for mode of delivery after caesarean section	Women's experience were a process of seeking control in the midst of uncertainty	Canada
A22	Nascimento, R. R. P., Arantes, S. L., de Souza, E. D. C., Contrera, L., & Sales, A. P. A. 2015. Choice of type of delivery: factors reported by puerperal women. *Revista Gaucha de Enfermagem, 36*(spe), 119-26. http://dx.doi.org/10.1590/1983-1447.2015.esp.56496	Qualitative	Puerperal women	25	To know the factors listed by puerperal woman that influenced the choice in type of delivery	Desire for the type of delivery and respect for the chosen type and factors that influenced choice	Brazil
A23	Newnham, E., McKellar, L., & Pincombe, J. 2017.'It's your body, but…'Mixed messages in childbirth education: Findings from hospital ethnography. *Midwifery, 55, 53*-59. https://dx.doi.org/10.1016/j.midw.2017.09.003	Ethnography	women; midwives; doctors	16	To investigate the personal, social, cultural and institutional influences on women making decisions	Women were not given full disclosure of information	Australia
A24	O'Brien, D., Casey, M., & Butler, M. M. 2018. Women's experiences of exercising informed choices as expressed through their sense of self and relationships with others in	Action research	women	15	To explore women's experiences of	Influencers included their sense of self and the quality	Ireland

	Ireland: A participatory action research study. *Midwifery, 65*,58-66. https://doi.org/10.1016/j.midw.2018.07.006				the concept of informed choice	of their relationships with care providers	
A25	Oliveira, V. J., & Penna, C. M. M. 2016. Every birth is a story: process of choosing the route of delivery. *Health of Women and Child, 71(suppl 3*):1228-36. http://dx.doi.org/10.1590/0034-7167-2016-0497	Qualitative discourse analysis	women; obstetrician nurses; obstetricians physician	36; 10; 14	To analyse the discourses on the choice of the route of delivery from the perspective of women and health professionals	Between the preference and the decision there is no choice it necessary to legitimise the choice of the woman	Brazil
A26	Preis, H., Eisner, M., Chen, R., & Benyamini, Y. 2019.First-time mothers' birth beliefs, preferences and actual birth: A longitudinal observational study. *Women and Birth, 32*, e110-e117. https://doi.org/10.1016/j.wombi.2018.04.019	Observational study	first time pregnant women	342	To test predictive model of how beliefs translate into birth preferences	Preferences mediated the association between birth beliefs and the actual birth	Israel
A27	Preis, H., Gozlan, M., Dan, U., & Benyamini, Y. 2018. A quantitative investigation into women's basic beliefs about birth and planned birth choices. *Midwifery, 63, 46*-51. https://doi.org/10.1016/j.midw.2018.05.002	Observational study	women with singleton pregnancy	746	Assess women's beliefs about birth as a natural and safe or medical process	Beliefs were associated with women's birth intentions	Israel
A28	Soriano-Vidal, F. J., Vila-Candel, R., Soriano-Martin, P. J., Tejedor-Tornero, A., & Castro-Sanchez, E. 2018. The effect of prenatal education classes on the birth expectations of Spanish women. *Midwifery,60*,41-47. https://doi.org/10.1016/j.midw.2018.02.002	Multicentre, observational, prospective study	pregnant women	212	To evaluate the influence of prenatal educational classes led by midwives upon women birth preferences		Spain

A29	Torigoe, I., & Shorten, A. 2018. Using a pregnancy decision & I support program for women choosing birth after a previous caesarean in Japan: A mixed methods study. *Women and Birth, 31, e9*-e19. http://dx.doi.org/10.1016/j.wombi.2017.06.001	Mixed method	pregnant women	33	To explore women's decision making experiences	Change in women's knowledge on birth choices, clarifying women's birth preference and feelings about shared decision making	Japan
A30	Weltens, M., de Nooijer, J., & Nieuwenhuijze, M. J. 2019. Influencing factors in midwives' decision-making during childbirth: A qualitative study in the Netherlands. *Women and Birth, 32, e197*-e203. https://doi.org/10.1016/j.wombi.2018.06.009	Qualitative	midwives	10	Gain understanding of underlying factors in the decision-making process	Knowledge as a basis of reasoned decision	Netherlands

4.3.2 Methodology and design

The articles (Table 4.1) that were included in the scoping review objective varied from qualitative, quantitative and mixed method. Qualitative studies (19) aimed at collecting data from participants through their own voice and this yielded rich data from the in-depth interviews carried out (Grove & Gray 2018). Observational studies (6) also formed part of the study in which participants were observed over a stipulated period knowingly or unknowingly to identify traits and answer research questions. Observational studies have a strength in ensuring that the participants display what exactly is happening in practice.

In addition, quantitatively (3) analysed studies also formed part of the sample for the scoping review. Quantitative research reaches out to a larger population in answering a research problem which in turn promotes the generalisation of the results (Creswell, 2014). Moreover, mixed method (2) articles also fit the inclusion criteria and formed part of the sample. The diversity in the methodology and design ensured the rigor and reliability of the scoping review.

4.3.2 Population

The target populations (Table 4.1) for the selected articles 22 comprised of women (sampled population ranged from 6 to 3006 being the highest sample for women) at different stages of their maternal health and the caregivers who included midwives (sample size ranged from 3 to 14), obstetricians (sample size varied from 2 to 50), educators (collectively or individually) (7) and published articles (scoping) (1). The diversity in the populations strengthened the main objective of the scoping review of identifying the best practices in the facilitation of childbirth-choices among women. Facilitation involves women as the epicentre of the care and the health care professionals as the information givers to ensure that informed choices are made. The population of women also varied as it was inclusive of first time pregnant and multiparous women with high-risk pregnancies and those without risks to identify the ideal facilitation that they hope or look forward to when they are with healthcare professionals.

4.3.3 Sample size

The sample sizes (Table 4.1) that were incorporated in the scoping review varied widely between 2 participants to as large a sample as 9750. The difference in populations also portrays the different methodologies that were used as qualitative research does not concentrate on numbers rather on the richness of the data collected and saturated (Grove & Gray 2018). Whereas quantitative data is much larger and hence the results may be generalised in the larger population.

4.3.4 Study aim/ purpose

The study purpose of any study is the core of any research that is being undertaken. For the scoping review, the articles reviewed had differing aims (Table 4.1) from assessing the attitudes of women towards the medicalisation of birth (Benyamini et al., 2017) to obtaining the experiences of women in differing areas such as decision making (Attanasio et al., 2018; Boz et al., 2016; Happel-Parkins & Azim, 2016) and what influenced the decisions of women regarding childbirth (Homer et al., 2015; Loke et al., 2015). There is a need for patient led care and understanding the experiences of women from the different stages of care as this helps in intervening accordingly for the women to get the care, they need to have positive birth experiences (ICM, 2018; WHO, 2018).

4.3.5 Country of research study

The setting of the study articles (Table 4.1) was from 16 different contexts as depicted in Table 4.1. The articles were spread in different proportions across the six continents in the world. The continents represented by the articles were namely, Africa (2), North America (5), South America (2), Europe (10), Asia (6) and Australia (4). The wide range of study settings allowed for a diverse input in the evidence base and that which may be applicable in the context under study. The distribution of the studies included in this research clearly reflects that the majority

were from Europe (with 10) and the continents with the least studies were Africa and South America which had 2 each.

4.4 THEMES IDENTIFIED IN SCOPING REVIEW

Content analysis classifies in text words into different categories (Grove & Gray 2018), hence allowing for looking for repeated ideas in the articles that were included in the scoping review. The scoping review revealed one main theme following the direct content analysis of the articles which was ‘best practices’ and four sub-themes that were identified, namely, ‘patient centred care’, ‘shared decision making’, ‘informed consent and information giving’ and ‘institutional guidelines and protocols’. The main theme and subthemes (Table 4.2) are discussed in detail to exhibit the research findings.

Table 4.2 Subthemes derived from the scoping review

Code	Author	Implication to practice	Sub-themes/Central concepts
A1	Attanasio, L. B., Kozhimannil, K. B., & Kjerulff, K. H. 2018. Factors influencing women's perceptions of shared decision making during labour and delivery: Results from a large-scale cohort study of first childbirth. *Patient Education and Counselling, 101, 1130*-1136. https://doi.org/10.1016/j.pec.2018.01.002	Strategies designed to improve the quality of patient-provider communication, information sharing and shared decision making must be attentive to the needs of the vulnerable groups to ensure that such interventions reduce rather than widen disparities.	• Shared decision making • Information sharing
A2	Benyamini, Y., Molcho, M. L., Dan, U., Gozlan, M., & Preis, H. 2017. Women's attitudes towards the medicalization of childbirth and their associations with planned and actual modes of birth. *Women and Birth, 30,* 424-430. https://dx.doi.org/10.1016/j.wombi.2017.03.007	Understanding women's views of childbirth medicalisation may be key to understanding their choice and how they affect labour and birth	• Patient centred care • Choices
A3	Borrelli, S. E., Walsh, D., & Spiby, H. 2018. First-time mothers 'expectations of the unknown territory of childbirth: Uncertainties, coping strategies and 'going with the flow'. *Midwifery,63,*39-45 https://doi.org/10.1016/j.midw.2018.04.022	Women and their support systems appreciate receiving accurate and realistic information from the caregivers starting in pregnancy and continuing during labour and birth to alleviate the state of uncertainty typical of the childbearing event.	• Information giving and sharing • Protocols and guidelines
A4	Boz, I., Teskereci, G., & Akman, G. 2016. How did you choose a mode of birth? Experiences of nulliparous women from Turkey. *Women and Birth, 29,359*-367. http://dx.doi.org/10.1016/j.wombi.2016.01.005	It is critical to obtain the preferences of women in-terms of mode of birth mode so as to offer knowledge, support and care appropriately thereby enhancing their involvement in the decision making process for their mode of birth	• Patient centred care • Information giving • Shared decision making
A5	Bringedal, H., & Aune, I. 2019. Able to choose? Women's thoughts and experiences regarding informed choices during birth. *Midwifery, 77,123*-129. https://doi.org/10.1016/j.midw.2019.07.007	Instead of using the term "informed choice", women discussed involvement, participation and being heard and seen as individuals. Furthermore, midwives play an important role during pregnancy to encourage and inform women under their care	• Shared decision making • Patient centred care • Information giving
A6	Butler, M. M. 2017. Exploring the strategies that midwives in British Columbia use to promote normal birth. *BMC Pregnancy and Childbirth,17*:168 http://creativecommons.org/licences/by/4.0/ DOI 10.1186/s12884-017-1323-7	Midwives work closely with women from early pregnancy to prepare them for a normal childbirth	• Protocols and guidelines

A7	Chen, M., McKellar, L., & Pincombe, J. 2017.Influences on vaginal birth after caesarean section: qualitative study of Taiwanese women. *Women and Birth, 30, e132*-e139. http://dx.doi.org/10.1016/j.wombi.2016.10.009	Women who previously had a C/S are prepared to have a vaginal birth but are not always supported to make a decision	• Patient centred care • Choice
A8	Coates, D., Thirukumar, P., & Henry A. 2020. Making shared decisions in relation to planned caesarean sections: What are we up to? *Patient Education and Counseling, 103, 1176*-1190. https://doi.org/10.1016/j.pec.2019.12.001	Patient experiences will be improved when there is shared decision making and not clinician led however, it will require the clinicians to be trained and the implementation of shared decision making interventions	• Patient centred care • Shared decision making • Protocols and guidelines
A9	Cutajar, L., & Cyna, A, M. 2018. Antenatal education for childbirth-epidural analgesia. *Midwifery, 64, 48*-52. https://doi.org/10.1016/j.midw.2018.04.024	Improvements and consistency in the way educators provide information to parents also has important implications for future midwifery practice, education and research	• Information giving/ sharing • Protocols and guidelines
A10	Davis, D., Homer, C, S., Clack, D., & Turkman, S. 2020. Choosing vaginal birth after caesarean section: Motivating factors. *Midwifery, 88*, 1002766. https://doi.org/10.1016/j.midw.2020.102766	Women should be given balanced information for them to make informed decisions	• Informed consent and information giving
A11	Diamond-Brown, L. 2018. It can be challenging, it can be scary, it can be gratifying: Obstetricians' narratives of negotiating patient choice, clinical experience, and standards of care in decision-making. *Social Science & Medicine, 205,* 48-54. https://doi.org/10.1016/j.socaesarean sectioncimed.2018.04.002	Standardisation of medical practice should be based on evidenced based research, protocols and guidelines	• Protocols and guidelines
A12	Feeley, C., & Thomson, G. 2016. Tension and conflicts in 'choice': 'women's' experiences of free birthing in the UK. *Midwifery, 41,* 16-21. http://dx.doi.org/10.1016/j.midw.2016.07.014	Raising awareness amongst health professionals about women's legal rights regarding choice and guideline development to support midwives and women choice of birth	• Choice • Protocols and guidelines
A13	Hallam, J., Howard, C., Locke, A., & Thomas, M. 2018. Empowering women through the positive birth movement. *Journal of Gender Studies, 28:3, 330*-341. https://doi.org/10.1080/09589236.2018.1469972	Preparing women for a positive birth is paramount and not limiting their ability to make 'free' choice	• Choice • Patient centred care
A14	Happel-Parkins, A., & Azim, K, A. 2016. At pains to consent: A narrative inquiry into women's attempts of natural childbirth. *Women and Birth, 29,310*-320. http://dx.doi.org/10.1016/j.wombi.2015.11.004	Health care professionals need to examine the usage of medical model of care while respecting the choices of women and agency	• Patient centred care • Choice

A15	Hinton, L., Dumelow, C., Rowe, R., & Hallowell, J. 2018. Birthplace choices: what are the information needs of women when choosing where to give birth in England? A qualitative study using online and face to face focus groups. *BMC Pregnancy and Childbirth,18*:12 http://creativecommons.org/licences/by/4.0/ DOI 10.1186/s12884-017-1601-4	Introducing options early in pregnancy is important as well as deferring the decision making about birthplace when the woman has had time to consider and explore	• Informed consent and information giving • Choice • Protocols and guidelines
A16	Homer, C. S. E., Watts, N. P., Petrovska, K., Sjostedt, C. M., & Bisits, A. 2015. Women's experiences of planning a vaginal breech birth in Australia. *BMC Pregnancy& Childbirth, 15:89.* DOI10.1186/s12884-015-0521-4	Women desire autonomy to choose mode of birth and be supported in their choices with quality care	• Patient centred care / Choice
A17	Lee, S., Ayers, S., & Holden, D. 2016. How women with high risk pregnancies perceive interactions with healthcare professionals when discussing place of birth: A qualitative study. *Midwifery, 38, 42*-48. http:A19//dx.doi.org/10.1016/j.midw.2016.03.009	Healthcare professionals need to acknowledge women's concerns and give impartial evidenced based advice	• Informed consent and information giving
A18	Loke, A. Y., Davies, L., & Li, S. 2015. Factors influencing the decision that women make on their mode of delivery: the Health Belief Model. *BMC Health Services Research,15:*274 http://creativecommons.org/licences/by/4.0 DOI 10.1186/s12913-015-0931-z	Importance of designing educational programs for pregnant women to inform them on the benefits, risks and severity of the two different modes of delivery based on the constructs of the Health Belief Model	• Information giving and informed consent • Patient centred care
A19	Mohamed, S. L., & Fouly, H. 2016. Women's Preferences for Mode of Delivery in Upper and Lower Egypt: A Comparative Study. *Best practice & Experiences of women* https://www.researchgate.net/publication/301942893	Educating all women about mode of delivery including effective counselling on the pros and cons of the different modes of childbirth	• Patient centred care • Informed consent and information giving
A20	Mselle, L. T., Kohi, T. W., & Dol, J. 2018. Barriers and facilitators to humanizing birth care in Tanzania: findings from semi-structured interviews with midwives and obstetricians. *Reproductive Health, 15:137.* https://doi.org/10.1186/s12978-018-0583-7	In-service training as well as in cooperation of respectful maternity care during pre-service training is key to changing the culture in the labour ward	• Patient centred care • Informed consent and information sharing
A21	Munro, S., Janssen, P., Corbett, K., Wilcox, E., Bansback, N., & Kornelsen, J. 2017. Seeking control in the midst of uncertainty: Women's experiences of choosing mode of birth after caesarean. *Women and Birth, 30,129*-136. http://dx.doi.org/10.1016/j.wombi.2016.10.005	Intervention to support choice of mode of delivery should be given early following the primary C/S	• Patient centred care • Informed consent and information sharing
A22	Nascimento, R. R. P., Arantes, S. L., de Souza, E. D. C., Contrera, L., & Sales, A. P. A. 2015. Choice of type of delivery: factors reported by puerperal women. *Revista Gaucha de Enfermagem, 36*(spe), 119-26. http://dx.doi.org/10.1590/1983-1447.2015.esp.56496	The importance of health education beginning the prenatal stage highlighting need to equip women to exercise a conscious choice	• Patient centred care

			• Informed consent information giving / sharing
A23	Newnham, E., McKellar, L., & Pincombe, J. 2017.'It's your body, but…'Mixed messages in childbirth education: Findings from hospital ethnography. *Midwifery, 55, 53*-59. https://dx.doi.org/10.1016/j.midw.2017.09.003	Midwives to provide unbiased information to women, hospital cultures and policies also influence the way information is given	• Information giving • Protocols and guidelines
A24	O'Brien, D., Casey, M., & Butler, M. M. 2018. Women's experiences of exercising informed choices as expressed through their sense of self and relationships with others in Ireland: A participatory action research study.*Midwifery,65,*58-66. https://doi.org/10.1016/j.midw.2018.07.006	Informed choice is experience as a relational construct women's relationships with maternity care professionals	• Informed choice information giving
A25	Oliveira, V. J., & Penna, C. M. M. 2016. Every birth is a story: process of choosing the route of delivery. *Health of Women and Child, 71(suppl 3)*:1228-36. http://dx.doi.org/10.1590/0034-7167-2016-0497	Route of delivery is determined by physicians and women are not proactive – women's perspective	• Informed choice and information giving • Patient centred care
A26	Preis, H., Eisner, M., Chen, R., & Benyamini, Y. 2019.First-time mothers' birth beliefs, preferences and actual birth: A longitudinal observational study. *Women and Birth, 32*, e110-e117. https://doi.org/10.1016/j.wombi.2018.04.019	Women's beliefs should be recognised and birth preferences respected	• Informed consent and information giving • Patient centred care
A27	Preis, H., Gozlan, M., Dan, U., & Benyamini, Y. 2018. A quantitative investigation into women's basic beliefs about birth and planned birth choices. *Midwifery, 63, 46*-51. https://doi.org/10.1016/j.midw.2018.05.002	Women need to be allowed to choose how they would like to birth in accordance with their beliefs	• Informed consent • Patient centred care
A28	Soriano-Vidal, F. J., Vila-Candel, R., Soriano-Martin, P. J., Tejedor-Tornero, A., & Castro-Sanchez, E. 2018. The effect of prenatal education classes on the birth expectations of Spanish women. *Midwifery, 60*, 41-47. https://doi.org/10.1016/j.midw.2018.02.002	The changes in the birth plans could suggest that prenatal educational classes have an influence upon maternal birth preferences	• Information giving • Patient centred care
A29	Torigoe, I., & Shorten, A. 2018. Using a pregnancy decision & I support program for women choosing birth after a previous caesarean in Japan: A mixed methods study. *Women and Birth, 31, e9*-e19. http://dx.doi.org/10.1016/j.wombi.2017.06.001	Emphasis on the need to support women emotionally throughout the process of decision making	• Shared decision making • Informed consent

A30	Weltens, M., de Nooijer, J., & Nieuwenhuijze, M. J. 2019. Influencing factors in midwives' decision-making during childbirth: A qualitative study in the Netherlands. *Women and Birth, 32, e197*-e203. https://doi.org/10.1016/j.wombi.2018.06.009	Adequate information for women to make well informed choices	• Informed consent information giving

4.4.1 Main theme: Best practices in the facilitation of childbirth-choices

Best practices are identified through evidenced based research which has beneficial effects in nursing for improved outcomes for women, healthcare providers and institutions (Grove & Gray 2018). The scoping review formed the basis of evidenced based practice for this study.

4.4.1.1 Patient centred care

WHO (2018) and ICM (2018) agree and advocate for the promotion of patient centred care as an approach that upholds the rights of women under the care of health professionals. Torigoe and Shorten (2018) state the importance of emotional support for women as they undergo the process of decision making. Emotions are different in different women and hence when the emotions of women are considered it implies their being put first in the model of their care. Women possess different preferences when it comes to birthing and following information giving, healthcare professionals need to be able to individualise the care they give women and give the support and care appropriately for the different women that are under their care (Boz et al., 2016).

Patient centred care does not identify women from where they are coming from, that is, their socio-economic status or race but rather embraces all women as equal and subject to receive the best care. Attanasio et al. (2018) allude to the fact that women from marginalised communities were less likely to verbalise shared decision making by purporting that assumptions are made and women may not be given a chance to express their concerns or views with regards to the way they birth. Women that may be young and less educated expressed more positive attitudes towards caesarean section birth (Benyamini et al., 2017) and this may be because the information given is not understood and the health professionals, since they are trusted, may get away with the flawed information shared. In addition, there is a need to understand the views of women on childbirth (Benyamini et al., 2017) as they are different and

require different interventions for them to be able to make a choice. Therefore, individualising women is of significant importance as they have different needs.

Women have different needs hence they need to be supported individually for the best decisions to be attained. Women with a previous birth experience should be guided and given information from the beginning when they present for ANC and this illuminates individualised care (Chen et al., 2017). Women face a violation of rights when they are not accorded the information they need and are not given choices for their mode of birth, hence raising awareness in the health professionals that women have the right to choose is important (Feeley & Thomson, 2016).

Health professionals are guided by ethics but they still need to respect the choices that women make for their childbirth mode (Happel-Parkins & Azim, 2016). The rights of childbearing women also attest to them having autonomy regarding their care and choices (Homer et al., 2015) following the full disclosure of impartial information regarding the different modes of childbirth (Hallam et al., 2018; Hinton et al., 2018; Mohamed & Fouly, 2016). Diamond-Brown's (2018) study found that healthcare professionals have the authority on the appropriateness of the mode of birth on a case-to-case basis which is in fact not founded as the women need to have a say in their care.

4.4.1.2 Shared decision making

Shared decision making is among the ICM code of ethicaesarean section (ICM, 2014), that encourages that midwives need to support women so that they will be able to actively participate in decisions concerning their care. The above code of ethics was supported by the articles in the scoping review which were examined to identify the best practices in the facilitation of childbirth-choices among women. There is a need for the development of strategies that will enable shared decision making among women (Attanasio et al., 2018). The results from the study by Attanasio et al. (2018) identified that women who reported not being

included in the decisions were mainly from marginalised social groups and black women. According to the Universal rights of childbearing women (White Ribbon Alliance, 2011; Windau-Melmer, 2013) and the oath taken upon completion of the nurse-training, there needs not be any exclusivity when it comes to the race, ethnicity or the social status of the patient under midwives' care.

In addition, Borrelli et al. (2018) allude that women are the main actors in their care hence they need to be included in the decisions that determine their care. There is a need for partnership between and among the women and the healthcare professionals as Butler (2017) emphasises that from early pregnancy women and midwives should work closely together and this will help to prepare women for childbirth. Having women in early pregnancy being given information and being listened to for their previous experiences also helps in women making decisions regarding their birth (Chen et al., 2017). Women need support from the healthcare professionals during pregnancy and also during the decision making process (Chen et al., 2017; Coates et al., 2020).

A scoping review conducted by Coates et al. (2020) identified that women reported lack of information that would enable them to make informed decisions. Furthermore, shared decision making which is not led by the health professional was found to positively improve the experiences of women (Coates et al., 2020), and this emanates from the fact that the women feel ownership of the choice made (Chen et al., 2017).

4.4.1.3 Informed consent and information giving

Information giving and understanding is the basis of informed consent and the two cannot be separated. Bringedal et al. (2019) proffer that women are influenced by how they retrieve information on birthing choices and all this should be through the midwives who play an integral part in providing such information to the women. Not only do midwives and health professionals offer information but the information needs to be impartial and evidenced based (Lee et al., 2016). In addition, there is a need for the formulation of educational programmes for women whereby they receive information from the healthcare providers (Loke et al., 2015). Impartial information includes the healthcare professionals offering women the pros and cons of the different childbirth modes and that is vaginal birth and caesarean section, and from the information given the women are able to make informed decisions (Loke et al., 2015; Mohamed & Fouly, 2016). Women trust that midwives and doctors are impartial and as such that they will give them correct and unbiased information. This alludes to the fact that they trust the health professionals to give them information that is trustworthy and this increases the trust between the woman and healthcare professional (Homer et al., 2015).

It is imperative that women are given a chance to state their previous experiences as well as their perceptions regarding birth (Loke et al., 2015; Mohamed & Fouly, 2016; Munro et al., 2017). The above scholars agree that women have experiences that need to be heard in order for midwives to give them impartial information and during this process women may be able to make informed decisions regarding their mode of birth.

Furthermore, midwives have a mandate of giving women unbiased information regarding the mode of birth (Newnham, McKellar & Pincombe, 2017), thus the women are supposed to be given information of both vaginal birth and caesarean section regardless of what they are opting for, and from the information given, the women will be able to make sound decisions. Midwives should not make assumptions that when a woman had a previous birth mode, then it

follows that they will definitely choose the same. Instead, they should listen to their previous experiences and then provide sound educational advice of the different modes of birth which will ensure that they will be able to make informed decisions. Moreover, in a study by O'Brien et al. (2018), women identified or experienced informed choice as the relationship between the woman and the healthcare professionals in the maternity setting, which means that they will give impartial information. Therefore, knowledge emanating from adequate information becomes the basis of reasoned decision making among women (Weltens et al., 2019) and having it in a balanced manner ensures that women can make informed choices (Davis et al., 2020).

4.4.1.4 Protocols and guidelines

Institutions have the backbone of how procedures are followed and this is governed or regulated by the protocols and the guidelines that are in place. There is a need therefore, for institutions to have policies that guide the ANC health education information to be given in a harmonious manner (Cutajar et al., 2018). Cutajar et al. (2018) further state that the appropriateness of the language during information giving and the duration differed in their study but the basics of the harmonious information and structure should not be compromised.

In addition, women from different contexts reported limited shared decision making in different studies in this current scoping review (Coates et al., 2020; Hallam et al., 2018). Women also highlighted having information throughout their pregnancy for them to make sound decisions (Hinton et al., 2018) and this could be achieved through institutions having protocols that speak harmoniously. This resonates with the purpose of the present study which is to develop a model for midwives in the facilitation of choices among women in public healthcare settings in Namibia. There is a need that the standardisation of medical practice be based on evidence in all aspects including research, protocols and guidelines that direct practice (Diamond-Brown, 2018).

Furthermore, Feeley and Thomson (2016), proffer that woman are faced with the violation of their rights in institutions pertaining to choice and if the regulations and guidelines are in place, this will enhance the care given to women. Happel-Parkins et al. (2016) encourage the examination of medical models in order to ensure that they respect the choices women make and this may be possible when guidelines are in place. Therefore, there is a need to incorporate respectful maternity care as a pre-requisite for in-service training as this enables institutional routines and cultures to change for the betterment of the care of the women (Mselle et al., 2018).

4.5 LIMITATIONS

Limitations in this objective of the scoping review were identified. The scoping review only included peer reviewed articles that have been published in English and that have an abstract. Articles in other languages were not included in this study and this may have an impact on the results of this study. Dissertations, articles and grey literature were also excluded from the study hence the phenomenon would have been explored and described more if the scope of the scoping review had been wider and allowed more sources of literature. The study was also limited to articles published from 2015 until 2020 and this may also have limited the evidence in prior years which were excluded.

4.6 CONCLUSION OF THE FINDINGS

Table 4.3 portrays the frequencies the articles had in relation to the subthemes that were identified through content analysis of the data. The four main sub-themes which emanated from the articles demonstrate that women from different settings value the information which they receive from the healthcare professionals who are looking after them.

A total of 27 out of the 30 articles alluded to the fact that women need to be given information regarding the different modes of childbirth which are available to them, and what may possibly

transpire during the birthing process as discussed above. Women expressed their disappointment in that they anticipated information from the healthcare professionals but unfortunately the information was not provided to them (Benyamini et al., 2017; Borelli et al., 2018; Boz et al., 2016).

Patient centred care is a universal aspect that advocates for health professionals to ensure that care revolves around the patient. This is no exception in the midwifery fraternity where women are cared for by health professionals. In order to increase patient centred care, there is a need for healthcare professionals to pay particular attention to shared decision making (Attanasio et al., 2018) as this alludes to the patient having the autonomy to decide on the mode of birth. According to Pembroke (2008, as cited in Borelli et al., 2018), women are the main actors that invite the health professionals to be present in their care hence they need acknowledgement. Furthermore, Boz et al. (2016) further argue that women aspire to own the decisions of childbirth yet they are not accorded to do so by the healthcare professionals. The notion of patient centred care was echoed by 19 of the articles in the scoping review (Table 4.3).

Despite the low rates of caesarean section births in the public sector of Namibia as depicted by the quantitative results in Chapter five of this study (24%), women should still be consulted pertaining to their care. In the present Namibia context, women are spoilt for choice but mainly in the private sector (Mlambo, Morgan-Cramer & Young, 2020) which is in contradiction with the public sector and the current study suggests that women from low socio-economic backgrounds and the vulnerable (Attanasio et al., 2018; Loke et al., 2015) were not awarded the information they needed to make informed decisions.

Informed decision or choice according to this study may be understood as pertaining to a woman who has received trustworthy and evidenced-based information from healthcare professionals from the beginning of their care (Borelli et al., 2018; Boz et al., 2016; Butler,

2017; Mohamed & Fouly, 2016; Nascimento et al., 2015). Furthermore, the information given to women should have the balance of pros and cons of the modes of childbirth that are available (Bringedal & Aune, 2019; Cutajar & Cyna, 2018; Davies et al., 2020; Lee et al., 2016; Mohamed & Fouly, 2016; Newnham et al., 2017) as this will open a door of inquiry for the woman to weigh their options for the choice to be made.

Information at the beginning of pregnancy which is evidenced-based means that the woman has ample time to consult and also weigh the options (Attanasio et al., 2018; Boz et al., 2016; Coates et al., 2020; Torigoe & Shorten, 2018). Therefore, this encourages shared decision making as the woman during the course of the pregnancy will inquire more from the healthcare professionals. However, the above 'patient centred care', 'shared decision making', and 'information giving and informed consent' may not be possible without some protocols and guidelines being in place in the different healthcare settings in any given context. Protocols and guidelines are there to ensure the consistency in the information and how it is disseminated to the women (Borrelli et al., 2018; Butler et al., 2017; Coates et al., 2020; Cutajar & Cyna, 2018; Diamond-Brown, 2018; Feeley & Thomson, 2016; Hinton et al., 2018; Newnham et al., 2017). Therefore, this speaks to the validation of the aim of the current study which is to develop a model for midwives for the facilitation of childbirth-choices among women in Namibia.

Table 4.3 Frequency table of sub-themes

Sub-themes	Article codes depicting the sub-theme	Frequency
Patient centred care	A1; A2; A4; A5; A7; A8; A12; A13; A14; A16; A18; A19; A20; A21; A22; A25; A26; A27; A28;	19
Shared decision making	A1; A4; A5; A8; A15; A29	6
Informed consent/choice and information giving	A1; A2; A3; A4; A5; A7; A9; A10; A12; A13; A14; A15; A16; A17; A18; A19; A20; A21; A22; A23; A24; A25; A26; A27; A28; A29; A30	27
Protocols and guidelines	A3; A6; A8; A9; A11; A12; A15; A23;	8

4.7 CHAPTER SUMMARY

Best practices are of paramount importance as a means to inform practice and that was the basis of the scoping review in this chapter, namely, to identify the best practices in the facilitation of childbirth-choices among women. The scoping review included 30 articles and these were analysed and one major theme emerged as well as four sub-themes. The following chapter (five) presents and discusses the quantitative data of the selected public healthcare facilities on the different modes of birth that occurred in the period under study.

CHAPTER FIVE

DATA ANALYSIS, PRESENTATION AND DISCUSSION OF THE QUANTITATIVE DATA

5.1 INTRODUCTION

Chapter four presented and discussed the findings of the scoping review in which the best practices in childbirth-choice facilitation were discussed. This chapter presents the quantitative data which focused on the selected public healthcare facilities that formed the sample. The findings are presented in graphs, tables and pie charts. The main aim of the quantitative objective was to have a background or overview of the study setting and its uptake of ANC, booking as well as the different childbirth types offered. Moreover, the gist of the study was to understand the childbirth-choice facilitation in the public sector which would have be under represented without the current objective of analysing the different childbirth types and the reasons if any.

5.2 OVERVIEW OF METHODOLOGY

The study adopted a stratified sampling technique to ensure that the two birthing modes were all represented in the study. Data collection began in March 2020 following ethical and institutional clearances to conduct the study. Data were collected in the four participating hospitals, that is HOSPITAL A, HOSPITAL B, HOSPITAL C and HOSPITAL D and process spanned from February (Pilot test) till June 2020, and this was successfully done despite the disruptions of the Covid-19 pandemic restrictions. Data were collected using a checklist (Appendix G; pg 284) in order to gather the different variables of the childbirth type and the reasons for caesarean sections from the patient files who were admitted from April 2018 to March 2019. Data were sorted and numbered for easier identification of any errors if ever they

would occur. With the help of a statistician, data were entered into the SPSS v-26 software and analysed. Detailed data collection and analysis procedures are presented in Chapter three.

5.3 PARTICIPATING HOSPITALS

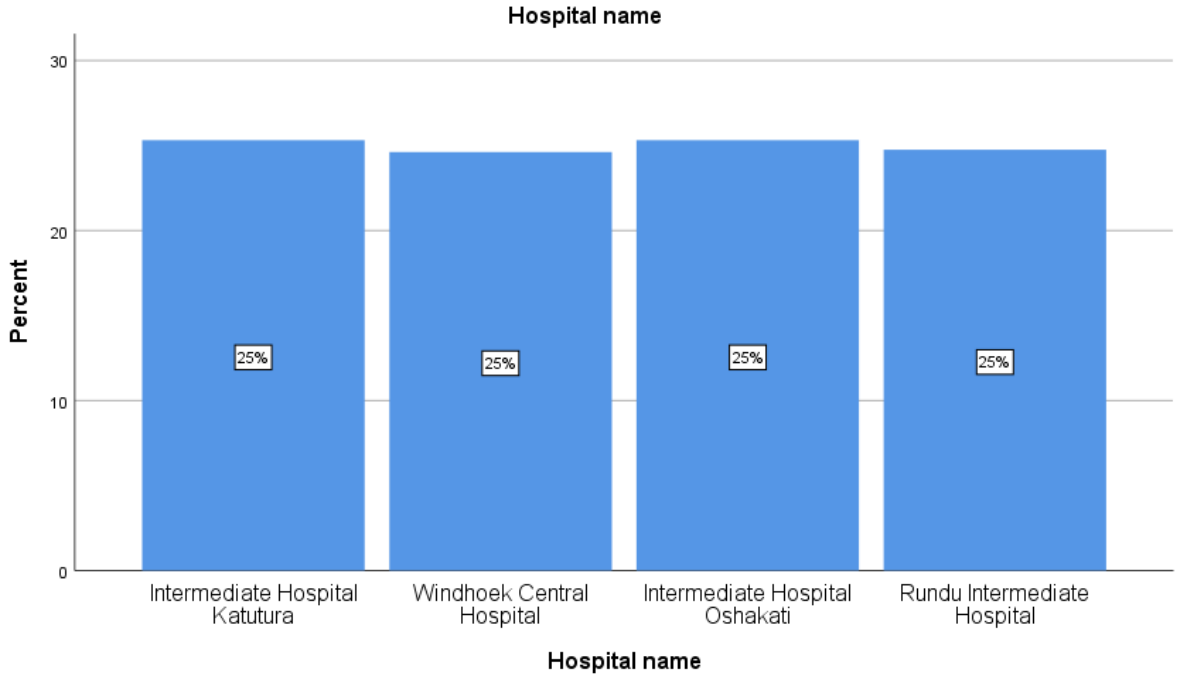

Figure 5.1 Participating hospitals

For the purpose of the study objective, four public hospitals were included in this study as depicted in the figure 5.1. The researcher chose HOSPITAL B, HOSPITAL A, HOSPITAL D and HOSPITAL C as they are the intermediate hospitals in Namibia and as such, they are representative of the nation at large. As a result of the stratification sampling, the researcher ensured that the public hospitals were equally represented with 25% for each. The results of this study may therefore be generalised to Namibia as the researcher targeted the intermediate hospitals with a greater population density in terms of childbirth statistics.

5.4 DEMOGRAPHIC CHARACTERISTICS

Demographic information is paramount in the identification of gaps or areas that need more interventions after the analysis and interpretation of data. The study identified different variables that would help the researcher to identify the trends and the gaps in the research. The

variables included; hospital name, age, gravity, parity, booking status, employment status, and marital status. Table 5.1 depicts the findings of the demographic characteristics of the research objective. The variables are discussed as subheadings below to give a reflection of the current study.

Table 5.1 Demographic characteristics

Variables	Frequency (n)	Percentage (%)	Cumulative percentage (%)
Age:			
Missing	1	0.1	0.1
15-19	153	10.6	10.7
20-29	780	53.9	64.6
30-39	448	31.0	95.6
40-49	64	4.4	100.0
Employment stats			
Missing	10	0.7	0.7
Employed	352	24.3	25.0
Unemployed	938	64.9	89.9
Other	146	10.1	100.0
Gravidas:			
1-Primigravid	409	28.3	28.3
2-4 Multi-gravid	866	59.9	88.2
5+ Grand-multi-gravid	171	11.8	100.0
Parity:			
0-1Primiparity	845	58.4	58.4
2-4 Multi-parity	529	36.6	95.0
5+ Grand multi-parity	72	5.0	100.0
Booking status			
Missing	2	0.1	0.1
Booked	1399	96.7	96.9
Un-booked	46	3.1	100.0
G/A at birth			
Missing	25	1.7	1.7
>28-32	49	3.4	5.1

33-36	269	18.6	23.7
37-40	1042	72.1	95.8
41+	61	4.2	100.0
Marital status			
Missing	4	0.3	0.3
Married	213	14.7	15.0
Cohabiting	16	1.1	16.1
Single	1213	83.9	100.0

5.4.1 Age variable

A total of 1446 checklists were included in this objective as these included the sample size. Out of the total sample there were four main categories as depicted in table 4.1. The majority of the women in this study were in the 20-29 age group which made up 53.9 %. A total of 153 checklists represented women who were between the 15-19 age group. The study categorised them as such as they are teenagers. A teenager is defined as anyone between the ages of 13 to 19 (WHO, 2018). According to Jeha, Usta, Ghulmiyyah and Nassar (2015), there are risks when young girls fall pregnant such as placenta praevia, hypertensive disorders, anaemia and gestational diabetes among others. The proportion of teenagers that birthed during the period under study shows that there is need for vigilance for midwives to engage in supporting and educating the age group as this may cause school dropouts that will result in unemployment.

5.4.2 Employment status

In the current study, most of the participants (938) which is 64.9% were unemployed at the time they registered for birth at the different hospitals, whereas 24.3% of the participants were employed and 10.1% (146 participants) fell under the other category which included students and learners as recorded on the admission records. Underpinning the age variable which identified 10.6 % to be teenagers and 53.9% being between 20 and 29 could be a result of teenage pregnancy and resultantly dropping out. According to Jeha et al., 2015 employment status and the time a woman begins bearing children is closely linked.

5.4.3 Gravida

Gravidas refers to the number of times a woman has been pregnant (Sellers, 2018) and in this study it was important to know the variable in terms of childbirth-choice facilitation. The majority of the participants as represented by 59.9% (866) of the respondents were multigravida, meaning they had had at least one previous pregnancy. Primigravida women constituted 28.3 % of the population, and these are women that are pregnant for the very first time. Childbirth facilitation cuts across the spectrum as all women, regardless of their gravidas, expect and need the highest quality of individualised facilitation when pregnant. This is substantiated by different scholars (Attanasio et al., 2018; Borelli et al., 2018; Boz et al., 2016; Preis et al., 2018) who carried out studies with different women in terms of their gravidas.

5.4.4 Parity

According to Sellers (2013), parity refers to the number of previous viable pregnancies and in the current context that would be 28 weeks of gestation and above still born or alive. Most of the participants at 845 (58.4%) were primi-para, meaning that they have had one viable pregnancy (Sellers, 2018). Of the total population, 36.6 % were multiparous women who had two or more viable pregnancies. Different scholars carried out studies with women with differing parity and the needs for facilitation had similar responses of women needing health information for the childbirth-choices (Bringedal & Aune, 2019; Chen et al., 2017; Cutajar & Cyna, 2018). Grande multipara constituted 5% of the population and these are women that have had five or more viable pregnancies and they formed the least quantity of the total population.

5.4.5 Booking status

ANC booking is essential in maternity for women to receive information regarding childbirth and to detect abnormalities early enough. The study found that most women (96.7%) were booked cases, denoting the fact that they understand the importance of ANC visits, hence women come for ANC, and in this regard, midwives need to give the women the information

that is evidenced-based and involve them in their care (Coates et al., 2020). The ANC attendance in Namibia (Lee et al., 2016) further states that women who opt for a hospital birth are unlikely to question what the health professionals tell them hence the need for health professionals to be factual and accurate in the information they give to the women.

5.4.6 Gestational age at birth of child

The study categorised the GA into four different categories as displayed in Fig 4.1 because women may birth at different times of their pregnancy. Of the total participants in this study, 72.1% of the participants birthed between 37 and 40 weeks which is plausible. A full-term pregnancy is described as one that has 37 to 40 completed weeks (Sellers, 2018). According to WHO (2018), full term is from 38 completed weeks and 37 weeks is regarded as late preterm. The study found that 18.6% of the population comprised of babies born between 33 and 36 weeks.

5.4.7 Marital status

The study objective also focused on the marital status of the patients whose files were analysed. It was found that the majority of the women that is 83.9 % identified themselves as single, of which the status may be linked to different inferences. Single refers but is not limited to one being not married or uninvolved in a stable sexual relationship (Oxford Dictionary n.d.). Married women in this objective constituted 14.7 % of the total, which could be a traditional wedding or constitutional marriage. The burden of pregnancy and decision making on women without a partner is not necessarily influenced by their marital status as any significant other may have an influence and stand in as a support system.

5.5 CHILDBIRTH TYPE IN THE PUBLIC SECTOR

Childbirth types in the public sector of Namibia are vaginal birth and caesarean section. The current study focused on the above as well as they are supposedly the ones that women may have a choice on.

5.5.1 Childbirth type distribution

Worldwide there is an outcry on the increase of medicalisation in birth and Namibia is no exception in this outcry (Mlambo, 2018; Mlambo et al., 2020). The current study carried out a stratified sampling technique for both types of childbirth (caesarean section and vaginal birth). The study found that (see Figure 5.5) 76% of the population under study during the year from April 2018 to March 2019 had vaginal birth and 24% represented the caesarean section births in that year. The statistics are in agreement with different scholars who have recorded similar results in their studies showing that the public sector in Namibia has a larger proportion in vaginal birth than in caesarean section (Makenzie, 2017; Mlambo et al., 2020). However, worth noting is that the WHO emphasises that it is not the rates that matter; instead women need to be well acquainted with the procedures. According to the WHO, the recommended caesarean section rates should be between 10 and15% (WHO, 2015).

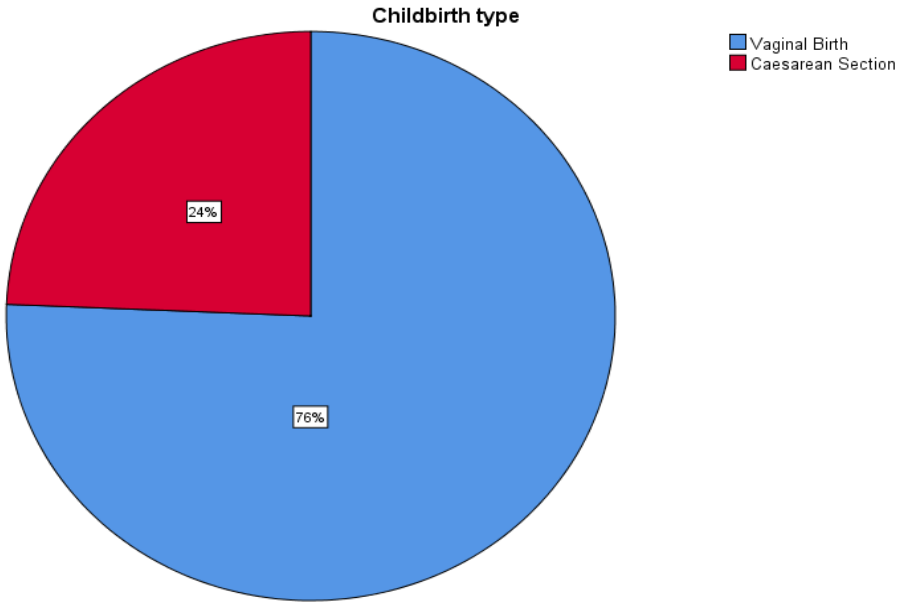

Figure 5.5 Childbirth type distribution at selected public hospitals

5.5.2 Maternal complications during pregnancy

Pregnancy may be an uneventful process which is satisfactory, but it may also have many challenges and complications that come with it. Figure 5.6 shows the different complications that may be present in pregnancy for different women. The study mainly focused on pre-eclampsia, APH, PET, pre-term labour, cardiac disease, gestational diabetes and others. The majority of the women (91%) had no complications during ANC. The results portray that most women have low risk pregnancies and indeed midwives are primary caregivers of women with low-risk pregnancies. The maternal complications in this study objective included pre-term labour (3%) and other (which included PROM, APH, anaemia, PIH) (3%).

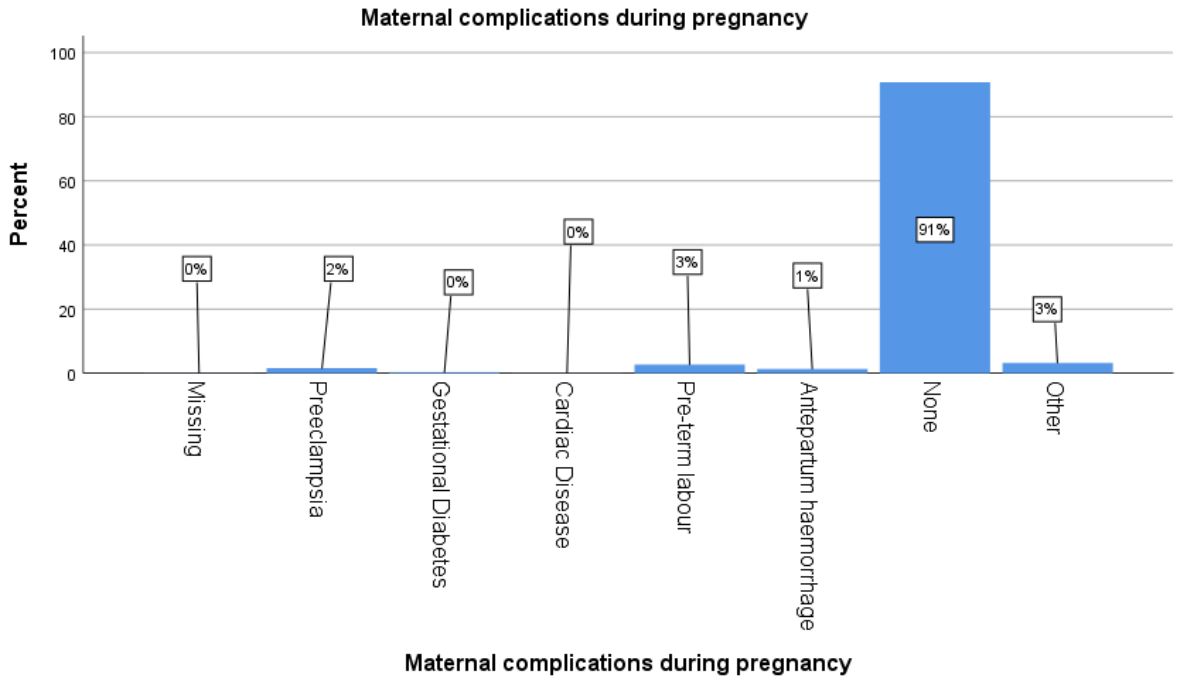

Figure 5.6 Maternal complications during pregnancy

Preeclampsia constituted 2% of the total population in the complications during pregnancyin the study results. Hypertensive conditions were also found in the 'other' of the variables depicting those hypertensive conditions are present in the Namibian context. Preeclampsia is one of the causes of maternal mortality and morbidity which needs to be well monitored during ANC which constitutes facilitation. This notion is supported by Mounier-Vehier, Amar, Boivin, Denolle, Fauvel, Plu-Bureau, Tsatsaris and Blacher (2016), who state that the complications that arise from hypertensive conditions are the leading cause of morbidity and mortality among women.

In addition, APH was also an indicator having 1% of the complications during pregnancy, of which it can signify different conditions like placenta praevia and abruption placentae which presents with bleeding. Haemorrhages present risks to the mother and the foetus as well, and may lead to morbidity and mortality (Sellers, 2018). Furthermore, cardiac complications were also noted to be amongst the complications in women.

5.5.3 Reasons for caesarean sections

Caesarean section is a major life-saving operation which is performed as an emergency or on request. According to this study (Figure 5.7) 75.59% represents the women that birthed via vaginal birth and some of the missing variables in some of the files that were not indicated. Prolonged labour formed 1.38% of the population for reasons for caesarean section. Foetal distress stood at 4.77%, whereas previous caesarean section had the most significant percentage that represented the reasons for caesarean section with 10.44%. Failed IOL was represented by 0.28% of the population which also concurs with Mlambo et al.'s (2020) findings on the private sector of Namibia as one of the reasons for caesarean sections. Transverse or oblique lie had a proportion of 0.07%, whereas breech presentation had a proportion of 1.11% and 6.36% represented others in the population that was under study.

According to Hatupopi, Nghamukamo, Nghitanwa and Tuhadeleni (2019), in a study conducted at Hospital C, the leading cause of caesarean section was foetal distress followed by previous uterine scar and CPD. In the current study, previous caesarean section constituted the lead with 10.44% thus repeat caesarean section was the reason for the subsequent caesarean section.

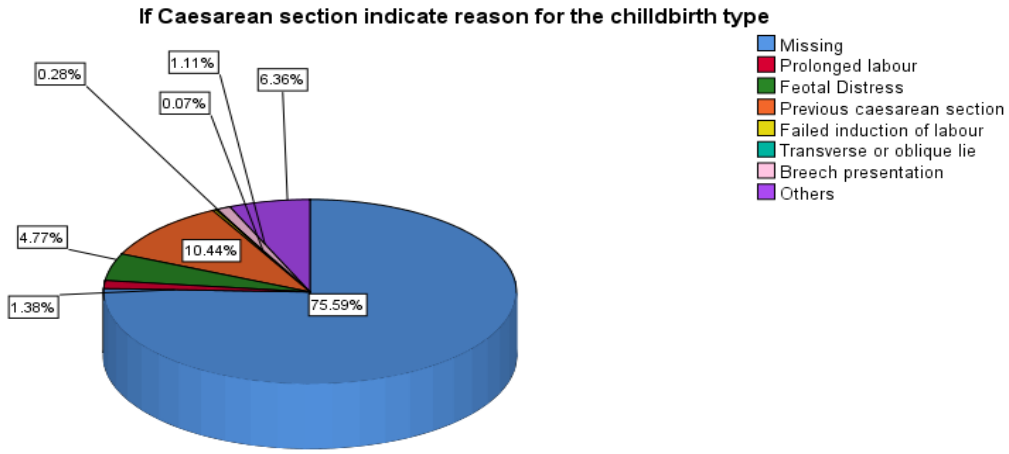

Figure 5.7 Indications for childbirth type

5.6 CHAPTER SUMMARY

The current chapter presented the quantitative analysed data and discussed the results of the objective to identify the different childbirth types in the public sector of Namibia. The majority of the women booked early to attend ANC, whilst the majority were unemployed and single. Moreover, the leading reason for caesarean section in this study was as a result of the previous caesarean section. The identified concepts in this objective were women who attended ANC showing vigilance, unemployment among women being high and teenagers being among women under their care was also significant, thereby calling for more vigilance on childbirth-choice facilitation. In light of the above, the objective portrayed that women book for ANC and as such, it becomes the mandate for the midwives to give them facilitation that is women centred and caters for the needs of the individual woman. Chapter six presents and discusses the qualitative data for the sub-objective of phase one of the identification of concepts.

CHAPTER SIX

DATA ANALYSIS, PRESENTATION, AND DISCUSSION OF THE QUALITATIVE DATA AND MERGING OF FINDINGS

6.1 INTRODUCTION

Chapter five presented the quantitative data results and the analysis thereof. This chapter (six) focuses on the analysis, presentation and discussion of the qualitative data that were gathered in this study. The chapter is divided into Section A and Section B as the qualitative data were conducted with two different populations that is midwives and women. The data were collected concurrently but the analysis was done independent of the other. The major themes and subthemes of the analysed data are discussed and controlled with literature as well.

6.2 OVERVIEW OF DATA COLLECTION AND ANALYSIS

The research objectives in this chapter were met by following a qualitative exploratory approach to collect data from the participants. The researcher obtained ethical clearances prior to data collection and concurrently while collecting data for sub-objective four in phase one. Purposive sampling was done among the maternity files to get the contact details of the women. Following the retrieval of the contact details, the researcher contacted the prospective participants and briefed them about the purpose of the study and how participants were being requested to contribute. Data were collected through face-to-face interviews using an interview guide (Appendix F; pg 282), while recording was done with a voice recorder, and due to the Covid-19 pandemic, some participants were interviewed telephonically. Data were analysed following the six steps of data analysis by Creswell (2014) and narratives were used to present and discuss the findings. The detailed data collection and analysis procedures were presented in Chapter three.

6.3 SECTION A: EXPERIENCES OF MIDWIVES IN FACILITATION

The objective was to explore and describe the experiences of midwives in facilitating childbirth-choices in public healthcare facilities. The study objective yielded results after the analysis and these are presented through a demographic table and themes and sub-themes are presented through narrative analysis.

6.3.1 Demographic characteristics for midwives

The demographic characteristics are depicted in Table 6.1 with the different variables that included pseudonyms, age, gender and years of experience. The ages of the research participants ranged between 28 and 54 years which gave the variety of the participants and this should have helped to provide different views. The research objective included two male participants who are referred to as accoucheurs and eight female participants, which shows that from the current study, male participants were not a lot. However, this did not affect the data quality as the ratio of male and female midwives is a true reflection on the number of male midwives in the profession within the Namibian context (Mlambo, 2018). The varying of the years of experience from 3 years to 7 years was an added advantage as it brought out the views from the eyes of different but experienced participants hence giving in depth in information.

Table 6.1 Demographic characteristics for midwives

Pseudo name	Age	Gender	Years of Experience
M1	32	Female	3 years
M2	30	Female	3 years
M3	28	Female	6 years
M4	54	Female	5 years
M5	37	Female	3 years
M6	40	Male	9 years
M7	27	Male	3 years
M8	35	Female	2 years
M9	26	Female	4 years
M10	29	Female	3 years

6.3.2 Emerging themes and sub-themes (experiences of midwives)

Midwives were interviewed for the purpose of understanding how they facilitate women during ANC when the women present at the healthcare institutions. Two themes were identified, namely barriers in facilitation of childbirth-choices and lack of childbirth-choices. Moreover, the main themes also had subthemes that came with them and they are as follows: choice, rights of women and protocols and guidelines for the first theme, and childbirth type information, timing of childbirth information giving and shortage of staff for the second theme. The themes and subthemes were formulated after data analysis following the six steps by Creswell (2014).

Table 6.2 Themes and subthemes of midwives' experiences in childbirth-choices

THEME	SUB-THEME
1. Barriers in facilitation of childbirth-choices	• Shortages of staff/ workload • Timing of information giving • Information sharing during ANC
2. Lack of childbirth-choices	• Provision of rights of women regarding choice • Lack of woman centred care • Enforcement of protocols and guidelines • Cultural influences of childbirth types

6.3.2.1 Barriers in facilitation of childbirth-choices (Theme 1)

A barrier may be described as an obstacle that hinders the progress or the continuation of an event (Oxford Dictionary, n.d.). In this study, objective barriers in facilitation were identified also as the hindrances that midwives encounter knowingly or unknowingly when facilitating women with childbirth choices. The talk pertaining to choice should identify first the choice the woman needs to make and thereafter information giving on the pros and cons of the choices available, and finally supporting the woman in the choice taken (Nieuwenhuijze & Low, 2012). In this study, the factors identified as hindering midwives from facilitating childbirth-choices included but were not limited to the following: shortage of staff, timing of information giving and information sharing during ANC. The above-mentioned sub-themes are discussed in detail below.

6.3.2.1.1 Shortage of staff/workload

Shortage of staff refers to the staff that are working with the patients in a unit not having enough nurse-patient ratio to meet the standard care of the patients. According to Suresh and Ritu (2020) a ratio of 1:5 in India is appropriate in a medical ward. In this study, midwives expressed that the nurses that are in the ANC departments did not tally with the patients that they would receive each day for ANC visits. According to the current study, the midwives expressed that they have staff shortages as they do not have enough staff and yet the patients are many and at times the time will not be enough for them to provide dedicated and adequate care as they will be rushing to serve all the patients. The above is supported by the following verbatim statements from the respondents:

> *M4 "Maybe 10 to 15 minutes it's not long and if they are many you also try to become faster not to waste time on one patient"*
>
> *M5 " ... when we see 150 patients yah and we are only 4 midwives at the moment so on average it's like plus or minus 40 patients per midwife per day and that is too much"*
>
> *M3 "... and also there is not a lot of staff in ANC it makes it a bit hard to go really in depth with everything pertaining the mode of delivery."*

The above responses from midwives indicate that in as much as the midwives may be willing to give the health information to women, the staff shortages make it difficult as they are always racing against time. This however, does not justify the poor provision of information to women as some of the midwives also stated that they give information when the women present individually in the rooms.

6.3.2.1.2 Timing of information giving

According to the IP-SDM model (2010), timing is everything when it comes to shared decision making, which is also vital in the facilitation of childbirth choices. In-order for one to be able

to make a decision, they need to be given a chance to reflect on the information and the choices available to them before they can commit to the final decision. The following verbatim statements cement the timing of information giving as reported by the midwives:

> *M3 "In ANC we give health education to the women usually during their first ANC visit"*
>
> *M2 "My experience with women when they come to ANC for their first visit we give them health education … Yes we give them (information on types of delivery) mostly if they are about nine months or six months… It is good to give them information according to the trimester… if you know more about delivery about delivery what about this minor element she might come back feeling nauseous"*
>
> *M6 "Once you give them that education at an early stage they tend to forget"*
>
> *M4 "I think it's proper to start when it's in the third trimester when you start supposed to ask them that. Because in third trimester… When it's early and you talk to them about delivery they will not take you seriously because it is still small"*

6.3.2.1.3 Information sharing during ANC

Midwives are the primary caregivers for pregnant women in the public healthcare sector, hence they need to be equipped with knowledge for them to be able to facilitate childbirth choices. According to the patient charter (MoHSS, nd) of Namibia, women have a right to receive information that pertains to their health and that will ensure positive birth experiences as supported by WHO (2016).

> *M6 "When they start ANC we tell them about delivery … And the ceaser is only done when there is a complication to save the baby or you. Just to give them information of how or why people get Caesar"*

M7 "It is important for the patient to be aware of the advantages and disadvantages of the different modes because some patients are just misinformed by others that Caesar is good. Some with information will refuse Caesar but if necessary the patient should be given information"

M6 "…..they will end up they want C/S if you tell them information on that. ……. If you keep repeating they feel it's useless"

The verbatim extracts denies the women adequate information with the idea that women will choose caesarean section which is refuted by best practice in that if women are given adequate information they will make the best informed decision (Loke et al., 2015).

6.3.2.2 Lack of childbirth-choices (Theme 2)

Childbirth is a lifetime experience and each birth is different and hence needs to be noted and seen as such. Childbirth-choices stem out from the availability of information to the women so as to be able to make informed decisions (Attanasio et al., 2018; Davis et al., 2020; Loke et al., 2015). In this study, most midwives concurred that there is an assumption that if women were low risk they did not get information relating to the childbirth choices.

M6 "Most primis we told them when its caesarean they cut your flesh open your uterus and this one it's not your own choice like in modern life there is elective Caesar. No l don't want to feel the contraction"

M7 "When we do our own examination we determine what type of delivery a woman is suitable to have. We do not ask them on what they want because when you ask them most patients will ask to go for Caesar. …… they do not have the absolute right for mode of delivery"

M4 "No we are not discussing it we are sending them especially the Caesar we are sending them to the Dr to decide whether they are going to have a second one"

Midwives in this study refer women mostly to the Dr if there be any discussion of caesarean section meaning that they also forfeit their role as primary caregivers. Midwives need to ensure health education on choices begins from the beginning of ANC.

6.3.2.2.1 Provision of rights for women regarding choice

Respectful maternity care (RMC) works through the many different networks to ensure that all the women under their care receive RMC that also ensures that the rights of women are not infringed. In this study, some midwives highlighted the fact that women were given information regarding birth especially those who have had a previous caesarean section as indicated below:

M3 "For example someone who had a previous Caesar and you will have to counsel her and she will have to decide, discuss with the patient and tell them the disadvantages and advantages of vaginal birth and Caesar also she will have to decide on the type of delivery they want to have"

M2 "Yes we tell them about the advantages and disadvantages of delivering vaginally and ceaser if they are about …"

M6 "Women has the right for childbirth if they want C/S we refer them to the Dr and the Dr also gives them health education"

M9 "if they don't have any risk we really do not discuss with them anything regarding Caesar otherwise they will get confused"

It is worth noting that some midwives gave information to women about the advantages and disadvantages of caesarean section in advocating for VBAC in this context. Midwives

analysed the reason the preceding caesarean section that was done and gave the information accordingly.

6.3.2.2.2 Lack of woman centred care

Woman centred care refers to the care that is individualised and focusses on the woman independent of other women that present with a similar problem (Benyamini et al., 2017; Boz et al., 2016; Bringedal & Aune, 2019; Chen et al., 2017; Coates et al., 2020) so as to give information which is relevant to the particular woman. In this study, it was evident that midwives paid particular attention to giving health information to a group of women with different characteristics as evidenced by the verbatim extracts below;

> *M3 "For women who do not have high risk what we do is we do group health education in terms of just giving them everything"*
>
> *M6 "When they start ANC we tell them about delivery when they are in a group"*

Patient led care is a concern and this is being advocated for in the aspect of RMC and in other studies, women in Canada expressed that it is important that they lead their care (Vedam, Stoll, McRae, Korchinski, Velasquez, Wang, Partridge, McRae, Martin & Jolicoeur, 2019) as they feel respected. This notion was also alluded to by other scholars (Afulani, Phillips, Aborigo & Moyer, 2019; Benyamini et al., 2017; Boz et al., 2016; Bringeal & Aune, 2019) as women allude to being involved and leading in the facilitation by being given information hence, they understand the different types and left to decide after guidance from the professionals.

It is the mandate of midwives to ensure patient led care which in the present study was found to be lacking due to the said staff shortages which then influences the time spent with the patient and the information that is given.

6.3.2.2.3 Enforcement of protocols and guidelines

Protocols and guidelines are the blueprint for midwives and these need to be enforced and ensured to satisfy the client that is under their care. Protocols may only be adopted and implemented if there is regular training to inform the users about the available protocols to ensure that they are understood (Coates et al., 2020; Feeley & Thomson, 2016; Hinton et al., 2018; Newnham et al., 2017). Moreover, not only should the protocols and guidelines be taught to the health professionals, but they should be ensured that they are implemented to the consumers and in this case it is the women in ANC (Coates et al., 2020).

The standardisation of protocols and guidelines within a context should always be guided by evidenced based research (Diamond-Brown, 2018) that is context based hence ensuring quality of care for the women under care. The assumption of choice among midwives that every woman 'wants vaginal birth' should be a starting point in ensuring that all women have an equal share in the facilitation they receive from midwives and the information of both modes of delivery should be made available to them. The following verbatim extracts substantiates the notion of going with the flow in the public healthcare facilities.

> *M4 "We just found it like that, we are only giving health talks without the mode of delivery that is what l found there. If there is something to that l have not seen it"*
>
> *M10 "When l joined also noticed the talks don't include mode of delivery other than just we ask them following the pink card then we know that how did they deliver"*
>
> *M3 "It is only on the first visit and also depends on who is giving it but mode of delivery really is not part of it"*

In Namibia the existing protocols and guideline are broad and not specific to childbirth-choices hence the need for the developmemt of the model for midwives. The available protocols in Namibia is the Patient Charter (MoHSS, nd) and the Scope of practice (Republic of Namibia,

2014) that reiterate the importance of information giving to patients for them to have informed choices but are not discipline specific to the childbirth-choices.

6.3.2.2.4 Cultural influences on childbirth-choices

Culture is the way of life that a certain group of people adopt and live by. Childbirth-choices are no exception to the cultural influences that come with them among women when it comes to giving birth. In this study, midwives attested to the fact that there are instances when the woman needs a caesarean section birth but due to the society they are coming from it becomes difficult as is evidenced by the verbatim extracts below:

> *M4 "..... maybe to be cut for the fourth time or what maybe they can have sterilisation or what its them to choose some of them it's like no am going to talk to my husband or what and then will come back with what partner say"*

> *M9 "some women when you tell them they are going for a Caesar they will tell you that they first want to talk to their relatives or husbands to know if it's the right way"*

The above verbatim extracts are supported by Preis et al. (2019) that the beliefs of women need to be put into consideration when birth is concerned. Involving women and giving them time to process the information about birth may help them to understand and have a positive childbirth experience (Nascimento et al., 2015).

6.4 SECTION B: WOMEN'S EXPERIENCES WITH CHILDBIRTH FACILITATION

The objective sought to understand the experiences that women had with midwives during their pregnancies in being facilitated with childbirth choices. Qualitative data helped the researcher to understand in depth the experiences of the participants and this enabled the researcher to have a deeper understanding of the phenomenon.

6.4.1 Demographic characteristics for women

Women that participated in the research had different characteristics and all these were part of the research interview guide. The participants had to indicate their age, parity, gravidas, ANC booking, and level of education as indicated in Table 6. 2.

Table 6.3 Demographic characteristics for women

Participant code name	Age	Parity	Gravidas	ANC booking	Level of education	Type of childbirth
W1	20	1	1	Yes	Tertiary	Vaginal birth
W2	42	1	1	Yes	Secondary	Caesarean section
W3	20	1	1	Yes	Tertiary	Caesarean section
W4	35	3	3	Yes	Secondary	Vaginal birth
W5	35	4	3	Yes	Secondary	Caesarean section
W6	27	1	1	Yes	Tertiary	Caesarean section
W7	23	1	1	Yes	Tertiary	Caesarean section
W8	27	2	2	Yes	Tertiary	Vaginal birth
W9	32	3	3	Yes	Secondary	Vaginal birth
W10	29	5	5	Yes	Secondary	Vaginal birth
W11	24	2	2	Yes	Secondary	Vaginal birth
W12	19	1	1	Yes	Secondary	Vaginal birth

The women represented in Table 4.1 were from the four public healthcare hospitals in the study, namely, Hospital A, Hospital B, Hospital D and Hospital C. A total of twelve women participated in this study who had varied age groups from 20 years up to 42 years. The variance in age groups helped create the experiences from wide spectrum of women in different age groups and how they may experience the phenomenon under study varies due to their age groups. In addition, the parity of the women varied from one to four, meaning that some of the women were mothers for the very first time and others had experienced motherhood more than

once as depicted in Table 6.2. Moreover, the population of women consisted of women who had carried between one pregnancy and five pregnancies which may have helped them to understand their experiences through the lens of women with different gravidities. The researcher incorporated this component to try and identify if their experiences with facilitation was different from their expectations.

Furthermore, the study focused on the type of childbirth they had for the pregnancy during the time of the study period that is April 2018 to March 2019. The experiences of these women with different childbirth types would converge or diverge and taking note of their experiences gave the researcher a greater understanding of the study phenomenon. The level of education varied as well with the different participants giving the study objective more credibility in terms of the experiences with facilitation of childbirth choices as interpretations about life and the present phenomenon can be influenced by education levels.

6.4.2 Emerging themes and sub-themes (Women's childbirth experiences)

The research objective for the experiences of women on childbirth-choice facilitation yielded some themes and sub-themes following data analysis. The main themes that were found in the data analysis were childbirth-choice experience (with the following sub-themes: choice and decision making) and information giving (information sources, information women prefer to receive, information received and timing of information giving were the sub-themes). The themes and sub-themes identified are presented and discussed in detail in this chapter in the quest to understand the experiences of women with childbirth-choice facilitation.

Table 6.4 Themes and subthemes: Experiences of women

MAIN THEME	SUB-THEMES
Women's childbirth-choice experience	Lack of choice
	Inadequate decision making
Information giving	Information sources of childbirth-choices
	Information women prefer to receive
	Actual information received
	Timing of information giving during ANC

6.4.2.1 Women's childbirth-choice experiences (Theme 1)

Childbirth-choice facilitation is essential to all the women receiving ANC and it must be given by the midwives that are caring for them in the healthcare facilities. The main theme portrays the experiences that women had with facilitation in the four participating hospital in Namibia. According to the WHO (2018), women need to have positive birth experiences and this in-turn helps them psychologically and this should begin from the point of contact when a woman comes into the health facility. In addition, women in this study expressed their experiences and this is the standpoint of the women in the public healthcare sectors of Namibia.

6.4.2.1.1 Lack of choice

The research participants in this study expressed different experiences based on the notion of choice. Choice is defined as the final decision that an individual makes in relation to their care, and this refers to women in this context. Women's choices are to be understood by healthcare professionals as the legal right of a woman (Feeley & Thomson, 2016) following education, transparency and information from the healthcare workers (Stirling et al., 2018). Women expressed notions of 'assumed choice' in that they were not given the options but rather the midwives and the woman assumed that they would have a vaginal birth. According to O'Brien et al. (2017), informed choice should follow in-depth discussions with the caregiver for the

woman to make an informed choice. In this study, the research participants expressed it differently as seen from the verbatim extracts below:

> *W1 "As far as l can remember I was not told anything about delivery, they ehh only told me about the diet and the clothing"*
>
> *W2 "They told me that because of my age l might not giving birth on my own maybe l will get surgery it was not really clear"*
>
> *W3 "at first it felt like the nurses and doctors will decide for me which delivery but later l realised they can't decide for me l have to go the natural way. They did not decide for me and they did not even ask"*

The above verbatim extracts zoom into the daily ANC services the women are receiving in the public sector and this shows that both the women and the midwives have the assumption that women have choices and yet in actual fact they do not. To substantiate on the issue of choice, this should start information giving about the available options, their pros and cons and then the woman making an informed decision. Participant W3 expressed that the healthcare professionals in as much as 'they did not decide for her' 'they did not even ask', thus clearly depicting the fact that assumed choices are present. Participant W3 is supported by Stirling et al. (2018) who allude to the fact that there is a 'societal misconception' in which women believe that healthcare professionals are the ones to make the decision regarding their childbirth type (Mlambo et al., 2020).

Women who previously have had caesarean sections need to have the information given to them so that they may understand and be able to choose the mode that is the best if the circumstances permit. The fact that a woman had a previous caesarean section does not always warrant a repeat caesarean. The following were some of the views with regards to this phenomenon:

W5 "when you come for ANC they ask you how you gave birth last time and if you gave birth by caesarean they always put you on the list for operation"

W2 "first they should allow women to choose what type of birth they want to have without making them feel bad, weak and incompetent especially caesarean section"

One woman expressed that the midwives should not make women feel bad when they choose a certain type of childbirth but instead they should support the women. The above narrative alludes to the fact that women may need a certain type of birthing mode but they are not free as they may be judged by the healthcare professionals. Women's choices and agency need to be respected at all times by all healthcare professionals (Happel-Parkins & Azim, 2016) as this identifies with women centred care which proffers that women should be the driving force behind the birthing decisions (Afulani et al., 2019; Happel-Parkins & Azim, 2016; Vedam et al., 2019) for them to have positive birth experiences (WHO, 2018).

In a study that was conducted in Canada on women pertaining to decision making, it was reported that women preferred to be the lead in the decision making with regards to the choice of mode of delivery even when interventions need to be done (Vedam et al., 2019). This is in contrast to some extent to what the current study objective found as the women in Namibia appeared to have no choice pertaining to birth but rather an assumption was made that all of them would go for vaginal birth. Furthermore, Vedam et al. (2019) reported less autonomy in women that were facilitated by physicians in the private sector in Namibia (Mlambo et al., 2020) though there was an indication that women cared for by midwives expressed more autonomy regarding choice.

It may be argued that women in the public sector hospitals are from less privileged backgrounds and as such they may not be fully involved in decision making as they are not given information on the different birthing modes, let alone asking them about their experiences. This is alluded

by Attanasio et al. (2018), who posit that women who are from marginalised social groups were less likely to report shared decision making. This is however in contrast to the Patient charter (MoHSS, nd) of Namibia, the Rights of Childbearing age groups and the ICM among many other bodies that are encouraging women centred care for positive birth experiences for women.

6.4.2.1.2 Lack of shared decision making

Decision making is a major component that needs to be incorporated in all healthcare provisions but this might not be truly there for the women. Shared decision making has a positive outcome as women will have increased satisfaction with the birthing experience (Attanasio et al., 2018; Stirling et al., 2018). Upon receipt of information from the healthcare providers, the woman should be able to discuss and come up with a decision that is aligned with their own beliefs, values and their circumstances in life (Stirling et al., 2018). Ownership in the decision will ensure that there are less chances of the mother feeling depressed in thinking that they let themselves down, thus leading to depression or psychological breakdown (Attanasio et al., 2018; WHO, 2018).

> *W3 "yah l would say that even during the first weeks it will also be nice l think it will even be better because you will get enough time to ask information on it and to do research on it and also tell your family about it and they give you also their point of view about it"*

The above extract is a true reflection of the experiences a woman would appreciate before making a decision pertaining to the childbirth type which they may undergo. According to the IP-SDM (2010) model, decision making is a process and as such there should be some time until a patient makes a decision. For women in ANC, pregnancy takes about 40 weeks from conception until there is the birth of a child. This then informs practice because women have a

long period until they give birth and this should be taken advantage of by the midwives as they provide information early on for the information to be absorbed and thought through (Begley, Daly, Panda, & Begley, 2019; Stirling et al., 2018). The researcher takes cognisance of the fact that some women present late for ANC and as such, they may not have a long period with the woman, but this does not mean that women should not be given the time to make decisions.

In addition, from the demographic information in Table 6.2, there is a clear depiction that all the women at some point presented themselves for ANC and this should be the time that the women are given information. The decision making may take long in other women and shorter than others due to different circumstances that may influence the woman's decision inclusive of complications, previous experience, and or significant others (Begley, Daly, Panda, & Begley, 2019; Legare et al., 2010; Stirling et al., 2018). Without adequate information, decision making becomes flawed as expressed in the verbatim extract below:

> *W2 "they told me because of my age l might not give birth on my own. ……. I was told l had developed High blood pressure, but l was told on the very same day I gave birth that l was going to have a caesarean section"*

The above shows that W2 was evaluated according to her age, which is one of the various reasons why a woman can have a caesarean section, and this should have helped the woman to cope with the situation at hand as the woman was assessed and given the information. However, not all women with an advanced maternal age almost always end up having a caesarean birth as evidenced above when the woman had a caesarean section due to high blood pressure. Decision making is a process and it should be regarded as such. Women should be given the information and they should be guided, if need be, for them to make decisions but health care professionals need to know that a woman is autonomous (Stirling et al., 2018). Borelli et al. (2018) further proffer that the woman is the primary actor who invites the healthcare

professional through attending ANC and as such the women should be given the autonomy to make the choices that suit them best. The review of a birth plan as the pregnancy progresses should not be a limitation for the healthcare provider as a low risk pregnancy may have an uneventful turn and decisions can thus be adjusted (Attanasio et al., 2018; Borelli et al., 2018; Stirling et al., 2018).

> *W10 "Do we even have anything to say about the birth? We just come to the ANC and we just wait for when the pains come then we go and deliver ehh they never asked me anything about giving birth"*
>
> *W12 "I was just told to get my bag ready and when l was almost 8 month and l was scared to ask how l was going to deliver"*

From the verbatim extracts above, it is worth noting that women just go with the 'flow', and the assumption is that they must deliver physiologically and they should know only that. Shared decision making moves away from assumptions but rather incorporates the women to understand their position in the process in order for them to make informed decisions (Borelli et al., 2018; Boz et al., 2016). In order to improve shared decision making, women need to be engaged as they share their experiences to ensure that future pregnancies may involve the women in their care and thus also inform practice (Borelli et al., 2018). In a study done in Australia, healthcare professionals alluded to shared decision making and also at the same time admitted that often this is not realised in their setting (Coates et al., 2020).

6.4.2.2 Information giving (Theme 2)

Information giving is an important aspect in health for patients to make informed decisions according to the Patient Charter and scope of practice of a midwife (MoHSS, nd; Republic of Namibia, 2014). According to Respectful Maternity Care (WHO, 2018), women need to be furnished with information that will lead them to decision making and finally the choice that

they will come up with (Stirling et al., 2018). According to the Universal rights of childbearing women (Windau-Melmer, 2013) information giving is a right that women need to be accorded, meaning that the childbirth types which are available should be discussed with the women despite the final childbirth mode that they will choose or that will be done (Bringedal & Aune, 2019; Butler, 2017; Cutajar et al., 2018). The patient charter (MoHSS, nd) of Namibia also cements the need to give information to the patients that seek help from the health facilities and maternity is no exception.

Theme two has three subthemes that focus on the different sources of information to women, the information that women would appreciate to receive, the information the women received during ANC and also the timing of the information. The subthemes are presented and discussed in detail below.

6.4.2.2.1 Information sources

Women do not live in isolation, and they do have support systems that need to be alluded to by the healthcare providers attending to them when they present themselves to the health facilities. When women fall pregnant, be it the first or subsequent pregnancies, they have perceptions and views on how they will give birth (Preis et al, 2018). However, it is the duty of the healthcare providers to attend to any misconceptions or myths that are in contrary to the evidence-base of pregnancy and childbirth (Loke et al., 2015). Various participants in this study concurred that their family was an important part of their information source as alluded to by the following verbatim narratives:

> *W3"My late mother told me about vaginal birth that labour is painful and all ladies need to go through that and there is no way you can escape it."*

> *W9 "My friends told me how they had given birth and how scared they were of the process"*

W11 "Yah when just in the village you hear a lot from the big people about giving birth and we just listen and most of them just know one

The IP-SDM (Legare et al., 2010) alludes to the fact that each and every one comes from an environment with family and friends who have to an extent an influence on the decisions that they make. This goes to show that in as much as midwives do not ask the women if there are any external factors that have given them information this is not a strange aspect. In fact, midwives need to take the onus upon themselves to clear any misconceptions that may be of negative impact to the women. According to Loke et al. (2015), there is a need to understand the health belief model when women are seeking information on childbirth choices. From the verbatim narratives below, it can be shown that women have a strong relationship with their mothers even to the grave.

W1 "As far as l can remember, I was not told anything about delivery, they ehh only told me about the diet and the clothing"

W2 "They told me that because of my age l might not giving birth on my own maybe l will get surgery"

W3 "At first it felt like the nurses and doctors will decide for me which delivery but later l realised they can't decide for me l have to go the natural way. They did not decide for me and they did not even ask"

The above narratives show that women did not receive information pertaining to childbirth types or choices when they come for ANC. Assumptions that women know about the different childbirth types may be misleading. In another study by Coates et al. (2020), it is reported that women did not have the information and this relates to the present study that information is not given. Information sources play an important role in shaping and preparing the women in their plans for pregnancy (Cutajar et al., 2018), hence the importance of evidenced based

information from the healthcare professionals to dismiss or correct any myths and misconceptions (Davis et al., 2020; Feeley, Thomson & Downe, 2020; Stirling et al., 2018).

Midwives have a mandate to involve the family or at least the significant other that would be able to receive the information together with the woman. The approach will then acknowledge the information the family has and clear any misconceptions, thereby bringing the aspect of shared decision making into play (Nieuwenhuize & Low, 2013). Women are greatly influenced by their friends and this should not go unnoticed (Boz et al., 2016) and this was evident in this study from the narratives below:

> *W11 "My friends told me that labour is very painful and l was so scarred if the nurses had asked me l would have chosen to be cut because the labour was painful"*
>
> *W10 "My cousin was cut and she is always complaining that she gets pain every now and again so because of that l always wanted a normal birth"*

Moreover, women come to the hospital because they expect to get information that is reliable. In the UK, women receive information from the National Health Services that offers women antenatal classes that have a focus on the expectations during labour and any other information that is of importance to the women (Hallam et al., 2018). The above concurs with the practices in Namibia where women receive information from the midwives in the hospitals where they attend ANC. However, a limitation has been noted in that women, as long as they have a low-risk pregnancy, are not informed or educated on any other childbirth types besides the normal vaginal birth. In as much as vaginal birth is the most physiological and one that has less complications associated with it, women centred care dwells on the importance of providing women with information for them to make informed decisions (Mohamed et al., 2016, MoHSS, nd; Republic of Namibia, 2014). In a study in England on birthplace choices, women verbalised

that their sources of information included the internet, recommendations from friends, antenatal classes and their own experiences (Hinton et al., 2018; Nascimento et al., 2015).

6.4.2.2.2 Preferred information

Understanding the experiences of women will help to identify gaps and also inform practice on what needs to be done for women centred care to be established. The women in this study expressed the information they preferred to or would be happy to receive regarding childbirth facilitation as depicted by the narratives below:

> *W2 "They need to inform us women on the good and the bad they might face based on the delivery type that they chose"*
>
> *W3 "They should be told on the different types of delivery so that we know what is good and bad for that delivery"*
>
> *W7 "the benefits and the side effects of each of the ways of delivering"*
>
> *W11 "The nurses should tell us everything about giving birth to a baby the normal way and also the other way because you never know what can happen in the way"*

There is great need for the information to be balanced so that the women get to know the pros and cons as this will help the women to decide (Nieuwenhuijze & Low, 2013). Not only does this help women to have the information but in the event of emergencies, the information will not overwhelm the woman as they will already have had the information of the possibilities of the procedure, for example, caesarean section. In accordance with the Health Belief model and the needs of women according to a study done by Loke et al. (2015), women preferred to be informed about the different modes of childbirth as this would ensure that they actively participated in decision making.

Some women in this study had emergency caesarean sections before full term and since they had no prior information, the acceptance of the procedure became difficult. Munro et al. (2017) state that being informed as well as being able to consider the feasibility of the options available to them is important before an actual choice is made. According to Vidal et al. (2018), it is important to emphasise information as the need arises in addition to the overall information given on the different birth types. Stirling et al. (2018) furthermore state that there is a need of reemphasis of information as the need arises, for instance, the sudden change in the preferred childbirth type due to unforeseen or unexpected complications in pregnancy.

W5 "I was 8 months when l got cut and the Sr did not explain just said l need to go to the Dr"

W10 "It was only when l had blood pressure that they ehh told me the only way to save my baby was to cut me and take the baby out, l was I think 7 months but l was not ready"

Women get confused when there is a sudden change of events and this is attested to by Boz et al. (2016), who state that women get confused towards the end as they only had information about a normal birth but did not get information about a caesarean birth. In as much as a physiological birth is the safest and has less complications (Gibbons et al., 2010), there is a need to inform women of other available as well as possible childbirth types as this will create less anxieties should the need arise.

6.4.2.2.3 Timing of information giving

Information giving is important and timing the information is necessary. Women in this study expressed different timings of the information of the childbirth types as in the narratives below:

W8 "I was not informed before until in my 34 weeks of pregnancy that l had pre-eclampsia. I had it in mind that l was going to push as l had no problems"

W3 "when you go for ANC it should be given in the semesters especially the last one because at that time the main concern of the woman at that time is giving birth to the child with no other thing to think about"

W4 "I was told at 6 months about how I will deliver the baby"

W5 "Information l was only given when l began ANC and they said they will give again when we are almost at the end. Information should be given three times in the beginning the middle and the end.

According to Borelli et al. (2018), women need to receive information during pregnancy and this health information needs to continue through labour and birth and this is the best way of ensuring that women understand the mode of birth that they have chosen. Furthermore, Butler (2017) states that midwives have the mandate to work with women from early pregnancy to prepare the families for normal childbirth. Upon the woman receiving the information and making an informed decision, the midwives need to be able to reinforce it each time they see the woman during the visits. Moreover, introducing the options earlier helps the woman to have time to reflect on the information given and to make a decision based on that information (Hinton et al., 2018).

In addition, the timing of the information on childbirth-choices is important as this is a process that women need to go through in order to make an informed decision. Early interventions and support need to be given to the woman following a primary caesarean section as this will help the woman to process it and prepare for the next birth if need be (Munro et al., 2017). Nascimento et al. (2015) also allude to the fact that women need information at the beginning of the ANC as this will equip them to make informed decisions. As the pregnancy progresses and with information being given, a woman's choice may change as a result of the educational

information they continue to get from the midwives or health professional that is looking after them, hence it should be an ongoing process (Soriano-Vidal et al., 2018).

6.5 MERGING OF THE RESEARCH FINDINGS

The merging of the research findings was ideal to consolidate the findings from the phase one objectives which sought to identify the concepts for the foundation of model development in this study. The merging was done through summarising the research results thereby identifying the challenges and finally bringing out the central concepts of the study as identified in Table 6. 5.

In this study, the findings consolidated with one another in that woman in the context under study had a high turn up of ANC attendance (96.7%) indicating the sense of responsibility on the side of the women to seek care at the hospital. Despite the high attendance for ANC, women shared their experiences that they had limited to no information on the different childbirth types for them to make an informed choice. They alluded to the fact that there was assumed choice in that all women that have low risk had no reason to be told about the different types of childbirth available and being accorded a choice. The women in this study reported receiving minimal to no information at all on childbirth-choices and being offered a choice contravening the Patient Charter (MoHSS, nd) and the Scope of practice of a midwife (ICM, 2017; Republic of Namibia, 2014) which encourages information giving. Midwives concurred with the experiences of women in that they attested to the fact that due to the staff shortages, the workload of the nurses becomes high and they concentrate on serving everyone in the queue rather than giving quality care to the women through giving them adequate information for them to make choices regarding birth.

Table 6.5 Summary of findings, conclusions, merging of findings and central concepts

Objective	Results	Conclusion	Merging	Concepts derived	Central concepts
1. Best practices	**Scoping review** Best practices in the facilitation of childbirth-choices • Shared decision making • Patient centred care • Implementation of protocols and guidelines • Informed consent/choice • Information giving	**Facilitation of childbirth-choices** • Shared decision • Patient centred care • Provisions of protocols and guidelines (resources) • Informed consent/choice • Information giving	**Facilitation of childbirth-choices** • Shared decision (Objective 1,3,4) • Patient centred care (Objective 1,2) • Provisions of protocols and guidelines (resources) (Objective 1,2,3) • Informed consent/choice (Objective 1,2,3) • Information giving (Objective 1,2,3,4) **Barriers in facilitation influences choices (objective 2)** Provision for childbirth-choices • Provision of rights	• Shared decision • Patient centred care • Provision of protocols • Informed consent • Information giving • Barrier influencing choice • Provision of rights • Woman centred care • Provision of childbirth-choices	Facilitation • Shared decision making • Patient centred care • Information giving • Provision of protocols and guidelines • Barrier modification • Provision of childbirth-choices Childbirth-choices • Right • Consent
2. Experiences of midwives	**Qualitative** Barriers in facilitation of childbirth-choices by midwives • Shortage of staff/workload • Timing of information giving • Information sharing during ANC • Cultural influences on childbirth types Lack of provision for childbirth-choices by the midwives • Provision of rights of women regarding care • Lack of women centred care • Enforcement of protocols and	**Barriers in facilitation influences choices** Provision for childbirth-choices • Provision of rights • Women centred care • Provisions of protocols and guidelines (resources)			

	guidelines on childbirth choices		(Objective 1,2) • Women centred care (Objective 1,2,3) • Provisions of protocols and guidelines (resources) (1,2,4)		
3. Experiences of women	**Qualitative** Women experience inadequate childbirth-choices • childbirth-choices • shared decision making Women experiencing inadequate Information on childbirth-choices • Information sources • Perceived information • Received information • Timing of information	childbirth-choices • Provision of childbirth-choices • shared decision making **Information for childbirth-choices** • Sources • Timing • Perceived information • Awareness • Actual information			
4. Different childbirth types and reasons	**Quantitative** • High ANC booking status - 96.7% • Childbirth type distribution (vaginal birth - 76%; caesarean section - 24%) • Maternal complications during pregnancy (91% none) • Reasons for caesarean section (previous caesarean section - 10.44%; Foetal distress - 4.77%)	• High ANC booking that could influence the facilitation of childbirth-choices and information • High caesarean section (24%) above the WHO recommendation (10-15%) that could be due to wrong or mal information			

Moreover, from the evidence above, best practices indicate that women need to be informed about the different childbirth-choices that are available as well as their pros and cons, and to allow them to make an informed decision during the course of the pregnancy. Shared decision making is a best practice that is lacking to an extent in the context under study.

6.6 CHAPTER SUMMARY

Chapter six presented and discussed the qualitative objectives, which were the experiences of women and midwives in the facilitation of childbirth choices. The data were presented using verbatim extracts and literature was also used to support the emerging data. Finally, the data were merged with the results from the other objectives and central concepts were derived from the data results. The following chapter (Chapter seven) focuses on the definition of concepts and the construction of relationships between the concepts and statements.

CHAPTER SEVEN

DEFINITION, CLASSIFICATION AND CONSTRUCTION OF RELATIONSHIPS BETWEEN CONCEPTS AND STATEMENTS

7.1 INTRODUCTION

Chapter six presented and discussed the qualitative objectives of the study, followed by the merging of the study findings for Phase one (Table 6.5) and central concepts and statement were derived. Chapter seven commences with contextualising the study findings from the scoping review as indicated by the dynamicaesarean section as well as the challenges identified in the study objectives summarised in Table 6.5. Furthermore, the chapter defines the central concepts and statements identified in Chapter six following the merging of the findings in Phase one of the study through four sub-objectives, classification and the conceptualisation of the study through the construction of relationships between statements and concepts as guided by the IP-SDM model (Legare et al., 2010) and the Nursing process (Orlando, 1961). This chapter focusses on Phase two of the study objectives through defining the central concepts with significant importance for the foundation of the development of the model for midwives in the facilitation of childbirth choices.

7.2 IDENTIFICATION OF THE CENTRAL CONCEPTS

The current study followed a pragmatism world view in that it sought to identify the concepts in the study through the pragmatist inquiry. The approach helped the researcher to understand the best practices in the facilitation of childbirth-choices through the scoping review, the different types of childbirth and their reasons in the facilities chosen and the experiences of women and midwives. From the identified concepts, the central concepts were "**facilitation**" and "**childbirth-choices**". The concepts identified in the study are summarised in Table 6.5 of

this study (see Chapter six). The central concepts revolved around the study aim, of which in the current study the ultimate goal was to develop a model for midwives in the facilitation of childbirth choices. Through the rigorous analysis of the objectives in Phase one, the following central concepts were identified: "**facilitation"** and **"childbirth-choices**" (Table 6.5, Chapter six).

7.2.1 Facilitation

Based on the scoping review objective in Phase one, the study found that for healthcare professionals to provide effective facilitation of childbirth-choices to women and their families, there needs to be shared decision making amongst the women and health care professionals. Shared decision making helps women to feel involved in their wellbeing and thereby make decisions regarding their health. In addition, for successful facilitation, midwives and doctors need to be aware of the protocols and guidelines that guide them in facilitating them in choosing a birth type that best suites them for them to have positive birth experiences. **Facilitation** is incomplete without the provision of information to women and their families on the different childbirth types, as well as the advantages and disadvantages of each, as a means for facilitating informed consent regarding childbirth. The best practices for facilitation concluded in this study can be summarised as follows: Facilitation involves midwives and other healthcare providers adhering and following guidelines in giving health information to women in order for them to make informed decisions regarding their childbirth.

The second objective in the study sought to identify the different childbirth types that are in the public health sector. Women showcased that they understand the importance of ANC as the attendance was 96.7% in terms of ANC bookings. Vaginal birth constituted 76% of the total births which is plausible in that physiological birth is what midwives need to ultimately advocate for. Midwives need to ensure that they take advantage of the high ANC attendance

for them to facilitate the women by giving them unbiased information regarding childbirth-types and this could also reduce the rates of previous caesarean section (10.44%) by encouraging VBAC. The caesarean section rate which stands at 24% may thus also be reduced through giving information and women understand and choose VBAC if permitting.

Midwives in this study also highlighted the barriers that hinder the facilitation of childbirth choices as shortages of staff, lack of choices, and subtle enforcement of protocols and guidelines among staff. Therefore, there is need for midwives to allude to the rights of women regarding childbirth as well as providing timely information for women to make informed decisions and thus creating positive childbirth experiences.

7.2.2 Childbirth-choices

Midwives in the public healthcare facilities need to ensure that the education of women in the ANC should include the different childbirth types that may be available or may occur. The importance of offering education about childbirth types is the readiness the woman will have in the event of any of the childbirth type. Through facilitation as mentioned before, women and their families need to be aware of the pros and cons of the different childbirth types. The rights of the women regarding childbirth types and the best available choices should be upheld through adherence to protocols and guidelines that guide the profession.

7.3 DEFINITION OF IDENTIFIED CENTRAL CONCEPTS

The identified concepts were "**facilitation**" and "**childbirth-choices**" which were defined independently using dictionaries, thesaurus, published peer reviewed articles and the internet were also explored to get the different interpretations and uses of the identified concepts. Moreover, the facilitation of childbirth-choices was the drive behind the whole research.

7.3.1 Facilitation

Facilitation emerged as a central concept in this study and it was defined according to the dictionary, subject and context under study in order to fully understand the meaning and interpretations. The purpose of the definitions was to help the researcher in the reduction and the final definition of the concept facilitation.

7.3.1.1 Dictionary definition "facilitation"

The following dictionary definitions were included in the study:

According to the Oxford Dictionary (2020), facilitation means to:

- "Make a **process** or **action easier**"

According to the freedictionary.com (2020), facilitation is:

- "To make **easier** or **less difficult**"

According to the definition.net (2020), facilitation is defined as:

- **Ease**
- **Alleviate**
- **Make easier**

According to the Cambridge online dictionary (2020), facilitation is described as:

- "The process of making something **possible or easier**"
- "the act of **helping** other people to deal with a process or reach an agreement or solution without getting directly **involved** in the process or discussion"

According to the Macmillan (2020) facilitation is defined as;

- "making it **easier** or **possible** for something to happen"

According to the Your Dictionary (2020) the following is the description

- Facilitation is the act of making something **easier or happen**

According to Association of Talent Development (2020)

- Facilitation is the act of **engaging participants** in creating, discovering and applying learning insights.

The thesaurus (Oxford, n.d) also had the following synonyms that may be used for the concept "facilitation" which are as follows:

- **Simplification**
- **Enablement**
- **Assistance**
- **Help**
- **Expedition**
- **Acceleration**

7.3.1.2 Subject definition "facilitation"

- According to Behruzi (2010) facilitation means **considering the values** of women, their **beliefs** and **feelings** and r**especting** the woman's **dignity** and **autonomy** during childbirth.
- Preis et al. (2018) concur that women should be facilitated according to the **beliefs** that they have and there should be **respect** of the choices that they make.
- According to Newnham et al. (2017), facilitation is the **provision** of **unbiased information** to women regarding childbirth-choices

  According to the online medical dictionary (2020), facilitation is the **encouraging o**f the patient to take more **responsibility** of their health

7.3.1.3 Context definition of “facilitation”

The contextual definition is explained as how facilitation was currently being done when the researcher undertook the study. The facilitation according to the context may not be the ideal or the best practice; however, it is the practice currently in place in the selected public hospitals. The definition of facilitation in this context could be concluded as:

- **lack or limited shared decision making,**
- **lack of patient/woman cantered care,**
- **biased information sharing,**
- **lack of childbirth-choices,**
- **relaxed protocols and regulations, and**
- **Existence of barriers that hinder the facilitation among women.**

The barriers in facilitation in the current context were expressed as there being **shortages of staff** hence the midwives become overwhelmed for them to give adequate information to the women regarding the childbirth choices. Furthermore, **timing of information** giving of childbirth types in this context was found to be applicable towards the end of the pregnancy only.

7.3.1.4 Reduction of identified criteria of the concept “facilitation”

According to Walker and Avant (2011), a reduction of identified criteria stems out of the definitions that the researcher made use of. In the current study, the researcher made use of dictionary, thesaurus, and subject and the context definitions to identify the reduced criteria. The following were identified following the dictionary and subject definition:

Table 7.1 Reduction of identified criteria for “facilitation”

Definition	Reduction of identified criteria
Dictionary definition: **Cambridge online dictionary (2020)** **Your Dictionary (2020)** **Association of Talent Development (2020)**	▪ Process ▪ possible or easier ▪ Help ▪ involved ▪ engaging ▪ Simplification ▪ Enablement ▪ Assistance ▪ Help ▪ Expedition ▪ Acceleration
Subject definition **Behruzi (2010)** **Lee et al. (2016)** **Homer et al. (2015)** **Munro et al. (2017)**	▪ considering the values ▪ their beliefs ▪ feelings u ▪ respecting the woman ▪ dignity ▪ autonomy ▪ encouraging ▪ responsibility
Context **Table 6.5**	Factors that hinder facilitation • Shortage of staff/workload • Timing of information giving • Information sharing during ANC • Cultural influences on childbirth types • **Lack of provision** for **childbirth-choices** by the midwives • **Lack of provision of rights** of women regarding care • Lack of **women centred care** • Enforcement of protocols and guidelines on childbirth choices

7.3.1.5 Reduction process of the identified criteria; “facilitation”

The following criteria in Table 7.2 were deduced as the essential and related characteristics of the concept “facilitation”.

Table 7.2 Characteristics of essential and related criteria for the concept "facilitation"

Essential criteria	Related criteria
Facilitation is a process of involving, engaging, assisting, helping and enabling women to make childbirth-choices	Considering values of women through o dignity o autonomy o respect o beliefs Provision of childbirth-choices by midwives through: o Information sharing o Enforcement of protocols and guidelines Provision of resources to ensure facilitation o Staffing o Timing Shared decision making o Information giving o Awareness of childbirth-choices

7.3.1.6 Definition of the concept "facilitation"

A deduction of the definition of the concept facilitation was formulated based on the criteria in Table 7.2.

Facilitation is an **enabling process** that includes **engaging, assisting, helping and involving women** and their **families** through the **assessment** of their **environments,** by considering the **values**, **beliefs and respecting the dignity** and **autonomy** for the women to make childbirth-choices through **information sharing**, **awareness, provision of the resources**, barrier **modification**, **enforcement of the protocols** and **guidelines** leading to **shared decision making, an informed woman and family,** and a **positive childbirth experience**.

7.3.2 Childbirth-choices

The gist of the study was central to the childbirth-choices and facilitation among women in the public healthcare facilities of Namibia. The dictionary, subject and contextual definitions were included in this study as described below. The dictionary definition saw the researcher splitting childbirth-choices to give an independent meaning of the words.

7.3.2.1 Dictionary definition of "childbirth-choices"

According to the Oxford Dictionary (2020), childbirth is defined as the:

- Process of giving birth to a child

According to the online Merriam Webster dictionary (2020), childbirth is defined as the:

- Act or process of giving birth to a baby: **parturition**

The researcher also used the thesaurus to find out the other words that may be used for the word childbirth and the search yielded the following results:

- Delivery
- Labour
- Childbearing
- Giving birth

The term choice or choices was also defined in this study according to the dictionary definition as follows:

- According to the Merriam Webster dictionary (2020), choice is described as an **option, alternative, preference, selection**
- Choice suggests the **opportunity or privilege of choosing freely**

The Collins Dictionary (n.d) defines choice as the:

- Act of **choosing or selection**
- The **power, right or chance to choose**

The thesaurus (Collins Dictionary, n.d) was also consulted in the study and yielded the following results

- **Selections**
- **Picks**
- Elections

- **Adoptions**
- **Choosing**
- **Varieties**

7.3.2.2 Subject definition: “childbirth-choices”

The subject definition of childbirth-choices was derived from different scholarly works that the researcher found to be relevant for the current study and through a scoping review as presented in Chapter four, Table 4.2 and finally the following definitions were derived:

- **Information sharing**
- **Shared decision**
- **Understanding women’s views**
- **Support systems**
- **Receiving accurate and realistic information**
- **Critical to obtain the women’s preferences**
- **Offer knowledge and support**
- **Enhancing the involvement of the decision making process**
- **Informed choice**
- **Involvement**
- **Participation**
- **Being heard**
- **Work closely with women**
- **Make decision**
- **Provide information**
- **Balanced information**
- **Educating**

- **Standardisation of medical practice**
- **Raising awareness on rights**
- **Free choice**
- **Introducing options early**
- **Deferring decision making**

7.3.2.3 Context definition “childbirth-choices”

In the context under study, childbirth-choices is defined, as there is a lack of rights and consent when it comes to childbirth choices. As portrayed in Table 6.5, women in the selected public hospitals of Namibia did not receive adequate information pertaining to childbirth types and neither were they given choices. The women in context have ‘assumed choices’ hence the choices are not availed to them and neither do they request them. According to the study findings, the following were the definition findings:

- **Lack of provision of childbirth-choices by the midwives**
- **Lack of woman centred care**
- **Poor adherence to the protocols and guidelines**
- **Infringement of the rights of women regarding care**

7.3.2.4 Reduction of identified criteria of the concept “childbirth-choices”

The reductions identified are as follows:

- The act of **enabling** women to **choose** how they **give birth,** thereby giving them the **responsibility** of the health decision
- Midwives should be in a position to offer women the **options** that are available for childbirth during the ANC visits and this will enable women to make **informed decisions**

Table 7.3 Reduction of the identified criteria of the concept “childbirth-choices”

Definition	Identified
Subject definition Reference (Refer to Table 4.2 of the Scoping review)	▪ Information sharing ▪ Shared decision ▪ Understanding the women views ▪ Support systems ▪ Receiving accurate and realistic information ▪ Critical to obtain the women’s preferences ▪ Offer knowledge and support ▪ Enhancing the involvement of the decision making process ▪ Informed choice ▪ Involvement ▪ Participation ▪ Being heard ▪ Work closely with women ▪ Make decision ▪ Provide information ▪ Balanced information ▪ Educating
Context definition Reference (See Table 6.5)	The study results yielded the following: ▪ Lack of provision of childbirth-choices by the midwives o Educating women on childbirth-choices ▪ Lack of woman/family centred care o Involvement of women in decision making o Women making the decision ▪ Poor adherence to the protocols and guidelines o Childbirth-choices o Provision of the rights of childbearing women o Universal human rights o Patient charter (MoHSS, nd) of Namibia o Robson Classification (WHO, 2017) ▪ Infringement of rights of women regarding care o Respect o Autonomy o Dignity

7.3.2.5 Reduction process of the identified criteria “childbirth-choices”

It is of essence that women in the public sector be accorded the information for them to make **childbirth-choices** regarding their pregnancies. There is need for involvement in the deliberation **process** until the women **choose** the **childbirth type** they prefer.

Table 7.4 Essential and related criteria of the concept “childbirth-choice”

Essential criteria	Related criteria
Childbirth-choices denote assessing the awareness of women, their involvement and participation in their health, thereby educating them and giving relevant information regarding birth	• Awareness o Childbirth-choices o Childbirth-choice rights o Protocols and guidelines • Involvement o Decision making o Process of facilitation • Participation

- Decision making
- Childbirth choices

- Education
  - Childbirth types
  - Childbirth-choice rights
- sharing information
  - Timing of information
  - Perceived information
  - Sources of information

7.3.2.6 Definition of the concept "childbirth-choices"

Childbirth-choices are a **women/family centred support system** aimed at provision through **awareness**, **involvement**, **participation**, **education, sharing information**, and **shared decision** in order for the woman and **family** to make right and informed decisions about childbirth choices.

7.4 DEFINITION OF THE STATEMENT "FACILITATION OF CHILDBIRTH-CHOICES"

The current study reverted to the main statement which is facilitation of childbirth choices. In this context, facilitation of childbirth-choices can be alluded to include **information giving**, **shared decision**, **women centred care, provision of protocols, barrier modification, provision of childbirth-choices, rights and informed consent**, by the midwives that are the primary caregivers of woman in the public sector (Table 7.5). Midwives have the mandate to **inform** women with **evidence-based information**, allow them to **process** it, and **guide** them in making decisions although not forgetting the **autonomy** of the woman to make an **informed decision.**

Table 7.5 Final reduction of the criteria "facilitation of childbirth-choices"

ESSENTAL CRITERIA	RELATED CRITERIA
Facilitation is an enabling process that includes involving, sharing decisions, engaging, assisting, helping by considering the values, beliefs, respect of dignity and autonomy for the women to make childbirth-choices through information sharing, awareness, provision of the resources, barrier modification and enforcement of the protocols and guidelines	• **Information giving** of realistic and unbiased information regarding childbirth-choices • **Shared decision making** after information has been received by the women • **Patient centred care** in that the opinions of the woman should be acknowledged for the realisation of a positive childbirth experience

	• **Provision of protocols and guidelines** that are the roadmap of the midwives to provide the best care • **Barrier modification** of the staff overload, timing of information sharing and also the type of information • **Provision of childbirth-choices** for the women to be aware and make decisions
Childbirth-choices are a women/family centred support system aimed at provision through awareness, involvement, participation, education, sharing information, shared decision for the woman and family to make right and informed consent (decision) about childbirth choices.	• **Right** by enabling the woman to choose the childbirth type, by giving information (**awareness**) of childbirth-choices and involvement in **decisions** • **Informed consent** through active **participation**, **education** and **shared decision making** in ANC

7.5 THEORETICAL FRAMEWORK AS A BASIS FOR CONCEPTUALISATION

The study adopted the Inter-professional Shared Decision Making (IP-SDM) (Legare, Stacy & IP Team 2010) model and the Nursing Process (Orlando, 1961, as cited in Toney-Butler & Thayer, 2021) to guide the researcher in developing a conceptual framework for this study. The researcher chose the IP-SDM model due to its appropriateness in health and its broadness as it encompasses many role players that are connected to the patient who is in the care of healthcare professionals. Contextualising the model to the study, midwives are the primary care givers of women in the public healthcare facilities of Namibia (Mlambo, 2018) and linking the model to the current phenomenon helped the researcher to clearly understand the phenomenon of childbirth-choice facilitation among women.

7.5.1 Inter-professional Shared Decision Making (IP-SDM)

The Inter-professional shared decision-making model by Legare et al. (2010) guided the development of the conceptual framework of the study. The researcher followed the elements in the IP-SDM which included the actors, process and the environment, which were key in ensuring decision making for childbirth-choices as well. Table 7.6 gives clear information on how the application of the IP-SDM to the study was done.

Following data collection, analysis and conceptualisation, the researcher came up with a conceptual framework that aided in the development of the model for the facilitation of childbirth-choices. The actors do not work in isolation hence the environment plays a major role in the assessment and planning stages. The woman, family and healthcare professionals are influenced by the environment they work in for them to successfully facilitate the childbirth-choices.

7.5.1.1 Actors

The actors according to the IP-SDM (Legare et al., 2010) include the patient, family and the healthcare professionals. In the current study, the actors relate to the pregnant woman, family members), nurse-midwives and medical doctors as shown in Table 7.6.

7.5.1.2 IP-SDM Process

According to Legare et al. (2010), the IP-SDM process includes the decision be made, information sharing during the process, values and preferences, feasibility, preferred choice, actual choice, implementation, outcomes and time. The process as identified in this study was applied through awareness, educating, adherence to protocols and guidelines, sharing of information and the modification of barriers in relation to the facilitation of childbirth-choices.

7.5.1.3 Environment

Through the lens of the IP-SDM model (Legare et al., 2010), the environment is described through the family and patient context and the IP team context. In this study, the environment was represented by the internal and the external environment. The internal environment included the healthcare facilities and within the facilities the organisational structure, protocols, guidelines and resources were included. The external environment is represented by the community, and the socialisation, culture, norms and experiences are within the community.

Table 7.6 Application of the IP-SDM model

Elements	Application
ACTORS	
Patient	Pregnant woman
Family	Family members
Healthcare professional	Midwives, nurses, doctors
ENVIRONMENT	
Family and patient context	External environment (community)- socialisation, culture, norms, experiences
IP team context	Internal environment (healthcare facilities) - organisational structures, resources, protocols and guidelines
PROCESS	The process includes:
Decision to be made	Awareness
Information sharing	Educating
Value preference	Adherence
Feasibility	Sharing information
Preferred choice	Modification of barriers
Actual choice	
Implementation	
Outcomes	
Time	

7.5.2 Nursing Process Theory of Ida Jean Orlando (1961)

The researcher adopted the Nursing process theory in the study to enhance the facilitation of childbirth-choices among women as they are a part of the decisions that they need to make during pregnancy and childbirth. Originating in 1961 from Ida Jean Orlando, the Nursing process aims at holistic care, client centred approach and evidence-based practice (Toney-Butler & Thayer, 2021). The application of the Nursing Process is tabulated in Table 7.7.

7.5.2.1 Assessment

Assessment refers to the collection of subjective and objective data (Toney-Butler & Thayer, 2021) when a patient presents at a healthcare facility. In this study, the assessment centres on the assessment of actors (nurse-midwives, doctors, and woman) and their environment (internal and external). The actors are assessed for their knowledge, roles, skills and the challenges they face with the facilitation of childbirth-choices. The internal environment assessment is done on the healthcare facilities, the organisational structure, resources, protocols and guidelines. Assessment of the external environment includes the family and

community the woman is coming from, which includes the socialisation, culture, norms and beliefs. Independent of the environment, the woman is assessed for her preferences, support system(s), beliefs and experiences if any.

7.5.2.2 Diagnoses

A diagnosis is referred to as a clinical judgement towards potential or actual health problems on the patient (Toney-Butler & Thayer, 2021). The application in this study involved the judgement on the actors for their skills, knowledge and roles in facilitation and those of the environment for potential or actual problems. In this study, the diagnoses is characterised by the lack of childbirth-choices, lack of woman centred care, non-adherence to protocols and guidelines, lack of provision of rights and the presence of barriers for the effective facilitation of childbirth-choices.

7.5.2.3 Planning

Planning refers to the formulation of goals and outcomes that have a direct impact on the patient (Toney-Butler & Thayer, 2021). Planning in this study included the identified problems in childbirth-choice facilitation in terms of the environment and the actors. In this study, planning for the provision of childbirth-choices include the provision of woman centred care, adherence to protocols and guidelines, provision of rights and barrier modification.

7.5.2.4 Implementation

According to Toney-Butler and Thayer (2021), implementation refers to the action to be taken to ensure that goals and outcomes are met. In this study, this includes the creation of awareness of childbirth-choices, educating women on childbirth types, involvement of women to actively participate in decision making, information sharing and availing resources. Implementation also includes the awareness of childbirth-choices by educating the woman on

the different childbirth types that are available. In addition, women's active involvement in their care as they make the decision following giving unbiased information on the childbirth types and ensuring that nurse-midwives are available to cater for the numbers of women attending ANC forms part of this process.

7.5.2.5 Evaluation

Evaluation refers to the reassessment of interventions implemented for a positive patient outcome (Toney-Butler & Thayer, 2021). In this study, the reassessment is done to note if there is any informed woman and family, shared decision making, positive birth experience.

Table 7.7 Application of the Nursing process theory

Element	Application to the study
Assessment	• **Actors** Women (knowledge, roles and responsibilities and challenges) Health care professional (knowledge, skills, roles and responsibilities, challenges) • **Environmen**t **External** (Community) - socialisation, culture, beliefs, experiences **Internal** (healthcare facilities) organisational structure, resources and protocols and guidelines
Diagnosis	These diagnoses are derived from the actors, and external and internal environment • Lack of childbirth-choices • Lack of woman centred care • Poor to non-adherence to protocols and guidelines • Lack of rights • Barriers [shortage of staff, culture, timing of information]
Planning	• Provision of childbirth choices • Provision of woman centred care • Adherence to protocols and guidelines • Provision of rights • Barrier modification
Implementation	• Awareness of childbirth-choices • Educating women on childbirth types • Involve women to actively participate in the decision making • Adequate midwives to ensure that they are not overwhelmed by women so as to give adequate information to the women
Evaluation	• Informed woman/family • Shared decision making • Positive birth experience

7.6 CONCEPTUALISATION OF THE FINDINGS AND ADOPTION OF THEORIES

The contextual dynamicaesarean section and challenges of the study were identified through the scoping review (Chapter four), the different childbirth type distribution (Chapter five), and the experiences of midwives and women (Chapter six) on how they facilitated and were facilitated during pregnancy. The central concepts of the study were identified through the merging of the study findings in Table 6.5 which were then defined to ensure their applicability to the current study. The researcher furthermore adopted two theories namely the IP-SDM model (2010) and the Nursing process (1961), to guide the conceptualisation of the findings. Through the rigorous processes described, the researcher formulated the conceptual framework (Figure 7.1) that guided the development of the model for midwives for the facilitation of childbirth-choices. The conceptual framework is furthermore described based on the theories and the findings that culminated from Phase one of the study. The conceptual framework included the actors, environment, dynamics, assessment, diagnosis, implementation and evaluation as illustrated in Figure 7.1.

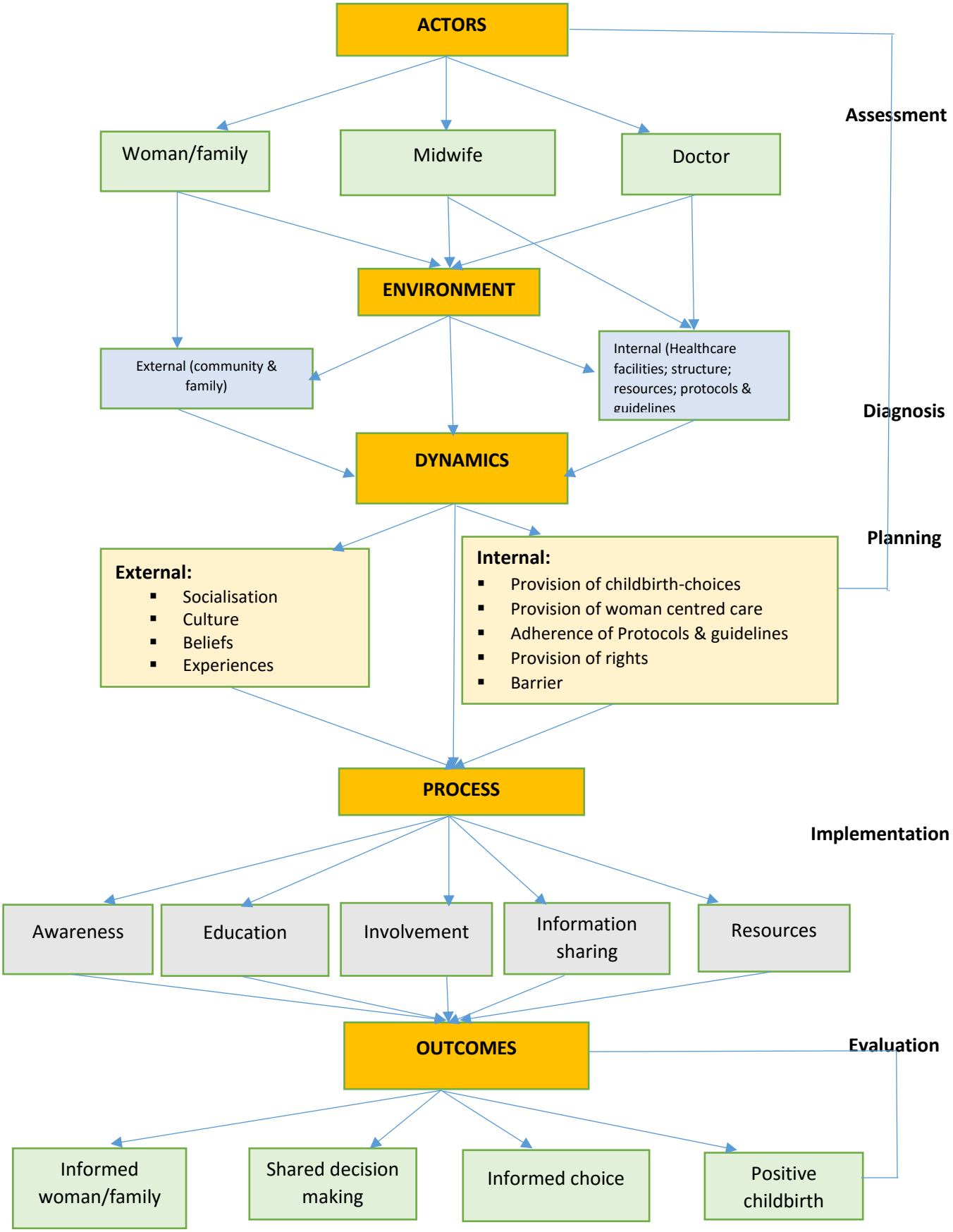

Figure 7.1 Conceptual framework of the study (Source: Author's formulation)

7.6.1 Actors

The IP-SDM model takes cognisance of different actors that are of relevance when a patient is to be involved in the shared decision making of their health and these are described below. The current study sought to understand how women are facilitated regarding childbirth-choices when they attend ANC. A description of the actors, their responsibilities, skills and the challenges are explained to bring clarity of the role they play in the facilitation of childbirth choices. The woman is the main actor, having the family, midwives and the medical doctor as support structures in the decision making, although these are in different capacities.

7.6.1.1 Woman

The woman may be described as the chief player in the process of childbirth-choice facilitation. According to Borelli et al. (2018), the woman is described as the "principal actor" as the woman comes for ANC thus inviting the healthcare providers to be present in her journey of pregnancy and childbirth. The woman allows the other actors into the whole process by informing them of the pregnancy that she now has.

According to the model, central to shared decision making is the patient, thus justifying the process as evidenced by the patient coming to a healthcare facility during ANC. The above agrees with the WHO, which advocates for patient centred care (WHO, 2018), and this is in agreement with the present study for midwives to focus on the woman who presents for ANC. In this study, the patient is the pregnant woman who presents at ANC and expects professional help as a way to begin the process of being facilitated. The findings of this study showed that 96.7% of women attended ANC during the period under study, which supports the fact that indeed women present at hospitals for them to be facilitated. ANC attendance contributes greatly to the experiences that women have in childbirth and this may instil fear or happiness during pregnancy and childbirth depending on how they are facilitated.

7.6.1.1.1 Knowledge of childbirth-choice

The woman presents at the healthcare facility for ANC as evidenced by the 96.7% booking rate made by women. However, the central question is, do the women have knowledge of childbirth- modes which are available? The research results suggest that women in the current context have knowledge which emanates from the previous experience as well as information from family and friends. Boz et al. (2016) attest that some women described their experiences as confusing and yet a decision has to be made anyway. The above affirms that women even with little to no information, end up having to make a decision which was also noted in this study as one woman attested that, “they just told me then that I need to give birth”. Bringedal et al. (2019) furthermore reiterate that women need different resources and abilities to cope and that they are greatly influenced by how information is retrieved. The data analysed in this study found that some women end up going with the flow as they are unsure and do not know that they even have any options.

Women in the study believed the healthcare professionals had to make the decision for them. Considering that most women that come to the public healthcare setting possibly to a greater extent do not have health insurance, this may be a determining factor of the information that they receive. This notion is supported by Attanasio et al. (2018), who state that shared decision making is less in women who belong to marginalised social groups. Inequalities in health are reported by Maswime and Masukume (2017) and Mlambo et al. (2020), as the facility may not have the information due to being overwhelmed with the number of women hence time constraints become a critical factor. On the other hand, women with private insurance also received biased information, thereby leading to medicalisation of birth. In addition, women who had previous caesarean section were to be referred to the medical doctor at 34 weeks, for a decision towards their birth to be made for them. It was however unclear if women had a lead in the decision making.

According to Borelli et al. (2018), women understand labour and childbirth as an unknown territory and hence this makes it central for facilitation to be prioritised. Midwives in the public sector assume the choices of women; however, women need to be treated individually (Stirling et al., 2018) and that facilitation begins at the first meeting and this has to be an ongoing journey from pregnancy and labour till birth (Borrelli et al., 2018). Considering the above, it can be concluded that the knowledge that women have of childbirth is influenced by the family (including friends) and healthcare practitioners that surround them. Therefore, the midwives as the primary caregivers, have the mandate to ask the foreknowledge of childbirth that every woman has and this serves as a departure point for facilitation.

7.6.1.1.2 Role and responsibilities in childbirth-choice facilitation

The roles and responsibilities of women in childbirth choice facilitation are indicated through being able to attend ANC as soon as they find out that they are pregnant. In this study, the uptake of ANC was significant as a total of 96.7% women attended ANC, meaning that they had contact with the midwives at one point in time in their pregnancy. Women need information on their rights in childbirth and this will help them in understanding their roles and responsibilities.

7.6.1.1.3 Challenges of childbirth-choice facilitation

The challenges faced by women in this study were presented through themes in Table 6.5. The experiences echoed lack of childbirth choices and rather assumed choices, as well as reduced shared decision making as the women did not receive information regarding the childbirth types. The women in the public sector of Namibia have limited to no choice in childbirth selection.

7.6.1.2 Midwife

The midwife is an independent professional who is guided by the scope of practice (Republic of Namibia, 2014) which emanates from the law and the confines of the discipline. In order to do justice to the description of the midwife, the researcher found it important to focus on the scope of practice (Republic of Namibia, 2014) of the nurse and midwife in Namibia, the scope of practice (Republic of Namibia, 2014) of a midwife according to the ICM, the core competences of a midwife as proposed by the ICM (2018), and the challenges that the midwives face in the facilitation of childbirth-choice. The scope of practice (Republic of Namibia, 2014) and the core competencies of midwives echo the skills, knowledge, roles and responsibilities of the midwife and they are intertwined in nature.

7.6.1.2.1 Skill and knowledge

A midwife is regarded as a professional who has undergone training and is registered with a midwifery board or nurses' board (ICM definitions) and based on the ICM essential competences (ICM, 2017). The knowledge of the midwives for them to facilitate childbirth choices includes the adherence to and knowledge of protocols and guidelines. The scope of practice (Republic of Namibia, 2014) of the midwife is broad and this study zoomed into the scope of practice (Republic of Namibia, 2014) of a registered nurse/midwife in Namibia, the ICM scope of practice of a midwife and the core competencies of a midwife.

a) *Scope of practice (Republic of Namibia, 2014) of a registered nurse/midwife in Namibia No 206 of 2014 (Government Gazette)*

The scope of practice (Republic of Namibia, 2014) of the registered midwife in Namibia is elaborate in identifying the 'patient' as the mother and the child (child also referring to the unborn). With the above in mind, the midwife needs to familiarise with the scope of practice (Republic of Namibia, 2014) to be able to identify the expectations in the profession and in

caring for pregnant women. In the scope of practice (Republic of Namibia, 2014) it is alluded that a midwife is required to render:

> "…scientific application of the **principles of midwifery** … the **providing of assistance** and **medical care** … including scientifically based **physical**, **psychological**, **social**, **educational**, chemical and technological means… in the course of **pregnancy** …" (Republic of Namibia, 2014)

The above extract can be viewed as the summary of what the midwife must do when facilitating women during their pregnancy. Firstly, the midwife needs to base the practice on the principles of midwifery when offering facilitation to women in the ANC. Midwives base their principles on physiological birth and thus, they promote vaginal birth by giving women enough and realistic information about vaginal birth. In this study, the midwives assumed that women knew about birth and not much detailed information was given as presented and discussed in Chapter six. Midwives confirmed the inadequate health information pertaining to childbirth owing to staff overload and time constraints. Therefore, from the above, despite the midwives being overwhelmed, there is need for information to be given to women pertaining to vaginal birth.

In addition, the scope of practice (Republic of Namibia, 2014) reinforces the **medical care** to be offered by the midwives. The women in the current study echoed reluctance when it came to caesarean section birth as they were told in the spur of the moment when a decision needed to be done. During the midwifery training, there is usually the abnormal labour syllabi content, which is taught, and with such training, this gives the midwife competencies to enact the role to explain the different types of childbirth to women, albeit in as much as they advocate for physiological birth. Midwives need to understand that despite advocating for physiological birth, there is need for them to **respect** the **rights** of women by giving them **information** which will equip them in **shared decision making** and resultantly **informed choice**. When the

midwife **provides assistance**, this echoes facilitation in whatever information that the women receive, but not to 'assume choices', but rather to ask about the preferences of women, their foreknowledge and past experiences if any, to help in decision making.

Secondly, the midwife must include the following in the care of the woman: **physical**, **psychological**, **social**, **educational, chemical and technological means applicable to health …** in the course of their pregnancy. Caring for a woman holistically means including all the above that is the physical aspect of the woman, such as caring for the pregnancy with routine ANC check-ups to make sure that she is alright. In addition, there is the psychological dimension which includes the midwife getting to know the woman and asking about any previous experiences that may be affecting the current pregnancy. The women in this study voiced that besides being asked which mode of birth they previously had; the midwives did not dwell much on their previous experiences. The social aspect includes the family and significant others of the woman as she does not live in isolation. Women in this study echoed having heard about childbirth from different sources outside of the health professionals. Furthermore, midwives have a role in educating women regarding pregnancy and childbirth types. It can therefore be summarised that as women are a part of a society and have had experiences of their own, midwives ought to **understand the experiences**, **identify the foreknowledge** and its **sources,** and identify the **support system,** and this becomes the departure point in **educating women** and **facilitating childbirth-choices**.

The midwife is furthermore supposed to "**facilitate** communication **by and with a patient** in the **execution** of the … and midwifery regimen" (Republic of Namibia, 2014) within the scope of practice (Republic of Namibia, 2014). The midwife in the above needs to always ensure communication with the woman under her care. The current study established that communication was not exactly what the women would prefer as some assumed that the 'decision of mode of birth was made for them' while the midwives assumed that women had a

choice or already had knowledge to make decisions. The scope of practice (Republic of Namibia, 2014) further states that midwives need to offer **effective advocacy** thus **enabling** the woman to receive the care she **needs**. The issue of **enabling** a patient gives the woman the **autonomy** to express her needs with regards to the childbirth she desires, as well as her standpoint as a way to enable the midwife to **facilitate** exactly what the **woman needs** and **educate her**, **clear misconceptions**, **create awareness** and **ensure shared decision making**, hence the facilitation of childbirth-choices.

b) Scope of practice of a midwife (ICM, 2017)

The scope of practice of the ICM is adopted by many countries as it is the international governing body of the midwives. This study took cognisance of the scope of practice in order to shape and align the model development with midwifery governing bodies. The application of the scope of practice helped in developing the model and this helped the researcher to stay in the confines of the guidelines of which the midwife has to work within. The following is the scope of practice of the midwife:

- 'A responsible professional and accountable professional working in **partnership** with women' (ICM, 2017 p 1)

The main aim in the facilitation of childbirth-choices is to acknowledge that women are partners in their health. Midwives have a mandate to treat women as such, hence enabling an environment that is inclusive and allows shared decision making for the woman. The women in the current study expressed that they did not know that they had choices. This goes contrary to the idea the midwife:

- 'Gives necessary support, advice, and care in pregnancy … the promotion of normal birth' (ICM, 2017 p1)

When midwives give support to women, this does not mean that they agree with the choices that women make. The point is to offer support, education, and awareness of the different choices available by giving women the time to digest the information and consult whomever they see best and then ultimately make a choice. Some midwives in this study assumed that if women were to be given a choice between vaginal birth and caesarean section, they would choose caesarean section, but this contrasts with the women as they expressed that if information is adequately given, they would make the best decision for their baby and themselves. Midwives are responsible for counselling and educating women regarding their health.

- 'Responsible for health counselling and education, not only for the woman but includes the family and community… antenatal education and preparation for parenthood' (ICM. 2017 p1)

Health counselling should not limit the information to be given as that infringes the right to information and freedom to choose. There is need for balanced information when giving it to women as this makes the women partners in decision making, thus valuing their autonomy and regarding their rights. In this study, many women voiced that information is given but not on the childbirth types or how they would deliver as it was assumed that they would be in the know.

c) Essential competences of Midwifery practice (ICM, 2018)

The essential competencies of midwifery practice are categorised into four, which are general competences, competences specific to pre-pregnancy and antenatal care, competency specific to care during labour and birth, and competencies specific to the ongoing care of women and new-borns. The current study focused on the first two mentioned competencies as they are more specific to the current study of the facilitation of childbirth-choices. A competency is a

skill that is combined with knowledge that is required to execute duties (Meriam-Webster Dictionary, 2020).

General competencies

The midwife, with regards to the general competences, needs to be **aware of the scope of practice (Republic of Namibia, 2014) and the law** that governs their practice and be accountable as a professional. In addition, the midwife is aware of the relationships that she has with women and should ensure that practice is evidence based. The midwife is also expected to uphold the trust of the public, which means that women and the society look up to the midwife as an epitome of knowledge and help when they are in ANC.

Furthermore, the midwife is expected to **educate** women about their **rights in sexual** reproductive health. Choice is a right that all women deserve but for it to be informed unbiased information should be given and the woman takes time and informs practice what they think is best for them. In the current study, women thought the decision for childbearing rested with the health professionals while some midwives assumed that if women are given a choice, they would choose caesarean section.

Women are to be the **central decision makers** in their care hence they need to be accorded that, and midwives have the mandate to advocate for women. In as much as midwives are advocates of physiological birth, there is need for them to accord the responsibility of making a decision to women by giving them all the information they need to know. In doing so, the midwife develops a comprehensive plan that respects **the woman's preferences and decisions**. The current study aimed at **knowing the woman**'s **experience** and knowledge, thereby helping the midwife to **educate**, **create awareness** and allow the woman to make **informed decisions** of childbirth.

Pre-pregnancy and antenatal competences

As the midwife is the primary caregiver for women in the public healthcare sector of Namibia, they need to have sound knowledge on pregnancy for them to be able to give the woman information that will help them in making decisions. The **information** to be given to the **woman** and **family** needs to be **accurate** and **clear** and meeting **individual needs**. Midwives have a mandate to treat each woman individually, thus the promotion of **woman centred care** as well as well as inclusivity and acknowledging the family and support system.

The competency encourages the **discussion of options**, **preferences** and **contingency plans** with **woman** and **support persons** and **respecting** their **decisions**. The competency dimension is clear in urging midwives to make facilitation about the woman and her family. The childbirth types are to be given as options to the woman when they come for ANC and the preferences of women must also be put into consideration. In as much as the woman has the preferences, unbiased information needs to be given in detail for the different childbirth types as this will curb uncertainties and provide a sense of helplessness when the choice is not what happens. A woman is an autonomous being and she should thus be accorded such and not dimply assuming that they know about childbirth.

7.6.1.2.2 Role and responsibility in childbirth choices

The role of the midwife according, to Stirling et al. (2018), is providing women with scientific and evidenced based information about the risks and benefits of the childbirth types. Furthermore, to ensure shared decision making and informed consent/choice in childbirth-choices, women should be given unbalanced information regarding the childbirth types. Based on the essential competences for midwives (ICM, 2019), they need to educate women, bearing in mind the autonomy of the women to make their own decisions. In the Namibian context, most midwives have undergone training of four years which is inclusive of General Nursing

and Midwifery combined and they should have the competencies to care for the women who are pregnant.

The first point of contact for the patient is when they require the decision to be made and this role can be played by the healthcare professional present. In the current study, the woman in the public sector first meets up with a nurse or midwife. Midwives in the public healthcare facilities are the primary caregivers to pregnant women (Mlambo, 2018). Midwives as the primary care givers need to encourage and inform women during pregnancy of the choices that they have inclusive of the pros and cons that each childbirth type may have (Bringedal & Aune, 2019). In this study, results portray that midwives are the first point of contact hence they become the initiators of the process of facilitation.

Despite the best childbirth type being physiological birth, in the absence of complications, there is need for the initiator of the process to ensure that women receive adequate and unbiased information. The booking status (96.7%) of women in this study is an illustration that women in the public sector at one point of their pregnancy come to the healthcare facility where there are professionals with expertise.

The midwife is trained to support the patient through the decision making process (Legare et al., 2010); however, the midwife guides and does not make the decision for the patient. The midwife in the public healthcare sector is the main coach hence she needs to be skilled and knowledgeable so as to be able to facilitate the decision-making. The midwife may not have direct influence on the decision that the women makes but has the information to guide women in decision making. Mselle et al. (2018), encourage family integrated care as part of respectful maternity care, thus the midwives do not have to make decisions for the women under their care. The findings in this study indicate that midwives' assumed decisions are already made when the women came to the hospital, and without any complications, midwives assumed that

the women would need physiological birth. Midwives in this study coached women to a lesser extent by giving them information only on vaginal birth which was also towards the end of the pregnancy when they assumed that the women were ready for the information.

The WHO (2018) developed the intrapartum care for a positive childbirth which centred on the care of women through a holistic, women centred approach, and taking cognisance of the human rights of the women under their care. Facilitation is an ongoing process and for women to be involved in decision making in the intrapartum care, they need knowledge from the ANC, be it the childbirth type or coping strategies. Facilitation being a process, requires the midwives to take up the role of informing women early for them to make the informed decisions (Borelli et al., 2018; Stirling et al., 2018).

7.6.1.2.3 Challenges in childbirth-choice facilitation

Childbirth choice facilitation in the current context is hampered by assumed choices and a fear of women choosing what midwives perceive as not being the right choice. In addition, midwives expressed that work overload is one of the major contributors in them not giving adequate health education on childbirth types. Midwives need to be aware of the law that governs them in-order for them to ensure that women are respected as autonomous beings. Policies and guidelines need to also be reinforced to encourage midwives to facilitate childbirth-choices among women under their care.

7.6.1.3 Medical doctor

The medical doctor in the Namibian context forms part of the healthcare professionals in the public sector settings. As evidenced by the findings within the study, medical doctors play an important role though this is at a later stage in the pregnancy of women. In this study, women are referred by the midwives at +/- 36 weeks, that is, if they had had a previous caesarean section, of which the current study in its interventions refutes the current practice. This is so

because there is a need to form relationships with women as they give them information so that they will be able to make informed decisions since trust would have been gained (Bringedal & Aune, 2019). Trust has to be built hence there is a need to begin the facilitation when the woman begins ANC.

7.6.1.3.1 Skills and knowledge of childbirth-choice facilitation

The medical doctor is a skilled health professional who is equipped with knowledge that assists in caring for the women referred to them in cases of shared role play in their management. The medical doctor in the current setting is exposed to women who require obstetric health information and care. It is noted in this study that women are referred for ultrasound scans and for other specialised interventions for any other complications that are outside the scope of practice (Republic of Namibia, 2014) of the midwife.

7.6.1.3.2 Roles and responsibilities in childbirth-choice facilitation

The medical doctor, like any healthcare professional, has a mandate to provide the woman and her family unbiased health information pertaining to childbirth. Thus, with regards to the doctor in relation to women who had previous caesarean section, there is need to give such women with the available options and also giving them time to understand the options, and also consulting them before making a decision on their behalf. Contingency plans are a part of information giving, which allows the women to understand that if something wrong happens, their choice may be disregarded for another option that would then be fully known to them, hence the creation of shared decision making and woman centred care.

7.6.1.3.3 Challenges of childbirth-choice facilitation

The midwife in the current setting, refer women to the doctor in their 36^{th} week or so if there is need for interventions which the medical doctor only can render. In as much as this may be

ideal, it needs midwives to at least along the ANC journey, give women information about different childbirth types as this will equip the women with knowledge. The importance of giving women information early on means that they will be able to research and thereafter when they meet the doctor, they will be discussing something of common interest which encourages shared decision making. According to the study findings, the women in this context do not have a mutual relationship with the doctor and that visit may be the first and last that they have with them, and in such a situation, we cannot expect informed choices to be made as the process is missed or absent.

7.6.1.4 Family

The family plays an important role and as such should be accorded space in the healthcare facilities. The inclusion of the family makes the woman to feel safe and the patients do not live in isolation and the healthcare professionals need to acknowledge the fact that they influence the decisions made by the patients.

7.6.1.4.1 Knowledge, roles and responsibilities in childbirth-choice facilitation

Midwives need to be able to involve or take cognisance of the fact that the woman lives in a society which influences her decisions. According to Mselle, Kohi and Dol (2018), in a study done in Tanzania, it was found that institutional norms were seen to be prohibitive of family involvement in the decisions that women make. There is a need for health professionals to change their mind set and identify the barriers that influence the decisions of women regarding the childbirth type and to encourage family participation and respecting the choices of women when appropriate (Mselle et al., 2018), for them to become more active participants. In this study, midwives reported that some women would ask if they could enquire with their family or partner first before they could make an absolute decision, which signifies the importance of giving room for the family support to be present.

7.6.1.4.2 Dynamics in childbirth-choice facilitation

Despite the current Covid-19 health regulations, women should be encouraged to bring along a partner or support system throughout their pregnancy and labour. RMC (2019) urges all stakeholders to include the family and significant others while caring for their loved ones. The core competences of midwives, the scope of practice (ICM, 2018; Republic of Namibia, 2014) and the Patient charter (MoHSS, nd) of Namibia all acknowledge the inclusion of the family in the care of women.

Figure 7.2 illustrates the actors that are involved in the facilitation of childbirth-choices; however, the women should be considered to be at the centre. The main aim of facilitation is to ensure woman centred care with shared decision making, thereby leading to informed choice.

7.6.2 Environment

The environment is an important determining factor in shared decision making in that it has the ability to influence the decisions that the women make regarding their childbirth type. Women are influenced by a number of factors that include family, previous experiences, professional patient interaction and social media that all influence the decisions that women make (Nascimento et al., 2015). The environment in the study was discussed under internal (healthcare facilities) and external environment (family/community).

7.6.2.1 Internal environment

The internal environment consists of the organisational structures and the protocols that are within the health facility where the woman attends. In addition, healthcare professionals that are involved with the care of the woman at that point in time or depending on the state of the patient, are a part of the internal environment. Midwives are the primary caregivers in the public healthcare settings and they need to be abreast with new information so as to give

accurate information to the women that are under their care. Hence women need to be given the chance to express their choices, given time to think about the options and the platform to discuss their preferred choices, concerns and fears and this culminates in facilitation (O'Brien et al., 2017). Within the context under study, the researcher noted that midwives have a routine whereby they communicate the childbirth-choice type almost towards the end of the pregnancy instead of making it a process from the very beginning of their encounter with the woman. Therefore, there is great need for organisational structures and routines to be based on the evidence and sound research when giving women information (Diamond-Brown, 2018; Nascimento et al., 2015). Midwives need to engage in meaningful relationships with women outside their organisational routines but with the needs of the women that present to them (O'Brien, et al., 2017). Furthermore, healthcare workers need to provide safe, effective, equitable, timely, efficient and client centered care (O'Brien et al., 2017) and in the current context, women are the clients who need to be provided with the facilitation information by the midwives and the doctors.

7.6.2.2 External environment

The external environment consists of the different factors that may influence the woman in their childbirth type choice and it includes but is not limited to family, socialisation, culture values and norms. The family in some instances may make or influence decisions on behalf of the patient hence involving them from the beginning is best (Loke et al., 2015). There is a need for health professionals to applaud the influence that the family has on the decisions and the support that women need during pregnancy (Preis et al., 2018). In the context under study, some women expressed not being woman enough if they had a caesarean section which then brings about negative experiences within the woman hence the need for midwives to facilitate this through identifying the environment the woman hails from.

7.6.3 Process

The IP-SDM model emphasises the process that has to be followed before a decision is made (Legare et al., 2010). Women attend ANC at different gestational weeks of their pregnancy and this is when the process needs to be initiated as this is not a one-day decision. When considering the micro level, that is the individual and the social environment that she hails from, midwives need to have background information on the prior knowledge and then give women information regarding childbirth types. By so doing, the midwife gives the women the time to discuss and clear any myths or misconceptions that may be there and also address the socio-cultural barriers that may be present (Bringedal & Aune, 2019; Mselle et al., 2018). In this study, women were not accorded the facilitation process as they were either informed about the childbirth type at the end of the pregnancy hence there was assumed choice.

Furthermore, investment in time is crucial for the patient to make sound decisions and also for the midwife to facilitate the childbirth choice. The first visit at ANC, childbirth-choice facilitation should already be initiated. Investment in time almost always ensures a satisfied patient. According to Munro et al. (2017), it is crucial to let women begin the facilitation of decision making soon after the preceding birth as this gives the woman the time to make informed decisions. Midwives should offer childbirth type information as soon as the woman presents at the ANC as this will help to clear any misconceptions the woman may have and thus help the women (Butler, 2017). As illustrated in Figure 7.1, the process is ongoing, ensuring that the woman is aware, educated and informed among others at the different stages of ANC and facilitation. The introduction of choices at the beginning of the ANC has an influence in facilitating childbirth-choices as the woman has time to think about the options that they have (Hinton et al., 2018; Loke et al., 2015).

7.6.3.1 Awareness

Awareness refers to the knowledge or perception of a situation (Oxford Dictionary, n.d). During the first contact with the patient, the midwives need to find out the foreknowledge that the women have on childbirth-choices. Midwives should then inform the woman of the two foremost different childbirth modes which are vaginal birth and caesarean section. The experiences of women need to be heard and all the information pertaining to childbirth should be at the disposal of women right from the onset (O'Brien et al., 2017). Furthermore, O'Brien et al. (2017), states that informed choice means more than receiving information but should include discussions that are in depth with the midwives that are known to them. The current study unveiled that women were not asked in-depth about what they knew about childbirth types or choices.

7.6.3.2 Educating

Educating can be described as informing on a particular subject (Oxford Dictionary, n.d). Support needs to be given to the patient during this process to ensure that the health outcomes are favourable. The midwife should facilitate ongoing care and support through the childbirth process to ensure that the woman experiences positive birth outcomes. The healthcare professionals need to involve women and their families from the beginning with accurate and realistic evidenced based information to women to make informed decisions about the birthing mode (Borelli et al., 2018). Borelli et al. (2018) further state that the facilitation should begin from the pregnancy at the initial meet up with the woman as this will avail ample time for the decisions to be made. There is need to educate all women during ANC on the benefits, risks and the severity of the two childbirth types that are available for women despite the foreknowledge that they may have (Loke et al., 2015). The notion behind informing women on both childbirth types which are available enables women to be active participants for choosing

a suitable mode of birth that is right for them without cohesion (Hinton et al., 2018; Loke et al., 2015).

7.6.3.3 Adherence to protocols and guidelines

Protocols and guidelines are the basis of any institution and the public sector in Namibia is no exception. The study through the scoping review identified some best practices that enabled women to have memorable and positive childbirth experiences. The Patient charter (MoHSS, nd) of Namibia, Human rights, Robson Classification (WHO, 2017) and the Universal rights of childbearing women (White Ribbon Alliance, 2011; Windau-Melmer, 2013) are among the protocols that midwives need to adhere to when facilitating childbirth choices.

7.6.3.4 Sharing of information

Clear tabling of the choices that are available for the patient should be clarified. The pros and cons of the available options should be shared professionally with the patient (Weltens et al., 2017). The midwife should be able to give the woman evidenced based information on the benefits and harms of the different childbirth options which are vaginal birth and caesarean section. According to Nottingham-Jones, Simmonds and Snell (2020), women sought support from friends and their own research hence the importance of identifying and communicating the information. O'Brien et al. (2018) further state that supportive relationships are key when facilitating childbirth-choices to women. The results deduced from the conceptual analysis state that information exchange was hampered by timing and also the information sharing was only on the childbirth type that the midwives found suitable for the woman. In other instances, when women needed to have a caesarean section the doctor was then involved to discuss this with the woman.

7.6.3.5 Modification of barriers

Barriers are hindrances that may obscure the carrying out of a task (Oxford Dictionary, n.d). Midwives need to be aware that the values and preferences of the woman have an effect on the choice that they make hence it is important to take cognisance of them. Women live in societies that have different norms and beliefs and the facilitation should be done in accordance with their beliefs and also the importance of strengthening the beliefs of women when facilitating the childbirth-choices (Preis et al., 2018).

The availability of expertise and time factor are important, and these should be considered and discussed with the patient hence they should not be ignored. Women may request a caesarean section and the possibility should not be ignored but rather discussed with the women, so they are able to make informed decisions. According to Attanasio, Kozhimannil and Kjerulff (2018), the availability of choice may also be influenced by the social group of a woman as marginalised women may be affected by not getting the information and as such the shared decision making may be compromised. Maswime and Masukume (2017) emphasise that in Africa, inequalities, inclusive of the availability of the procedure and reach to the facility with the capacity for undertaking the procedure are contributing to the final childbirth types that women may end up with.

With the input from the different actors in the process and evidenced based from the healthcare professional, the patient makes a preference. The healthcare professional may as well give a recommendation. Midwives as trained and knowledgeable professionals may give recommendations that are evidenced based but not rely on the implied preferred choice of the woman. Loke et al. (2015) emphasise that women need to make decisions that they believe to be right for them to have memorable experiences. Patients' choices should be identified together with their beliefs, values and their individual circumstances (Diamond-Brown, 2018).

7.6.4 Outcomes

It is important to revisit outcomes with the patient, their families and the healthcare team to evaluate if the outcomes were not desirable. The midwife, family and the patient need to evaluate the birth mode that the patient chose so as to applaud or disapprove the choice as the experience may be used as reference with the following childbirth and this may influence future choices. The outcomes of the shared decision process should leave the woman with an experience that is positive and worth reliving, and all the rights of women should have been respected by giving information regarding childbirth (Loke et al., 2015; WHO, 2018; O'Brien et al., 2017).

7.6.4.1 Actual choice

The patient makes the actual decision and this should be ideally consented to by all involved and also agreed to by the healthcare professional. The woman finally makes the actual choice with regards to the mode of childbirth. The midwife should preferably be in agreement with the actual choice in order to facilitate the implementation. It is important to understand the perspectives of women about childbirth as they are the main actors who consult the professionals regarding their care and hence they have to be accorded the final say in the actual choice (Borelli et al., 2018).

7.6.4.2 Informed woman/family

The aim of facilitation of childbirth choices is to create awareness among women and their families about the different childbirth types that are available and their role in being educated in this regard. Women, following unbiased facilitation, should be able to make informed decisions regarding their childbirth-choice even in the emergency cases as they are aware of what each childbirth type entails. When women are informed, they make rational decisions and this contributes to positive childbirth experiences.

7.6.5 Adoptions of the Nursing process theory (Orlando, 1961)

The adoptions of the Nursing process were discussed in line with Figure 7.1 and Table 7.7. The Nursing process ensures a holistic approach through the assessment of subjective and objective data, which leads to the diagnoses of the patient, thereby making way for implementation and evaluation. The Nursing process is an ongoing process which allows the patient and the nurse to revisit goals if need be for a positive experience. Contextualising the Nursing process to the facilitation of childbirth-choices, pregnant women attend ANC for them to be assessed and to receive information regarding birth, and midwives should be flexible and encourage women to allow positive childbirth experiences. The adoption of the Nursing process assisted the researcher to contextualise and map the development of the model for midwives for facilitation.

7.6.5.1 Assessment

Within the assessment stage, the woman (and or family) approaches the healthcare facilities to attend ANC services voluntarily. Assessment encompasses critical thinking on the part of the healthcare professional (Tony-Butler & Thayer, 2021) through subjective data from the woman and objective data from the part of the midwife. In the assessment phase, the midwife checks the foreknowledge of the woman and if they know their responsibilities and roles as based by the Patient charter (MoHSS, nd) of Namibia. The midwife has the duty to treat each and every pregnant woman differently hence leading to woman centred care. Midwives in the context under study attend to pregnant women that come for ANC follow ups and from the results of this study as depicted in Table 6.5, there are barriers that affect the assessment stage. In addition, the barriers include the high workload and shortage of staff hence the engagement with the women becomes reduced. Resultantly, a full assessment of women in identifying their personal experiences or foreknowledge is not fully identified, thereby leading to ‘assumed choices’.

7.6.5.2 Diagnosis

Diagnosis because of limited time in the assessment stage may become faltered. The diagnoses in the current study was evidenced by the lack of childbirth-choices, lack of woman centred care, poor adherence to protocols and guidelines, lack of rights as well as barriers as articulated in Table 7.7. Women have rights in healthcare that advocate for them to have information that will help them to make informed decisions. According to Toney-Butler and Thayer (2021), diagnosis in the nursing process takes cognisance of Maslow's Hierarchy of needs which articulates the importance of physical and emotional health. In cognisance of Maslow's Hierarchy of needs, women are not accorded their rights to choose the childbirth type in the current setting. Midwifery strives for the positive childbirth experiences (WHO, 2018) of all women regardless of the type of birth that the woman has as long as there is thorough preparation for birth. Women in this study verbalised that they were informed mainly about the diet and what to wear and nothing in detail about how they were going to give birth.

7.6.5.2.1 Actors

The actors in this study include the woman/family, the midwife and the doctor. In the public healthcare facilities, the woman initiates the process hence the process should be patient-centred (Toney-Butler & Thayer, 2021) when they present at ANC as they have identified that they are pregnant. This initial step suggests that women have become aware of the need for them to attend ANC as this is also reflected in the study findings which showed that 96.7% of women's files included in the study were booked for ANC. Bearing that in mind, midwives as the primary care givers for pregnant women should be there to facilitate women in the childbirth choice and birth preparations and ensuring that women are involved in each and every step of the way.

On the other hand, women may at one point in time of their pregnancy meet up with the doctor, specifically when there are complications that may arise along the way and previous births as well. The skill, knowledge and responsibility (Table 7.7) of the doctor is to ensure that the woman receives evidenced based information on the options for them to make informed decisions. The nursing process is no exception in equipping the woman, yet still with the onus of deciding what health intervention is good for them. In this study, women were referred to the doctor approximately at 36 weeks if there was a previous intervention like caesarean section for them to 'hear' what the doctor would say and plan for birth. There was little to no reassurance that women were actively involved in the decision making as some women actually thought that doctors and midwives would tell them what type of childbirth they would have.

The family in the present context has little to no contact as far as childbirth-choices are concerned. Respectful maternity care (WHO, 2018) and the Universal Rights of Childbearing women (White Ribbon Alliance, 2011) advocates for the presence of a companion throughout maternity care of a woman. The presence of a companion ensures that women are safe as misconceptions and fears may also be dealt with during the facilitation process.

7.6.5.2.2 Environment

The environment plays a major part in the nursing process as this is the heart of where the decisions take place. An environment that is enabling will ensure that women centred care is encouraged and sustained. The environment of the current study was constrained by a number of factors that were illustrated in Table 6.5 and these include but not limited to the staff compliment being overwhelmed. The midwives in this study expressed that as women are many, they do not dwell much on the childbirth types so the experiences and concerns of women are not fully explored. Policies need to be strengthened in the facility environments to ensure that women receive information during ANC which will in turn help them to make

decisions if needed as they would have been educated about it and this does not come to them as a new or foreign territory.

Within the environment, the midwife needs to assess the knowledge that the woman has on childbirth and this will provide insights on the areas of special focus when facilitating childbirth-choices. The experiences that women have may influence the direction that they need to take when settling for a childbirth type (Bell & Anderson, 2016). Women who may have had a bad experience may tend to be fearful of childbirth and this is not the positive childbirth experience as advocated for by WHO (2018). Critical thinking on the part of the midwife is needed in assessing the environment in which the woman finds herself in or is coming from. The midwife needs to assess if there are any supportive relationships that the woman has and this can be done through active listening skills as implored by the Maslow's hierarchy of needs, which is, love and belonging (Toney-Butler & Thayer, 2021).

On the contrary, the midwife needs to assess the environment that the woman finds herself in and that is the hospital set up. By so doing, the midwife needs to identify polices if any, that are in place to guide in the facilitation of childbirth-choices. The policies and guidelines need to be aligned with the international standards of care and these include the rights for childbearing women, the scope of practice (Republic of Namibia, 2014), and Patient charter (MoHSS, nd) amongst others. From the study findings, the midwives assumed that women knew that they had choices and at the same time the women assumed that midwives and doctors were the ones to tell them how they are going to give birth until the day was already there or when emergencies crop up.

7.6.5.3 Planning

Goals and outcomes are formulated in this stage and they need to directly impact the patient positively. Good planning is determined by how best the assessment and diagnoses were

done. Midwives have to understand the needs of their clients without judgement and preconceived ideas and assumptions as one midwife noted, that ‘if women are given choices, they will choose caesarean section’. This was disputed by one participant who verbalised that, ‘if l had received all the information, the birth experience would have been great……. I was scared from all I had heard’. In the planning stage, from the results of the study, it shows that there is need for midwives to plan the information that they will give women based on the assessment that was undertaken. The experiences and or preferences that the woman may have help in the planning of the facilitation implementation phase.

7.6.5.3.1 Provision of childbirth-choices

The provision of childbirth-choices to women is pivotal in ensuring that women are able to make informed decisions. According to Loke et al. (2015), it is critical for women to receive information on the benefits and risks of the different childbirth modes that are there and that is vaginal birth and caesarean section. The importance of planning for this is to ensure that all women during ANC have this education in case there are complications and the woman need to change a birth plan, then they are well informed of the benefits and the risks thereof.

7.6.5.3.2 Provision of woman centred care

Planning for women centred care ensures that the maternity unit has put up information that women need to know pertaining to the different childbirth types as well as the information on the Patient charter (MoHSS, nd) and the Rights of childbearing women. ICM (2017) advocates for women centred care, thus midwives in their capacity as primary care givers need to identify how woman centred care may be attained and this could be through shared decision making and involving the woman. Standard protocols need to be followed when planning how women will be involved in their care (Toney-Butler & Thayer, 2021).

7.6.5.3.3 Adherence to the protocols and guidelines

Midwives are governed by the scope of practice (Republic of Namibia, 2014) as well as the protocols in the facilities where they work. The scope of practice (Republic of Namibia, 2014) emphasises on the need for educating women by giving them the health information so that the women can make informed decisions. According to the Patient charter (MoHSS, nd) of Namibia, health information is the right of the patient and in as much as physiological birth is to be advocated for by the midwives, the different types must be known by the women. Respecful Maternity Care (WHO, 2018) encourages midwives to accord women the chance to be autonomous when it comes to decision making through empowering women with the information which will then enable to them make informed decisions.

7.6.5.3.4 Provision of rights

Midwives and healthcare professionals should be aware of the rights for women through in-service trainings and teaching them on Respectful Maternity Care (WHO, 2018), the Patient charter (MoHSS, nd) of Namibia, and the Universal rights of childbearing women (White Ribbon Alliance, 2011; Windau-Melmer, 2013) among others. Equipping midwives and doctors with knowledge guarantees greater compliance and ensuring that the implementation will be well executed and to the best of the positive experience of the client. Pamphlets and posters should be made available for women and their families to be able to access them and when implementing this, they will have foreknowledge.

7.6.5.3.5 Barrier modification

Barriers in this study included the shortages of staff, timing of information as well as the cultural influences on childbirth types. Barrier modification entails involving stakeholders in ensuring that women are able to receive the best care that enables them to have positive childbirth experiences. The most important modification is to ensure that midwives are able to

be open minded regarding ethnocentricity so as to accommodate women from different backgrounds and experiences (Preis et al., 2019). Great and feasible planning is needed to ensure that women have their preferences put into consideration, as well their values and beliefs not to be infringed (Preis et al., 2019). Furthermore, public health facilities need to have more staff that will ensure that midwives are not overburdened by the high turn up of women hence them being able to give appropriate health education. Maternity unit managers or matrons may need to advocate and motivate for more staff to be recruited o avert the shortage in the units.

7.6.5.4 Implementation

Implementation becomes successful based on how the assessment and planning was conducted. Midwifery interventions are required to ensure that all that was planned by the midwife and the woman and or family comes into reality. Implementation is best done when the woman has been considered from the beginning as the woman will take ownership of her health as advocated for by FIGO (2014). To ensure implementation in the facilitation of childbirth-choices, the midwife ensures awareness, education, adherence to protocols, sharing of information with women, and modifications of barriers as discussed.

7.6.5.4.1 Awareness

Awareness is described as the knowledge or perception of a situation (Oxford, n.d). In this study, women can be made aware of the different childbirth types that are available and that may occur despite being an emergency or a planned birth plan. Midwives have a mandate to create awareness on the universal rights for childbearing women, the availability of choices, the patient charter (MoHSS, nd) and the roles of the midwives and other health professionals that may assist them during pregnancy. Awareness is strengthened by midwives through educating women and their families on childbirth-choices.

7.6.5.4.2 Educating

Midwives as educators need to execute this stage by ensuring that their knowledge and skills on the different childbirth types will enable women to understand. The different childbirth types need to be explained to women for them to understand the pros and cons of the different types. Education enhances the understanding of individuals and clears any misconceptions and myths that women may have. In this study, perceptions of failing or being a failure when a woman had had a caesarean section may be corrected when a woman totally understands that in some cases there is need for the woman to be operated on in order to save both the unborn foetus and the mother. Implementation ensures that midwives identify and give unbiased information to the women that are under their care.

7.6.5.4.3 Involvement and participation

Shared decision-making is being advocated for as women are autonomous beings hence, they can make informed decisions on their own. One respondent highlighted that midwives should not ‘make them feel bad if they choose a caesarean’. Such a verbatim finding illustrates that women feel intimidated or bad if they must choose a certain type of birthing type which is also alluded to by Oliveira and Penna (2016), who state that women are not proactive when it comes to decision making. This should not be so if awareness is created, education is well implemented and women are involved throughout the process right from assessment when they present for ANC (Homer et al., 2015; Mohamed & Fouly, 2016). Not only should women participate but they need to actively participate right from the beginning when rapport is established and fears are identified and the goals and objectives identified, then implementation becomes a win situation.

7.6.5.4.4 Sharing of information

According to Cutajar and Cyna (2018), information sharing stems from the assessment when the midwife identifies and enquires about the knowledge that the woman has on childbirth. The fears and myths that the women may have are then identified and corrected by giving women evidenced based information of the different types of childbirth and the benefits and disadvantage of each type. Following the information sharing about the advantages and disadvantages of vaginal birth and caesarean section, the midwife needs to ensure that the information is available to the woman at any given time depending on the need. Women in this study voiced the different times they thought were ideal for receiving the information; at the beginning of the pregnancy, throughout and some at the end. Worth noting is the unplanned changes in birth plans which may be due to maternal or foetal factors. It therefore becomes imperative that implementation of information sharing becomes part and parcel of each and every visit that the woman has. Continuous information sharing helps the woman to make an informed decision based on the information received.

7.6.5.4.5 Provision of resources

Implementation may be difficult due to the lack of resources in the public health sector (Maswime & Masukume, 2017). Despite the fact of resources being limited, women may be informed of the feasibility of the childbirth type of their choice and through discussion and involvement, women may choose the best childbirth type which is also available to them at the time. Empowering women with information even outside the feasibility of the type encourages woman centred care as well as recognising the autonomy and right to information that they have. Upon evaluation, which is the next step in the nursing process, midwives are able to identify gaps and hence improve care.

7.6.5.5 Evaluation

Positive patient outcome is the ultimate goal (Toney-Butler & Thayer, 2021; WHO, 2018) and this should be what every midwife strives to achieve for every woman that comes for ANC. This step may be conducted at the end of the facilitation process or frequent reassessment depending on the need for emergencies in the change of birth plan which could be hypertension as one participant stressed that their plan changed due to a complication and they were not ready as they were not fully aware of the new mode.

7.6.5.5.1 Actual choice

The choice that every woman makes needs to be assessed to ensure that it was the best possible for the woman based on her preferences, beliefs, knowledge and values. Evaluation more often than not has to be done once the woman has birthed. Inclusive of the evaluation should be the information the woman had during ANC, and how and when it was presented to her. Evaluating this helps the midwife to identify if the woman and family had a childbirth of their choice and what information led them to the decision (Benyamini et al., 2017; Boz et al., 2016).

7.6.5.5.2 Informed woman/family

The culmination of the facilitation of childbirth-choices is to have women and families that are well informed of the different childbirth types that are available. In addition, timely information needs to be given to women during pregnancy and throughout the pregnancy as well as during the birth itself (Borelli et al., 2018). Evaluating the extent to which women and families are helps midwives to plan and improve any areas of shortcomings if any with regards to how to facilitate childbirth-choices.

7.7 RELATIONSHIP OF THE STATEMENTS

"A relational statement declares that a relationship of some kind exists between two or more concepts" (Grove & Gray 2018, p. 134). The relational statements in this study stem out of the essential and related criteria, the concepts as well as the mental map of the researcher and they are as follows:

- Women are **assessed** for their **knowledge, beliefs, support system** and **experiences** within the environment (**external- family and community**) that they are coming from and the healthcare facilities (**internal environment**)
- Facilitation of childbirth-choices occurs within the healthcare facilities (**Internal environment) (ANC)**
- The **facilitation process** includes the **awareness**, **education, involvement** of women, **information sharing** and **provision of resources** to enable **childbirth-choices**
- Midwives assess (**Assessment and diagnoses**) the need of the woman and **plan** the **implementation** of care ensuring that **unbiased information** is given to the woman and family to make **informed choices**
- Effective **facilitation** of **childbirth-choices** involves the provision of childbirth choices for women by midwives attending to them
- Midwives need to create an **environment** for women that **promotes shared decision making** through **involvement** and **woman centred care**
- Healthcare facilities (**internal environment**) need to ensure that **guidelines** and **protocols** are adhered to and implemented in their settings to ensure the provision (**process**) of evidenced based **facilitation of childbirth choices** that will ensure an **informed woman** and **family**, **shared decision**, **informed choice** and a **positive childbirth**

7.8 PROPOSED STRUCTURES OF THE MODEL

The proposed structure was guided by the identified central concepts, that is, 'facilitation' and 'childbirth-choices', the IP-SDM and the Nursing process. The IP-SDM model was adopted as well, together with the main concepts, that is, the actors, environment and the SDM process (Table7.6) and through the Nursing process (Table 7.7) which included the assessment, diagnosis, planning, implementation and planning. Following the central concepts, the IP-SDM model (Legare et al., 2010) and the Nursing process (Orlando, 1961), the proposed structure has three phases which are the initiation phase, facilitation phase and the terminal phase.

7.8.1 Structure for initiation phase

The proposed structure for the initiation phase comprises of the actors and the environment that have a direct effect on the facilitation of childbirth-choices for women. The actors refer to the midwife, pregnant woman, family and medical doctors. In the structure, the environment represents the community and the healthcare facilities that the actors are within. Figure 7.2 depicts the proposed structure with the woman in the middle as both environments have an effect.

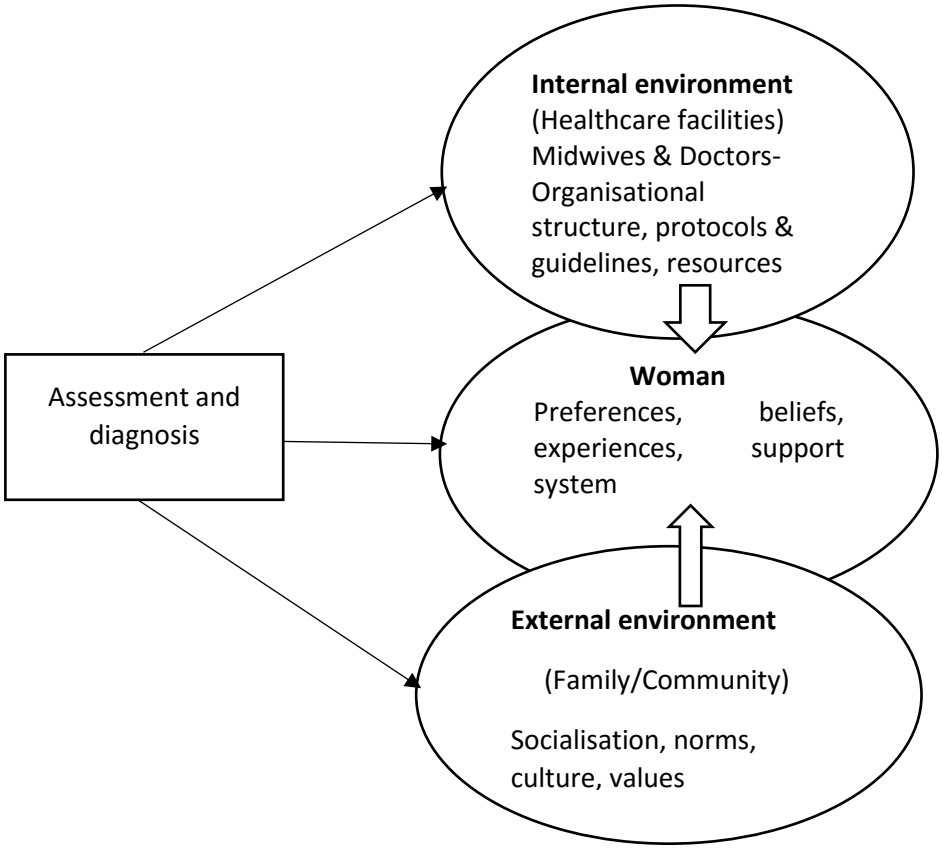

Figure 7.2 Proposed structure for initiation phase

7.8.2 Structure of the facilitation phase

The proposed structure for facilitation comprises of the planning for the facilitation phase as derived from the study results. Planning will include the provision of childbirth choices, provision of woman centred care, adherence to protocols and guidelines, provision of rights and barrier modification as articulated in Table 7.7. Figure 7.3 proposes the structure for the facilitation phase and also includes the implementation of facilitation of childbirth-choices through awareness of the childbirth-choices by education of the childbirth types, the rights of women when it comes to childbirth-choices as well as involving women in their care. The information given needs to cater for the perceived information as well as when to inform the woman of the different childbirth types that are available (Figure 7.3).

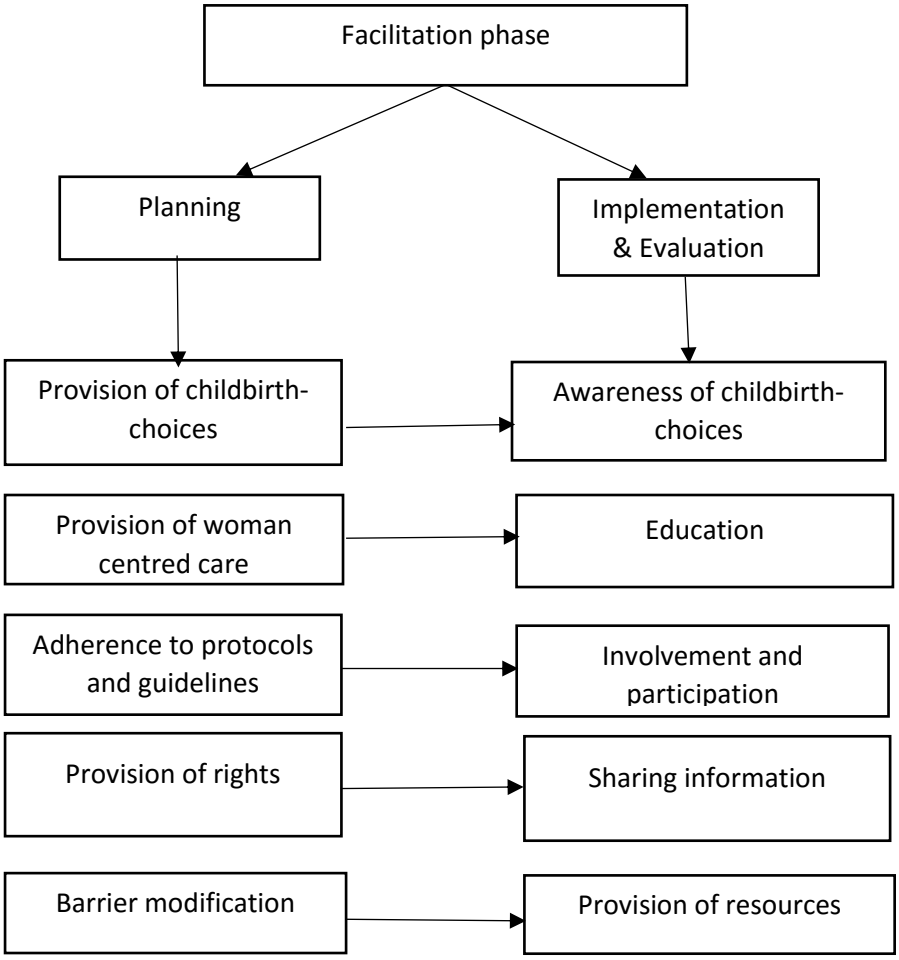

Figure 7.3 Proposed structure for the facilitation phase

7.8.3 Terminal phase

The proposed structure for the terminal phase which is the outcome of the facilitation of childbirth-choices is depicted in Figure 7.4. The outcome as referred to by Legare et al. (2010) in the IP-SDM, explains the result of shared decision making that will result in an informed patient. Figure 7.4 illustrates the proposed structure of the terminal phase, that is, an informed woman and family, shared decision making, informed choice and a positive childbirth.

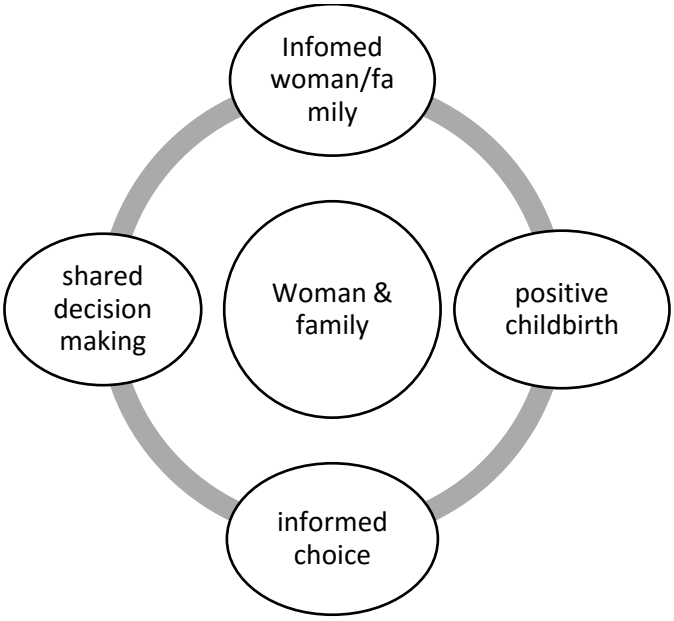

Figure 7.4 Proposed structure for the terminal phase

7.9 CHAPTER SUMMARY

Chapter seven was the culmination of the contextual dynamics and challenges of the study and identification of the central concepts (phase one), which was followed by the conceptualisation of the findings and adoption of the IP-SDM model (Legare et al., 2010) and the Nursing process (Orlando, 1961), to formulate the conceptual framework. Conceptualisation of the findings guided the development of the model for midwives for the facilitation of childbirth-choices. Relationship statements were identified from the derived concepts of the study. Proposed structures for model development were also identified and described, that is, what they entail. Chapter eight focuses on the description, evaluation and operational guidelines of the model for midwives for the facilitation of childbirth-choices.

CHAPTER EIGHT

DESCRIPTION, EVALUATION AND DESCRIPTION OF THE GUIDELINES OF THE MODEL FOR MIDWIVES FOR FACILITATION OF CHILDBIRTH-CHOICES

8.1 INTRODUCTION

Chapter seven defined and conceptualised the concepts that were identified in the study following the analysis and in cooperating the IP-SDM (Legare et al., 2010) and the Nursing process (Orlando, 1961), which helped the researcher in the development of the model. The purpose of this chapter was to describe the model that was developed in chapter seven and give meaning to the reader in detail. The aim of this chapter was to describe a model for midwives for enhancing the facilitation of childbirth-choices among women under their care. The evaluation of the model was also described in detail in this chapter as proposed by Fawcet and Parse (2005), to get an understanding of its applicability to practice. For a model to be fully functional, it has to be accompanied by guidelines to operationalise it, and these are also included in the current chapter.

8.2 MODEL DESCRIPTION

The description of the model is purposed to enlighten the reader on the modalities in order to gain an understanding of the phenomenon under study and the results thereof. Model description is articulated under the following headings: overview of the model, purposes of the model, structure of the model, nature of the model and process of the description of the model.

8.2.1 Overview of the model

A presentation of the model for midwives for facilitation of childbirth-choices among women has been incorporated below (Figure 8.1). For the overview of the model, the researcher describes the different components and their importance to the whole model. The model was designed under the guidance of the IP-SDM model and the Nursing process for it to be more

conclusive and clearer. The model clearly depicts the facilitation process that midwives need to undertake when caring for pregnant women in ANC.

Firstly, before the facilitation can take place, a needs analysis has to be undertaken and in the present model, it is represented by the assessment stage which seeks to understand the woman and the environments that she finds herself in. Secondly, when the midwife and the woman and family have identified the needs, possible challenges and the environments they are in, then the need for planning arises based on the needs. Following planning, there is a need for implementation to ensure the awareness of the woman and her family through education, involvement in shared decision making and availing the different types of childbirth. Last but not least, the need for the outcome to be positive and woman/family centred for them to make informed decisions on the childbirth type of their choice.

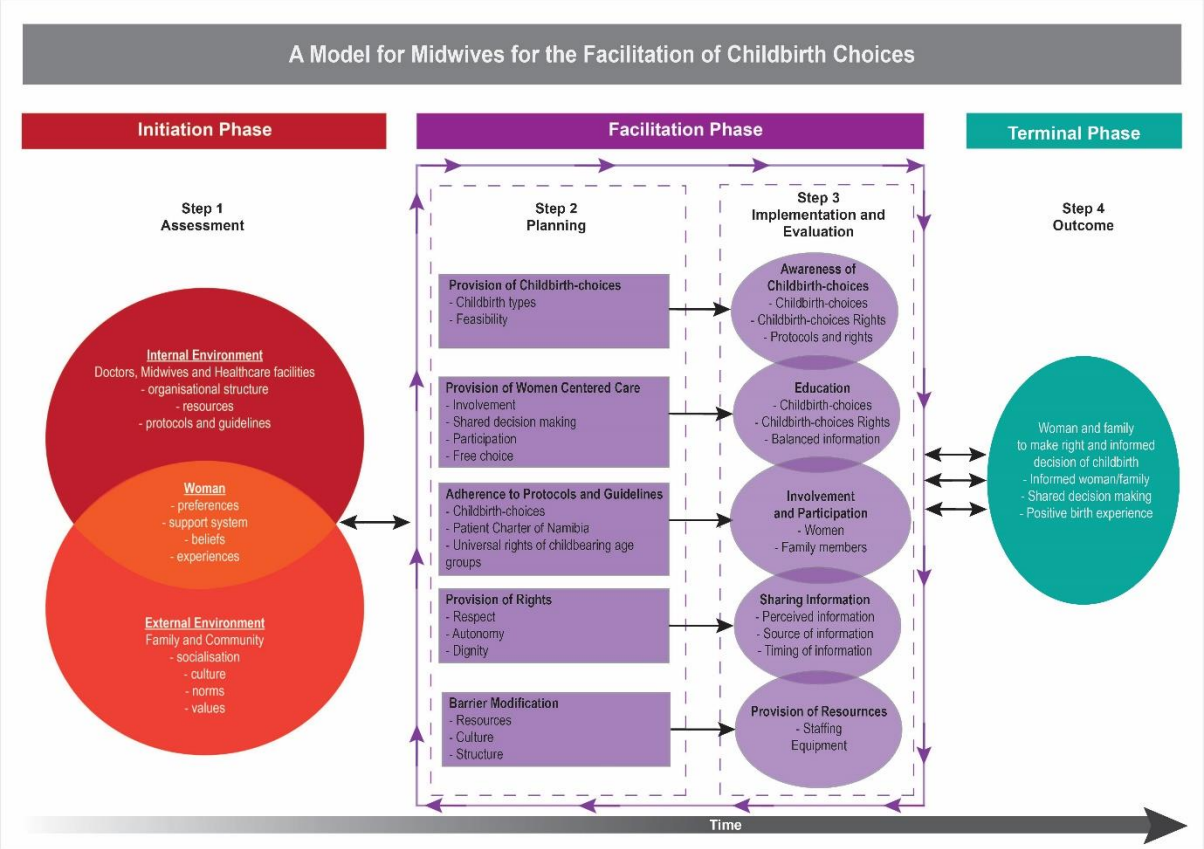

Figure 8.1 A model for the facilitation of childbirth-choices (Source: Author's formulation)

8.2.2 The purpose of the model

The purpose of the model is to be a guiding tool for midwives when facilitating childbirth-choices among women, thereby helping to give women a voice which must be heard. The activities that are further described in each phase are to ensure that facilitation for childbirth choices is done in an evidenced-based manner. Being unheard in the previous experiences may negatively affect future pregnancy experiences if needs analysis is not done. Furthermore, fears and misconceptions may also be communicated and clarified before the woman gives birth or makes a decision. The incidence of repeat caesarean section may be reduced as this has contributed significantly in the reasons for caesarean section among women in the different participating hospitals for this study.

8.2.3 Structure of the model

The model structure elaborates the components of the model for easier understanding. The model structure in this study is discussed under the assumptions of the model, the definition of the central related concepts and the theoretical definition of the central related statement.

8.2.3.1 The assumptions of the model

Assumptions relate to statements that are taken for granted or may be considered true in as much as they have not been tested scientifically (Grove & Gray 2018). The assumptions in this model are based on the facilitation of childbirth-choices by midwives in healthcare facilities. The study adopted the IP-SDM model (Legare et al., 2010) and the Nursing process (Orlando, 1961). The following are the assumptions underlying the model for midwives for the facilitation of childbirth-choices:

- Facilitating childbirth-choices requires midwives, doctors, pregnant women and their families to plan, implement and evaluate the childbirth type for all women
- An assessment of the woman's preferences, her support system, beliefs and experiences, if any, have an impact on the facilitation of childbirth-choices to be a success. An assessment of the actors' roles and responsibilities together with the environment helps planning to be specific, thereby making implementation goal oriented for a positive outcome.
- Facilitation of childbirth-choices is an **enabling process** that includes **involving** women and their families**, sharing decisions, engaging, assisting, and helping** women to make informed decisions about their childbirth-choices.
- Facilitation of childbirth-choices takes place and is considerate of the **values**, **beliefs**, and has **respect** for the **dignity** and **autonomy** of the women
- Through facilitation, women make childbirth-choices through **information sharing**, **awareness, provision of the resources**, **enforcement of the protocols** and **guidelines.**

- The midwife (actor) aims at the provision of **awareness**, **involvement**, **participation**, **education, information sharing**, and **shared decision** in order for the woman and family to make the right and informed decision about childbirth-choices.
- Facilitation of childbirth-choices includes **information giving**, **shared decision**, **and women centred care, provision of protocols and guidelines, barrier modification, and provision of childbirth-choices, rights and informed consent**.

8.2.3.2 Theoretical definition of the central related concepts (facilitation" and "childbirth - choices")

The central related concepts of "facilitation" and "childbirth-choices" were identified in this study and they are defined as follows:

Facilitation is an **enabling process** that includes **involving, shared decision making, engaging, assisting, helping** by considering the **values**, **beliefs**, **respect** of **dignity** and **autonomy** for the women to make childbirth-choices through **information sharing**, **awareness, provision of the resources**, barrier **modification**, and **enforcement of the protocols** and **guidelines.**

On the other hand, childbirth-choice is defined as follows:

Childbirth-choices are a **women/family centred support system** aimed at provision through **awareness**, **involvement**, **participation**, **education, sharing information**, and **shared decision** in order for the woman and **family** to make right and informed decisions about childbirth choices.

8.2.3.3 Theoretical definition of the central related statement ("facilitation of Childbirth choices")

The central related statement was derived from the concepts that were identified in the study and this may be defined as follows:

In this context, facilitation of childbirth-choices can be alluded to include **information giving**, **shared decision**, **women centred care, provision of protocols, barrier modification, provision of childbirth-choices, rights and informed consent**, by the midwives that are the primary caregivers of woman in the public sector (Table 7.5). Midwives have the mandate to **inform** women with **evidenced based information**, allow them to **process** it, and **guide** them in making decisions although not forgetting the **autonomy** of the woman to make an **informed decision.**

8.2.4 Nature of the model

The nature of the model gives a more detailed description of the model itself. Different concepts and elements were used to come up with the model. Within the model, different colour codes were used and this has some significance. In the initiation phase, the red colour predominantly stands out as it signifies the importance of assessment in the facilitation of childbirth-choices. The researcher adopted the triage colour **red** which signifies that immediate attention is needed. In the current study, the researcher chose red to signify the need to attend to all women individually and identify their needs regarding childbirth, hence an individual assessment is to be made.

Within the facilitation phase, the woman is represented by the **orange** colour, which is identified as the colour of excitement, enthusiasm and determination. The symbolism tallies well with the expectant mother as feelings of joy, excitement and happiness are also felt by a woman when they find out that they are pregnant, and they are determined to ensure that all goes well.

The facilitation phase in the model is portrayed in the **purple** colour which symbolises the future, compassion and wisdom. Following the midwife identifying the needs of the woman, the future which is the childbirth, needs to be planned for, implemented and evaluated and this could be done several times to ensure that the childbirth is a memorable experience for the

woman. The dotted line that surrounds the facilitation phase signifies the constant planning when the need arises, to ensure that the childbirth-choices are well facilitated. Within the facilitation phase, arrows are continuous signifying that planning and implementation can be a continuous process as the midwife and woman sees fit. Pregnancy is a closed book and as revealed by the study, some women begin the road of facilitation poised for a vaginal birth or caesarean section and along the pregnancy life happens and there is a need for planning.

The terminal phase is symbolised by the colour **green** which represents life, renewal, freshness and safety. Following the identification of needs, the midwife informs and educates the woman to create an awareness of the childbirth-choices through involvement, shared decision making, barrier modification and provision of rights, the woman is enabled to make an informed decision regarding childbirth. The back to front **arrows** in **black** and **bolded** signify that the facilitation continues and be it that as it may, the woman changes willingly, or complications arise but there is room to revisit the information within the facilitation phase.

Time is represented by a bold continuous **black** arrow that signifies boldness and not tiring. In the context under study, midwives are encouraged to ensure that the facilitation process commences at the first contact and continues with each visit the woman makes to ANC and not just at one specific visit as is portrayed by the findings of the study.

8.2.5 Process of description of the model

The process for describing the model was done as guided by the three (3) phases that were included in the model as described individually.

8.2.5.1 Phase one: Initiation phase

The initiation phase (Figure 8.2) marks the beginning of the facilitation when the woman presents at the healthcare facility for ANC. In the initiation phase, there is **Step 1** which is **assessment** as an important aspect to begin facilitation. The midwife has a mandate to ascertain their own prior knowledge in terms of the facilitation of childbirth-choices. Apart from the

knowledge of the different childbirth types, the midwife also needs to ascertain their skills and the resources to ensure smooth facilitation.

Figure 8.2 Initiation phase

The midwife in the initiation phase gets the opportunity to engage with the woman for the first time and identifying the childbirth preferences the woman has, what support system they have during the pregnancy, and their beliefs on childbirth and experiences if any. Identifying the needs of the woman recognises the woman as a holistic being who does not live in isolation of the environment, they find themselves in.

The internal environment consists of the healthcare facilities and these relate to the organisational structure, protocols and guidelines in relation to the childbirth choices and the resources to ensure positive childbirth. Despite the internal environment playing an important role, there is also the external environment that consists of the community that the woman came from. The community highlights the socialisation that the woman has had, the cultural aspects inclusive of norms and the values pertaining to childbirth.

8.2.5.2 Phase two: Facilitation phase

The facilitation phase (Figure 8.3) commences once the midwife and the woman have established the environments and the attributes for each one of them. The initiation phase acts as a drawing board to identify the needs of the woman in terms of the facilitation of childbirth-choices. Phase two is divided into two steps, namely, planning and implementation/evaluation. The **planning** step (**Step 2**) sets out the midwife to look into the activities that should occur during the facilitation and they include the provision of childbirth-choices, provision of women centred care, adherence to protocols and guidelines, and the provision of rights and barrier modification.

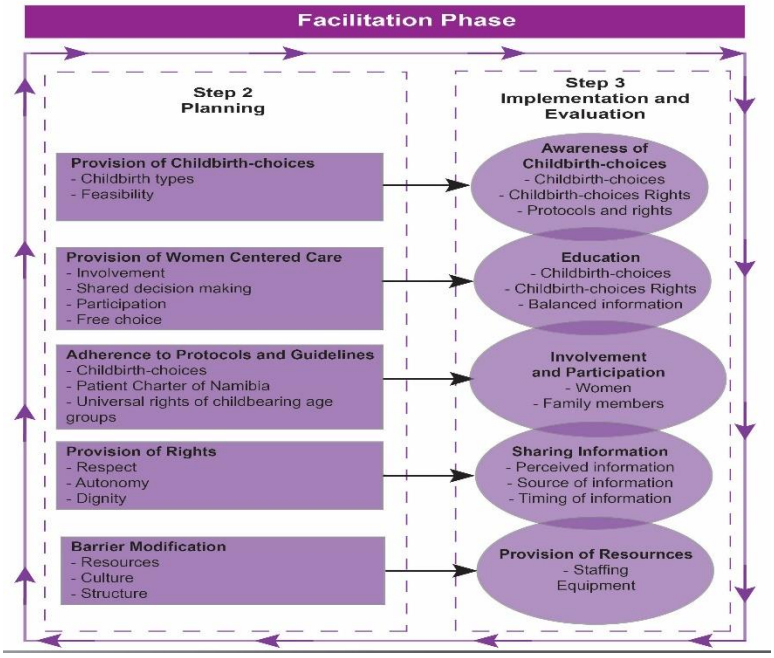

Figure 8.3 Facilitation phase

Step 3 of the facilitation phase includes the **implementation and the evaluation** of the woman pertaining to the awareness of childbirth-choices, educating on childbirth-choices, active participation and involvement of the woman in the process. Moreover, sharing of information is paramount as well in this step, focussing on the perceived information of the woman, their sources of information and the timing thereof. Finally, is ensuring the provision of resources for the smooth facilitation of the childbirth-choices.

8.2.5.3 Phase three: Termination phase

The termination phase (Figure 8.4) concludes the facilitation process, with a woman/family that are well informed of vaginal birth and caesarean section, meaning that the information received was balanced for the woman to make an informed decision of the childbirth type of her choice. The environment created by the facilitation enhances the woman to make an informed decision. The termination phase should have a woman well involved in the decision-making process, thereby leading to the choice they make.

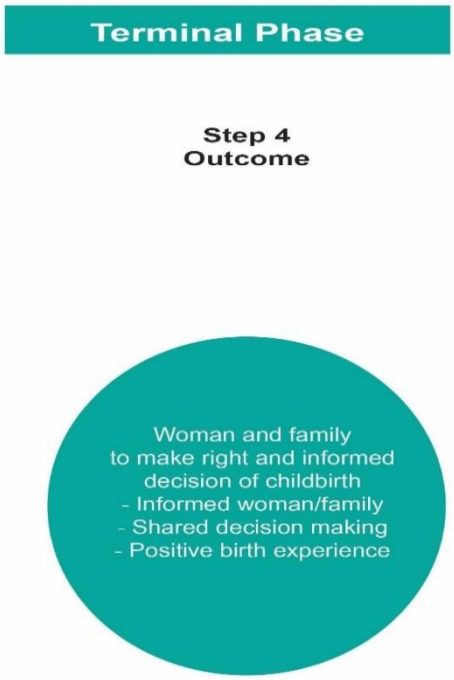

Figure 8.4 Terminal phase

8.3 Evaluation of the model

Following the development of the model, the researcher went on to evaluate the model and to guide this process (Parse, 2005; Fawcett, 2005). The reasoning behind the two theories is their similarities in model evaluation in ensuring that the models or theories developed are academically sound and evidenced based. The criteria which was incorporated in its totality in this study was by Fawcett (2005) and the criteria is as follows: significance, internal consistency, parsimony, testability (grand theories; middle-range theories), empirical adequacy

(grand theories; middle-range theories) and pragmatic adequacy. The researcher described and explained how the criteria was applied in the current study.

8.3.1 Significance

The study followed and incorporated the following assumptions to illicit the explicitness of which the theory is based and they are as follows: methodological assumption, rhetorical assumption, axiological assumption, epistemological assumption and ontological assumption. The concepts in the model were aimed at midwives facilitating childbirth-choices among women attending ANC. The model stemmed from the IP-SDM Model (Legare et al., 2010) which formed the basis for the framework of the model development for the facilitation of childbirth-choices among women.

The IP-SDM model alluded to the actors, process, environment as well as the outcomes in the process of shared decision making. The model included the woman, midwives and doctors as the actors in the process of facilitation. The actors and the process occur in environments that are both internal and external as they tend to influence the decision-making process. The outcome brings about a woman and her family that are empowered to make informed decisions that are based on the information given and received from the actors.

The researcher acknowledged the precedent knowledge from other authors through conducting a literature review as well as a scoping review. There was consistency in the referencing of the authors that were cited in the study as in the references list. The acknowledgement was important as it helps the readers and fellow researchers when reviewing the study, referencing or when conducting studies in different settings. Furthermore, it also helps to differentiate the different contexts that the literature referred to.

The model proposes to empower midwives in their engagement and facilitation of women for a more positive childbirth outcome. Facilitating women as individuals creates an environment

that is permitting to shared decision-making through alluding to their childbearing rights hence respectful maternity care and making informed decisions regarding birth.

8.3.2 Internal consistency

The context and content of the theory both need to be consistent (Fawcett, 2005). The philosophical claims, concepts, conceptual model and the propositions are all congruent to one another. Concepts were defined according to the dictionary, as well as subject and context definitions in Chapter seven, and this was done to link the congruency in these concepts. The main concepts in the study (childbirth-choices and facilitation) were defined as indicated above and this ensured that the model was clear. The connections within the phases in the model were indicated by arrows to show consistency between the model and the narrative explanations of the model itself.

8.3.3 Parsimony

Parsimony according to Fawcett (2005) is how clearly and concise the theory content is presented. The researcher clearly explained the detailed steps that were followed in developing the model in Chapter seven of this thesis. Furthermore, there is detailed description of the model in Chapter eight on the model. There are three phases which are initiation, facilitation and termination phase of the model. The descriptions are well detailed and concise to ensure that the reader gets an understanding of the model for the facilitation of childbirth-choices among women.

The different colour codes that are within the model depict the different processes that are occurring in the phase. The concepts used in the model are clear and simple to follow and understand. The phases are presented in such a way that the implementer (midwives) can clearly understand how to use the model. Aesthetically, as described by Parse (2005), this is

important for making sure that the model is simple and the colour codes give it an aesthetic finish.

8.3.4 Testability

The present research followed a mixed method approach in a quest to identify gaps and how best the contextual problem could be addressed. A scoping review was carried out to identify the ideal situation and the best practices regarding the care and information giving to pregnant women by midwives in the public sector. The scoping review hence set out as the guiding or foundation of model development as the researcher incorporated the main concepts identified in the study. Secondly, the study sought to find out the different childbirth types in the public healthcare sector and if there are any reasons for the selected childbirth type. The quantitative inquiry focused on maternal files so as to have insights as to how women are birthing.

Thirdly, a qualitative approach was undertaken to deduce the experiences of midwives in facilitating childbirth-choices and also the experiences of women being facilitated. The results from the mixed method study gave the model development a greater advantage as the actors in the healthcare delivery were included and this ensured the testability of grand theories. The triangulation of the different data sets helped the researcher to strengthen the development of the model by identifying the different concepts that were the foundation for model development.

8.3.5 Empirical adequacy

The degree of confidence that the model brings is important in measuring the empirical adequacy of the model or theory (Fawcett, 2005). The personal experiences of the midwives and the women in this study are congruent to the assertions that have been made by literature through the scoping review (Chapter four). The concepts that were derived from the data analysis are congruent with what the literature proposes for the facilitation of childbirth-choices

among women. The data or results of this study were derived from a number of different sources, hence allowing the study to triangulate the findings and answer the research question of facilitation of child-birth choices. Different contexts in the scoping review revealed congruency across the whole spectrum of facilitation of childbirth-choices.

8.3.6 Pragmatic adequacy

According to Fawcett (2005), there is need for the researcher to identify if the model or theory has pragmatic adequacy at different levels. The researcher suggests that before the model is applied in practice, there will be a need for sensitisation of the model to the midwives in order for them to be able to understand the model. For the implementation of this model, the researcher endeavours to carry this out during the post-doctoral level of research to ensure that the teaching and implementation can be supported as this requires many stakeholders to partake in the implementation process and to ensure that the model is understood before it can be incorporated into practice. The general feasibility of implementing this into practice is a long-term goal as implementation requires the involvement of a number of stakeholders as indicated above.

The expectations of the midwifery practice are that women have positive experiences of birth (WHO, 2018) in which they were a part of the decision-making process through informed consent. The Universal rights of childbearing women (White Ribbon Alliance, 2011; Windau-Melmer, 2013) emphasise the importance of consented care for women and this is supported by the Patient charter (MoHSS, nd) of Namibia. Considering the expectations of midwifery practice, the model for midwives in the facilitation of childbirth choices will lead to favourable outcomes for women and their families. The model is designed in such a way that individualised care is given to women and ensures that the midwife deals with the woman's expectations and fears and attends to them by providing balanced information regarding childbirth from the beginning of the first visit until the birthing day.

The researcher, through the findings in this study on the experiences of women identified a gap in that women were not given adequate information regarding childbirth types. The study also identified 'assumed choices' regarding birth hence women's birth experiences may not be real and what they desired. The researcher presented in depth how the model was developed as well as the methodology of the study in Chapter three to ensure transferability to other contexts. The researcher identified the best practices (Chapter four) in midwifery practice in that patient centred care is paramount in shared decision making, which was also found to be lacking in the current context as women experienced inadequate to no information regarding childbirth types. Midwives on the other hand, voiced the workload as one of the limitations in giving balanced information to women that were under their care.

According to Parse (2005), pragmatics refers to 'effectiveness' and to strengthen this, the researcher will publish the research findings and also present the findings to expects. The researcher also sent out the model to peers for them to review it and make some comments which were then incorporated into the model to ensure that the model's effectiveness is achieved. The review of the model was done according to Chinn and Kramer (2018) criteria for evaluation (Appendix: I) and the reviewers emphasised the importance of the model as giving women voices and rights in childbirth which enables positive experiences among women. The reviewers varied and included practising midwives who facilitate childbirth-choices, researchers, midwifery educators as well as an expect in model development who was the research main supervisor as depicted in Table 8.1.

Table 8.1 Model Evaluators for pragmatic adequacy

Respondent	**Designation**	**Institution**
1	Midwifery Educator	University
2	Midwifery Educator	University
3	Researcher	Research Institute
4	Practising Midwife	MoHSS
5	Practising Midwife	MoHSS
6	Practising Midwife	MoHSS
7	Practising Midwife	MoHSS
8	Researcher	University

9	Practising midwife	Private sector
10	Expect Researcher in Model Development/ Main Supervisor	University

8.4 GUIDELINES FOR OPERATIONALISING THE MODEL

A guideline is defined as a set of directives that are meant to show direction through a process as well as provide an overview of what is expected (WHO, 2014). Guidelines are important in that they translate best evidence into best practices (Rosenfeld & Shiffman, 2009). This study carried out an identification and conceptual analysis that yielded the best practices in the facilitation of childbirth-choices through the scoping review (Chapter four) and experiences of midwives and women (Chapter six) in facilitation in the current context. The aim of the guidelines is to strengthen the best practices in midwives facilitating childbirth-choices among women. According to the American Psychiatric Association (APA, 2017), guidelines need to be formulated based on the Population Intervention Comparison and Outcome (PICO). The application of the PICO format is tabled in Table 8.2.

Table 8.2 Application of PICO in formulation of guidelines for operationalising the model

Component	Application
Population	Midwives - skilled and knowledgeable to facilitate childbirth-choices among women Women - pregnant women attending ANC at public healthcare facilities in Namibia
Intervention	Improving and strengthening of the best practices in the facilitation of childbirth-choices through activities that create an enabling environment through: • Provision of childbirth-choices • Provision of woman centred care • Adherence to protocols and guidelines • Provision of rights • Barrier modification
Comparison	Best practices that are evidenced by the scoping review in Chapter four which are: • Shared decision-making • Patient centred care • Implementation of protocols and guidelines • Informed consent/choice • Information giving
Outcome	• Woman and family that are informed of the different childbirth types (pros and cons as well as indications) • Woman and family involved in shared decision-makingthrough an environment that allowed deliberations leading to an informed choice of childbirth • Informed choice free of cohesion but rather free choice • Positive childbirth experience as the woman and family were involved throughout the process

In the current study, guidelines will be used to direct midwives in the facilitation of childbirth-choices. The conceptualisation of the findings and development of the model guided the development of the guidelines as the identified gaps helped the researcher to identify interventions for improving the facilitation of childbirth-choices among women in public healthcare facilities. The guidelines articulate the activities that midwives should do based on the three phases of the model (Figure 8.1), namely initiation phase, facilitation phase and terminal phase, to ensure that strengthening of the best practices is realised in the context under study.

8.4.1 Guidelines for the initiation phase

The initiation phase of the model was adopted from the Helping Relationship in Counselling or Nursing, which applauds getting to know the patient before the beginning of trying to help. The helping relationship has been defined and categorised by many scholars and ultimately this has to be patient centred (Brammer, 1985; Egan, 2002; Osipow, Purkey & Schmidt, 1987; Walsh & Tosi, 1980).

8.4.1.1 Aim

The aim of the initiation phase in the model is to help midwives to assess the actors and the environment for a diagnosis to be made regarding childbirth. Furthermore, the assessment of the internal and external environments is done to identify the challenges that may compromise the process and activities of the initiation phase.

8.4.1.2 Activities for assessment

Assessment is defined as the plan of care that sets out to identify the specific healthcare needs through data collection and analysis, thereby leading to the diagnosis of the patient (George, 2014). In this study, assessment will be conducted by the midwife at the beginning of the ANC visit when the woman comes for her first visit. The knowledge that the woman has personally,

her social norms as well as a flexible environment are closely related with the satisfaction of the woman regarding her decisions (Cook & Loomis, 2012). The activities for assessment will be described with the focus on the actors and the environment to ensure that the needs or challenges are identified and how they may influence the woman in the facilitation of childbirth-choices. The environment activities are divided into the external and internal as they are separate entities despite the influence they have on the facilitation and choices that women make.

Actors

The following activities should be considered by midwives when assessing the actors to aid the facilitation of childbirth-choices. The actors in this study are the women, midwives and doctors. The actors will be assessed independently to ensure that the activities are clear.

- **Midwives**

The following activities should be considered in the assessment of midwives. The midwife should:

- Assess the knowledge on respectful maternity care of giving women unbiased education on childbirth-choices
- Assess own knowledge on the scope of practice (Republic of Namibia, 2014) which guides the midwife in caring for the pregnant woman
- Assess own knowledge on the Patient charter (MoHSS, nd) of Namibia, which stipulates that patients need to be given information
- Assess the knowledge of the midwives in the facilitation of childbirth-choices in light of the childbirth types (vaginal birth/caesarean section) to enable information sharing
- Assess the competence of the midwife in giving information of the advantages and disadvantages of vaginal birth and caesarean section

- Demonstrate good listening skills during assessment by ensuring that the woman expresses herself fully

Woman

The woman in this study is considered as the pregnant woman that has come to attend ANC. The following activities need to be included in assessing the woman. The midwife should:

- Assess if the woman has a preference in childbirth (vaginal birth/caesarean section)
- Assess if the woman has any support system (partner, husband, friend/family) to be with her during the pregnancy and childbirth as they have an influence on how women make decisions
- Allude the role and responsibility of the woman for coming to ANC for care
- Assess the learnt, shared or transmitted values (culture) that may have a direct impact on the choice of mode of birth
- Ask the woman if she has any experiences in childbirth and how that birth experience can help guide the present childbirth
- Assess the knowledge of the woman in terms of vaginal birth and caesarean section to determine her understanding of the childbirth type
- Assess if the woman knows their right in receiving information that is balanced regarding childbirth choices
- Assess any myths that the woman may have on childbirth (caesarean section and vaginal birth) to help focus the facilitation process

Medical Doctor

The medical doctor in this study is part of the healthcare team who may at one point of pregnancy facilitate childbirth-choices. The following activities should help the midwife in

assessing inrelation to the medical doctor in facilitating childbirth-choices. The midwife should:

- Assess the knowledge of the doctor pertaining to vaginal birth and caesarean section in order for them to facilitate the women referred to them
- Assess the knowledge on the different cultures (learnt, shared or transmitted values) in the Namibian context pertaining to childbirth which may influence decisions and allay any fears in childbirth-choices
- Assess the ability to include shared decision-makingwith the woman
- Assess the ability to facilitate patient centred care (providing care which is respectful and responds to the needs of the patient) to ensure a positive childbirth experience
- Assess the ability to give balanced information regarding the advantages and disadvantages of vaginal birth and caesarean section for women to make informed decision

Environment

This refers to any forces, circumstances or conditions that may have an impact on the behaviour or decision that a person may make (George, 2014). In the current study, the environment was discussed under the external and internal environments. The guideline activities are divided as well into the external and internal environment.

- ***External environment***

The external environment is considered as external the forces that may affect life and development (George, 2014). Midwives should consider the following activities when assessing the external environment and these include the community where the woman is coming from:

- Assess the community the woman is coming from as it may influence the decision-makingregarding childbirth: Namibia has different tribes that all perceive childbirth and its happenings independent of each other
- Midwives should be able to assess the different cultures (learnt, shared, and transmitted values, beliefs that guide thinking, decisions and actions (George, 2014)) that may influence women and hinder any active participation in decision-making
- Midwives should identify the norms and values that the woman and family uphold when it comes to childbirth so that discussions after planning may be done
- Assess the communication level of the woman as culture, norms and values may hinder the facilitation process

Internal environment

According to Mosadeghrad (2014), the internal environment refers to the working environment in which a healthcare service is provided including the available resources. The internal environment in this study refers to the public healthcare facilities offering ANC to pregnant women. The purpose of assessing the healthcare facilities is to identify organisational structures as well as culture in the facilitation of childbirth-choices. The internal environment plays a critical role in the facilitation of childbirth-choices and the midwife needs to assess this in order to ensure that the environment is suitable for the process of facilitation. The following activities should be considered by the midwife to assess the internal environment.

- The midwives should assess the knowledge of the midwife being the primary caregiver in the healthcare facility to spear head the facilitation process.
- The midwives should assess the staffing that is adequate for the effective facilitation of childbirth-choices, which means that the midwife patient ratio should be established.

- Midwives have to assess the available protocols and guidelines that improve the facilitation of childbirth-choices
- Midwives should assess the protocols and guidelines that are in place to ensure a conducive environment for the facilitation of childbirth choices. The protocols to be assessed if available should include and not be limited to: the Patient charter (MoHSS, nd), Scope of practice (Republic of Namibia, 2014), Robson Classification (WHO, 2017) (previous birth mode and current status of pregnancy has a bearing on facilitation) and the seven Universal rights of childbearing women (White Ribbon Alliance, 2011; Windau-Melmer, 2013) (for example information, informed consent, respect for her choices and preferences) to guide the facilitation process
- Assess the implementation of the Patient charter (MoHSS, nd) of Namibia for adhering to the norms of giving women accurate information which is unbiased
- Assess the provision for the implementation of the Robson Classification (WHO, 2017) for facilitating mode of birth

8.4.1.3 Activities for diagnoses

The following are the activities that midwives need to consider when diagnosing pregnant women. Activities for diagnoses should not be a one size fits all as there is need for woman-centred care. Diagnosing is described as a process which is goal oriented in the collection and integration of case-by-case information that aims at the reduction of uncertainty for medical or educational decisions to be made (Bauer, Fischer, Kiesewetter, Shaffer, Fischer, Zotttmann, & Sailer, 2020).

8.4.1.3.1 Actors

Midwives

- Integrate the knowledge and skills they have regarding the different childbirth types

- Interpret the knowledge of the scope of practice (Republic of Namibia, 2014) in childbirth-choice facilitation
- Analyse the knowledge of the Patient charter (MoHSS, nd) and how to incorporate it in the facilitation of childbirth-choices
- Consolidate the knowledge on respectful maternity care regarding balanced information about childbirth-choices
- Interpret the timeframe that is there to ensure that the woman receives all information timeously

Women

Midwives should

- Analyse the knowledge that the women have demonstrated in the assessment on what vaginal birth and caesarean section is
- Interpret the culture/community that the woman is coming from to ensure planning for implementation
- Integrate the knowledge women have on the information they have to receive and when
- Midwives should integrate the information that women gave regarding their previous experiences that may have an effect on the childbirth-choice decisions

8.4.1.3.2 External environment

According to George (2014), diagnosis includes behavioural statements that identify the actual or potential problem of the patient. In this study, the potential or actual problem was identified as women not having the information that they have choices in childbirth and their rights in receiving information. The following are the activities to consider in diagnosing the external environment:

- Diagnose the culture of the woman to see if there may be any impediments to the facilitation of childbirth-choices
- Diagnose the values of the woman regarding childbirth that may have an effect on them making a decision
- Ascertain the language that the woman is comfortable with to ease the facilitation process
- Ascertain the role that culture plays in decision-makingfor the woman and her family
- Identify cues in the data collected in the assessment that may hinder the facilitation process
- Make conclusions regarding the community that the woman identifies with as well as the culture that may influence the facilitation of childbirth-choices

8.4.1.3.3 Internal environment

Diagnosing the internal environment will help the midwife to analyse the data that was collected in the assessment thereby identifying the health problems, strengths and any potential risks (George, 2014). In this study the midwives should:

- Analyse the timing of information giving based on the assessment of the internal environment
- Midwives as facilitators should analyse the reasons for the lack of woman centred care which could be as a result of communication barriers, lack of knowledge and insights or the barriers in delivering care
- Midwives should analyse the challenges with regards to the lack of enforcement of protocols and guidelines that include involving the woman in decision-making

8.4.2 Phase two: Facilitation phase

Facilitation goals include creating an environment for effective communication, focused discussion, engaged participants, an opportunity for voices to be heard and an environment where trust and support are available, meaning that disagreement and discussion can surface (Porteus, Howe & Woon, n.d.).

8.4.2.1 Aim

The first aim in phase two is to plan goals which are specific, measurable, attainable, and realistic and time oriented (Toney-Butler & Thayer, 2021). The second aim in the facilitation phase is to implement the goals that have been planned for the facilitation of childbirth-choices. The objectives are elaborated with the activities that midwives ought to do to ensure RMC.

8.4.2.2 Activities for planning

Planning determines what action needs to be done to ensure that the patient is assisted well in relation to health problems (George, 2014). The activities for planning include the provision of childbirth-choices, woman centred care, adherence to protocols and guidelines, provision of rights and barrier modification in facilitations.

8.4.2.2.1 Provision of childbirth-choices

Provision of childbirth-choices promotes autonomy and independence for the women through teaching of the different childbirth types (Cook & Loomis, 2014). Autonomy is the ability of an individual to act on their own values and interests (Oxford Dictionary, n.d). In this study, women lacked autonomy in decision-makingas evidenced by the verbatim extracts in Chapter six of this study. Autonomy and independence are important aspects in childbirth-choice facilitation as they give women ownership over their childbirth hence creating positive

childbirth experiences. The following activities should be incorporated in planning for childbirth-choice facilitation:

- Midwives should prepare for teaching on vaginal birth and caesarean section to women and their families for them to be involved in decision-makingthrough creating pamphlets and posters that will be used in health education and also to take them home
- Midwives should gather information on the advantages and disadvantages of vaginal birth and caesarean section
- Midwives need to create an environment that allows women to ask about the different childbirth-types and answer any questions that may arise
- Midwives should create an environment that is conducive for women to ask questions without intimidation and they have to create room for individual health education regarding childbirth types and choices
- Create an environment where the preferences of the woman are put into consideration

8.4.2.2.2 Provision of woman centred care

Kuipers, Cramm and Nieboer (2019) affirm that patient centred care can be defined as "providing care that is respectful of and is responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (p. 2). In the current study, the lack of woman centred care came out, hence the need to create activities that will involve the needs of women in childbirth choices. It is of utmost importance that women remain the centre of the birthing experience and that they are well supported through continuous consultation and information sharing in order to enhance informed choices (Cook & Loomis, 2012). The centrality of the activities should on the women and their families. The following activities improve planning for childbirth-choices:

- The midwives need to familiarise themselves with the Robson Classification (WHO, 2017) especially for the women that have previous caesarean section, to help them facilitate positive childbirth
- Midwives should provide care that responds to the social, emotional, cultural and physical needs of the women under their care
- Midwives should acknowledge that women have control and choice regarding their childbirth experience such that they can centre the care on the woman rather than the healthcare professional
- Midwives should listen to the views and concerns of women regarding childbirth
- Midwives should not be judgemental in relation to the woman's views or beliefs regarding childbirth
- Midwives should avoid dominating the facilitation all the time but rather let the woman take the initiative in their health

8.4.2.2.3 Adherence to protocols and guidelines

The utilisation of guidelines in any setting is aimed at improving the quality of care rendered to patients and resultantly improving health outcomes (Amoakoh-Coleman, Klipstein-Grobusch…, Agyepong, 2016). The following activities can help the planning to materialise so that the positive facilitation of childbirth-choices can take place.

- Midwives should familiarise themselves with the Patient charter (MoHSS, nd) of Namibia, Universal rights of childbearing women (White Ribbon Alliance, 2011; Windau-Melmer, 2013) and the Robson Classification (WHO, 2017) (WHO, 2017)
- In-service training should be done to ensure that midwives are knowledgeable about the Patient charter (MoHSS, nd), Universal rights of childbearing women (White

Ribbon Alliance, 2011; Windau-Melmer, 2013) and the Robson Classification (WHO, 2017)

- Involvement of other healthcare stakeholders to advocate and ensure the implementation of the protocols
- Midwives should familiarise themselves with the organisational structures in the healthcare facilities they are working in to know that they are the primary caregivers in childbirth facilitation
- Midwives should revisit their scope of practice (Republic of Namibia, 2014) for them to understand their duty when facilitating pregnant women

8.4.2.2.4 Provision of rights

Taking cognisance of providing rights to women during the facilitation of childbirth-choices ensures that their autonomy materialises, thus constant consultation with the woman regarding care (Cook & Loomis, 2014; Windau-Melmer, 2013). The following activities in the planning will encourage and ensure that women's rights are not infringed upon.

- Midwives should respect the woman's right to choose their preferred birth mode
- Midwives should source and avail the Patient charter (MoHSS, nd) of Namibia, the Universal rights of childbearing women (White Ribbon Alliance, 2011; Windau-Melmer, 2013) and the Robson Classification (WHO, 2017) for them to be able to give information to women and direct them without directly influencing the woman's choices
- Collaboration with other healthcare professionals to ensure that the rights of women are known by the professionals and to ensure the availing and implementation of such

8.4.2.2.5 Barrier modification

Barrier modification strives to remove any obstacle that hinders progress (Merriam-Webster, 2020). In this study, the barriers identified to be hindering facilitation of childbirth-choices included shortages of staff, timing of information, information sharing during ANC and cultural influences on childbirth types. The following activities are there to enhance barrier modification:

- Midwives should involve the support system of the woman as this could help to modify barriers such as culture
- Midwives should create an environment that is culture-sensitive and catering for all women without discrimination, thereby enabling childbirth-choice facilitation
- Midwives should, through the healthcare facility management, ensure that midwives are adequate, that is proportionately to the women that are attending ANC as a way to enable the facilitation of childbirth-choices
- Midwives should plan accordingly so that they can have health education being given from the beginning of the ANC visit and spread through the whole pregnancy
- Midwives should familiarise themselves with different cultural factors that may hinder the facilitation of childbirth-choices for them to be able to facilitate childbirth choices for the benefit of the woman
- Acknowledge the different socio-cultural factors that may affect the facilitation of childbirth-choices
- Engaging relevant stakeholders like the MoHSS to disseminate information of childbirth types through messages on cellular phones as this will help to create awareness to the society and reduce ignorance but actually encourage childbirth-choices

8.4.2.3 Activities for implementation

"Implementation is defined as action initiated to accomplish a goal" (George, 2014, p. 7). In accordance to this study, there is need for women to be facilitated in childbirth-choices for them to have positive birth experiences. The activities for implementation will be described under awareness, educating, involvement and participation, sharing information and provision of resources.

8.4.2.3.1 Awareness

Awareness is described as knowledge and understanding of a certain fact or happening (Merriam-Webster Dictionary, 2020). Women in this study were not aware of their choices in childbirth, hence the need for guideline activities that will ensure awareness of childbirth-choices. Effective and successful awareness depends on a number of factors that create an atmosphere for acceptability (Santra, 2018). The following are strategies that may lead to effective awareness according to Santra (2018) and as applied in this study:

- Midwives should determine the needs of the woman which was done in the initiation phase of childbirth-choices
- A team approach should be adopted by the midwives, ensuring that the woman and family are enabled to participate in childbirth-choices
- Midwives should clarify the purpose of the facilitation so that women have clarity of the process of awareness, thus childbirth-choice facilitation for positive childbirth experiences is the purpose
- Midwives should empower the women thus giving them ownership by ensuring that they put into consideration the woman who should remain at the centre of the facilitation

- Midwives should give information to women about vaginal birth and caesarean section, and the information should be balanced as information is vital for women to make informed decisions
- Midwives should ensure that they refer and show women the pamphlets and posters on their rights hence empowering them to make childbirth-choices

8.4.2.3.2 Educating

Educating refers to giving training or information on a specific subject (Oxford Dictionary, n.d.). A lack of education regarding childbirth-choices was unravelled in this study hence activities to encourage education regarding childbirth-choices are important. Educating is an important aspect of ensuring that women make informed decisions based on the information received (Regan et al., 2013). In educating women during childbirth-choices, midwives should:

- Ensure the credibility of the information being given to the women on childbirth-choices
- Ensure that the interests of the discussion are sought from the women
- Ensure full participation of the woman in the discussion of childbirth-choices
- Motivating women during facilitation by keeping them engaged
- Educating the woman by starting with what the woman knows to the new knowledge

Midwives should educate the woman that:

- Vaginal birth and caesarean section are the birth modes that are available to them
- The advantages of vaginal birth and caesarean section including their indications when they are done
- How women can cope with birth and pain in both vaginal birth and caesarean section
- They have to decide for themselves as to which mode of birth they want

8.4.2.3.3 Involvement and participation

In order for involvement and participation to be effective, there is need for emphasising the information being given to women and how it is communicated (De Freitas, Massag, Amorim & Fraga, 2020). De Freitas et al. (2020) acknowledge that hindrances to patient involvement include lack of access to information, suboptimal communication, offering fewer opportunities and being less involved in decision making. The activities are in the quest of ensuring that women are involved in the process of facilitation of childbirth-choices.

- The midwife has the mandate to ensure that woman centred care through involving the woman, and shared decision-makingby identifying the role of the woman in the facilitation
- Midwives should respect the values of the woman when it comes to childbirth
- Midwives should allow women to ask questions about anything that they do not understand
- Midwives need to create an atmosphere where there is active participation for the woman during the facilitation so as to encourage free choice that culminates into a positive childbirth experience
- The awareness of midwives of the universal rights of any person and this has to be ensured by creating an atmosphere where the woman is respected and her dignity upheld during the facilitation

8.4.2.3.4 Sharing information

Health education is fundamental in ensuring that women are equipped with the knowledge, and that this needs to begin as early as possible in ANC (Nascimento et al., 2015). Giving women information of vaginal birth and caesarean section that is balanced leads women to make informed decisions regarding childbirth (Newnham et al., 2017). The midwives should:

- Ensure the training of midwives on the rights of women regarding information of birthing choices
- Midwives should conduct planned learning activities in childbirth types so as to empower women for them to make decisions
- Engage stakeholders like the MoHSS and the training institutions as a way to create awareness by educating pregnant women on vaginal birth and caesarean section in their communities as this may also lessen the burden on the workload of midwives in the public healthcare facilities.
- Stakeholder involvement is encouraged to ensure community support groups for pregnant women who are led by midwives so as to give health information on childbirth that is credible
- Midwives should give information regarding childbirth from the beginning of pregnancy to allow women to make informed decisions
- Midwives should give information to women when they need it no matter the time of pregnancy they are
- Information should be balanced and not directed towards a certain childbirth mode

8.4.2.3.5 Provision of resources

According to WHO (2016), sufficient resources, be it human or physical, should aim to ensure and promote favourable health outcomes. The study identified staff workload as a barrier in ensuring childbirth choice facilitation. The following activities are hoped to ensure that women are not short-changed as a result of staff that are not there.

- Stakeholder engagement in staffing the ANC units with adequate human resource to meet the demands in health education which require time with all the women

- Stakeholder engagement in creating support groups for women that address health information on childbirth-choices that works with the women in the communities.
- The midwives also need to engage the woman on how feasible the two childbirth types are in their setting and beyond
- Provision of woman-midwife ratio to ensure engagement of women in discussion regarding their care and not worrying about the long queues that may increase because of the information giving time being accorded to the women

8.4.3 Phase three: Terminal phase

In every process, there comes a point to terminate the process and in this study it is when the woman and the midwife have come to an agreement of the childbirth-choice the woman has made. Terminal is defined as bringing something to an end (Merriam-Webster Dictionary, 2020) and in this model there will be a need to terminate the facilitation for the current pregnancy during ANC and possibly in labour when the actual choice is implemented.

8.4.3.1 Aim

The aim of the terminal phase is hinged on the fact that the woman and the family are able to make the right and informed choice regarding childbirth. The decision may be made at the end of her final ANC visit as well as in the labour ward when the final decision is made and the actual choice has been implemented.

8.4.3.2 Activities for evaluation

Evaluation involves the appraisal of behavioural changes in a patient (George, 2014). In this study, evaluation aims at ensuring that the facilitation process has fully informed the woman through health education and involvement for them to have acquired knowledge to make informed decisions. The activities in the terminal phase are crucial as they signify a positive facilitation of childbirth-choices among women in order for them to have positive childbirth

experiences that are memorable regardless the childbirth type. The activities for the midwife should:

- Ensure that the woman and her family are well informed of all the childbirth types (vaginal birth & caesarean section) that are available and how they came about
- Ensure that women express or demonstrate knowledge of the childbirth types by giving back information to the midwife on what they have been informed on and making the decision
- Appraise shared decision-makingthat is not coerced as they display depth of the content on the information that is shared
- Appraise a positive birth experience shared by the woman to the midwives

8.5 CHAPTER SUMMARY

Chapter eight focused on the description of the model, its evaluation thereof and the description of the guidelines to operationalise the model. The model assumptions were identified in this chapter and the overview structure of the model was well elaborated. The aims for the three phases of the model, namely, initiation, facilitation and terminal phases were described to give the reader the understanding of the model for midwives. Furthermore, the chapter also focused on the activities that are expected in each of the guidelines as a way to operationalise the model as a guide to the midwives in the health facilities. Chapter nine presents the conclusions, recommendations, limitations and contributions of the study.

CHAPTER NINE

CONCLUSION, RECOMMENDATIONS, LIMITATIONS, CONTRIBUTION TO KNOWLEDGE AND DISSEMINATION OF THE STUDY FINDINGS

9.1 INTRODUCTION

Chapter eight described the model, evaluated the model and described guidelines for the model for midwives for the facilitation of childbirth-choices. The aim of the study was to develop a model for midwives and hence the required guidelines for easier operationalisation. Chapter nine concludes the study, presents the recommendations as identified during the analysis, the limitations of the study, contributions that the study makes and how the research findings are planned to be disseminated by the researcher.

9.2 PURPOSE OF THE STUDY

The purpose of the study was to develop a model for midwives for facilitating childbirth-choices among pregnant women in selected public healthcare facilities in Namibia. The realisation of the purpose followed four main objectives which were identified as phases in the study namely: concept analysis, construction of relationships, development, description and evaluation of the model, and the development and description of guidelines to operationalise the model for midwives for the facilitation of childbirth-choices.

9.3 CONCLUSIONS OF THE STUDY

The researcher concludes the study followed through each of the objectives to ensure that the purpose of the study was achieved. The conclusions are described giving the concise findings that stood out in the research.

9.3.1 Phase One: Identification and analysis of concepts

The central concepts of this study derived from the identification and analysis were facilitation and childbirth-choices. The identification and concept analysis comprised of four objectives and they are described independently below to conclude the study:

9.3.1.1 Explore and describe the best practices on the facilitation of childbirth-choices for women by midwives in public healthcare facilities

The research objective was achieved through a scoping review which followed the PRISMAR-ScR. A total of 30 peer reviewed articles were included in the final review following exclusion of articles that did not meet the inclusion criteria of the review. The articles included in the scoping review had different approaches in their data collection, thus giving the scoping a broader advantage in terms of rigor. One theme which emerged was with regards to the best practices with four sub themes which were namely, patient centred care, shared decision making, informed consent and information giving, and institutional guidelines and protocols.

- Best practices for childbirth-choice facilitation

The study concluded that the best practices of the facilitation of childbirth-choices should include shared decision-makingbetween the healthcare professionals and the woman. Secondly, patient centred care should be a priority in all settings as the woman's positive experiences will ensure that they are involved in their care. Thirdly, there should be protocols and guidelines which are in place that enable the facilitation of childbirth-choices in the healthcare facilities. Informed consent/choice came out strongly in the best practices objective as facilitation of childbirth-choices needs to lead to a woman making the best choice that is informed for the childbirth type. Above all, information giving was found to be quite critical for ensuring that the woman and her family are involved in decision-makingthereby resulting in informed choice.

9.3.1.2 Analyse the different types of childbirth and reasons if any in public healthcare facilities

The following conclusions were drawn from the analysis of the different childbirth types:

- Vaginal birth in the public sector of Namibia in the selected healthcare facilities stood at 76% while caesarean section was at 24%
- Of the 24% of the caesarean section, 10.44% constituted the repeat caesarean section, meaning that this proportion could be reduced by adequate facilitation, which can possibly lead to VBAC
- A majority of the women (90%) had no reported complications during ANC which means that most of the pregnancies were low risk
- Participating facilities had an equal distribution of participation, meaning that 25% representation was for each of the facilities
- Of the total population, 96.7% had booked for ANC, meaning that women understand the importance of the visits and information to be received there

9.3.1.3 Explore and describe the experiences of midwives in facilitating childbirth-choices in public healthcare facilities

Individual interviews were conducted with midwives from the four selected hospitals. Two main themes were identified which were barriers in the facilitation of childbirth-choices and lack of childbirth-choices. The objective may be concluded as follows:

- The midwives in the context under study exposed barriers in childbirth-choices that included but were not limited to the following: staff workload, and timing of information giving. The midwives expressed that seeing many women at the healthcare facilities compromised the information giving and woman centred care as they were rushing to finish the queue of those who would be waiting to be served.
- Midwives also expressed the lack of childbirth-choices as a direct consequence of no provision of rights regarding choices, which also led to lack of woman centred care, a

lack of enforcement of protocols such as the Patient charter (MoHSS, nd) and the cultural influences on women regarding childbirth.

9.3.1.4 Explore and describe the experiences of childbirth-choice facilitation among women in public healthcare facilities

Individual in-depth interviews were conducted with the women and the following two main themes emerged: women's childbirth-choice experience and information giving.

- Women's childbirth-choice experience

Women expressed a lack of choices regarding childbirth-choices, and some were even surprised that they had a choice. Women identified the inadequacy of decision-makingas they are either not involved or informed about a decision on childbirth without any time for them to consider the little information they receive about decisions of childbirth. Decision-makingis a critical aspect when informed decisions need to be made.

- Information giving

A paramount part of facilitation is information giving which was not found in the current context. Women had little to no information of childbirth types or choices meaning that the facilitation process lacked shared decision-makingas there was no balanced information for women to make choices.

9.3.2 Phase two: Construction of relationships and statement for the development of a model for midwives

The researcher in the current study merged the study findings in the concept analysis so as to identify relationships and also to synthesise the study. Facilitation from all the study objectives meant that there is shared decision making, patient centred care, information giving, provision of protocols and guidelines, barrier modification and provision of childbirth-choices. Childbirth-choices were concluded as having a woman and her family making an informed decision and ensuring that the women's rights are observed.

The central concepts derived from the concept analysis and the identification of concepts were facilitation and childbirth-choices. The definition of facilitation as deduced from the current study can be described as follows: Facilitation is an **enabling process** that includes **engaging, assisting, helping, involving women** and their **families** through the **assessment** of their **environments,** by considering the **values**, **beliefs**, **respecting dignity** and **autonomy** for the women to make childbirth-choices through **information sharing**, **awareness, provision of the resources**, barrier **modification**, **enforcement of the protocols** and **guidelines** leading to **shared decision making, an informed woman and family** and a **positive childbirth experience**.

On the other hand, the following best defines childbirth-choices as deduced from the study findings: Childbirth-choices are a **women/family centred support system** aimed at the provision of childbirth-choices through **awareness**, **involvement**, **participation**, **education, sharing information**, and **shared decision** for the woman and **family** to make right and informed decision about childbirth choices.

The adoption of the IP-SDM and Nursing Process helped the researcher in developing a conceptual framework in relation to the study findings. The conceptual framework included the actors in the facilitation of childbirth choices, the dynamicaesarean section (as identified in the scoping review), and the environment that enables the facilitation of childbirth-choices as well as the outcomes as the end product of the facilitation. Through the process of adoption, the researcher also used the Nursing process in which assessment and diagnosis were made of the actors and the environment that play an integral part in the facilitation process. Planning in light of the challenges or dynamicaesarean section identified in the assessment and diagnosis was also done, leading to the implementation for a positive outcome, which happens when the women and their families are informed about the childbirth-choices.

9.3.3 Phase three: Develop, describe and evaluate the model for midwives for the facilitation of childbirth-choices

The development of the model went through a rigorous process. Following the construction of relationships, the researcher under the guidance of the research supervisors came up with the conceptual framework that helped to guide the model as the end product. The conceptual framework was guided by the IP-SDM model (Legare et al., 2010) and the Nursing process (Orlando, 1961) where the assessment of actors and the environment were done to identify the challenges in the study settings as well as the dynamics through the scoping review. The planning and implementation and the evaluation of the actors and the environment acted as the foundation of the model development.

The model was presented and described in Chapter eight of the study, based on the three phases of the model which are the initiation phase, facilitation phase and the terminal phase. The initiation phase included the assessment stage of the actors and the environment for the facilitation of childbirth-choices. The facilitation phase was described with the planning and implementation of the facilitation of childbirth-choices for the environment to be conducive for the actors and therefore influence positive childbirth-choices. The terminal phase was also described to portray the outcome of the facilitation process for childbirth-choices. The model concluded that facilitation is not a one-day practice but spans over time to ensure understanding and informed choices.

The evaluation of the model was conducted by making use of the criteria as proposed by Parse (2005), which helped to identify the strengths of the model and improve it as well. The criteria as identified by Parse (2005) includes: significance, internal consistency, parsimony, testability, empirical adequacy and pragmatic adequacy. The model was also refined through the constant supervision from the research supervisor in clearing out any ambiguities and inconsistences.

9.3.4 Phase four: Develop and describe guidelines for operationalising the model

The final phase required guidelines development, which was done under the auspices of PICO (APA, 2017) to ensure its relevance to the context. PICO was as well guided by the concept analysis where the best practices were identified, the contextual situation was described through the analysis of the childbirth types in the current context, and the challenges identified in the context through the experiences of midwives and women in the facilitation of childbirth-choices. The proceeding phases (one to three) were fundamental in developing guidelines as there needs to be relationships in-between the phases. Guidelines were developed for the model to be operational, thereby familiarising midwives in the public healthcare facilities with the aims and activities carried out in each phase of the model.

9.4 CONTRIBUTION TO THE BODY OF KNOWLEDGE

The following are the contributions that the current study brings to the body of knowledge:

9.4.1 Challenges affecting the stakeholders (actors) in the facilitation of childbirth-choices

The stakeholders in this study context included the women, their families, midwives and doctors. The model and the study may contribute in helping improving the facilitation of childbirth-choices through the use of the designed model which is simple and applicable in the Namibian context. Through the study and the introduction of the model for testing to the healthcare providers, mainly midwives, awareness may be enhanced as they can reminisce and reattribute their actions to policies and guidelines can that help in the positive facilitation of childbirth choices.

9.4.2 Conceptualisation process of the development of model for facilitation of childbirth-choices

Following the identification of the concepts and analysis thereof, which included the definitions of the concepts identified, the identified concepts were defined and through the adoption of

theories, a conceptual framework was identified and this led to the development of the model of the study. The conceptualisation process of this study may help to serve as a guide for future researchers when conducting research in a similar field of study and also when conceptualising phenomenon. The researcher also grew in research as she embarked on the tedious journey of conceptualisation. In addition, the researcher will now be able to supervise scholars that undertake the same route of research studies.

9.4.3 Conceptual framework for facilitation of childbirth-choices

The conceptual framework serves as a guide to ascertain or to contribute to the body of knowledge, and it will also help in the transferability should other scholars be willing to use the study as a literature review. The conceptual framework will also help other researchers as reference when they embark on their own studies.

9.4.4 Model for facilitation childbirth-choices

The model developed in this study may contribute to the emotional wellbeing of the women as they may feel involved in the decision-making process. The model may also help midwives when they are facilitating the women, for them to understand the dynamics that they need to ascertain when facilitating child-birth choices. Moreover, the rights of the women will be upheld as the midwives will be inclusive.

9.5 LIMITATIONS

Limitations in a study pertain to the theoretical and methodological restrictions that could decrease the generalisation of the findings (Grove & Gray 2018). The present study looked at the methodological and implementation limitations.

9.5.1 Methodological limitation

The methodological limitations in the current study included the inception of Covid-19 which influenced data collection methods as most of the interviews had to be held conducted telephonically. Covid-19 came with restrictions of social distance and to have special permits

to travel from one point to the other. Telephonic interviews hampered the researcher from observing the behaviours and body language that the participants may have exhibited when responding to questions. In the Northern part of the country, the interviews were telephonically conducted as there was lack of access to the research participants due to floods. Secondly, the research only focused on the four public healthcare facilities in the country which might not derive the same results for other health facilities not included in the study, and more the private sector. Moreover, data from other healthcare facilities could have improved the study findings. Thirdly, the researcher selected women and midwives that were well versed in the English language; therefore, some valid data may have been left out from the study by not including those who could not speak English well.

9.5.2 Implementation limitations

The model and guidelines developed in this study were not implemented due to financial and time constraint. However, all factors held constant, this will be done as part of the post-doctoral studies if the researcher manages to go that far. The limitation resulted from the breadth of the study hence funding will be sought for the post-doctoral level of study. However, the developed model was evaluated for its applicability in practice and education in Chapter seven of this study.

9.6 RECOMMENDATIONS

The study categorised the recommendations into the nursing practice, education and research as described below:

9.6.1 Recommendations for practice

- Implementation and evaluation of the model and guidelines by midwives in practice for best practice implementation in the facilitation of childbirth-choices in public healthcare facilities

- Midwives have a mandate to give women time during ANC, for them to identify the previous childbirth experiences in order for them to identify the needs the woman may have regarding the current pregnancy. Moreover, this will help the midwives to understand the decisions that women make.
- Midwives need to give women unbiased information during the beginning of ANC attendance for women to be able to have informed decisions with regards to the childbirth type they have in the end
- Accord women their rights of making autonomous and informed choices regarding the childbirth type
- Decentralisation of care through midwifery led units apart from the intermediate hospitals and referral hospitals for the easing of workload on midwives for ANC as well as birth

9.6.2 Recommendations for education

- Incorporating the model and guidelines following implementation and evaluation to the curriculum for training hence adoption in practice may have a swift transition
- Midwifery educators need to include RMC in their education, which ensures that the rights of women are not infringed
- Midwifery educators should ensure that student midwives regard the facilitation of childbirth-choices as a process, hence the developed model may be used in education as a tool to guide educators
- Midwifery educators need to be abreast of the protocols and guidelines for ensuring the facilitation of childbirth-choices in order for them to impart knowledge to the student midwives

9.6.3 Recommendations for research

- Implementation and evaluation of the model for midwives in the facilitation of childbirth-choices in public healthcare facilities of Namibia
- Evaluation of the guidelines for operationalising the model for midwives for the facilitation of childbirth-choices in Namibia
- Experiences of midwives in the labour ward with women who have been informed about the different childbirth types when in the labour ward
- Knowledge of women on the Patient charter (MoHSS, nd) of Namibia and the Universal rights of childbearing women (White Ribbon Alliance, 2011; Windau-Melmer, 2013)
- Attitudes of student midwives regarding the Patient charter (MoHSS, nd) of Namibia and the Universal rights of childbearing women (White Ribbon Alliance, 2011; Windau-Melmer, 2013) for the improvement of maternal health

9.7 DISSEMINATION OF STUDY FINDINGS

The goal of the study was to ensure that all the study findings and procedures would be reported so as to enhance the body of knowledge and also clinical practice. The final thesis will be disseminated to the MoHSS as well as participating hospitals, and copies will also be submitted to the University of Namibia as part of the fulfilment of the PhD degree. Furthermore, the researcher will disseminate the study results as well in other forms as indicated hereunder:

9.7.1 Proposed publication papers

- Best practices for the facilitation of childbirth-choices for women: A scoping review
- Analysis of childbirth types and their reasons in public healthcare facilities of Namibia
- Experiences of childbirth-choice facilitation among women in public healthcare facilities of Namibia

- Midwives' experiences in facilitating childbirth-choices among women in public healthcare facilities of Namibia
- Development of a conceptual framework for the facilitation of childbirth-choices
- Development and evaluation of a model for midwives for the facilitation of childbirth-choices

9.7.2 Paper presentation

The following papers are proposed to be presented within the Independent Midwifery Association of Namibia, together with national as well as international audiences:

- Women's experiences on the facilitation of childbirth-choices
- The importance of the model for midwives for the facilitation of childbirth-choices

9.8 CHAPTER SUMMARY

Chapter nine concluded the study by emphasising on the key findings according to the objectives of the study. The chapter also focused on the contributions that the study achieves, the limitations of the study and how the study results would be disseminated. Last but not least, recommendations were outlined based on the research gaps the study identified for research, education and practice.

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APPENDICES

Appendix A: ETHICAL APPROVAL FROM THE UNIVERSITY OF NAMIBIA

UNAM
UNIVERSITY OF NAMIBIA

ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: SON /500/2019 **Date: 10 October, 2019**

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: A Model For Midwives Towards The Facilitation Of Childbirth Choices Among Women In Public Health Facilities In Namibia

Researcher: SARAH MLAMBO

Student Number: 201067099

Supervisors: *Dr. Hans J Amukugo (Main) Prof L. Pretorius (Co)*

Faculty: School of Nursing

Take note of the following:

(a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the UREC. An application to make amendments may be necessary.

(b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the UREC.

(c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by UREC.

(d) The UREC retains the right to:

(i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,

(ii) Request for an ethical compliance report at any point during the course of the research.

UREC wishes you the best in your research.

Dr. J.E. de Villiers: Chairperson

Ms. P. Claassen: Secretary

Appendix B: ETHICAL APPROVAL FROM THE MoHSS

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: 061 – 203 2507
Fax: 061 – 222558
E-mail: itashipu87@gmail.com

OFFICE OF THE EXECUTIVE DIRECTOR

Ref: 17/3/3 SM
Enquiries: Mr. A. Shipanga

Date: 05 February 2020

Ms. Sarah Mlambo
PO Box 50453
Windhoek

Dear Ms. Mlambo

Re: A Model for midwives towards the facilitation of childbirth choices among woman in Public Health Facilities in Namibia.

1. Reference is made to your application to conduct the above-mentioned study.

2. The proposal has been evaluated and found to have merit.

3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**

3.1 The data to be collected must only be used for academic purpose;

3.2 No other data should be collected other than the data stated in the proposal;

3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;

3.4 A quarterly report to be submitted to the Ministry's Research Unit;

3.5 Preliminary findings to be submitted upon completion of the study;

3.6 Final report to be submitted upon completion of the study;

3.7 Separate permission should be sought from the Ministry for the publication of the findings.

4. All the cost implications that will result from this study will be the responsibility of the applicant and **not** of the MoHSS.

Yours sincerely,

EXECUTIVE DIRECTOR
MINISTRY OF HEALTH AND SOCIAL SERVICES

BEN NANGOMBE
EXECUTIVE DIRECTOR

"Health for All"

Appendix C: APPROVALS FROM PARTICIPATING HOSPITALS

9-0/0001

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag X5501
OSHAKATI

Tel: + 264 65 2233000
Fax: + 264 65 221390/224564

INTERMEDIATE HOSPITAL OSHAKATI

Enq: Dr K V Amutenya

26 February 2020

Ms Sara Mlambo
P O Box 50453
sarahmlambo@yahoo.uk
WINDHOEK

REQUEST TO CONDUCT A STUDY 9 – 15 MARCH 2020.

Your communique dated 20 February 2020 on the above received and refers.

This note serves to inform you that you are granted permission to conduct your study at Intermediate Hospital Oshakati.

During your stay you must adhered to the rules and regulations of the institution and of the Ministry.

On arrival you can liaise with Drs Kibandwa, Bangtang, Mr Nandjila and Ms Nakapipi.

Yours Sincerely

MINISTRY OF HEALTH AND SOCIAL SERVICES
PRIVATE BAG 5501
OSHAKATI 9000 NAMIBIA
HOSPITAL

DR K V AMUTENYA
ACTING MEDICAL SUPERINTENDENT

"Your Health, Our Concern"

13/03/20 Rec.
Conduct research Oshakati H.C ANC PP.

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services
OSHANA REGIONAL DIRECTORATE

Private Bag 5501
Oshakati

Tel: + 264 65 2233060

Fax: + 264 65 221390

Enquiries: Dr. F. E. Indongo

12 March 2019

To: PHC
Supervisor

1. The request to conduct a case study
2. Please assist:

    1. **Sarah Mlambo, ID:85033011162**

The above mentioned is to conduct a study on a model for midwives towards the facilitation of childbirth choices among women in public health facilities in Namibia.

Thank you

MINISTRY OF HEALTH AND SOCIAL SERVICES
Private Bag 5501
2020 -03- 12
District PHC
PMO Office
Oshana
Namibia

Dr F.E. Indongo
SMO Oshakati District

"Health for all"

Republic of Namibia

Ministry of Health and Social Services

Private Bag 13215
WINDHOEK
Namibia

Intermediate Hospital Katutura
Independence Avenue
WINDHOEK

Telephone (061) 203 4004/5
Telefax (061) 222706

Enquiries: Dr. F. M. Shiweda

Date: 27 February 2020

OFFICE OF THE CHIEF MEDICAL OFFICER

Ms. Sarah Mlambo
P.O. Box 50453
Windhoek

Dear S. Mlambo

RE: **A MODEL FOR MIDWIVES TOWARDS THE FACILITATION OF CHILDBIRTH CHOICES AMONG WOMAN IN PUBLIC HEALTH FACILITIES IN NAMIBIA.**

The above mentioned subject refers:

This office hereby grants you permission to do research a Model for midwives towards the facilitation of childbirth choices among women at Intermediate Hospital Katutura, Khomas Region, MoHSS.

Thank you,

Please provide this office with a copy of your findings.

Yours in health,

.....

DR. F. M. SHIWEDA
CHIEF MEDICAL OFFICER

MINISTRY OF HEALTH
AND SOCIAL SERVICES
P/BAG 13215
WINDHOEK NAMIBIA
28 -02- 2020
INTERMEDIATE HOSPITAL KATUTURA

Private Bag 13215 Windhoek Namibia	Harvey Street Windhoek Central Hospital	Tel. No: (061) 203 3024 Fax No: (061) 222886
Enquiries: Ms.S.Iipinge	Ref. 17/3 / 3	Date: 27 February 2020

OFFICE OF THE CHIEF MEDICAL SUPERINTENDENT

Ms.Sarah Mlambo
P.O.BOX 50453
Bachbrecht
Windhoek

Dear Ms.Mlambo

SUBJECT: PERMISSION TO COLLECT DATA FROM MATERNITY WARD AT WINDHOEK CENTRAL HOSPITAL

1. Reference is made to your application to conduct the above-mentioned study.

2. This letter serves to inform you that permission has been granted for you to collect data at Windhoek Central Hospital, on the above mentioned subject as you have requested and does not include any remuneration.

3. Patient/Client's information should be kept confidential at all times.

4. Preliminary findings copy to be submitted to Customer care office, Windhoek Central Hospital upon completion of the study.

Thank you.

Yours sincerely,

27 -02- 2020

DR.F.ZAM
ACTING CHIEF MEDICAL SUPERINTENDENT

Noted
5/3/2020

Appendix D: PARTICIPANT INFORMATION AND INFORMED CONSENT FORM

TITLE OF THE RESEARCH PROJECT: A model for midwives towards the facilitation of childbirth-choices among women in public healthcare facilities Namibia

REFERENCE NUMBER: SON/500/2019

PRINCIPAL INVESTIGATOR: SARAH MLAMBO

ADDRESS: 50453 BACHBRECHT, WINDHOEK

CONTACT NUMBER: +264814234235

TO: MIDWIVES

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Research Ethics Committee at The University of Namibia and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and Namibian National Research Ethics Guidelines.

You have been invited to participate in the study because you are a midwife and you have in your line of work met and helped pregnant women during pregnancy and childbirth. Hence you are well positioned to share your experiences in the facilitation of childbirth choices. Your responsibility is to respond to the interview questions truthfully to ensure trustworthiness of the research.

The purpose of this study is to develop a model for midwives in Namibia to help facilitate childbirth-choices among women in health facilities harmoniously.

With your permission, you will participate in this study whereby you will be interviewed to describe your experiences of childbirth-choice facilitation for women under your care. The interview will take about 30- 40 minutes to complete. A voice recorder will be used during the interview session to ensure trustworthiness of the data. The recording will be deleted after the study is completed. The researcher will share the transcribed materials with the study supervisors. Your input in this research will be highly appreciated.

As a research participant you will not benefit directly from this research in terms of material gain. The indirect benefit may be an enhanced awareness on the facilitation of childbirth-choices among women in Namibia and the provision of insight in the role of midwives, health facilities and women as a shared responsibility in childbirth-choice facilitation.

Any information that is obtained in connection with this study will remain confidential in that no personal information will be divulged in the presentation of data and results. All data will be handled by the researcher and supervisors, and will be anonymised before it is processed, transcribed or analysed. Confidentiality will be maintained by means of the use of pseudonyms and all data will be in my safe custody under a password protected laptop. The data will be used for academic purposes only. The interview will be conducted in a private room so that no one can hear the conversation except the researcher.

This research is voluntary and as such there will be no remuneration for participating. However, your transport costs will be catered for should there be need to travel from your place of residence, hence there will be no costs for you.

If you have any questions or concerns about the research, please feel free to contact Mrs Sarah Mlambo, the researcher on +264814234235, or email sarahmlambo@yahoo.co.uk. *You can contact the Centre for Research and Publications* **at +264 061 2063061; pclaassen@unam.na** if you have any concerns or complaints that have not been adequately addressed by the investigator. You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I ……..……. agree to take part in a research study entitled *(insert title of study).*

I declare that:

a) I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.

b) I have had a chance to ask questions and all my questions have been adequately answered.

c) I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.

d) I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

e) I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ……..... on (*date*) ……..…..... 2020.

..... **.....**

Signature of participant Signature of witness

Declaration by investigator

I …… declare that:

- I explained the information in this document to ……...
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) .....….....…….... on (*date*) ……...……... 2005.

..... **.....**

Signature of investigator Signature of witness

Declaration by interpreter

I *(name)* declare that:

a) I assisted the investigator (*name*) ……. to explain the information in this document to (*name of participant*) ……...……... using the language medium of (Oshiwambo, Oshiherero, Afrikaans, etc.)

TITLE OF THE RESEARCH PROJECT: A model for midwives towards the facilitation of childbirth-choices among women in public healthcare facilities in Namibia

REFERENCE NUMBER: SON/500/2019

PRINCIPAL INVESTIGATOR: SARAH MLAMBO

ADDRESS: 50453 BACHBRECHT, WINDHOEK

CONTACT NUMBER: +264814234235

TO: WOMEN

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Research Ethics Committee at The University of Namibia and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and Namibian National Research Ethics Guidelines.

You have been invited to participate in the study because you are among the women who have birthed within the period under study and have received health services from health professionals to have the birthing choice you had. Hence you are well positioned to share your experiences. Your responsibility is to respond to the interview questions truthfully to ensure trustworthiness of the research.

The purpose of this study is to develop a model for midwives in Namibia to help facilitate childbirth-choices among women in health facilities harmoniously.

With your permission, you will participate in this study whereby you will be interviewed to describe your experiences of childbirth-choice facilitation by your health professionals that attended to you during your pregnancy. The interview will take about 30- 40 minutes to complete. A voice recorder will be used during the interview session to ensure trustworthiness of the data.

The recording will be deleted after the study is completed. The researcher will share the transcribed materials with the study supervisors. Your input in this research will be highly appreciated.

As a research participant you will not benefit directly from this research in terms of material gain. The indirect benefit may be an enhanced awareness on the facilitation of childbirth-choices among women in Namibia and the provision of insight in the role of midwives, health facilities and women a shared responsibility in childbirth-choice facilitation and decision making.

Any information that is obtained in connection with this study will remain confidential in that no personal information will be divulged in the presentation of data and results. All data will be handled by the researcher and supervisors, and will be anonymised before it is processed,

transcribed or analysed. Confidentiality will be maintained by means of the use of pseudonyms and all data will be in my safe custody under a password protected laptop. The data will be used for academic purposes only. The interview will be conducted in a private room so that no one can hear the conversation except the researcher.

This research is voluntary and as such there will be no remuneration for participating. However, your transport costs will be catered for should there be need to travel from your place of residence, hence there will be no costs for you.

If you have any questions or concerns about the research, please feel free to contact Mrs Sarah Mlambo, the researcher on +264814234235, or email sarahmlambo@yahoo.co.uk. *You can contact the Centre for Research and Publications at* **+264 061 2063061; pclaassen@unam.na** if you have any concerns or complaints that have not been adequately addressed by the investigator. You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I ……..……. agree to take part in a research study entitled *(insert title of study)*.

I declare that:

f) I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.

g) I have had a chance to ask questions and all my questions have been adequately answered.

h) I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.

i) I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

j) I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....….....…….. on (*date*) ……...……... 2020.

..... **.....**

Signature of participant Signature of witness

Declaration by investigator

I *(name)* declare that:

- I explained the information in this document to ……...
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) .....….....…….. on (*date*) ……...……... 2020.

..... **.....**

Signature of investigator Signature of witness

Declaration by interpreter

I …… declare that:

b) I assisted the investigator (*name*) ……. to explain the information in this document to (*name of participant*) ……...……... using the language medium of (Oshiwambo, Oshiherero, Afrikaans, etc.)

Appendix E: CHECK LIST FOR PUBLIC HEALTHCARE FACILITIES

TITLE: A model for midwives towards the facilitation of childbirth-choices among women in selected public healthcare facilities in Namibia

STUDENT: SARAH MLAMBO

SECTION A: DEMOGRAPHIC DATA

Hospital Name:

1. Age: 2. Employment status

3. Gravity: 4. Parity: 5. Booked/Un-booked

6. Gestational age at birth:

7. Marital status

Characteristic	Tick
Married	
Cohabiting	
Single	

SECTION B: CHILDBIRTH TYPE

1. Childbirth type

Characteristic	Tick
Vaginal birth	
Caesarean Section	

2. Maternal complications during pregnancy

Characteristic	Tick
Preeclampsia	
Eclampsia	
Diabetes	
Cardiac disease	
Pre-term labour	
APH	
None	

3. If Caesarean section indicate reason for the childbirth type

Characteristic	Tick
Prolonged labour	

Foetal distress

Previous Caesarean section

Failed induction of labour

Patient request

Transverse or oblique lie

Breech presentation

Others

Appendix F: INTERVIEW GUIDE

FOR: MIDWIVES IN THE PUBLIC HEALTHCARE FACILITIES

TITLE: A model for midwives towards the facilitation of childbirth-choices among women in selected public healthcare facilities in Namibia

SECTION A: DEMOGRAPHIC

Age:

Years of experience:

Health facility:

Main question:

1. Would you please tell me your experiences on facilitating childbirth-choices among the women who come through your healthcare services?

Possible probing questions

1.1 Would you describe to me how you facilitate childbirth-choices in your health facility?
1.2 At what stage of pregnancy do you initiate facilitation of child birth choices?
1.3 Which childbirth-choices do you offer the women that are under your care?
1.4 Would you describe how actively involved pregnant women are in terms of childbirth choices?
1.5 What in your opinion are the possible interferences in facilitating childbirth-choices among women?
1.6 What in your view may enhance facilitation of women regarding childbirth choices?
1.7 Would you explain if women in your health facilities have the independence for a childbirth choice?
1.8 Would you like to add anything regarding childbirth-choice facilitation in your health facility?

FOR: WOMEN THAT HAVE BIRTHED BETWEEN APRIL 2018 AND MARCH 2019

TITLE: A model for midwives towards the facilitation of childbirth-choices among women in selected public healthcare facilities in Namibia

SECTION A: DEMOGRAPHIC

Age:

Gravity … Parity …

Health facility:

Level of education: Primary: Secondary Tertiary

SECTION B

Main question:

1. Would you please tell me your experiences on what information you received when you were expecting your child from the healthcare professionals regarding different delivery types?

Possible probing questions

1.1 What information did you receive from midwives during pregnancy about delivery types?
1.2 Which delivery types were explained and offered to you?
1.3 How can you describe your involvement in the delivery type you finally ended up having?
1.4 What are the primary factors that influenced your decision for the delivery you had?
1.5 How can you describe the benefits of the chosen delivery type for future pregnancies?
1.6 At what stage of your pregnancy where you told about delivery choices?
1.7 How did the assistance from the healthcare professionals influence your previous choice of birth choice if you already had one?
1.8 Could you describe the pros and cons of the delivery choices that were given to you?
1.9 What would you suggest should be done regarding childbirth facilitation (delivery type) in healthcare facilities?
1.10 Is there anything else you would like to add regarding the topic?

Appendix G: SAMPLE TRANSCRIPTION

TRANSCRIPT WOMEN RW01

I – How are you

RW01 – I'm doing well how are you?

I – I'm alright. Thank you so much for accepting to participate?

RW01 – You are most welcome

I – is it fine if we continue telephonically?

Rw01- yah

I – Like l said l am a student from UNAM and am doing a research on facilitation of childbirth choices. So l will ask you a few questions and you are free to answer and not answer the ones you do not understand

RW01 – Ok

I – Ok. How old are you ma'am?

RW01 – I am 20 years old

I – And how many pregnancies have you had?

RW01 – Only one

I – ok. And to which level did you finish school?

RW01 – Actually l was a 2nd year at UNAM but now l dropped out so l only have one qualification.

I – Would you tell me your experience on the information that you received during your pregnancy before you gave birth as in the different ways in which a woman may deliver.

RW01 – Ehh Types of delivery?

I – Yes the types of delivery

RW01 – Honestly speaking l did not get that type of information during my pregnancy

I – Is that so? How many visits did you attend?

RW01 – Yes l did and l only attended twice.

I – okay twice. So even when you visited the first time they did not give anything on the way you were going to deliver

RW01 – No they don't maybe if l forget but as far as l can remember they did not.

I – They did not okay. What information did they give you when you went in for booking?

RW01 – At first visit they told me more about the clothes that l should wear like the loose clothes and food the pregnant woman should eat.

I – Okay so they sold you about clothes to wear and the food to eat?

RW01 – Yes

I – Okay what type of delivery or childbirth did you have?

RW01 – I went the natural way

I – You went the natural way okay. And how did you hear about the natural way did you have any information which told you that the natural way is the way to go?

RW01 – Actually I did not get any information on it, when l went to the hospital when l was in labour l was only taken in the delivery room with no questions or anything. There was no complication at all.

I – Ok I understand but do you know the advantages and disadvantages of a normal birth and a c/s?

RW01 – Actually l don't know the advantages of the births

I – Do you think it will be beneficial if you would receive information of the different types of childbirth and will it help a woman when they are pregnant and when they deliver?

RW01 - Yah l think it will be good to tell pregnant lady about the ways to deliver so they choose themselves how they will deliver.

I – and when do you think this message needs to be given to women?

RW01 – I think during the visits for ANC, when you go for ANC it should be given in the semesters especially the last one.

I – why do you say the last one?

RW01 – Because at that time the main concern of the woman at that time is giving birth to the child with no other thing to think about.

I – Is it? But is it not fair for you to have information during your pregnancy so that you make decisions depending of the information being

RW01 – yah I would say that even during the first weeks it will also be nice I think it will even be better because you will get enough time to ask information on it and to do research on it and also tell your family about it and they give you also their point of view about it.

I – In your view how was your experience with a natural birth

RW01 - Well my experience was fine and l will recommend it for all women because there are no complications about it and you will not be left with any scars on your body like the operation one

I - And how did you manage with pain? Did you receive any information about that during ANC?

RW01 – My late mother told me that labour is painful and all ladies need to go through that and there is no way you can escape it.

I – and the midwives did they mention how to deal with pain in labour?

RW01 – Aaah no l cannot recall that

I - Is there anything you would like to see improvements with regards to childbirth types information

RW01 - They should be told on the different types of delivery and how a mother can handle the baby after delivery and l think the other thing is to recommend more on breast feeding because nowadays l see most women only want bottle feeding they don't want breast feeding. I think it will be fair and good to recommend it on every lady so it can change their mind set on bottle feeding. Information is very good, there are some people willing to change their mind set provided they get proper information

I – When did you make the decision that l am going to deliver myself

RW01 – 8 months at first it felt like the nurses and doctors will decide for me which delivery but later I realised they can't decide for me l have to go the natural way. They did not decide for me and they did not even ask

I - If there are no other questions thank you so much for your time

RW01 - Most welcome

Appendix H: LANGUAGE EDITOR LETTER

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28 October 2021

To whom it may concern

LANGUAGE EDITING – MRS SARAH MLAMBO

This letter serves to confirm that a **DOCTORAL DEGREE IN NURSING SCIENCE dissertation** entitled ***A MODEL FOR MIDWIVES TOWARDS THE FACILITATION OF CHILDBIRTH-CHOICES AMONG WOMEN IN SELECTED PUBLIC HEALTHCARE FACILITIES IN NAMIBIA*** by Mrs Sarah Mlambo was submitted to me for language editing.

The dissertation was professionally edited and track changes and suggestions were made in the document. The research content or the author's intentions were not altered during the editing process and the author has the authority to accept or reject my suggestions.

Yours faithfully

DR NELSON MLAMBO
PhD in English
M.A. in Intercultural Communication
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B. A. English & Linguistics

APPENDIX I: MODEL EVALUATION FORM

TITTLE: A model for midwives towards the facilitation of childbirth-choices among women in selected public healthcare facilities in Namibia

STUDENT: SARAH MLAMBO

UNIVERSITY: UNIVERSITY OF NAMIBIA

PURPOSE: EVALUATION OF A MODEL

The study problem emanated from the fact that women in public healthcare facilities have no choice or rather have assumed choices when it comes to childbirth-choices. Universal rights of childbearing women, Patient Charter of Namibia, Human Rights among others all advocate for giving unbiased information in order for them to make informed decisions. I hereby ask for your expertise in evaluating the attached Model for midwives in the facilitation of childbirth-choices in public healthcare facilities to ensure that all women in the healthcare facilities receive balanced information, are involved in decision making and having an informed choice. The model was developed in accordance to the findings from peer reviewed articles, maternity registers, midwives and women who formed the population of the study. Therefore, your input is sought to either confirm or improve the model. The evaluation criteria are based on Chinn and Krammer (2018).

Kindly fill in as you answer the following in terms of the attached model:

1. HOW CLEAR IS THE MODEL?

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2. HOW SIMPLE IS THE MODEL?

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3. HOW GENERAL IS THE MODEL?

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4. HOW ACCESSIBLE IS THE MODEL?

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5. HOW IMPORTANT IS THE MODEL?

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Name: …….

Profession: ……..

Rank/Job title: …….....

Signature: ……..

Date: ……..

Thank you for your time and willingness to participate.