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EXPECTING MOTHERS' PREFERENCES OF MIDWIFE GENDER: IMPLICATION FOR MIDWIFERY DEPLOYMENT

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Abstract: *The purpose of this study was to gather expecting mothers' preference of midwife gender. This was motivated by the fact that, catering for expecting mothers' preferences in midwife deployment is a strategy to promote client centered service delivery in hospitals. It is also expected to reduce home deliveries by woman who fear exposing their bodies to males who are not their husbands. A combination of a descriptive survey and historical research design was applied in this study. Data was collected from a purposive sample of 100 expecting mothers through a self reporting questionnaire and focus group discussions. The study found that, male midwives were only allowed to train and practice as midwives when the Sex Discrimination Act of 1975 was implemented. Otherwise midwifery was a female to female affair. The majority of expecting mothers prefer female midwifes. There was an association between midwife preference and location. The majority of mothers in rural areas prefer female midwives. Factors contributing to these preferences include, age (mature mothers prefer female midwives while young mothers (10 – 20) years do not mind. Culture and religious beliefs are the other factors that contribute to female midwife preference. This study recommends that: (1)Gweru provincial hospital school of midwifery should train more female midwives than males. The study suggests a ratio of 2:3 for male: female midwife trainees. This midwife gender imbalance is based on the finding that more mothers prefer female midwives than male midwives. (2) More female midwives should be deployed in the rural areas and growth points where they are mostly preferred.(3) Further studies at a larger scale are called for since this research's findings are just a tip of an iceberg in the midlands province of Zimbabwe.*

Key Words: *Midwife, Gender preferences, Expecting mothers*

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INTRODUCTION

It may be absurd to debate over the gender of a person called midwife. The qualitative nouns like house wife and midwife are made up of the prefix house or mid and the common stem wife. Wife on its own is a feminine title assigning females to males. For example, Mr. Chinamasa's wife, has gender possessive connotations. In fact God made childbirth as the privilege of the female fork. From this angle one can be justified to question the logic of males being midwives when they themselves will never experience the pleasures and pains of child bearing.

Traditionally, maternal health issues have predominantly been seen and treated as a purely feminine matter. Women learnt midwifery through intuition and by taking care of themselves when pregnant and observing others giving birth. Fife (2004) reports that in the 16th century midwifery which used to be done by old experienced women, later became a profession of young women. Males joined midwifery in the 20th century due to modernization. Problems arise when expecting mothers find themselves being asked to undress in front of a male midwife. According to Smellie (2008) culturally it was a taboo for men to attend to a birthing woman.

Gweru hospital is a referral centre for hospitals in the midlands province. It trains midwives of both sexes. It recruits student midwives yearly of which less than a quarter will be males from different hospitals. Despite Gweru hospital being a training school for midwives it has only two male midwives, one in the labor ward and the other one in postnatal ward. The antenatal ward is still serviced by female midwives only who return to their stations post qualifying. McAllister (2007; 45) reported that "patients are dissatisfied when their expectations are not realized" therefore there is need to explore the midwife gender preference of expectant mothers in order to promote the utilization of midwifery care by clients.

STATEMENT OF THE RESEARCH PROBLEM

Some expecting mothers are uncomfortable to be assisted by male midwives during child birth. Expectant mothers who come at Gweru provincial hospital are from different cultural backgrounds and have different expectations from the maternity staff. Their requests for female midwives have not been catered for during midwife deployment. Midwifery is supposed to be client centered, providing services according to the preferences of the

expecting mothers. Unfortunately expectant mothers' preferences for midwife gender have not been gathered and documented for midwife deployment in Zimbabwe. This study seeks to establish the expectant mothers' preference of midwife gender as a basis for midwifery deployment in labour ward.

RESEARCH QUESTIONS

The study seeks to answer the following three questions:

1. What is the midwife gender preference of expectant mothers at Gweru provincial hospital?
2. What factors contribute to midwife gender preference of expectant mothers ?
3. How can midwives be deployed to meet expecting mothers' preferences?

RESEARCH HYPOTHESIS

According to Best (2009) a hypothesis is a tentative assumption drawn from knowledge, theory and is used as a guide in the investigation of other facts and theories that are yet to be known.

The study hypothesized that:

H_1: Midwife preference among expectant mothers is associated with location.

H_O: Midwife preference among expectant mothers is not associated with location.

SIGNIFICANCE OF THE STUDY

The study seeks to improve the delivery of midwifery services by meeting their clients' needs. It reduces some of the challenges that are experienced by expectant mothers who are assisted by male midwives against their cultural beliefs and expectations. Findings provide a basis for the deployment of midwives at both hospital and national levels. Schools of nursing use the findings to determine the recruitment ratio of midwife students by gender.

LITERATURE REVIEW

According to Roberts (2004) whilst in the history of nursing the feminine pronoun has been used when designating the midwife, it is recognized that midwives may be males as well due to changing midwifery trends. When dealing with some cultures a male midwife may be unacceptable to the woman, her husband and her family. This is a problem that has not been explored, although it is acknowledged that it is an important issue for midwife deployment. In the current set-up, midwives are not deployed according to gender or

expectant mothers' preference. They go to nursing schools as part of the human resources manpower development and return to their stations.

Smellie (2008) argued that childbirth is a life changing experience within all cultures and ethnic groups. It provokes a wide range of responses that are influenced by a complex interaction of different religious beliefs, culture, education, social status, economy and the perceived position of women within the society. According to Smellie (2008) at the centre of all these powerful forces is a unique individual with her own personality, needs, hopes and fears. Both the status and the perceptions of women are influenced by social class, education, religious beliefs and the degree to which the group has been exposed to different value systems.

Roberts (2004) advocates that since midwives have a professional duty to offer equitable care according to clients' needs, it follows that an understanding of the client's cultural background is a pre-requisite for satisfying the midwife gender preference of the expectant mother in any given situation. The current situation whereby male nurses are sent for midwifery training but may not practice because of the culture of the places they are working is disturbing. It leads to underutilization of national human resources.

HISTORY OF MIDWIFERY

Midwifery was traditionally seen as the care of pregnant women by women. According to Fife (2004) the Medical Acts of 1858 and 1886 consolidated the position of the "man-midwife", who became the forerunners of the obstetric specialist. Female practitioners gained legal recognition in the First Midwives Act of 1902. The midwives act of 1902 regulated the midwifery profession requiring certification for midwives and providing a penalty for any woman found practicing midwifery without certification, with the exception of legally qualified medical practitioners and those giving assistance in emergencies. Alison (2000) confirms that the midwifery act prohibited the practice of midwifery by unqualified women, although unqualified men could still practice. However this was not of any importance because untrained women were taking care of the pregnant women ever since the human species started to live. This loophole was closed in 1926.

The Midwives Act of 1952 prohibited men from training and practicing as midwives. In the late 1960s and early 1970s a small number of male nurses began challenging the idea that men cannot be midwives. In 1975 a bill to abolish sex discrimination in employment was

introduced. This bill made it illegal for man to be discouraged from practicing as midwives. Later that year an amendment to the bill removed the barriers to men entering midwifery, provided certain restrictions were abided by. As a result British lying-in hospital midwifery was allocated to train male midwives, but the male midwives were to be monitored to ascertain the suitability of men as midwives. This need for monitoring reflects stakeholders' suspicion for males practicing as midwives.

According to Alison (2000), the first men entered midwifery training in the British midwifery training schools in 1977. Speak and Aitken (1982) noted that by 1979 the "experiment" was deemed as being successful, and that "male midwives were generally acceptable to mothers, their husbands, midwifery and medical staff". In 1982 the Royal College of Midwives recommended that midwifery should be opened to men. Lewis (1991) noted that on 16th March 1983 the Secretary of State announced that the barriers contained in the Sex Discrimination Act (1975) relating to male midwives were to be removed and men were now free to train and practice as midwives. Allison (2000) reports that by 1995 there were 98,337 midwives registered with the UKCC, of these 135 were male and 98,202 were female (UKCC, 1995). In 1995 there were 35,310 midwives practicing in the UK, of these 87 were male and 35,223 were female (UKCC, 1995).

Nsululu (2013) a male midwife commented that "I qualified in 1997, and now work in a Midwifery Team working both in the community and the hospital environments. Currently (January 2001), I have been privileged in delivering 132 babies". This shows that man also enjoy delivering babies. Men first won the right to be registered as midwives just 20 years ago, following a long legal battle. They faced opposition from female midwives and expectant mothers. Even today, not all women are comfortable with a man delivering their baby. Some are suspicious of men's motives while others reject them on religious grounds. Occasionally the woman's partner might decide that he doesn't want another man in the delivery room. Taking into consideration the facts above one can deduce that although male midwives are happy to be in the labour ward, not all expecting mothers are comfortable with them. Health service delivery according to customer needs is compromised.

In the modern period, midwifery began to change from being a female art into a male occupation, although the shift was not a smooth one (Allison (2000). It began in 1522, when Dr. Wertt of Hamburg dressed up as a woman in order to observe midwives and learn about

childbirth. When he was discovered to be man, Wertt was burned alive. Later in the mid-sixteenth century, however, the renowned surgeon Pare laid a more solid foundation for men's work in the birthing room by aiding during child delivery by pulling babies out of the womb by their feet during difficult births.

Roberts (2004) observed that a contributing factor in this shift of gender roles was Louis XIV's use of male midwives to deliver his illegitimate children. As men delivered his mistresses babies, male midwives gained popularity. Allison (2000) agrees with Fife (2004) on the fact that the fight to include male midwives in the labour room was a struggle.

EXPECTANT MOTHERS' MIDWIFE GENDER PREFERENCE

According to Allison (2000) even though male midwives gained popularity, their acceptance was not unanimous. Some people believed that men did not belong to the birthing room; since men do not experience childbirth. Some believed that child birth is beyond the realm of male expertise. Such critics often cited the Bible Exodus chapter 1 verse 15-16, claiming the absence of men at recorded births. Roberts (2004) viewed male midwives as interlopers into other men's domestic territory. In a space where the husband or father was absent, the male midwife's presence stood out as inappropriate. It raised questions about the male midwives' potentially inappropriate behavior toward vulnerable female bodies since males never experienced labour pains. The researchers cannot expect them to interpret the expectant mothers' non-verbal communication. Thus issues of female modesty and male property emerged, and opponents called upon husbands to bar male midwives from their homes, thus male midwives were a potential source of problems with the spouse and other interested parties.

Allison (2000) observed that in Papua New Guinea people adhere to their diverse cultures, so much that in one culture a woman can bleed to death in front of a male midwife, because she doesn't want her private parts to be seen by a man. Women do not come to the antenatal clinic, because they don't want to be seen by male midwives. When there are male midwives woman don't come for delivery services. This observation shows that some expectant mothers are scared of male midwives. One can also attribute the fact that, some pregnant mothers are scared of male midwives, as a factor contributing to home deliveries in Zimbabwe.

Keukam a female midwife who was attended by a male midwife at birth was cited in Smellie (2008;3) saying that she admires male midwives' techniques so much that she strives to emulate them in her work. Smellie (2008; 5) cited Stone an expectant mother saying "Male midwives are the best, female midwives are believed to be aggressive and impatient at times." One would wonder if all the male midwives are good and most female midwives aggressive or inconsiderate. However gender is just not an issue, but the midwives need a certain personality to do the job.

Society now might be more accepting of male midwives than 20 years ago (Fife, 2004). It must be recorded that, not all women are comfortable with a man delivering their baby. Some are suspicious of men's motives while others reject them on religious grounds. Fife (2004:91) commented that "clearly, a better mix of midwives from varying racial, ethnic, and cultural backgrounds is needed". Fife (2004) was silent on midwife gender.

Smellie (2008) reveals that one male midwife succinctly stated that "gender is very rarely an issue for some clients." Many women reported being initially hesitant about having a male midwife, but once rapport was developed gender was no longer a consideration. Furthermore, one woman reported that her male midwife was "much more caring and sympathetic" than her female midwives. Another midwife explained that if the male midwife has "the skills and attributes that midwives need, it doesn't matter what the gender is and it's usually pretty easy to convince women of that." The overall emerging theme is that gender isn't necessarily related to caring practices and men in midwifery credit the women they serve with the ability to discriminate the difference.

Smellie (2008) proposes that while many Christian women prefer male midwives because they say men are more attentive, Muslim women claim that it is against their religion for men other than their husband to see them naked. Some expectant mothers charged that male midwives often caused more problems than they solved. They lacked the natural tenderness that one woman has for another. Unfortunately they did not describe the nature of problems caused. However there are but too few midwives who are sufficiently mistresses in their profession.

Given equal ignorance in the practice of the men and the women, one may draw a further distinction between them, favoring the female practitioners. Smellie (2008) pointed out that female midwives are incapable of doing so much actual mischief as the male-ones. Males

with less tenderness and more rashness go to work with their instruments, where the skill and management of a good midwife would have probably prevented instrument delivery.

Roberts (2004) continues by defending the historical preference evidenced both by the general public and the medical profession for female midwives and by concurring with other critics in attributing the fashion for male practitioners to the French and their eternal fondness...for novelties. These ranged from a settled preference on the part of some women for female attendance in intimate circumstances to heartfelt objections on religious and moral grounds to male intrusion into the most private of female domains.

Roberts (2004) and Fife (2004) expresses doubts about the objectivity of men particularly young men when they employ "the touch" as part of their diagnostic procedures. "In pure justice to all parties," they observed that besides many other points to be learned only by ocular inspection and manual palpation, of which no theory by book or precepts can convey satisfactory or adequate notions, that great and essential point in the nursing profession. A skill in the touching is not acquired without a frequent habit of recourse to the woman's sexual parts where the indications are taken. And in this nothing but personal experience can perfect the practitioner.

Although with respect to the motives of men in midwifery, Smellie (2008) presents a much more balanced view than does Roberts (2004) although at root, the concerns of the two critics of male midwifery are essentially identical. Smellie (2008) noted that men-midwives were too often ignorant, rough, impatient, too stiff in the hands and fingers, and over-ready to use the injury-inflicting instruments of their trade. Fife (2004;99) purports that "a woman-practitioner will employ, without stint, or remission, all that is necessary to predispose the birth passages, for the least pain, and the greater safety; patiently."

Though feelings on both sides of the midwifery issue ran high, Jenkins in Fouche (2002; 25) stated that he often gets a reaction from women and their families when he walks through the door, but he finds it easy to develop a rapport. Alan Jenkins in Fouche (2002: 30) advised that "I think you have to try to understand each individual situation on the few occasions that happens, there could be religious reasons or it could be because women have been treated badly by men or it could be that the partner doesn't like the idea of a man handling her." Fife (2004; 102) commented that in defense, some people suggest that having a male

midwife is no different from having a male doctor but it is. Midwifery is a much more intimate form of caring."

MIDWIFERY MODEL

The midwifery structural model of care which was proposed by the Queensland Nursing Council (2000) was used to guide the survey of expecting mothers' preference of midwife gender. The midwifery model of care identified four elements that comprise midwifery namely: the woman as the central focus, the midwife as the provider of care, the professional partnership and the environment in which this occurs. The midwifery model of care guides midwives through areas that need to be considered when changing a practice model. Queensland health (2000) stated that midwifery does not occur in a vacuum, it is anticipated that the use of the midwifery framework would encourage midwives to recognize that quality client care depends on a broad range of factors. Some of the factors include satisfying the expecting mothers' preference of midwife gender. The midwifery model of care also emphasizes respect for patients' values, preferences and expressed needs which should be attended to, to ensure patient satisfaction.

According to Queensland (2000) the midwifery model provides guidance for assessing the current quality of care and how new practice model can be implemented. The model therefore was suitable to use in this study as inclusion of male midwives continue to be considered as new. It experiences little welcome in the field of midwifery, there is need for continuous evaluation of the inclusion of males in the midwifery. The midwifery model also provide the logical structure that guides the decision making process of midwives, provides guidance for assessing the quality of midwifery care that results from current ratio of the midwife gender at Gweru hospital.

RESEARCH DESIGN

This survey of the expectant mothers' preferences of midwife gender at Gweru hospital was guided by a combination of a descriptive research and the historical research design. Descriptive research design survey facilitates the researcher's extraction of the expectant mothers' preferences of midwife's gender, describe the distribution of the preferences and factors that influence the preferences.

Borg and Gall (1989) defined a historical research design as the systematic search and interpretation of facts from the past to deduce meaning for the present. The researcher

used the historical research design to establish the midwife gender preference in the past through reviewing literature. Historical research design helped the researcher to establish factors influencing expectant mothers' preferences in relation to the past set up in the midwifery practice.

INSTRUMENTS

The researcher used a self reporting questionnaire and a focus group discussion guide to capture the midwife gender preferences of expectant mothers. The questionnaire managed to capture age of the participating mother, identify each age range's unique preference and the possible factors that influence it. The study topic is sensitive and requires individual views collected in a way that ensures anonymity. The questionnaire was found appropriate for this study as it requires individual preferences. Most women of child bearing age are literate, able to interpret the questions on the questionnaire and record their preferences. The questionnaire provided a record to be kept and used as references later during the research process. A focus group guide was used to capture group perceptions and group preferences of the expectant mothers.

POPULATION AND SAMPLING

The population of this study was composed of the different age groups of expectant mothers who were attended at Gweru provincial hospital Antenatal clinic and labour ward. Each age range was considered unique and hence a rich source of information. In fact every pregnant women who would have agreed to answer the questionnaire was a rich source. The distribution of the variable is not known.

According to Sapsford and Jupp (2006) sampling is the selection of a representative subset of the population which is done strategically and systematically so that the researchers selects the subjects that meet a specific criterion for the study. The total number of expectant mothers and the distribution of variables were not known therefore the researcher used non-probability sampling. The expectant mothers were chosen according to their relative easy access and availability. Researchers selected the first ten expectant mothers on alternate days Mondays and Wednesdays until the number 100 was reached. N=100.

DATA COLLECTION

Data collection process was initiated by seeking permission from the medical superintendent of the hospital to collect data from the expectant mothers who come at Gweru hospital. The researcher had to seek permission from the matrons and sisters in charge of the antenatal and labour ward to dispatch the questionnaire and interview expectant mothers in the ward. Permission was granted after submitting the research proposal and questionnaire to the medical superintendent. The researchers promised to give a copy of the study to the hospital so that they can then implement the recommendations from the study.

The researchers introduced the purpose of the study orally to the group of the expectant mothers which the researchers had discussed with the project supervisor before pilot testing. The expectant mothers who agreed to complete the questionnaire were given a copy to complete whilst the researcher was waiting first thing in the morning before pretest counseling.

Researchers visited expecting mothers in 5 different churches and clinics. A total of 20 groups participated to facilitate generalization of research findings. Five groups were selected on daily bases at the Antenatal clinic first thing in the morning until the twenty groups were reached.

FINDINGS AND DISCUSSION

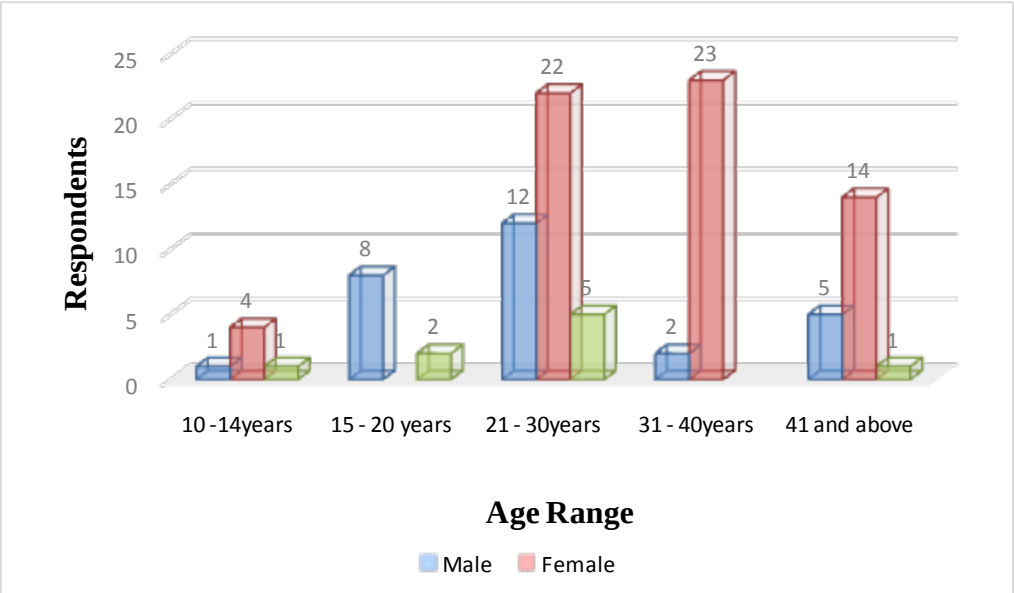

Figure 1: Expectant mothers' midwife gender preference by age. N = 100

The study shows that, the majority of expecting mothers who were in the age ranges (21 – 30) years and (31 -40) years prefer female midwives. These are mature woman who may be basing their decisions on experience. They raised strong sentiments from cultural background such as, "a woman's body is a private preserve of her only husband, hence cannot and should not be exposed to any other man." The expectant mothers preferred female midwives saying that female midwives understand the plight of women especially those who have infertility problems and end up conceiving at an advanced age.

Of interest is the (10 – 14) years group. Although the majority of mothers prefer female midwives, there is an equal distribution of those who prefer male midwives and those who did not worry about the gender of the midwife. Mothers within the (15 – 20) years prefer male midwives. They raised complaints about female midwives who scold them. These results imply that, male midwives can be deployed from expecting mothers within the ages (10 – 20) years. Female midwives can be deployed to mature mothers above 21 years.

Figure 2: Distribution of midwife gender preferences according to location. N = 100

The graph shows that, the majority of participants prefer female midwives. This preference is outstanding in the rural, growth-point and urban areas. Male midwives are preferred in urban, peri-urban and farming community. The 14% of expectant mothers who prefer males cited that they are moving with changing times whilst some cited bad experiences in the hands of female midwives. The expectant mothers who do not mind the gender stated that whether male or female the midwives undergo the same training.

The majority of participants (34%) from the rural area prefer to be attended by female midwives. The expectant mothers cited that their husbands are jealousy and culturally it is

not acceptable for women to be naked in front of a male other than her husband. The implication of these results is that, more female midwives should be trained than male midwives. Male midwives can be deployed more in urban than rural areas. In peri-urban areas an equal distribution of male and female midwives can be deployed.

Table 1. Factors contributing to gender preferences N. = 97

Response	Respondents	Percentage
Females are empathetic and understanding	**37**	**37%**
Males are patient with woman	**22**	**22%**
Both because they have the same knowledge	**10**	**10%**
Females are culturally accepted as midwives.	**28**	**28%**

Figure 4.3 shows that 37% of the respondents preferred to be attended by females because they think they are empathetic and understanding. 28% prefer female midwives because they are culturally accepted as birth attendance from the ancient period. The issue of culture as a controlling factor on the midwife gender preference of expectant mothers seems to be strong although it was not mentioned by some respondents. 22% prefer males because they are patient. Expectant mothers who preferred male midwives cited previous unpleasant experiences in the hands of female midwives. 10% of the expectant mothers were neutral (they preferred both sexes) because they believe midwifery training is the same to both males and female therefore they possess the same knowledge.

Table 2. Expectant Mothers' Midwife Gender preference and location. N = 106

Location	Male	Female	Both	Total
Urban	14 (9,3)	28 (34,1)	5 (3,1)	47
Rural	3 (7,3)	34 (26,8)	0 (2,4)	37
Peri-urban	4 (1,9)	4 (7,2)	2 (0,6)	10
Farm	1 (0,9)	4 (3,6)	0 (0,3)	5
Growth-point	0 (1,3)	4 (3,6)	0 (0,4)	7
Total	21	77	7	106

Table 2, shows observed frequencies and expected frequencies in brackets. At 5% level of significance V = 8df, X^2_{calc} = 21, 24 and X^2_{crit} = 15,507. Since X^2_{crit}= 15,507 < X^2_{calc} = 21, 24. The null hypothesis was rejected and the study concluded that midwife gender preference among expectant mothers is associated with geographical location. The implication is that, midwife deployment by gender should be associated with location. More female midwives should be deployed in rural areas and growth-points.

RECOMMENDATIONS

1. Gweru provincial hospital midwifery training school should train more female midwives than male midwives as they are the ones who are mostly preferred.
2. Awareness campaigns to sensitize expectant mothers on existence of male midwives can be done to improve their acceptability in the labor wards.
3. More female midwives should be deployed in rural areas were they are preferred. This may reduce the number of home deliveries due to fear of expecting mother being seen by a male mid wife who is not the woman's husband.
4. Further studies are called for to verify these findings

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