

LIST OF ABBREVIATIONS

| | | |
|---------------|---|--|
| CBOH | - | Central Board of Health |
| CSO | - | Central statistical Office |
| DHMT | - | District Health Management Team |
| FAWEZA | - | Forum for African Women Educationists in Zambia |
| G.N.C | - | General Nursing Council of Zambia |
| HMIS | - | Health Management Information System |
| I.E.C | - | Information Education and Communication |
| MOH | - | Ministry of Health |
| M.C.H | - | Maternal Child Health |
| NGO | - | Non Governmental Organizations |
| NSM | - | Ndola School of Midwifery |
| SPSS | - | Statistical Package for Social Sciences |
| STI | - | Sexually Transmitted Infections |
| TBA s | - | Traditional Birth Attendants |
| UNICEF | - | United Nations Children's Fund |
| UK | - | United Kingdom |
| US | - | United States |
| USAIDS | - | United States Agency for International Development Support |
| WHO | - | World Health Organization |
| ZDHS | - | Zambia Demographic and Health Survey |
| ZMA | - | Zambia Medical Association |

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background information

Long time ago giving birth was perceived as one function performed by women alone who had special knowledge and understanding which was overseen by female gods like Isis and Diana to whom pregnant women prayed for the delivery of their children (McKenna 1991). Male midwives appeared in the 17th century pursuing midwifery outside the medical profession. Members of the Chamberlain family were notable male midwives of that time who reputedly introduced the use of forceps into obstetric practice. Their scientific inclusion and creative skills established them as popular practitioners often caring for the rich and powerful from whom they received a good income (Lewis 1984).

The first men to start practicing midwifery were referred to as “Man Midwife”. Donnison states that the English Man midwife was often a failed medical student or an apothecary acting as unqualified doctor (Donnison 1997). Men midwives saw themselves as better practitioners claimed by William Semon who in 1971 wrote “The English midwife believed that a good midwife was one who sent for a male practitioner when labour became difficult (Mc Kenna 1991).

In 1988 a second medical act was passed in England making midwifery part of the training for medical profession to practice midwifery (Lewis 1984).The trend of being attended to by male midwives spread from France to England after Louis XIV employed Julien Clement to deliver his beloved Dauphin (Lindsay 1978).

In Yemen, because of the local cultural background, women were reluctant to share information regarding pregnancy with men and the

Yemen's women union felt strongly that only women could care for and supervise other women during child bearing (WHO 1994)

Augustine (Muteta1995) in his study on mother's attitude towards male midwives quotes Trandel Koren Chuck as having stated that in the USA, Judge E Roy ruled out against males practicing midwifery stating that the majority of women would not condone intimate care given by male midwives. He further stated that attitudes to male midwives among female midwives range from whole hearted support to thinking no men should be midwives (Muteta 1995).

This has been demonstrated by adjectives often used to describe men female colleagues such as: able, challenging, vocal, ambitious and questioning; this implied that men entering midwifery have had to be exceptional (Gaze 1990)

Midwifery in Zambia like many other countries was exclusively a female domain until 1987 when it became open to males. The question of allowing men to become midwives arouses mixed feelings and people debating for and against it (National Mirror 1992).

The training and practice of midwifery by males in Zambia started in 1986-87. Since then 230 registered male midwives and 130 enrolled midwives have graduated from the schools of midwifery. Out of the total trained male midwives only 270 are practicing while the rest have stopped (GNC 2008). Data from some of the male midwives interviewed randomly that are not practicing as midwives revealed lack of acceptance by the community being served and misplacement in the areas where they are working and being put in managerial positions in other clinical areas as factors contributing to their non practicing as male midwives.

A male midwife in Zambia has a general background of nursing, either as an enrolled or a registered nurse with experience in other fields (G.N.C 2004).

Training of male midwives was initiated by the government through the Ministry of health in conjunction with midwifery training institutions in an attempt to relieve the shortage of human resource especially in rural areas of Zambia.

This was mainly to fill the gaps left by female midwives when they leave rural areas to get married in urban areas. This tendency left the rural population with inadequate or no midwifery care at all.

Maternal care which is one of the components of primary health care has not been adequately implemented due to inadequate number of trained midwives, non acceptance of male midwives by some communities and unequal distribution of available midwives. This is evidenced by the low numbers of midwives found physically in clinical practice. It has been reported that about 67% of women in child bearing age 15-45 years receive care in health institution (MOH 2004). This raises a question as to why the other 33% are not accessing the services. The report calls for maximum utilization of all trained midwives to meet the health care needs of mothers, thus posing a challenge to health systems Zambia (MOH 2004)

1.2 Statement of the problem

Acceptability of male midwives in the context of Zambian traditional society has been received with mixed feelings. In Zambia, studies conducted have revealed that the majority of delivery service providers are women. With the changing society, men have been involved in assisting with births / delivery services,

The introduction of male midwives in Zambia has been measured against religious and cultural values by elderly, young, illiterate and educated alike whose views vary widely including health personnel (MOH 2004).

In Zambia, midwifery care has been traditionally associated with elderly female relatives who gave birth to one or more and had experience in deliveries to attend to an expectant mother.

Nurse training institutions started training of female midwives who served in maternity and MCH services across the Country (GNC 2008). This trend has now changed with introduction of male midwives.

Some of the principles of the Zambian model of midwifery include informed choice, choice of birth setting, continuity of care from a small group of midwives and respect for the woman as the primary decision maker (GNC 2000). However; this is not the case due to shortage of manpower.

Responses to the services offered by male midwives range from rejection, indifference to total acceptance by mothers and care providers though the extent has not been determined. The legality of allowing male midwives in maternal health services has been questioned by the community. The training institutions started training of male midwives on a small scale in 1986 with an average ratio of 1 male: 10 females. Currently the ratio has narrowed ranging between 1: 3 and 1: 5 (Records from Lusaka and Ndola midwifery training institutions 2008) with a view to increasing the number of midwives. Of the so many trained male midwives 75% were practicing midwifery while 25% were out of practice due to misplacement or in most cases lack of acceptance by mothers (MOH data base (2008).

At Fiwale Mission Hospital in Ndola Rural and Mpongwe Mission Hospital where the school takes student midwives for clinical practice, the late chief Mushili and chief Lesa respectively, representing their subordinates ordered a stop to male midwifery practice by male student midwives and two qualified male midwives in their chiefdoms (Ndola school of midwifery Data base 2008).

In May –June 2008, Muvi Television cited an incident where women were shunning use of a health centre in Kaoma district due to presence of male midwives.

Some mothers talked to in Lusaka and Ndola have reacted strongly to the idea of male midwives to attend to them in labour that they would rather deliver at home if that was the case. However, some mothers said they did not mind as long as everything went on well and others said that as long as there was a female counterpart by the side they wouldn't mind, but taking staff shortage into consideration this would not be possible.

Data from one of the health centres manned by a male midwife in Ndola revealed that between 40% and 60% of mothers attended to in ante-natal clinic were delivered by traditional Birth attendants or went to deliver in other health centres not manned by a male midwife(Ndola DHMT 2009)

Generally literature abounds from surveys that have been done in other countries including United states, UK, Philippines and Japan on acceptability of male midwives. It revealed that male midwifery was a socio-cultural and public health problem world wide .The same studies have revealed that a number of women shunned delivery services in health centres manned by male midwives worldwide (Kristin 1996).

However, cultural attitudes perceive nursing / midwifery to be a female profession and whilst care from a male doctor is considered to be acceptable, care from a male midwife is said to be embarrassing (Lodge et al, 1997).

Locally in Zambia the pattern is similar to the above. A number of factors influencing acceptability of male midwives could be attributed to marital status, economic status, education level, religious beliefs, social cultural background, traditional practices and age of the mother and spouse.

Anecdotal evidence suggests that in Ndola both health personnel and some members of the community have been against the idea of training of male midwives in large numbers. The schools feel male midwives are a resource to curb maternal mortality and infant mortality in Zambia since these are the major health personnel found in most rural Zambia.

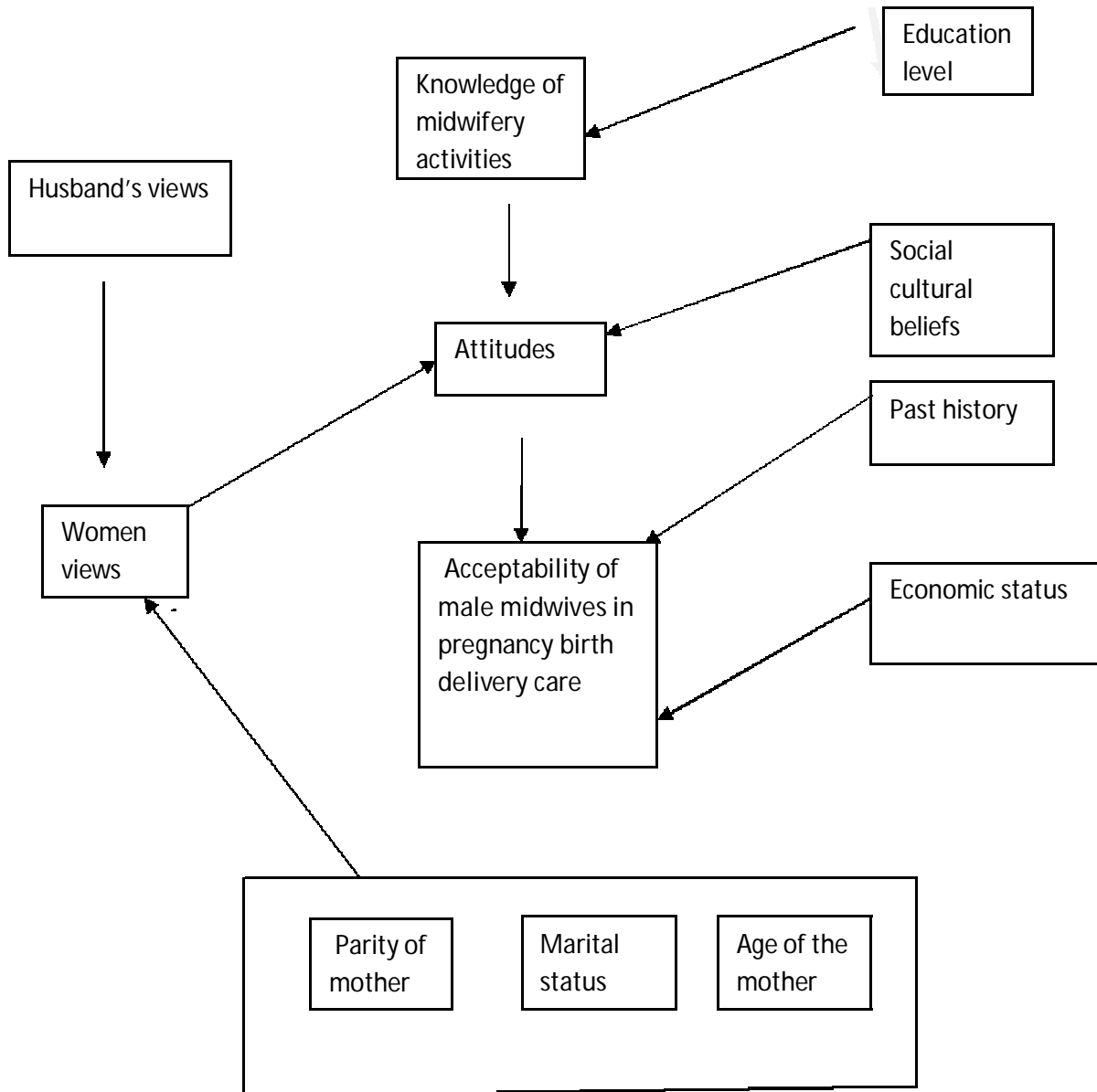
1.3 Justification of the study

In view of the above the researcher found it important to conduct a study to determine acceptability of male midwives in birth and delivery in Ndola.

This study is justified in that it will generate data as a basis for subsequent studies on acceptability of male midwives in birth and delivery interventions within Ndola .The study will provide baseline information for a much wider country specific study. The study findings will also assist training institutions who have found it difficult to respond to the outcry of refusing male midwives by the community to decide on future training of male midwives.

This study aims at establishing the acceptability of male midwives in the community. Further the factors contributing to the acceptability will be determined including the impact on midwifery services in the community

1.4 Problem Analysis Diagram



VARIABLES: A variable is a characteristic of a person or object which can take different values. The two major categories of variables are the dependent and independent variables. A dependent variable is the outcome which reflects the effect or response to the independent variable whereas the independent variable influences the dependent variable. (Polit & Hungler, 1997)

Variables Investigated.

a) Dependent Variable

Acceptability of male midwives

b) Independent variables:

Parity, Marital status, Education level, Economic status, religious beliefs, traditional beliefs and cultural beliefs and age of the mother.

1.5 Objectives of the study

General Objectives

To determine acceptability of male midwives in birth and delivery in Ndola.

Specific Objectives

- To establish the views of women and men towards male midwives attending to women in antenatal labour and delivery.
- To establish acceptability of male midwives in relation to socio economic background.
- To identify traditional and cultural beliefs associated with acceptability of male midwives in birth and delivery services.

1.6 Study Hypothesis

Ho: Both men and women have negative attitudes towards male midwives.

Ha: Both men and women do not have negative attitudes towards male midwives.

Research Questions:

1. To what extent have the male midwives been accepted during birth and delivery?
2. What is contributing to the non acceptability or acceptability of male midwives?
3. Should training Institutions continue training male midwives?

1.7 Operational Definitions

Acceptability: To make somebody welcome or welcome the idea of male midwives, to agree or approve of something, to allow male midwives to practice, to receive the service of male midwives as suitable or good enough, to say yes to an offer.

Attitude: The way mothers and husbands regard a male midwife

Chaperonage: The presence of a female when a male midwife is providing health care to a pregnant woman

Community: The people living in a particular area or location.

Male health care provider: Any man offering health care services to mothers.

Midwife: A person educated, trained and certified to care for pregnant mothers during pregnancy, labour and after delivery.

Semi intimate care: Care that involves some undressing and or revealing

‘private’ articles of clothing such as pants or bra, procedures like giving a bed bath, a bed pan or checking a sanitary pad for bleeding.

Knowledge: The information that pregnant women have on the activities of a male midwife.

Perception: This is the way women and men look at the male midwife.

Traditional beliefs: A strong feeling about what customs say.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

The literature review focuses on acceptability of male nurses/ midwives. Sources reviewed include books articles and internet. The studies reviewed were done in UK, America, Asia and Africa whose cultural beliefs, traditions and educational backgrounds are different from Zambia in particular and Zambia as well. This review will assist in establishing what has been done or known about the topic and to identify gaps in the existing literature

The literature that has been reviewed so far reveals mixed feelings about male midwives ranging from positive to negative attitudes, cultural factors and simply preference.

2.2 Global Perspective

Globally, extracts from the discussions held on the UK Midwives and consumers revealed that women didn't feel right about having male midwives and preferred to be transferred to a team with no male midwives when in labour (Katz 2008).

The degree of intimacy in a clinical situation was found to be predictive of same gender preferences. Whilst nursing is still generally perceived to be a "feminine" profession, a number of men practice as nurses (Lodge 1997). Thus, both male and female patients could encounter a nurse of either gender, although female nurses are probably encountered more often than males (Ekstrom 1999). With the possibility of a patient becoming distressed or uncomfortable, it is important to consider which patients prefer which gender of nurse, under what conditions or situations.

Research has found a relationship between preference for a same gender health care professional where a situation is “intimate” in nature requiring a patient to undress (Ackerman-Ross & Sochat 1980) or reveal private thoughts and emotions (Kerssens1997).

Researchers have also noted that patients value their nurse’s technical expertise (Greenhalgh1998). It is plausible therefore that in situations where such expertise is required a patient may have less concern about gender of a nurse ,as compared with situations requiring more intimate psychosocial interactions.

The literature reports that women patients prefer women nurses (Back and Wikblad 1998). Females have been found to prefer female health care providers for matters of reproductive and sexual health, and especially for consultations regarding intimate or psychosocial, issues (Brooks & Phillips 1996), whilst males also demonstrate this trend but to a lesser degree (Kerssens 1997).

Lodge et al (1997) indicated that previous experience with a male nurse in a group of gynaecological patients resulted in less preference for a female nurse. Thus exposure may result in acceptance of male nursing staff.

Nursing may be considered by patients to be a suitable profession for females, but not for males (Lynn 1975).This may be reflected in preferences when requiring care. It appears that patients tend to prefer a nurse of their own gender when situations are ‘intimate’ and are more accepting of either gender when clinical scenario is not emotionally invasive.

Tagg (1981) stated that women did not object to being cared for by a male nurse , all they wanted was permission to be sought from them prior to being attended to by a male nurse so as to create a favourable environment.

Lenin (1982) stated that intimate care when performed or given by male nurses or midwives would be very embarrassing. She further went to state that significant differences exist between patients' perceptions of their degree of embarrassment when being cared for by a male or female nurse in relation to taking underclothes off, discussing personal hygiene, bathing, giving a bedpan; checking sanitary pads; discussing sexual activity and discussing illness.

The idea of not being comfortable with male midwives is usually inculcated by health care providers because it was standard to prefer a female to a male midwife. Women preferred a female midwife who is able to empathize and understand their emotional state since she has similar anatomical structure and hormonal balance than a male has. (Kristin 1996) The same study revealed that some jobs were better suited for women or men.

For example if a man has an erectile dysfunction, he would prefer to be seen by another man who could appreciate the complicated psychological and physical interactions better than women. Similarly women traditionally in labour would want to be assisted by persons who have had children themselves.

Religion, culture, extreme embarrassment, past history of physical abuse or emotional abuse, in or outside relationship or just not wanting a man messing with their vaginas were some of the factors why women did not want a male midwife.

In other studies conducted in San Francisco, Austin Texas, Washington and Columbia by Kristin (1996) revealed that women were more comfortable with male midwife who would allow them to do it their own way as compared to a female midwife who have had children and would expect them to do it their way.

The paper further states that the debate on male midwives presents a problem for feminists who feel that there is a need to reserve a few spheres for themselves where men do not intrude. These protected spheres are essential for maintaining women's collective identity and power. Others thought that when one is in such pain what matters is the ability and personality of the care giver and given chance they would rather have a female midwife but would not dismiss the idea of having a male midwife though they might find it more uncomfortable.

Many women have described the idea of being cared for by a male nurse as uncomfortable. They believe that their permission should be obtained before being assigned to a male nursing student (Morin et al 1999).

Male nursing students experience more role strain in the obstetrical area than female students.

The difficulties are societal stereotypes which must be confronted by pursuing students to enhance the quality of their educational experiences, such as the nursing student characteristics, how they presented themselves, and the behavior in the clinical setting. These can improve clients' acceptance during the experience (Sherrod 1991).

A few male students in general nursing indicated that they were assigned only to male clients, they would want an equal opportunity to learn the science and art of caring. This has an implication in nursing education, therefore efforts should be made to give male nursing students educational opportunities equal to the opportunities given to female students (Kelly 1996).

In addition to give students the best possible educational experience and to provide optimal nursing care, nursing faculties are urged to plan male nursing students' assignments with the study findings in mind. Sensitization of nursing faculty to the various factors that affect a patient's decision about receiving care by a male nursing student is critical.

Patients should be provided with an option to accept or refuse being assigned to a male nursing student (Morin et al 1999.)

2.3 Regional Perspective

In Africa a few studies have been done. In a study on strengthening midwifery practices in Morocco by Susanne (2005), it is reported that midwifery practice is still regarded as domestic work and that pregnancy and delivery are seen as natural life experiences to be dealt with discreetly and with privacy which reflects that it is a domain of women.

In Yemen Hamaudi Hanafi director of USAIDs basic health reports that training and retaining women in health care had improved maternal and prenatal services. From the above discussions midwifery is seen to be a domain of women.

In Sudan the rapid reproductive health needs assessment was undertaken in order to map the environment of midwifery training the reproductive health services in South Sudan. The assessment revealed that community perception of a male midwife is generally disapproving. Women reported that they did not like male midwives for they do not want them to see their private parts while the men themselves could not imagine a man assisting women in delivery (AMREF 2008). This resulted in most women being assisted by older women in the community during birth and delivery.

2.4 National Perspective

In Zambia, unlike other countries where midwives have been practicing for some time, very little has been documented about male midwifery practice.

However the few studies that have been conducted revealed that, In North Western Province, women reported preference for female birth attendance during delivery as opposed to male attendant. This was in a report where Kasavasa health centre experienced an increase in the number of

supervised delivery because of the presence of a female clinical officer as opposed to the male clinical officer who was there. Similarly in *Zambezi District* the removal of a male midwife led to an increase in the number of institutional deliveries (MOH 2004).

In another study on gender and socio cultural perspectives in the provision of reproductive health services, male folks opposed to male staff attending to females during labour stating that male staff were more interested in viewing women's private parts and that it was against culture for a man to be present during delivery (Ndubani 2003).

In the same study in Chawama, Lusaka, it was reported that traditionally, it was not appropriate to be delivered by a man, on the other hand some women reported that they were beginning to accept the practice as it was becoming the norm but given chance they would opt to have a female attendant.

Women shun delivering in health centres where male midwives conduct deliveries because they believe that only females should be midwives. Usually such women end up being delivered by unskilled personnel (Nsemukila 1998).

Another study on factors associated with maternal mortality in Zambia revealed that most married women are gripped with fear of being delivered by a male midwife as they feel insecure because they wouldn't like their husbands to know as some of them risk being divorced. The single mothers were likely to deliver in the health facility and less likely to choose whether they should be delivered by a male or female (Nsemukila 1998). Mugala (2007) stated that 56% of women in Chongwe district preferred to be cared for by fellow women than by male providers citing un comfortability and traditional beliefs and influence by their husbands while 44 % had preferred either male or female since they receive the same training.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Research Design

A cross sectional study was done to determine acceptability of male midwives in birth and delivery in Ndola both rural and urban.

3.2. Research Setting

The study was conducted in Ndola district. Ndola district is divided into three zones namely: Southern, Northern and Central and has a total population of 487, 881 (Ndola DHMT HMIS 2009). There are eight health centres in the southern zone, five in central and seven in the northern zone. All the twenty health centres offer antenatal and postnatal services and only eight offer delivery services. The district had a total population of 107,334 women in child bearing age (22% of the total population). Of these 26,346 were expectant mothers (5.4 % of the total population).

The district had been chosen because it has a midwifery training school for both male and female students. The hospital and the clinics in Ndola had male midwives and male student midwives working in their maternal child health programs and labour wards.

3.3 Study Population

Pregnant mothers (All Antenatal mothers) and husbands of pregnant mothers.

3.3.1 Inclusion Criteria

Any pregnant woman who had delivered before ,and was attending antenatal care at the health facility.

Partners or spouses of the mothers included in the study, whose wives met the above criteria.

3.3.2 Sampling Frame

Clinics from south and northern zones of Ndola district

Clinic registers for ante natal women from the south and northern zones in Ndola district.

3.4 Sample Size and Selection

The sample size was calculated using Epi info.

Population size of antenatal mothers was 26,346

Expected frequency was 50%

Worst acceptable levels was calculated to be 45%

Confidence level was 95 percent

Sample size = 379

The sample was increased by 10% to cover dropout rate. Sample size was 416 which was rounded to 420.

3.5 Data Collection Technique

This was through a primary source which was face to face interview with antenatal mothers and focus group discussion with Husbands of the antenatal mothers.

3.5.1 Data Collection Tools

(A) Structured interview schedule was used to collect information. The questionnaire comprised both open and closed ended questions.

Systematic random sampling method was used to select mothers who formed the sample. A sampling interval of 1:5 was used.

Questions were presented to each respondent in the same way to ensure objectivity, to clarify questions which were not clear and to ensure and increase response rate since mothers were presumed to be illiterate, semi illiterate and unable to fill in the questionnaire correctly.

(B) Focus group discussion guide was developed to collect in depth information about acceptability of male midwives in birth and delivery care.

The respondents in the focus group discussion were married men and spouses / partners of antenatal mothers included in the study who were organized by the communities within the catchment areas of the clinics where the study was undertaken.

3.6 Data Collection Process

Data was collected over a period of 6 weeks after approval to proceed with the study.

3.7 Pilot Study

The pilot study was done at one health centre which was not part of the main study. It had similar characteristics with the other clinics in the study to test the validity and reliability of the data collection tools. Participants of the pre-test comprised 10 % of the total sample size.

3.8 Ethical Consideration

Clearance was sought from the Biomedical Research Ethics committee of the University of Zambia.

Written permission was sought from the Ndola Provincial health Office and Ndola District Health Management Team (DHMT) to conduct the study in

their territory. Written consent (Informed) was obtained from each of the respondents after explaining the purpose of the study ensuring that the information would be held in confidence. Those that could not write endorsed by a right thumb print.

The purpose and nature of the study was explained to the study participants. Study participants were assured of anonymity and confidentiality by interviewing them individually and in privacy. Participants' names were not written on the interview schedules and no other person apart from the research team was allowed to have access to the research data.

3.9 Limitations of the study

The limitations of the study were financial constraints and short period to conduct the study. Results will not be generalized to the whole country because we are unable to conduct a country wide survey due to limited resources.

3.10 Data Processing and Analysis

Quantitative Data

All questions were coded and open ended questions were categorized. Responses were coded using numbers. Frequency tables were used to describe the sample and Cross tabulations were done to show relationship between dependent and independent variables.

The SPSS package (Statistical Package for Social Sciences) was used during univariate and bi-variate analysis.

Data was analysed using CHI-Square to test for association and a p - value of less than 0.05 indicated significant association.

Qualitative Data

The qualitative data that was derived from the focus group discussions was read and transcribed into computer files. The data was categorized into themes and assigned codes and analysed by content analysis. The researcher sought the services of a specialist in this area to assist.

CHAPTER FOUR

4.0 PRESENTATION OF FINDINGS

4.1 Introduction

The findings were based on 403 antenatal mothers who were interviewed. There were 213 from Masala and Chifubu which are urban settings and 190 from Kavu and Kaniki areas which are rural settings. Kaniki and Kavu population comprised 58% of antenatal mothers aged between 15 and 24 years and Masala Chifubu mothers 68% were aged 25 years and above.

Table 4.1.1 below shows factors associated with acceptance of male midwives. Education, location and income were significantly associated with acceptance of male midwives. Higher rates of acceptance were observed among respondents with higher education level (68.5%) than respondents with up to primary level of education (54.6%). Respondents in Masala/Chifubu (69.0%) had a higher rate of acceptance than respondents in Kavu / Kaniki (53.3%). In addition, respondents who had higher income (68.9%) had a higher rate of acceptance respondents who earned less than K500,000. Age ,marital status and religion were not significantly associated with acceptance of male midwives.

**Table 4.1.1: Socio-demographic factors associated with acceptance
of male midwives.**

| Factor n=403 | Would accept male midwife | | | | | |
|--------------------------------|---------------------------|-----|------|--------|----|---------|
| | total | n | % | Chi sq | df | p-value |
| Age (years) | | | | 0.760 | 1 | 0.363 |
| 15 -24 | 174 | 113 | 64.9 | | | |
| 25+ | 229 | 139 | 60.9 | | | |
| Marital married | 354 | 220 | 62.1 | 0.341 | 2 | 0.843 |
| Separated/widowed | 49 | 32 | 65.3 | | | |
| Education None / Primary | 174 | 95 | 54.6 | 9.2 | 3 | 0.002 |
| Secondary/tertiary | 229 | 157 | 68.5 | | | |
| Location Kavu/kaniki | 190 | 105 | 55.3 | 8.1 | 1 | 0.004 |
| Masala/Chifubu | 213 | 147 | 69 | | | |
| Religion Christian | 393 | 245 | 62.5 | 0.244 | 1 | 0.621 |
| others | 10 | 7 | 70 | | | |
| Income None/less than K500,000 | 274 | 162 | 59.1 | 12.6 | 3 | 0.005 |
| K500,000 and above | 129 | 90 | 69.8 | | | |

Table 4.1.2 below shows associations of mothers' experiences with male midwives; traditional cultural values and religious values with acceptance of male midwives. Mothers' previous experiences with male midwives and traditional cultural and religious values were significantly associated with acceptance of male midwives. Higher rates of acceptance were noted among respondents who acknowledged that they felt very safe they were being attended to by male midwives (87.1%) as opposed to those who said they felt uncomfortable, embarrassed and shy when they were being attended to by male midwives (39.8%). Respondents who said they were not sure what their traditions and cultural values say about male midwives and that the idea of not accepting male midwives was slowly being done away with had a higher rate of acceptance of male midwives (83.0%) than respondents who said traditionally it was a taboo and unacceptable to be attended to by a male midwife (53.4%). Previous encounter with or knowledge of male midwife practice was not significantly associated with acceptance of male midwives.

Table 4.1.2 Association of mother's experience, tradition and cultural religious values with acceptance of male midwives?

| Factor n=403 | Would accept male midwife | | | | | |
|---|---------------------------|------------|-------------|--------|----|--------------|
| | Total | n | % | Chi sq | df | p-value |
| Has been attended to by male midwife | | | | 1,387 | 1 | 0.239 |
| yes | 226 | 147 | 65.0 | | | |
| no | 177 | 105 | 59.3 | | | |
| Experience after being attended to by male midwife | | | | 66.328 | 2 | 0.001 |
| Uncomfortable/embarrassed and shy | 113 | 45 | 39.8 | | | |
| Very safe | 124 | 108 | 87.1 | | | |
| Traditional Cultural values taboo/unacceptable | 279 | 149 | 53.4 | 7.148 | 3 | 0.001 |
| Not sure, being done away with. | 124 | 103 | 83.0 | | | |
| Religious Values nothing/silent/does not accept | 301 | 175 | 58.1 | 33.4 | 2 | 0.001 |
| Allowed in emergency only | 102 | 7 | 75.4 | | | |

Table 4.1.3 Below shows antenatal mothers' views association with acceptance of male midwives. Suggestions given by mothers regarding male midwives during antenatal, labour and delivery and what they would do if they found a male midwife providing care were significantly associated with acceptance of male midwives. Higher rates of acceptance were noted amongst mothers who said that male midwives should continue providing the care and those who said that male midwives should continue working but if possible confine them to antenatal clinics (75.9%). Lower acceptance rates were noted amongst those mothers who

said the practice should be discouraged (26.6%). Respondents who said they would accept to be cared for by a male midwife as this was a reality that was prevailing also had a higher rate of acceptance (73.2%) than their counter parts who said that they would refuse entirely to be cared for by male midwives and that midwifery was a woman's challenge.

Table 4.1.3 below shows Antenatal mothers' views association with acceptance of male midwives.

| <i>Factor n=403</i> | <i>Would accept male midwives</i> | | | <i>Chi -sq</i> | <i>df</i> | <i>p-value</i> |
|--|-----------------------------------|----------|----------|----------------|-----------|----------------|
| | <i>total</i> | <i>n</i> | <i>%</i> | | | |
| <i>Suggestions regarding male midwives during antenatal labour and delivery</i> | | | | | | |
| <i>Let it continue/only work in antenatal</i> | 294 | 223 | 75.9 | 166.3 | 3 | 0.001 |
| <i>Discourage the practice/others</i> | 109 | 29 | 26.6 | | | |
| <i>What would you do if found male providing care</i> | | | | | | |
| <i>Would accept reality</i> | 332 | 243 | 73.2 | 101.3 | 2 | 0.001 |
| <i>Would refuse/women challenge</i> | 71 | 9 | 12.7 | | | |

4.2 Focus group discussion findings

A total of 60 partners and spouses of ante- natal mothers included in the study were interviewed through focus group discussions which were held in each area. 15 from each locality were purposefully selected. The age group of these men ranged between 25 years and 65 years with a varied education and occupation backgrounds.

They discussed what their personal views were about male midwives attending to women during pregnancy, labour and delivery; reasons for preferring one gender of midwife in favour of the other; their influence during birth and delivery and some of the traditional beliefs such as type of teachings; taboos and practices held in their area concerning male midwives and how best to manage a situation where a midwife of less preferred gender is only one available to carry out a procedure.

4.2.1 Personal Views

Ten out of 15 men in Kaniki said “this is a good idea as nowadays we are talking of gender balance, therefore there should be equal representation of men and women even in the care of women and this will also provide employment for the men.” Five (5) out of fifteen (15) said “women are highly respected; you should train more female midwives. If men will be trained they should be in the company of female midwives when attending to mothers especially in labour and if possible men should just be advisors and not to conduct deliveries.”

In Kavuu, all men but two were against the idea of male midwives attending to women during pregnancy, labour and delivery.

They said “it is something unheard of, a woman is highly respected and only the husbands should see her nakedness or a fellow woman; this practice should be done away with by training more female midwives to avoid women delivering on their own resulting in many of them dying or losing babies.” The other two said “at the hospital there is no problem because it is far, at the centre it is difficult because we know the man very well.”

In Masala, 14 out of 15 men were against the idea of male midwives attending to women during pregnancy, labour and delivery. They said “the Ministry of Health errored, big mistake, they should have consulted us before starting to train male midwives; we should not be donor driven we will remain without culture, we should respect tradition. We should also consider age; some male midwives are too young you can imagine a young man delivering his o They further said that tradition should not be done away with as the nation may remain without any cultural heritage to be proud of.

In Chifubu area, the men were more positive on male midwives attending women during pregnancy, labour and delivery. All the participants (15) cited that “development is dynamic and the world is changing, male midwives should be trained in numbers and we are asking the government to train male traditional birth attendants. We are saying men and women are equal, therefore they should be allowed to work just like the females do.”

4.2.2 Reasons for gender preference

The reasons advanced for preferring one gender of midwife in favour of the other were that, 12 out of 15 participants were in favour of women stating that women keep professional ethics better than men.

They said that “in the communities we know each other so well and use same bars, shops ,churches and other facilities and that the problem with male midwives is that most of them drink beer and when they get drunk they expose whatever they have seen in labour about a woman. If men have to be considered then they should be in the older age group above 45 years as these would be mature enough to keep secrets.”Those that preferred male midwives in favour of women said that “men would be better especially for the younger age group of mothers who found them to be more comforting sympathetic, caring and reassuring.” They further explained that “men are strong, they work hard and in emergencies they can even cycle long distances to go and assist women in

labour. We are asking those who train to consider training of male TBAs to assist the women that stay very far from health centres.”

In Kavu 13 out of 15 men were in favour of a female midwife. They said, “Men usually get drunk and do not keep secrets as their female counterparts and that men are easily aroused by female nakedness forcing the to start proposing the women they attend to.” The Minority who were in favour of a male midwife said that male midwives are trained in the job and are caring, women midwives contribute to problems that occur in labour like taking long to deliver because they are too hush and they shout a lot at women in labour stating that they were not there when the pregnancy was made.”

Some participants from Masala also had a preference for a female midwife. Six of the 15 participants said, “We prefer women because men usually get drunk and do not keep secrets.” When asked about male doctors, they said “male midwives spend more time with the woman and they see and know a lot about the woman, the doctors are not found in our community they are found in the hospital and we don’t know them.”

Seven of the 15 participants said that since husbands are not allowed in the examination rooms, some women fear that their husbands may divorce them if another man sees their nakedness.

The other minority 2 out of 15 expressed that they would prefer a male midwife in favour of the female one stating that “men are more comforting and caring and they do not shout at women as female counterparts do.”

In Chifubu, there was a preference for a male midwife. Thirteen of the 15 participants cited that female midwives have been working since inception and women have expressed disappointments that they usually rush and shout a lot, where as male midwives have been reported to be more caring and comforting. In addition “biologically men are stronger than women and can work longer hours than women providing the care that the women need and there will be no artificial shortages of staff created by female midwives when they go on long maternity

leave as men do not go on this type of leave.” The other 2 out of 15 participants were in favour of female midwives they said “mothers are not free; they are tensed up because of the strange environment of being cared for by a male midwife.”

4.2.3 Problems faced by women

Participants in Kavu, Kaniki, Masala and Chifubu cited similar problems that women face when being attended to by male midwives. They said that a woman feels shy, insulted, belittled, cheap, disgraced and that the environment is strange as she is not used to undressing before a man who is not her husband.

4.2.4 Men’s influence during birth and delivery

Males’ influence during birth and delivery varied. In Kaniki and Chifubu it came out clearly, the participants said “since we are more educated and enlightened about male midwives, we should sensitize our women about the presence of male midwives during birth and delivery so that they slowly start getting used to the practice,” while Masala and Kavu participants said “given chance we would not allow our wives to be attended to by a male midwife and would rather take them to any other woman for help.”

4.2.5 Traditional beliefs, taboos and practices

Men in Kaniki said “traditionally, it is a taboo for men to assist women in labour and it is believed that if a man assists a woman in labour he would get mad or blind”.

In Kavu, men said “it is a taboo against culture and tradition for a man to assist a woman in labour and it is believed that a man would lose his libido if he is exposed to different vaginas and would fail to perform in his own home. We are yet to hear from the male midwife what would happen to him.”

Similarly, 10 participants from Masala said “tradition does not allow this practice; men and women should not mix when they are naked unless they are husband

and wife.” The other 5 participants said, “It is an abomination (Mipamba), men who deliver women are not normal they are polluting our culture (balekowesha intambi).”

Men in Chifubu said that according to culture a man will become confused after delivering a woman.

4.2.6. Situational Management

If a situation where the midwife of less preferred gender (male) is the only one available to conduct ante natal, labour and delivery services, 13 out of 15 men in Kaniki said “even if we are not comfortable with the situation, we would accept as this male midwife is trained to render the services.” And 2 out of 15 expressed that they would rush their wives to nearby women.

In Kavu 10 out of 15 men said, “This is rather a tricky situation, we would allow situation to take care of itself because of the critical shortage of man power but we would caution the man to keep secrets.” The other 5 out of 15 said “no matter what, we would rather take our wives to a nearby centre where there are female midwives or to TBAs.”

In Masala 13 out of 15 men said they would not allow their wives to be attended to by a male midwife and that they would look for women providers or any TBA around. Only 2 out of 15 men said they would allow the man to perform his duties since he is trained in the field.

In Chifubu, the men were very supportive of male midwife. All the 15 men said they had no problems but would just encourage them to keep secrets. They also said that they would encourage their wives to feel free and relaxed.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS

5.1 Demographic characteristics of the respondents-Ante-natal mothers

In this study the majority (56.8%) of ante-natal mothers were in the age group 25 years and 45 years and 15-20 years (43%) and most of them were married that is 88.1%. This shows that most of the ante natal mothers were married and that their acceptability of male midwives in birth and delivery could have been affected by their marital status and their age.

The respondents' education level was at least 55.9% of the respondents had attained secondary school education and 44.2% had below seven years or no education at all. However further analysis revealed that of the rural population 55.7% of the respondents had received primary education and no education at all and only 42 % had attained secondary school education. Similarly those from urban population, 59.6% had attained secondary education and above and only 31% had primary or no education at all.

The reason could be that those from urban setting are surrounded by an environment of educated people and live near schools and their parents are able to take them to schools where as those from rural setting are disadvantaged by the distances from schools and ability to pay for their education.

This could also be due to the fact that girls in rural areas lack social amenities, they become sexually active at a tender age and when they drop out of school due to pregnancy they are forced to get married to the man responsible for the pregnancy instead of encouraging them to go back to school.

In addition 69.5% of the respondents were unemployed and only 25% were engaged in some form of employment, this could be attributed to the fact that those that attained secondary education dropped out of school due to pregnancy and decided to get married, instead of pursuing their education, in order to look after their babies and get financial support from the men that impregnated them. This scenario would also affect how they would view or perceive a male midwife in birth and delivery.

However the study findings have revealed that education (p-value 0.026), location (p-value 0.004) and income (p-value 0.005) were significantly associated with acceptance of male midwives. Higher rates were observed among respondents with higher education level (68.5%) than respondents with up to primary level of education (54.6%). The study also discovered that there was a significant relationship between number of years spent in school and acceptability of male midwives in birth and delivery care (p-value 0.016). The majority of antenatal mothers with eight years and above in school (68.0%) had a higher rate of acceptance than their counterparts with 0-7 years in school (55.6%).

This result was statistically significant. This shows that with higher education level mothers have a better understanding of male midwifery practice and have moved away from the influence of tradition and culture.

The study also discovered that there was a significant relationship between area of residence and acceptability of male midwives in birth and delivery care (p-value = 0.004). Respondents in Masala / Chifubu (69.0%) had a higher rate of acceptance than respondents in Kavu / Kaniki (53.3%) This result was statistically significant.

Finally respondents who had higher income (68.9%) had a higher rate of acceptance. This could be attributed to the fact that educated people have higher income and would afford to stay in urban area, have a better understanding of the services rendered by a midwife as they are exposed to male midwifery care. These results could be due to the fact the urban

population is more exposed to male midwives practice as opposed to their fellows in the rural population. With higher education and away from the rural, the urban populations are divorced from some of the traditions and cultural beliefs that would affect their acceptance of male midwives.

This notion proves the report that was given in Northwestern province in Kasavasa health centre which is a rural population where attendance at the health facility for delivery only improved after a female midwife was taken to the health centre to replace a male attendant.

This is also in line with Back and Wikblad (1998) and Brooks & Phillips (1996) who said that women patients preferred women nurses for matters of reproductive and sexual health.

5.2. Discussion of Variables

5.2.1 Mothers' experience, traditional cultural and religious values

in relation to acceptance of male midwife.

The study findings revealed that mothers previous experience with male midwife, traditional cultural values and religious values ($p\text{-value} \leq 0.001$) were significantly associated with acceptance of male midwife. Higher rates of acceptance were noted among respondents who said they felt very safe when being attended to by male midwives (87.1%) The other 39.8% said they felt uncomfortable, embarrassed and shy This clearly indicates that most women do not have problems with male midwives during birth and delivery in line with what Tagg (1981) stated that women would not reject care given by male as long as permission was obtained and the procedure explained. Lynn (1975) also stated that significant differences exist between perceptions of their degree of embarrassment when being cared for by male or female nurse in relation to taking underclothes off. Those respondents who said they felt uncomfortable, embarrassed and shy will find it difficult to

accept being cared for by a male midwife while those who said they felt very safe under male midwife would readily accept to be cared for by a male midwife. In this case there should be enough proportion of female and male midwives to ensure women who preferred to be cared for, by women or do not wish to have a male midwife for intimate nursing have their wishes catered. However, most mothers enjoy being looked after by male midwife. The spouses felt women felt insulted, belittled, cheap and disgraced but with exposure and education the situation was being controlled.

Respondents who said they were not sure of what their traditional cultural values say about male midwives and that the idea of not accepting male midwives was slowly being done away with had a higher rate of acceptance of male midwives (83.0%) than respondents who said traditionally it was a taboo and unacceptable to be attended to by a male midwife (53.4%). This result was statistically significant. In addition respondents stated that it was not traditionally accepted as men usually end up proposing women in labour. The findings are somehow similar with Susanne's study in Morocco which stated that midwifery practice was still as a domestic work and that pregnancy and delivery are seen as natural life experiences to be dealt with discreetly and with privacy which reflects that it is a domain of women and that male practitioner are mainly found in private practice. These findings are somehow similar to Ndubani's findings in Chawama Lusaka where was reported that traditionally it was not appropriate to be delivered by a man and on the other hand some women reported that they were beginning to accept the practice as it was becoming the norm but given chance they would opt to have a female attendant (Ndubani 2003).

The spouses of the antenatal women outlined that traditionally it was against culture and tradition for men to assist de would get mad or blind, lose their libido and become impotent if exposed to numerous vaginas. Currently the situation takes care of itself but urged male midwives to learn to keep secrets as this was what came out during the interviews.

Respondents who said their religions allowed attendance by male midwives in emergency only had higher rates of acceptance (75%) than those who said their religion was silent and would not accept a male midwife (58.1%).

This clearly indicated that the respondents accepted male midwives with reservations, given chance they would opt for a female midwife.

Previous exposure to male midwife practice was not significantly associated with acceptance of male midwives.

5.2.2 Mothers' views associations with acceptance of male midwives.

When mothers were asked about what their suggestions regarding male midwives during antenatal, labour and ivery in relation to acceptance of male midwives , there was a igher acceptance rate (75.9%) amongst those who said let the practice continue but they should only work in antenatal than a ongst those who said the practice should be discouraged(26.6%).These findings were found to be statistically significant ($p\text{-value} = <0.001$) hence have an influence on the mothers acceptance of male midwives in birth and delivery care. This means that though there was a high rate of acceptance amongst mothers this was restricted to antenatal care and not birth and delivery care.

When antenatal mothers were asked what they would do if they found a male midwife providing care at their centre (table 4.1.3), there was a higher acceptance rate amongst those who said they would accept to be cared for by a male midwife as this was a reality that was prevailing (73.2%) than those who said they would refuse entirely and that midwifery was a woman's challenge (12.7%).

As Greenhalgh (1998) stated that "patients value their nurse's expertise, and it is plausible that in situations where such expertise is required a patient may have less concern about the gender of the nurse, as compared to situations requiring more intimate psychological interactions". This thought is somehow related to the findings in the study in that the respondents need the expertise of this male midwife for their own safety in birth and delivery care.

The findings of the study revealed that the male folk supported male midwives care citing that male midwives were better accepted by the younger age group of mothers who found them to be more sympathetic, caring and reassuring and that men are strong, they work hard in emergencies to the extent of cycling to long distances to assist women in labour. This is a better view as the younger age group of mothers will be the future older age group who will increase acceptance of male midwife for the generation to come.

5.2.3 Attitudes towards training of male midwives

Ndola has a training institution which trains male midwives. These male students are sent for clinical practice in both Ndola rural and urban clinics. The findings revealed that this training of male midwives should continue. The opinions given by antenatal mothers were significantly related to acceptance of male midwives. Higher rates were noted amongst mothers who said they would accept to be cared for by male midwives because they are more responsible and helpful (100%) and that male midwives are trained

(98.6%). Similarly respondents who were in agreement to training of male midwives had a higher rate of acceptance of male midwives (85.9%) citing shortage of midwives in the health sector and that they support it as an occupation (86.4%) and that men are more helpful and they keep secrets better than women.

Similarly, the spouses of women in the study had mixed feelings about training of male midwives stating that if men were trained, this will provide employment for men and in the long run provide the needed exposure. On the other hand, a few suggested that if men were trained they should not be left to work alone as they feared that their women would lose respect if another man other than their husbands saw their nakedness. However since development is dynamic, the world was changing and there was an advocacy on equal rights, men should be allowed to work in birth and delivery like the females as long as they were trained.

These findings are at variance with the evidence that was given in Ndola that both health personnel and some members of the community have been against the idea of male midwives in large numbers. This information would assist the training institutions to stick to their thinking that male midwives are a resource to curb maternal mortality in Zambia since these are the major health personnel found in most rural Zambia.

However a few were not in favour of male training hence lower acceptance rates (24.7%) were noted stating that they felt embarrassed and it was against tradition and culture and that labour matters were better understood by women and men should do something else.

These findings are in line with Kathy's' (Kristin1996) findings in which she stated that some jobs were better for women or men. She narrated that if a man had an erectile dysfunction, he would prefer to be seen by another man who could appreciate the complicated psychological and physical interactions better than women .Similarly women traditionally in labour would want to be assisted by persons who have had children themselves (Kristin1996).

5.3 Implications to the Health Care System

The study findings have policy, operational and institutional implications. The high infant and maternal mortality rates which the country is facing urgently require effective control measures The Ministry of health has put a lot of resources to improve maternal neonatal health.

The study in Ndola on acceptability of male midwives has demonstrated that acceptability of male midwives in birth and delivery care can substantially reduce the incidence of maternal neonatal deaths and its associated social and economic consequences and should be promoted. The findings have shown that acceptability of male midwives in birth and delivery care can be improved from 73.2% to 100% through increased Information, Education and Communication (I.E.C) in the community which can reduce the percentage of refusals so that health institution supervised deliveries go up.

It clearly demonstrated that acceptability of male midwives in birth and delivery care was above average because the percentage of refusals was fairly low which cited feeling of being embarrassed and uncomfortable to undress for a man not their husband, men should do something else and not midwifery, against culture and tradition and that labour issues are better understood by women.

The data in the study mainly from the male folk revealed that issues of non acceptability of male midwives in birth and delivery care was mainly due to policy and lack of program integrated monitoring and evaluation to address institutional and operational activities .These have led to the problems that have been highlighted.

In view of the above we would say that acceptability of male midwives in birth and delivery care would be higher with better health education and community involvement and training of more male midwives so that they are exposed. Therefore one the key challenges of acceptability of male midwives is community sensitization.

5.4 Conclusions

This study sought to determine acceptability of male midwives in birth and delivery care in Ndola.

The study revealed that 73.2% of the respondents were in support of male midwifery practice in birth and delivery care. Age and marital status were not significant in this study.

Educational level played a big role in acceptability of male midwives in birth and delivery. Most of the respondents had attained primary education and very few secondary and college level, this affected their employment status such that most of them were just house wives; their socio economic status was also affected.

Those from urban setting were working unlike their counterparts from rural setting who were un employed and were of poor socio economic status. These findings had an impact on acceptability of male wives in birth and delivery care in that there was a higher rate of acceptance of male

midwives in birth and delivery care amongst those with higher education, employed with higher income and residing in urban area.

When it came to knowledge and past experience, most of the respondents had not been exposed to male midwifery practice and that they were not sensitized about them. The majority of the respondents felt very safe and had no problems with male midwives as long as the procedures were explained and permission sought from them. Few felt shy, embarrassed and uncomfortable to be attended to by male midwives.

Traditionally and socially, majority of the respondents said it was a taboo traditionally for a man to attend to women in birth and delivery care and some women and men feared that the man would propose the women in labour.

Despite these sentiments the acceptance rate of male midwives was above 50%. The few that were not sure of their tradition views and those that said the idea of not accepting male midwives in birth and delivery care was slowly being done away with had a higher rate of acceptance.

The study also revealed that the respondents were in support of male midwives training because there was a critical shortage of midwives, they support it as an occupation, and men are helpful and keep secrets than women.

5.5 Recommendations for improving acceptability of male Midwives

To the Government:

The Government should do a pilot study before implementing a program which is sensitive to the community as this came out clearly with male folks that the community should have been consulted before implementing training of male midwives.

The Ministry of Health through partnership should set aside resources for sponsoring more male midwives as they are the ones found in rural areas where there is a critical shortage of man power. This will also improve on exposure as some clients cited that they had never had an experience with a male midwife.

A program which will provide antenatal mothers with learning materials and experiences that reflect equity and equality between male and female midwives in order to develop a gender sensitive and gender safe and delivery environment.

There is need for the Ministry of health in collaboration with the districts to ensure that there is continuous community sensitization on male midwifery practice throughout the year using different channels of communication, so that the messages reach the intended target groups in the community especially women.

The Ministry of education should strengthen the Forum for African Women Educationist in Zambia (FAWEZA) to ensure that girls that drop out of school due to pregnancy are followed up so that they return to school. This will improve their education, social status and level of understanding and analysis of situations including acceptability of male midwives.

TO The DHMT

The DHMT to educate parents on the importance of educating the girl child through workshops involving PTA members, teachers, union officials, teachers' trainers, administrators, policy makers and the media, all working together can create a supportive learning environment for all girls that drop out of school due to pregnancy. This will in turn improve acceptability of male midwife as the clientele will be an educated one.

The district administration should plan for and introduce weekly or monthly dialogue sessions with married women and their spouses concerning issues of male midwifery practice.

5.6 Further Research

The study must be duplicated on a larger scale in other geographical areas to enable generalization of the results .A study should involve the following as well:

Policy makers and top government leaders views on male midwives.

Care givers: the male midwives to identify their gaps and challenges they are facing during their practice and how they can be addressed.

Female midwives views to express their challenges of working with male midwives in the same environment.

5.7 Study Limitations

There are few studies that have been done in relation male midwives practice both in Zambia and the region which have been documented. This made it difficult to make comparisons with other s.

- The study was undertaken in parts of Ndola rural and urban thereby making it difficult to generalize the findings country wide.
- Finances were a limitation as assistant researchers had to be paid for the job and respondents also requested to be paid something for participating in the research.

5.8 Dissemination of Findings

The research findings will be presented to Ndola Distr Health Management team (DHMT) by conducting a one day workshop where the research findings, implications and the way forward will be discussed.

The respondents will be informed about the research findings through a talk that will be organized by the researcher and DHMT authorities.

A copy of the research report will be submitted to Ndo DHMT management for formulation of policies on community sensitization on presence of male midwives in their health institutions.

A copy of the research report will be submitted to the Community Medicine Department and School of Medicine library to serve as a source of information for literature review for other researchers and to the Ministry of Health for planning measures to improve on training of male midwives in order to curb the shortages that exist especially in rural areas and in the long run help meet the reproductive health millennium ment goals five and six(5&6) reducing maternal and infant mortality by the year 2015.

A copy of the research report will be sent to relevant authorities for journal publications of research findings.

5.9 References

Ackerman-Ross F.S & Sochat N. (1980) Close encounters of the medical kind; attitudes toward male and female physicians. **Social Science and Medicine** 14, 61-64.

AMREF (2008) Midwifery and Reproductive Health in Sudan from: <http://www.sudanvisiondaily.com/modules.php?>

Back E. & Wikblad K (1998) Privacy in Hospital. **Journal of advanced Nursing** 27,940-945.

Brooks F. & Phillips D (1996) Do women want women health workers? Women's views of the primary health care service. **Journal of advanced Nursing** 23, 1207-1211.

Donnison J (1997) Experience in Obstetric Nursing for Men in U S A, **Nursing Mirror** 114, 165 -166.

Ekstrom D.N (1999). Gender and perceived nurse caring in nurse – patient dyads. **Journal of Advanced Nursing** 23, 1393-1401.

Gaze A (1990). Delivery Equality, **Nursing times** 86, 16 - 17.

General Nursing Council of Zambia (2008) Data base as by 6th October.

General Nursing Council of Zambia (2004), **Registered Midwifery Curriculum**. Lusaka, Zambia, GNC.

General Nursing council of Zambia (2004). **Registered Midwifery Procedure Manual**. Lusaka, Zambia, GNC.

Greenhalgh J (1998). Nurse caring behaviours. **Journal of Advanced Nursing** 27,927-932.

Katz A. (2008) The **Examiner** .Review: documentary on Midwifery in the US delivery Jan 17, from: <http://www.examiner.com>

Jensen K.H. (1996). **The Modern Male Midwife**. A survey on how to make male midwives figure into modern American Gender relations. Article presented at the 36th Annual General meeting of the Northern Anthropological Association, 29th March 1996 from: <http://www.mthlyoke.edu/khensen/mdw.html> .

Hanafi H. (2007) To help reduce Yemen's maternal mortality rate, Midwives trained to manage their own private services available from:

<http://www.yementimes.com/article.shtmls?i=117op=health>
a=z

Kelly N. (1996) The experience of being a male student nurse. **Journal of Nursing Education, 35, 170–174.**

Kerssens J. (1997) Patient preference for genders of health professionals. **Social Science and Medicine 44, 1531-1540.**

Krueger R. (1994) **Focus Groups: A Practical guide for applied research**, 2nd ed. Newbury Park, CA: Sage Publications.

Lewis P. (1984) The inside Story. **Nursing Mirror 159, 17-18.**

Lewis P. (1984) **Men in Midwifery, Midwives Research and Child Birth** .3rd ed. Chapman and Hall, London.

Lewis P. (1991) **Men in Midwifery. Midwifery Research and Child Birth**. 5th ed. Chapman and Hall, London.

Lindsay G.P. (1978) Centuries of controversy. **Nursing Mirror 158, 17-18.**

Lodge N .(1997) A study to Ascertain gynaecological patients' perceived levels of embarrassment with physical and psychological care given by female and male nurse. **Journal of Advanced Nursing** 25, 893-907.

Lynn N.B. (1975)The challenge of men in a woman's world; a two part survey on the changing nursing profession. **Public Personnel Management** 4, 4 -17.

McKenna H.P. (1991)The developments and trends in relation to men practicing midwifery: A review of the literature. **Journal of Advanced Nursing** 16, 480–489.

Morin K.H, Patterson B. J, Kurtz B. & Brzowski B. (1999) Mothers' responses to care given by male nursing students during and after birth. **Journal of Nursing Scholarship**, 31, 83–87.

Muteta A. (1995). **Study to determine Mothers attitude towards male Midwives in Maternity Unit at St Francis Hospital, Katete.** Lusaka, Zambia. (Un published report)

Ministry of Health (1992) **National Health Policy and Strategies.** Lusaka, Zambia, MOH.

Ministry of Health (2004) **National Health Strategic Plan 2001-2008,** Lusaka, Zambia, MOH.

Ministry of Health (2004) Demographic Healthy survey. CSO, Lusaka, Zambia.

Mugala P. M. (2007) **Attitude of pregnant women Towards Male Health Care Providers** in Maternity Units in Chongwe District. Lusaka, Zambia. (Unpublished report)

Ndola District Health Management Team (2009) Health information Management system, Monthly **Health centre service delivery aggregation form, HIA .Ndola. NDHMT.**

Ndola School of Midwifery (2009) Health information Management system .Ndola, NSM.

Ndubani P. (2003) Towards implementing reproductive health policy in Zambia. **Medical Journal of Zambia** 3, 11- 12 Lusaka Zambia.

Nsemukila B.G. (1998) Review of Reproductive health Research in Zambia. **NHRR Workshop, Siavonga.**

Nsemukila B.G. (1998) **A Study of factors associated with Maternal Mortality in Zambia.** Lusaka, Zambia. CBo H, MOH.

Pallant J. (2005) **SPSS Survival Manual.** 2nded. Open University Press McGraw-Hill, UK.

Perkins J.L . (1993) Why men choose nursing. **Journal of Nursing and Health Care** 14, 34–38.

Polit D.F. & Hungler B.P. (1997) **Essentials of Nursing Research, Methods, Appraisals and Utilization.** 4th ed. Lippincott Company, Philadelphia.

Sherrod R.A. (1991) Obstetrical role strain for male nursing students. **Western Journal of Nursing Research** 13, 494–502.

Streubert, H.J. (1994) Male nursing students' perceptions of clinical experience. **Nurse Educator** 19, 28–32.

Suzanne K. Temmar F. & Bilkis V. (2005) International Midwifery, Midwifery in Yemen, strengthening Midwifery Practices in Morocco, a gender perspective. Montreal, Quebec, Canada.

Tagg P. (1981) Male Nurse in midwifery. **Nursing Times** 77, 1851-1853.

Temmar F. (2000) Meeting Women's Health in Yemen; a Midwifery Perspective. **Journal of Midwifery and Women's Health** 45, 72-78.

Thomas P. (2006) The Mid Person from: <http://www.menstaff.org/cqi-bin/daily.cqi>.

Ulin P.R. Robinson T.E. & Tolley E.E. (2005) **Qualitative Methods in Public Health: a field Guide for Applied Research**. 1st ed. Jossey-Bass, A Wiley Imprint San Francisco, U.S.A.

WHO (1992) Maternal Health and Safe Mother Hood Program Report .Geneva, WHO.

WHO (1994) Functions and benefits of home based maternal care report. Geneva, WHO.

WHO (2000). Midwifery from: http://www.who.int.health_topics/Midwifery/en. guest book archives.

APPENDICES

APPENDIX 1

STRUCTURED INTERVIEW WITH PREGNANT MOTHERS

UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF COMMUNITY MEDICINE

STRUCTURED QUESTIONNAIRE FOR INTERVIEW SCHEDULE

TOPIC: ACCEPTABILITY OF MALE MIDWIVES IN PREGNANCY, BIRTH AND
DELIVERY NDOLA DISTRICT

QUESTIONNAIRE NUMBER: _____

PLACE OF LOCATION: _____

DATE: _____

INSTRUCTIONS

1. Introduce yourself
2. Do not write names of respondent on the interview schedule.
3. Request the respondent to sign the consent before you start the interview.
4. Respondents should not be forced to be interviewed

Tick (v) against the appropriate answer in the box provided.

5. Answer all questions
6. All the information collected from respondents should be kept strictly confidential
7. Thank the respondents for answering the questions

SECTION A: DEMOGRAPHIC DATA

For official use only

1. Sex

1) Male []

2) Female

2. What was your age last birth day? _____ []

3. What is your marital status?

1) Married []

2) Single

3) Divorced

4) Separated

5) Widowed

6) Cohabiting

4. What is your residential address? _____ []

5. What is your Educational level?

1) Never been to School []

2) Primary school

3) Junior secondary school

4) Senior secondary school

5) College/University

6. How many years did you spend in school? _____ []

7. *What is your occupation?*

1) *House wife* []

2) *Self employed*

3) *Formal employment*

4) *Unemployed*

8. *What is your religion?*

1) *Christian* []

2) *Hindu*

3) *Islam*

4) *Any other specify*_____ []

9. *What is your tribe?* _____ []

10. *What is your income per month?*

1) *None* []

2) *Less than K500, 000*

3) *K500, 000 –K1, 000,000*

4) *Above K1, 000,000*

11. *How many children have you ever had (both living and dead)?*

_____ []

**SECTION B ATTITUDES OF MOTHERS TOWARD MALE
MIDWIVES /acceptability by women**

12. *Have you ever been attended to by a male midwife during pregnancy,
Labour and delivery?*

1) Yes []

2) No

13. *If yes to question 10 above what was your experience?*

1) Uncomfortable []

2) Embarrassed

3) Shy

4) Very safe

5) Any other response _____

14. *Given the chance, would you refuse to be examined or delivered by a
male midwife?*

1) Yes []

2) No

15. *Give reasons for your answer above:* []

16. *What are some of the traditional/cultural values regarding care by a male midwife during labour and delivery?* []

17. *What does your religion say about male midwives?* []

18. *In your opinion should training of male midwives continue?*

1) *Yes* []

2) *No*

19. *Give reasons for your answer to 18 above.* []

20. *What suggestions would you make regarding male midwives during antenatal, labour and delivery care?*

 []

21. *What would you do if you found a male midwife providing labour and delivery services at your health facility?*

 []

APPENDIX 2

FOCUS GROUP DISCUSSION GUIDE WITH HUSBANDS OF ANTENATAL MOTHERS

TOPIC : ACCEPTABILITY OF MALE MIDWIVES IN PREGNANCY, BIRTH AND DELIVERY IN NDOLA DISTRICT.

Before we start, I would like to urge you that there is no right and wrong answer in this discussion. Our interest is finding out what your views are on male midwives attending to women in pregnancy labour and delivery.

We will start by introducing ourselves one by one stating who we are by name, what we do in the community, our religion, education background. The members of the research team will also introduce themselves stating their roles.

In our discussion we will focus on the following:

1. What are your personal views about male midwives attending to women during pregnancy birth and delivery?
2. What are some of the reasons for preferring one gender of midwife in favour of the other in pregnancy labour and delivery?
3. Outline some of the problems women face when being attended to by male midwives
4. What is your influence during birth and delivery?
5. What are some of the traditional beliefs such as type of teachings, taboos/practices, beliefs held in the community regarding birth and delivery?
6. How best can you manage a situation where a midwife of less preferred gender is the only one available to carry out a procedure?

SUMMARY

Now that we have come to the end of our discussion, let us review the main points. Do you have any additions or any questions?

APPENDIX 3

INFORMED CONSENT

**TOPIC: ACCEPTABILITY OF MALE MIDWIVES IN PREGNANCY
LABOUR AND DELIVERY IN NDOLA URBAN DISTRICT**

INTRODUCTION

I, Janness Namusokwe Chilumba, a student of Master's of Science Degree in Public Health at the University of Zambia kindly requests you to participate in the above mentioned research.

PURPOSE OF THE STUDY

This study will assist to obtain information on community views about male midwives use in pregnancy labour and delivery. This is important as the information from the study will assist planners and policy makers, care givers and clients in decision making regarding birth and delivery to increase number of deliveries performed by skilled attendants.

VOLUNTARY PARTICIPATION.

Your participation in the study is entirely voluntary. It's up to you to decide to participate or decline, and if by any chance you decide to participate and later on you decide to withdraw, you can do so freely. This action will not compromise the standard of care that you receive at this clinic. Feel free.

RISKS AND DISCOMFORTS

Your participation in the study will not involve any procedure or any other harmful procedures. No risks and discomforts are involved apart from the use of your time in answering questions which will take approximately 10 minutes for mothers and a group discussion for husbands would take 20-30 minutes.

BENEFITS

By participating in the study you will be able to provide us with information that will be availed to relevant authorities and policy makers to come up with strategies and policies that will increase or improve male midwives' acceptability in pregnancy labour and delivery. This will in turn i on the number of women being attended to by skilled attendant and reduce on maternal morbidity and mortality. There is no monetary remuneration in exchange for information but your opinion may indirectly benefit the whole community.

CONFIDENTIALITY

Your research records and any information that will be collected from you will be kept confidential to the extent permitted y law. You will be identified by number and any personal information will not be released to any one without your permission unless required by law. Confidentially, the Ministry of Health, the School of Medicine or the University of Zambia Research Ethics Committee may review your records again.

INFORMATION AND CLARIFICATION

Kindly be informed that any time you seek clarifications or want to ask any questions about community acceptability of male midwives in pregnancy labour and delivery, we will be more than obliged to give you the required information.

For any further clarification, with due respect contact:

Ms Janness N. Chilumba

The University of Zambia

School of Medicine

Department of Community Medicine

P.O Box 50110

LUSAKA, ZAMBIA.

Telephone No's: 0955833539/0976516543

E-mail: janchilu@yahoo.co.uk

The Chairperson

The University of Zambia

Research Ethics Committee

P.O. Box 50110

LUSAKA, ZAMBIA.

E-mail: unzarec@zamtel.zm

Fax: +260-1-250753

Tel. No. 0211256067

APPENDIX 4

CONSENT FORM

The purpose of this study has been explained to me and I understand the purpose, the benefits, risks and discomforts and confidentiality of the study.

I clearly understand that taking part in the study is purely voluntary and that I can withdraw from the study without interrogations.

I
(Names)

Agree to participate in the study

Signed /Thumb print _____ Date: _____
(Participant)

Signed/Thumbprint _____ Date: _____
(witness)

Signed/Thumbprint _____ Date: _____
(Researcher)

BUDGET

| ITEM | UNITCOST(ZMK) | QUANTITY | TOTAL (ZMK) |
|---|---------------|-------------|------------------|
| 1. STATIONERY | | | |
| a) Flash Disk | 250,000 | 1 | 250,000 |
| b) Bond Paper | 31,000 | 6reams | 186,000 |
| c) Toner for printer | 800,000 | 1 | 800,000 |
| d) Pens | 1,000 | 4 | 4,000 |
| e) Pencils | 600 | 4 | 2,400 |
| f) Eraser | 5,000 | 4 | 20,000 |
| g) Note books | 10,000 | 4 | 40,000 |
| h) Correction fluid and thinner set(Tippex) | 15,000 | 1 | 15,000 |
| i) Staples | | | |
| j) Stapler | 15,000 | 1box | 15,000 |
| k) Folders | 60,000 | 1 | 60,000 |
| l) Bags for interview schedules | 15,000 | 4 | 60,000 |
| | 285,000 | 2 | 570,000 |
| SUBTOTAL | | | 2,022,400 |
| 2.PERSONNEL | | | |
| a) lunch allowance | 50,000 | 4x42days | 8,400,000 |
| b) Transport allowance | 20,000 | 4x42days | 3,360,000 |
| c) Secretary | 500,000 | 1 | 500,000 |
| d) statistical consultant | 700,000 | 1 | 700,000 |
| e) Train research Assistants | 200,000 | 1day | 200,000 |
| f) Ethics committee | 250,000 | 1 | 250,000 |
| SUBTOTAL | | | 13,410,00 |
| 3 .TRANSPORT | | | |
| a) To and from Lusaka and Ndola (to researchers and supervisors) | 300,000 | 6trips | 1,800,000 |
| SUBTOTAL | | | 1,800,000 |
| 4.TYPINGSERVICES | | | |
| a) Research proposal typing | 3000 | 70 pages | 210,000 |
| b) Photo copying research proposal | 250 | 70 pages x5 | 87,500 |
| c) Research proposal binding | 10,000 | 5 copies | 50,000 |
| d) Typing g Interview schedules | 3,000 | 7 pages | 21,000 |
| e) Photocopying interview schedules | 250 | 7pagesx500 | 875,000 |
| | 3,000 | 150pages | 450,000 |

| | | | |
|---|---------|----------|-------------------|
| f) Research report typing | 250 | 150pgsx5 | 187,500 |
| g) Research report photocopying | 100,000 | 5copies | 500,000 |
| h) Research report Binding | | | |
| SUBTOTAL | | | 2,381,000 |
| COMMUNICATION FACILITIES | | | 1,000,000 |
| TOTAL COSTS | | | 20,613,400 |
| CONTINGENCY FUNDS 10% FO TOTAL COSTS | | | 2,061,340 |
| GRAND TOTAL | | | 22,674,740 |

BUDGET JUSTIFICATION

STATIONERY

These are needed by the researcher to print, photocopy proposal, questionnaires final document and copies for distribution. The bags will be required for safe carrying and keeping of the questionnaires during data collection.

PERSONNEL

This will be required by the researcher and the staff who will assist data collection and preparation of the setting. Lunch allowance and transport allowance will be paid to the researcher and research sistant as they will be working out of station the whole day. The researcher will also need to pay the Research ethics Committee to go through and review the proposal for ethical approval.

TRANSPORT

The researcher will need to travel from Lusaka to Ndola and back for a pilot study, data collection, and for consultation with the supervisor and statistician during data analysis. Transport money will be required locally for the researcher and research assistant during data collection to the research sites.

TYPING AND SECRETARIAL SERVICES

The services of the secretary will be required for prompt and quick preparation of the proposal, compiling and report writing. Photocopying and binding services of the draft and final reports five copies of each will be required.

COMMUNICATION FACILITIES

For any project to progress, adequate and prompt communication is required. The researcher will need to get in touch with research assistant and the supervisors on the progress of the research? In view of the above money will be required for air time.

CONTINGENCY FUNDS

This is 10% of the total budget within six (6) months and other short falls during the research.

WORK SCHEDULE

Duration of the study is six (6) months from the time the Ethics Research Board will give approval.

The schedule will be as outlined on the GHANT chart as follows:-

Preparation of research proposal

Preparation of research instruments

Recruitment and training of research assistants.

Conducting interviews and administering questionnaires.

Data entry and analysis

Report writing

Submission of draft report

Submission of final report