THE ATTITUDES OF RURAL COMMUNITIES TOWARDS MALE MIDWIVES.A CASESTUDY OF MPONGWE.

BY

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DECLARATION

I declare that the work presented in this dissertation entitled, **The Attitudes of Rural Communities towards Male Midwives. A case study ofMpongwe** is to the best of my knowledge and belief my own work and that it is original. The dissertation contains no material that was once accepted by any university for an award of a degree or diploma. The author in this dissertation has duly acknowledged all other works.

Osborne Chimimba

Signed_____ Date_____

CERTIFICATE OF APPROVAL

The University of Zambia approves this dissertation of **Chimimba Osborne,** as fulfilling part of the requirements for the award of Degree of Master of Gender Studies.

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ABSTRACT

The study sought to identify attitudes inherent in rural communities towards the practice of midwifery by males in Mpongwe district. The objectives of the study were; to establish the views that men and women have towards male midwives, to determine factors that promotes or hinders acceptability of male midwives by rural communities and to describe the experiences of male midwives who worked in rural areas. A case study using qualitative method was employed. Purposive and Snowball samplings were used to select the sample. In-depth interview guide and focus group discussion guide were used to collect data. Thematic analysis was used to analyze data.As regards to the views that men and women have towards male midwives it was found that women were ambivalent whereas men were decisive in terms of the stand they had on male midwives. Men seemed to be more authoritative on pregnancy and delivery matters than the women. As regards to factors that promotes or hinders acceptability of male midwives by rural communities, there were more reasons addressing inhibitions than promotions. It was prohibited culturally to see a woman naked whom you are not married to. However, more women than men acknowledged the roles male midwives played in reducing mortality and morbidity. The experiences of male midwives who worked or are still working in rural areas confessed that working as a male midwife was not an easy job. Because the job was associated with providing intimate care, it exposed them to personal, interpersonal as well communal emotional challenges. Based on the findings, the study recommends the following: The Ministry of Health and other stakeholders like the nongovernmental organisations to partner and employ a holistic approach to inculcate a change in the mind set of our communities. It would be necessary in the immediate future to let the media start talking about it. Drama on gender should be organized in order to sensitize not only in Mpongwe but also other rural communities. The Ministry of Chiefs Affairs should have an authoritative voice to traditional leaders, a luminary in the field of male midwifery.

DEDICATION

This work is dedicated to my late wife, my childrenand my fiancée.

To mylate wife;Chisala Dorothy Kapindula because she was my inspiration. She always wanted and encouraged me to be a PHD holder. These were her words to me, **"Honey, do you know that you have the potential of one day being called Doctor Chimimba? Always remember that and don't let anyone take it away from you."** She sponsored my under graduate studies because during the time I was paying off a big loan. She toowas the one who bought me the application form for this very Master of Arts degree course. She died in the secondyear ofher first degreeundergraduate studies at the University of Zambia on 1st December, 2011. This was before the commencement of my masters studies in May, 2012.

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LIST OF ABBREVIATIONS

ACNM - American College of Nurse Midwives

CMNHL - Conference on the Maternal and New-born health, Lusaka

CNMs - Certified Nurse Midwives

CSO - Central Statistical Office

DHMT - District Health Management Team

ECSA-HC - East, Central and Southern African Health Community.

FGD – Focus Group Discussion

GHS – Ghana Health Services

G.N.C - General Nursing Council of Zambia

GCUC - Garden City University College

MAZ – Midwives Association of Zambia.

MDGs - Millennium Development Goals

MoH - Ministry of Health

M.C.H - Maternal Child Health

MMD – Movement for Multiparty Democracy

NCAH – National Council for Australian Health

NGO - Non Governmental Organizations

RDL – Radio Distance Learning.

SBAs - Skilled Birth Attendants

SMAGs – Safe Motherhood Action Groups

TBAs - Traditional Birth Attendants

UNICEF - United Nations Children's Fund

UNMC – Uganda Nurses and Midwives Council.

UK - United Kingdom

US - United States

WHO - World Health Organization

ZDHS - Zambia Demographic and Health Survey

ZNBC – Zambia National Broadcasting Corporation

CHAPTER ONE: INTRODUCTION

1.0 Background

In ancient Egypt, midwifery was a recognized female occupation, as attested by the Ebers Papyrus which dates from 1900 to 1550 BCE. Bas reliefs in the royal birth rooms at Luxor and other temples also attest to the heavy presence of midwifery in this culture (Jean, 1986).

Midwifery in Greco-Roman antiquity covered a wide range of women. It included old women who continued folk medical traditions in the villages of the Roman Empire. ibid).

Midwives are also mentioned in the Old Testament: in Exodus, Chapter 1. The Bible describes how the Egyptians became fearful because Israel (Hebrews) multiplied greatly. Pharaoh, therefore, commanded the Hebrew midwives (named Shiphrah and Puah) to kill all male babies delivered to the Hebrew women.."As such God dealt well with the midwives" (Exodus, Chap. 1, verse 20).

The ancient occupation of midwifery was the exclusive domain of women. During the time of Hippocrates (460 to 410 BC), it was thought that midwives in Athens should be required by law to have had children themselves (Nicopoullus, 2003).

However, there were certain characteristics desired in a 'good' midwife. As described by the physician Soranus of Ephesus in the 2nd century, he states in *Gynaecology* that, *"a suitable person will be literate, with her wits about her, possessed of a good memory, loving work, respectable and generally not unduly handicapped as regards her senses. The midwife be of sympathetic disposition (although she need not have borne a child herself) and that she keep her hands soft for the comfort of both mother and child"* (Valerie, 1986).

There appears to have been three 'grades' of midwives present in ancient times. The first was technically proficient; the second may have read some of the texts on obstetrics and gynaecology; but the third was highly trained and reasonably considered a medical specialist with a concentration in midwifery (Ralph, 1988).

1.1 Historical Midwifery

However, not much is known about individual English midwives before the fifteenth century, but mention is made in the Parliamentary Rolls for 1469 of an annual pension of £10 (then a substantial sum) granted to Margaret Cobbe, midwife to Elizabeth, Edward IV's Queen. The midwife's duties were incorporated into the oath in England. Midwives swore under the licensing system operated through the Church under an Act of 1512. As the sixteenth century progressed, so the new Renaissance spirit of enquiry was applied by leading surgeons to the anatomy of childbirth. Eminent among these pioneers was AmbroiseParé (1510-1590), a surgeon to four French kings and notable for his use of podalic version. The fame of men like Paré, spread through the printed word, in the vernacular rather than the traditional Latin, was to encourage male attendance in childbirth, first in 'extraordinary' cases and later in routine ones (Samuel, 1793).

Midwifery began to change from a female art into a male occupation in the early modern period. The shift was not a smooth one, 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 a 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. He aided in delivering babies during difficult birth by pulling them out of the womb by their feet. A major contributing factor in this shift of gender roles was Louis XIV. He used male midwives to deliver his illegitimate children. As men delivered babies of his mistresses, male midwives gained more popularity. More especially, there was a rapid population boom in Europe around this time which encouraged these social changes. As the population grew, universities increased the study of reproduction and anatomy. Childbirth not only became medicalized but also a masculinized domain. Case studies, rather than oral tradition, became the preferred method for educating individuals about childbirth (Schnorrenberg, 1981).

This development gradually spread throughout Europe. It was boosted further from the 1720s by the availability of the new midwifery forceps introduced in England

by the Chamberlain brothers. Like other surgical instruments, they belonged officially to the surgeon (Lewis, 1991).

William Smellie, born in Scotland in 1697, is credited with innovations on the shape of the forceps. He delivered women fully draped, unable to see his own actions beneath the cloth, and he encouraged his male students to wear dresses to births so to look like women (Casssidy, 2006).

The increasing use and development of surgical instruments during this time marks the beginning of obstetrics as we know it today. It also coincides with developments in anesthesia, and the propagation of exclusively male educational institutions. Men who were interested in attending childbirth became obstetricians. However, there are clear accounts that man-midwives went to great extremes to respect modesty and reduce embarrassment by all. Female childbirth attendants remained practicing empirical midwifery. This is because traditionally, women were excluded from educational institutions and thereby prohibited from using surgical instruments. This brought about new designations 'Man-midwife' in English, 'Accoucheur' in French, to refer to men who were usually surgeons and added midwifery to their practice. This divided midwifery and obstetrics along gender and philosophical lines for many years to follow (ibid).

Many midwives of the time bitterly opposed the involvement of men in childbirth. Some male practitioners also opposed the involvement of medical men like themselves in midwifery, and even went as far as to say that men-midwives only undertook midwifery solely for perverse erotic satisfaction (ibid). Samuel Gregory cited in "Man-Midwifery Exposed and Corrected, Boston, 1848," states that, *"Man-midwifery, with other 'indecencies,' is a great system of fashionable prostitution; a primary school of infamy as the fashionable hotel and parlour wine*

1.2 Midwifery in Africa.

Cameroon has drawn more men into midwifery in recent yearsbecause of the shortage of doctors and midwives in. However, men are not very much accepted more especially in the Moslem communities of the country (Scheffler,

2008).Ghana Health Services has begun training males as midwives in selected midwifery training schools in the country. The move has been described the move as part of efforts to promote gender equality to provide additional support for maternal health in Ghana which has a critical shortage of staff (UNICEF, 2009)

In Liberia, as the new role opens, men are testing new role as midwives by taking up the opened career. Liberia has roughly 3.8 million people but just 400 trained midwives. Health officials say another 1,200 midwives are needed (UNICEF, 2013).

Sudan, Chad and Kenya have alsostarted training male midwives. In South Sudan, they can only call a man when the woman has failed. Then the man will come with a spear to remove a baby, a stuck baby. Still, woman has to be around (ibid).

1.3 Midwifery in Zambia

In Zambia, attending to childbirth and the provision of basic care to women during the normal maternity circle has been the responsibility of Traditional Birth Attendants (TBAs). Usually these are older women who have given birth to a number of children. They have also acquired the skill of delivering children through experience. It is estimated that TBAs are engaged in the delivery of 23% [31% in rural areas and 5% in urban areas] of babies in Zambia; meaning that some babies are being delivered at home by TBAs, who may not be able to recognize or manage potential complications which results in the death of the child or the mother or both. A further 25% of babies are delivered by a family member and 5% of women are alone during delivery. The current health strategy in Zambia is to have a health system where all mothers and newborns should be looked after by a Skilled Birth Attendant. However, it will take time to train and deploy Skilled Birth Attendants (CMNHL, 2012).

More than 60 percent of Zambia's predominantly rural population lives in poverty. Fifty percent of women are married by the age of 18, and the adolescent pregnancy rate at its complications remains very high. HIV prevalence among adults is estimated at 12 percent. Maternal mortality has slightly declined since 1990 but remains very high. The 2007 road map to accelerate the reduction of maternal

mortality aims at increasing the availability, accessibility, utilization and quality of skilled obstetric care at all levels of the health system. The shortage of human resources is critical and staff turnover and attrition especially in rural areas is high. Malawi has good standards of midwifery regulation and education (ibid).

The government has been training and posting female midwives to health centers to take care of pregnant women even in difficult and complicated births. By the year 1980, with a total population of 5 679 800, there were 706 female midwives in the country. Of these, 249 were registered midwives while 457 were enrolled midwives. This gave a ratio of 1 midwife per every 6000 inhabitants according to the Ministry of Health (MoH, 1980). WHO's 2005 benchmark is 175 births per midwife. However, trained female mid-wives are reluctant to work in rural areas. As a result, there is always a critical shortage of trained midwifery personnel in rural areas. This has compromised the delivery of primary health care. The Ministry of Health (MoH 2006), laments that this area of the health sector has not been adequately implemented due to low number of midwives found physically in clinical practice especially in rural areas.

The training of male midwives in Zambia was initiated by the government in 1986 to fill up the gap. Before this time, midwifery was exclusively female dominated (National Mirror, 1986). Since then 326 registered, 185 enrolled and 53 certified male midwives have graduated from the schools of midwifery in Zambia and registered with the General Nursing Council (GNC). This gives a total number of 664 male midwives (GNC 2013). With this number of qualified personnel, the country's maternal mortality rate stands at 650 per 100 000 live births. Previously a male midwife in Zambia has had a general background of nursing, either as an enrolled or a registered nurse with experience in other fields (G.N.C 2004). Nonetheless, from 2012, three government nursing colleges have opened direct entry to grade twelve school leavers to both men and women for a three year midwifery training course (GNC 2013).

The introduction of health reforms in 1992 saw the revision of the 1970 Nurses and Midwives Act and on 20th December, 1997, a new Act No. 31 was ushered in. Before the revision of the Act, nurses and midwives were not allowed to operate on their own. They could not run nursing homes, due to legal barriers. The revised

Nurses and Midwives Act of 1997 has expanded the scope of practice of the Nurse and Midwife. The nurse/midwife is now allowed to provide therapeutic, palliative and rehabilitative care and treatment of illnesses normally carried out in nursing and midwifery practice and in a nursing home. Today, the nurses and midwives are operating under the Nurses and Midwives Act No. 31 of 1997.

1.4Statement of the Problem

Zambia like many other countries in the Southern hemisphere has been hit by a shortage of human resource for health. The attempts to alleviate the shortage of human resource mostly in rural areas in the health sector by creating gender neutral professions have been met with resistance in some parts of Zambia (MoH, 2004). Traditional leaders claiming to act as representatives of the rural communities have been reported to be chasing male midwives from their chiefdoms (The Post, May 7, 2013).

According to MoH (2006 – 2012) report, some health institutions are operating of only one or more qualified personnel. An evident scenario is that of Mpongwe district where male midwives have been reported to have been expelled. Lack of suitably qualified staff in the health sector especially midwives is crucial to maternal and neonatal survival. The critical questions are: What are the views of men and women towards male midwives? What factors promotes or hinders acceptability of male midwives by rural communities? What are the experiences of male midwives who worked in rural areas? This situation prompted the researcher to conduct a study and identify attitudes inherent in rural communities towards the practice of midwifery by males in Mpongwe district.

1.5 Significance of the Study

This study is significant for several reasons. To begin with, similar studies have been done by some researchers before mostly with the medical background and from the medical point of view. The problem is gender based hence the need for a gender expert to exhume the notorious confounders of the problem for mitigation. From the standpoint of traditional power it calls for the application of critical epistemology. Carspecken (1996) described critical epistemology as an understanding of the relationship between power and thought as well as power and

truth claims (Kincheloe& McLaren, 2003). To achieve an understanding between power, thought, and truth claims, there is need to examine the traditional value orientations (Kincheloe& McLaren, 2003).

Most of the researchers concentrated in interviewing mainly women and in some instances where men were interviewed, they were very few. Leaving out men in this kind of a study is tantamount to leaving out leaders of social institutions who mainly happen to be men. Social institutions are the custodians who transmit and perpetuate values, norms, beliefs and cultural practices through their teachings.

This study has identified entry points in institutions for bringing about change. It has shown that the attitude is based on the perceptions of institutional culture and bought out awareness to change agents that solutions to this problem require institutional changes.

It has also shown that gender sensitization and training that is reinforcing factors in institutions will bring about changes in the attitudes of the rural communities towards male midwives.

This study is justified in the sense that it has brought out data that will be used to solve the problem of midwifery rejection in the sense that the research was conducted in the area which is on record of chasing male midwives.

Male midwives are being discriminated upon from performing the work of their profession based on their sex. The study outcomes will add to the pool of knowledge in gender and cultural studies. It is also expected that Mpongwe District Health Office is likely to use the study outcomes for purposes of healthy education and designing community based interventions. The study outcomes in particular the categories that will be developed from the data may be used to inform a much wider quantitative inquiry.

1.6 The Main Objective

To identify attitudes inherent in rural communities towards the practice of midwifery by males.

1.7 Specific Objectives

a) To establish the views that men and women have towards male midwives.
b) To determine factors that promotes or hinders acceptability of male midwives byrural communities.
c) To describe the experiences of male midwives who worked in rural areas.

1.8 Main Question

What attitudes are inherent in rural communities towards the practice of midwifery by males?

1.9 Specific Questions

a) What are the views of men and women towards male midwives?
b) What factors promotes or hinders acceptability of male midwives by rural communities?
c) What are the experiences of male midwives who worked in rural areas?

1.10 Limitations and Strengths of the study.

The study had several limitations. Although data saturation was achieved, the limits set by our inclusion criteria, and cultural background, are acknowledged as limitations.

Another limitation was that our gender was different from that of the participants. Williams and Heikes (1993) found that researcher gender influences the content of in-depth interviews when participant and researcher are of different genders. They also state that male to male interviews achieve rapport more easily than when with women, thereby allowing a more natural flow of conversation. In contrast, male–female interviews are more prone to show a social desirability bias. This crate biased results when participants attempt to answer questions dependent on what they perceive to be the expectation of the researcher. This tendency becomes more apparent when interviews are conducted face-to-face and are voluntary in nature (Williams &Heikes 1993, Babbie 2001).

While the researcher accepts that any research that has a gender context is susceptible to bias the researcher considers that the data obtained are useful and

valuable. This is because the social circumstances, upbringing, the research questions and the relationship established between the researcher and the participants during interviews created a rapport. The researcher is therefore confident that, despite the limitations, findings make a positive contribution to the phenomenon under investigation.

1.11 Operational Definitions

Attitude: The way community regards male midwives

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

Gender: Refers to those social, cultural, and psychological traits linked to males and females through particular social contexts.

Gender roles: The expected attitudes and behaviors a society associates with each sex.

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

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

Traditional beliefs: A strong feeling about what customs say.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

The chapter focuses on the review of readily available researched information in the past, relevant to the current study. The need for further research arises due to gaps revealed in the previous researches. The studies under review are the history and modern midwifery; unique contributions, facing rejection and steps to success. The global perspective of midwifery outside Africa is also reviewed by looking at the United Kingdom, the United States of America, Japan, Canada, China and Australia. The African perspective is as well reviewed by focusing on Cameroon, Ghana, Liberia and South-Sudan. The regional perspective is reviewed under The East, Central and Southern African Health Community (ECSA-HC) by looking at Uganda and Zimbabwe. The national perspective takes in both substantive and research reports from all over the country Zambia.

2.1 History

History tells us that the ancient occupation of midwifery was the exclusive domain of women.Women have helped each other in childbirth from time immemorial; indeed, until relatively recently such attendance remained a female domain in which men very rarely played a part. Generally the midwife was the senior woman in the community. She was commonly a married woman or a widow who had herself given birth. With the gradual development of towns and cities came the specialisation of occupations, including midwifery, and with this the professional midwife. These women would acquire their skills over years as apprentices to older midwives. During the time of Hippocrates (460 to 410 BC), it was thought that midwives in Athens should be required by law to have had children themselves (Nicopoullus, 2003). During the seventeenth and eighteenth centuries, the advent of surgical instruments and institutional medical training brought many changes to midwifery and medicine in general. Initially, barber-surgeons, who carried with them destructive surgical instruments, were called to attend to difficult births by midwives in a desperate attempt to save the life of the birthing woman (Bynum, 1983; Cassidy, 2006).

This role evolved in seventeenth-century Europe into what was termed the 'man-midwife,' the predecessor of the obstetrician. These doctors who attended births were controversial from the onset. Their motives were questioned and they were often viewed as deviant, improper, and scandalous. Some men were certainly curious about birth; most men had never witnessed one. However, there are clear accounts that man-midwives went to great extremes to respect modesty and reduce embarrassment by all (Cassidy, 2006). When a man midwife was called to a birth, he would often drape the woman, tying the long cloth around his own neck, so that his eyes couldn't see what his hands were doing.

There are some accounts of man-midwives sneaking into a room, completing a difficult birth, and then exiting without ever being noticed by the laboring woman (Bynum, 1983; Cassidy, 2006). Other anecdotes suggest that the male birth attendant should be unsightly himself, in order to offset any jealousy by a husband or improper thoughts by the laboring woman (Nicopoullus, 2003).

The motivation of any man to attend a birth was often questioned, and the opportunity for a man to witness a birth was rare, if at all. Despite the controversy during this time, prominent men were making great strides to further the science of midwifery and what would later become the practice of obstetrics. At the Hotel-Dieu in Paris, men were being book-trained in midwifery and the use of surgical instruments for delivery (Cassidy, 2006). William Smellie, born in Scotland in1697, is credited with innovations on the shape of the forceps (Schuilling et al., 2005). He delivered women fully draped, unable to see his own actions beneath the cloth, and he encouraged his male students to wear dresses to births. The disguise reduced suspicion and controversy, but also provided ample room to hide instruments, such as forceps, which were experimental and ill-favored (Cassidy, 2006).

As midwifery began to develop so did the profession of obstetrics near the end of the century. Childbirth was no longer unjustifiably despised by the medical community as it once had been at the beginning of the century. But the specialty was still behind in its development stages in comparison to other medical specialities, and remained a generality in this era. Many male physicians would deliver children but very few would have referred to themselves as obstetricians.

The end of the 19th century did mark a significant accomplishment in the profession with the advancements in asepsis and anaesthesia which paved the way for the mainstream introduction and later success of the Caesarean Section where pregnant women with complicated births are attended to (Caplan, 1995).

By the late 19th century the foundation of modern day obstetrics and midwifery began to be laid. The delivery of babies by doctors became popular and readily accepted but midwives also continued to play a role in childbirth. Midwifery also changed during this era due to increased regulation and the eventual need for midwives to become certified. By the late 19th century many European countries were monitoring the training of midwives and issued main article certification based on competency. This means that midwives were no longer uneducated in the formal sense (Bryte, 2002).

The increasing use and development of surgical instruments during this time marks the beginning of obstetrics as we know it today. It also coincides with developments in anesthesia, and the propagation of exclusively male educational institutions. Men who were interested in attending childbirth became obstetricians. Female childbirth attendants, largely excluded from educational institutions (and thereby prohibited from using surgical instruments), would remain practicing empirical midwifery. Hence, midwifery and obstetrics would be divided along gender and philosophical lines for many years to come (Bynum, 1983; Schuilling et al., 2005; Cassidy, 2006).

2.2 Modern day midwifery

However, midwifery still remains a female territory, largely due to the commonly held belief that in essence, midwifery is about a female relationship. It is believed is that women seek out a midwife in the hopes of building a close and trusting relationship with another woman. Midwives themselves have stated that midwifery is about 'woman-to-woman' care. People have asked, 'What would a male midwife be called, amid husband?' This woman-to-woman relationship is characterized as nurturing, intuitive, patient, sensitive, and understanding. Midwifery care focuses on the intimate, intensely personal aspects of pregnancy and childbirth, along with well-woman care. Intimate care should be understood as

providing physical care that invades the client's personal space and requires the removal of some parts of their clothing or entailed a procedure that touched the client's genital area. Many believe that a man would not be able to bond with a woman in this way as he could not cultivate this relationship. This is partly because as a man he could never understand what a woman was going through. As such, many find men's motivations suspect. Questions are asked, why would any man want to be a midwife? Could the interest be sexual in nature? The male presence would be off-putting or embarrassing to a woman. The woman's partner may be intimidated or jealous of the bond between her and the male midwife. The underlying assumption is that socially it is simply inappropriate for a man to identify himself as a midwife. Midwives themselves are some of the most vehement proponents of this view (Kennedy, 2006).

Midwives, more than ever, are serving women and families from diverse backgrounds, socioeconomic levels, race and ethnicities, and sexual preferences (Barger, 2005). Midwives aim to serve the needs of these women and families with personalized, attentive care. Truly achieving this goal requires a diverse, culturally competent population of midwives.

In recent decades, women have overcome many barriers to practicing medicine and now make up a large proportion of obstetricians. It's generally socially acceptable for either male or female obstetricians to attend births. The same can't be said for midwifery, which until this day has largely remained the exclusive terrain of women (Bynum, 1983; Schuilling et al., 2005).

The issue isn't so much about men in childbirth, as it was in the seventeenth century, but of men in midwifery. Midwifery remains female territory, largely due to the commonly held belief that midwifery, in essence, is about a female relationship. The belief is that women seek out a midwife in the hopes of building a close, trusting relationship with another woman. Midwives themselves have stated that midwifery is about "woman-to-woman" care (Kennedy et al., 2006). Much of the public believes that a midwife by definition is a female provider. People have asked, "What would a male midwife be called, a mid-husband?" This woman-to-woman relationship is characterized as nurturing, intuitive, patient, sensitive, and understanding.

Midwifery care focuses on the intimate, intensely personal aspects of pregnancy and childbirth, along with well-woman care. Many believe that a man would be unable to bond with a woman in this way. He could never understand what a woman was going through. A man couldn't cultivate this relationship (Bynum, 1983). As was the case centuries ago, some find men's motivations suspect. Why would any man want to be a midwife? Could the interest be sexual in nature? The male presence would be off-putting or embarrassing to a woman. The woman's partner may be intimidated or jealous of the bond between her and the male midwife. The underlying assumption is that men's involvement in midwifery is questionable and problematic. And that it's simply socially inappropriate for a man to identify himself as a midwife. Midwives themselves are some of the most vehement proponents of this view (Kennedy et al., 2006). There are few professional spheres where one can continue to voice such harsh sentiments based entirely upon sexual stereotype and bias.

Recent articles and Web-based discussions have documented the experiences of male midwives. Despite the theoretical opposition described, many encounters that these men describe are remarkably positive. Repeatedly, male midwives and the women they serve described the quality of care given, and not the gender of the provider (Kennedy et al., 2006). One male midwife succinctly stated that "gender is very rarely an issue for clients (Armstrong, 2008). 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 (The Mid-Person, 2008).

Another midwife explained that if you have "the skills and attributes that midwives need, it doesn't matter what your gender is and it's usually pretty easy to convince women about that (Bynum, 1983; The Mid-Person, 2008). The overall 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 (Kennedy et al., 2006).

Men's motivations for choosing midwifery are also discussed. One man reported a long family history of involvement in midwifery; as a result, caring for pregnant

women came naturally to him. Others choose the profession precisely because of the relationship it allows the provider to form with the patient: the patient-provider rapport, continuity of care, and the opportunities for teaching (Armstrong, 2002; UK Midwifery Archives, 2008). In addition, evidence suggests that men in nursing tend to specialize in areas of high acuity (Armstrong, 2002). Some men may simply enjoy the critical care aspect of labor and delivery. Clearly, the motivations are multiple and varied just as they are among female midwives.

2.3 Unique contributions

Male midwives may not only possess the essential qualities of a midwife, but may also offer unique attributes to the childbearing family's experience precisely because they're male. Women appreciated and in some cases preferred a male midwife because of his "open" approach to pregnancy and childbirth. They shared encounters where male midwives displayed less "emotional baggage" than some of their female colleagues. These women recognized that male midwives lack preconceived ideas based on their own childbirth experiences (Kennedy et al., 2006; The Mid-Person, 2008). Additionally, rather than feeling jealous or intimidated, husbands and partners were instead relieved to have another man in the room (Bynum, 1983; Armstrong, 2002; UK Midwifery Archives, 2008). One male midwife found that most men "seem to find his presence comforting". It was suggested that the male midwife may explain things differently and relate to men more "on their level" (Armstrong, 2002; UK Midwifery Archives, 2008). Male midwives may also showcase the quality of gentleness that impacts how fathers view their role in the context of the new family (Kennedy et al., 2006; The Mid-Person, 2008). Rather than being problematic, some qualities of being male were viewed as distinctive attributes.

2.4 Facing rejection

Much of the argument against men in midwifery focuses on the occasions when women demand female providers. Male midwives (along with male obstetricians and gynecologists) have no doubt been refused by women. However, refusal is rare, and one male midwife reports being rejected only once or twice in 10 years of practice (The Mid-Person, 2008; (Armstrong, 2002; UK Midwifery Archives,

2008). Reasons for refusal include extreme embarrassment around the opposite sex, religious prohibitions, cultural ideologies, or a past history of abuse or trauma (sexual, physical, or emotional). All of these reasons are equally valid and male midwives respect these women's choices (The Mid-Person, 2008; UK Midwifery Archives, 2008). A woman's experience of pregnancy and childbirth, along with her healthcare in general, is layered with intimate personal, psychological, and socio cultural factors. A fundamental quality of any midwife is the ability to facilitate an environment in which a woman feels safe, secure, and at ease. If a male midwife's presence interferes with this environment, a female attendant is obtained. Male midwives advise not to take the request personally (Bynum, 1983; Armstrong, 2002; UK Midwifery Archives, 2008). Instead, the rejection is used as an opportunity to display culturally competent care, respecting the woman's individuality and freedom of choice (Armstrong, 2002; UK Midwifery Archives, 2008).

The term midwife simply means "with woman," and the midwifery model of care transcends gender. With the essential qualities of a midwife present, gender can fade to the background. These qualities include proper skills and training, a desire to serve women, and the ability to empathize and communicate. Even more critical, midwives must be good listeners. The quintessential midwife listens to women in order to cultivate a relationship that prioritizes their individualized needs. It's this same philosophy of respect for diversity and individuality that underscores the need for a more accepting environment for male midwives. A qualitative study conducted recently on 'Diversity in Midwifery' found that male midwives encounter unique adversity, and may be singled out by women and other midwives as being "different" (Kennedy et al., 2006).

Men interviewed in this study reported a sense of heightened personal awareness and increased respect for individuality due to their own minority status. Being male was a facilitator to culturally competent care. Researchers have concluded that these male midwives displayed the precise qualities and philosophies that all midwives wish to embody (Kennedy et al., 2006). Findings of one study were presented at the 2003 the American College of Nurse Midwives (ACNM) Annual Meeting. Although the response from the midwife audience was varied, the professional dialogue on gender diversity had begun.

2.5 Steps to success

Midwifery faculty and preceptors have been challenged to create an environment supportive of all midwives— male and female. There still exists, however, many barriers for men much like that for men in nursing in general. In a recent article in this journal, Fenki (2006) described barriers to recruitment of male nurses, detailing societal stereotypes and gender bias. He also discussed recruitment strategies, new educational frameworks for varied learning styles, and mentoring programs for men entering nursing. An expert from the Royal College of Midwives agrees that recruitment campaigns and media images inclusive of male midwives will encourage men to view midwifery as a valid and worthwhile career (The Mid-Person, 2008). These images will also raise public awareness. Many believe that in this day and age, men can practice in any area of nursing Armstrong, 2002). Male midwives cite the importance of finding mentors—either male or female—who will help them through challenges, both clinical and socially (The Mid-Person, 2008). Midwifery programs could aid in this by ensuring that these mentors are available.

2.6 Global perspective of midwifery outside Africa

In the United Kingdom, men were legally prohibited from practicing midwifery until a legislation abolishing sexual discriminations was passed in 1983. The legal battle for men to enter midwifery faced much opposition. Men presently make up slightly less than 1% of the midwifery workforce in the United Kingdom (The Mid-Person, 2008).

In the United States, there has been no legal prohibition to exclude men from midwifery, yet the percentage of male midwives is comparably low. The overwhelming presence of men in obstetrics demonstrates the social acceptance of men in childbirth. According to the most recent survey of certified nurse midwives (CNMs), the American College of Nurse Midwives (ACNM) found that 0.6% of its members are men (Schuilling et al., 2005). Although this number is reflective of members of the college, one can easily see that men account for a miniscule number of CNMs nationwide. The percentage of male student nurse-midwives is even lower. Diversity in American midwifery is limited on many fronts. Nearly 90% of CNMs are white females (Kennedy et al., 2006). Recognizing this

homogeneity, attention has recently been devoted to understanding why there's such a lack of diversity, and what can be done to remedy it.
The midwifery model of care holds that all women of all backgrounds deserve safe, effective, satisfying care throughout their lifetime. A guiding philosophy is respect for diversity, human dignity, and individuality (ACNM, 2005).

In Japan, midwifery was first regulated in 1868. Today midwives in Japan are regulated under the Act of Public Health Nurse, Midwife and Nurse (No. 203) established in 1948. Japanese only had female midwives but up to until March 1, 2003 men have been admitted to the career by law (http://www.midwifery.Org).

Despite the gains the midwifery profession has made in Canada over the past 10 years, it still faces many challenges. In the past, men have been excluded from maternity care due to the influence of traditional culture, and a number of factors centred on health service delivery issues. Involving men in the maternity care of their pregnant partners has become important because of the realisation that men's behaviour can significantly affect the health outcomes of the women and babies. Men have increasingly become aware of their critical role in reproductive health care. First Nations and Inuit midwives still face great challenges around training and regulation (http://wwwmenstuff.org).

In China there are a growing number of men who are taking up jobs previously seen as the exclusive preserve of women. China's first male midwife Li, says that in some ways a man is well-suited to providing postnatal care, as it is a physically demanding job. Many members of the public are still unsure about a man carrying out a job that has traditionally been done by women. Formerly a university lecturer with a master's degree in public management, Li quit his job and decided to train as a postnatal caregiver, feeling the profession offers brighter prospects. Professional caregivers are in high demand and command good prices for their services. Li says he understands that some may be opposed but he will stay the course and try to make a success of his new chosen career. (CAN Vol. pg. 23, 2012).

In Australia, there are 337,807 nurses and of those only 33,891 are male (2012 statistics from NCAH). This is roughly a tenth. That may not sound like a lot, but is the result of a major increase in recent decades and demonstrates considerable

growth and changes in social expectations around gender categories and behaviours. However, the same cannot be said for midwifery. In Australia there are just nine male registered midwives. This is nothing unique to Australia as 2% of midwives in the USA are men, 1 % of midwives in the UK are men There is nothing actually standing in the way of men training to be midwives, it is just uncommon and for various reasons. While there may still be a taboo for some, particularly people with strong religious convictions, there are men working in maternity wards and they're working extra hard to change the way people feel about male midwives (Dar P. et al. 2012).

2.7 The African Perspective

A shortage of doctors and midwives in Cameroon has drawn more men into midwifery in recent years. While many Christian men and women say they prefer male midwives for their attentiveness, Muslim men and women say that it goes against their religion for a male to attend to a woman during labour. The government introduced the country's first official midwife training programme in order to ensure the availability of skilled midwives regardless of sex. Women are unfazed when they find a man in the labour room attending to them, especially young girls who are having their first babies, are uncomfortable with male midwives. However, most women prefer male midwives. Generally, women prefer male midwives, but the problem is that there are very few male midwives in Cameroon. Women want male midwives because of that cordial relationship that exists between men and women. There is that natural flow or soft link between the man and the woman, so a man will always want to care for the woman.

Cameroon has never offered exclusive training for midwives, according to the Ministry of Health's delegation in the Southwest region. Keukam says that midwifery education has instead been available as a post-nursing program, and prerequisites included at least two years of experience as a nurse to both men and women (Scheffler, 2008).

The Ministry of Health in collaboration with the Ghana Health Services has begun training males as midwives in selected midwifery training schools in the country come 2013/14 academic year.

The ministry described the move as part of efforts to promote gender equality to provide additional support for maternal health in Ghana. The decision was arrived at after consultation with its stakeholders to implement the policy through a pilot basis approach with a very competitive written examination and an oral interview to select qualified candidates to pursue the programme.

Addressing the matriculation ceremony of the Garden City University College (GCUC), the Offinso Municipal Director of Health Services, Mrs Beatrice Appah, said the training of males to offer services to women in labour would address the posting of personnel to rural communities.

The first batch of males starts training this academic year for the pilot programme at Pantang, Goaso and Asante-Mampong, Post Basic Midwifery training Schools in the Eastern and greater Accra region respectively. They would be awarded diplomas in midwifery after training. The programme is currently opened to community health nurses or health assistants who have completed a 3-year working experience. Explaining, she said many female midwives often refused postings to rural communities after their training, a situation that greatly undermined the quest to reduce maternal mortality in the country.

"*With the training of males as midwives, the incident of high maternal mortality in the country will be greatly reduced because most female midwives have refused to accept posting to rural communities, leading to a high incidence of maternal mortality cases. The training of males as midwives will also fill the yawning gap that has been left behind, following the retirement of many midwives in the country*," she added.

Ghana currently has about 4,035 midwives, approximately 1 midwife to 6,155 patient ratio which is still yet to meet WHO's recommendation of 1 midwife to a 1,000 patients (Ghana Daily Graphic, 14th March, 2013).

In Liberia, as the new role opens, men are testing new role as midwives by taking up the opened career.

Figure 1.*Henry Tey (2009).Male midwife trainee in Liberia.*

Tey, gently slides down a blue hospital sheet to expose the bare belly of a pregnant woman. As he pokes around to feel the position of the foetus and places his ear against a foetal scope shaped like a horn, and presses it against the pregnant woman's belly to listen to the foetal heartbeat.

The young midwife-in-training knows he is breaking tradition and changing the face of obstetric care in Liberia.

"*In our setting, there are some women who are not really comfortable with men to check them… because of the private parts,*" he says, fiddling with his stethoscope.

In 2009, Teybecame one of the first men to be admitted to a midwifery training program in Liberia's southeast. The rural midwifery school, closed for 20 years due to war, was reopened by the British medical aid agency Merlin and Liberia's Ministry of Health and Social Welfare. The decision to recruit men seemed to make sense, said midwifery trainer SawahShaffa. *"[Liberia] has got male doctors. They got male nurses. So, midwifery should not be limited to only women."*

At the Martha Tubman teaching hospital in Zwedru, Tey invites another pregnant woman to lie down on the examination table. The young man explains how he jumped at the opportunity to become a midwife because of a personal tragedy – his 19-year old sister died giving birth while stranded in the bush. "*She was trying to walk from the nearby town to Kanweaken, where we have the clinic. She started bleeding severely and there was no car available.*" Villagers loaded the pregnant

woman into a hammock to carry her to the next town, but she died on the road before an ambulance could arrive.

In the packed hospital waiting room in Zwedru, a young pregnant woman winces in pain and clutches her belly. AlethaCherley, 22, is nervous because it's her first pregnancy but, although she's feeling cramps and back pain, she is reluctant to let Henry Re-examine her. "*For me, if a different man who is not my boyfriend sees my private parts, I can be too ashamed. …It's very shameful to me. That's why they have ladies here to do that. Midwifery is something private… it's woman to woman,*" says Cherley. The young man places his ear against a foetal scope shaped like a horn, and presses it against the pregnant woman's belly to listen to the foetal heartbeat. Unlike school officials, he's confident pregnant women will overcome their shyness and cultural taboos to seek medical care from him in the village.

"*I love this field so much… and you just have to approach women in a manner that you think she will be comfortable."*

A first class of 32 midwives including males graduated in December 2010, they signed contracts with the Ministry of Health that guaranteed them full-time job for three years, and they are serving across six rural counties in south-eastern Liberia.

A 2009 report by the United Nations Children's Fund (UNICEF) indicates that Liberian women have a 1 in 12 lifetime risk of dying from pregnancy or childbirth complications, usually due to obstructed labour, haemorrhage, or infection, resulting in the eighth highest maternal mortality rate in the world. UNICEF concludes that 80 percent of maternal deaths could be prevented by access to trained health workers. Liberia has roughly 3.8 million people but just 400 trained midwives. Health officials say another 1,200 midwives are needed (UNICEF, 2013).

Fifty-six-year Abdalla, known by all as "Mama Zeena," has spent nearly half her life training midwives in Sudan, Chad and Kenya's Kakuma refugee camp. She knows there are cultural barriers to introducing men into the traditional field of midwifery. She trained as a midwife after losing her own full-term baby in 1987. Today, she has become a vocal advocate for training more skilled birth attendants

in poor, post-war states. She said, "*In South Sudan, they can only call a man when the woman has failed. Then the man will come with a spear to remove a baby, a stuck baby. Still, woman has to be around.*"

She warns that the Millennium Development Goals of reducing the world's maternal mortality rate by three quarters by 2015 and providing universal access to reproductive health cannot be met without greater investment. And this includes male human resource in midwifery (ibid).

2.8 Regional Perspective

The East, Central and Southern African Health Community (ECSA-HC) is a regional inter-governmental health organization that fosters and promotes regional cooperation in health among member states. Member states of the ECSA Health Community include Kenya, Lesotho, Malawi, Mauritius, Seychelles, Swaziland, United Republic of Tanzania, Uganda, Zambia and Zimbabwe. It was established in 1974 to foster and strengthen regional cooperation and capacity to address the health needs of the member states.

ECSA has colleges without walls whose overall aim is to promote professional excellence and improve health services available to the people.

The mandate of ECSA HC is to promote and encourage efficiency and relevance in the provision of health services in the region. ECSA promotes the highest standards of health for the individuals, families and communities and harmonization of health policies and programmes.

In Uganda maternal deaths have been declining, latest WHO figures show that up to 438 mothers die for every 100,000 delivered babies. These occur because hospitals lack transfusion blood, manual vacuum aspiration kits, and critical medical personnel like midwives and nurses. But another cause of women dying, especially in the rural areas is, according to Dr Kiggundu, due to the irresponsibility or negligence of their partners who do not understand the gravity of the problem when for instance a woman goes into labour. According to the UNMC 2013, only 20% of health workers are working in rural Uganda, while 80% are based in the urban areas. On the contrary, 85% of Ugandans live in rural areas.

Uganda is largely male-headed; the time to bring men to fully participate in the reproduction process is now (UNMC, 2013).

The Pangolin Diary offers reflections and insights by an Australian male midwife working in remote, rural Zimbabwe in the early 1990s. Some stories are funny, many are sad, but they offer a range of perspectives on midwifery, health care and life in Zimbabwe. Doctors are well accepted but male midwives face a lot of challenges, says author David Stanley (http://www.amazon.co.uk/The-Pangolin-Diary).

2.9 National Perspective

> '*Currently Zambia is witnessing a retrogressive debate on the existence of male midwives*,' said the Midwives Association of Zambia (MAZ) president. He went on to say, '*male midwives just like their female counterparts were pivotal in ensuring equity of access to health care for all Zambians. Members of MAZ and other midwives are the pillars of maternal and neonatal and child health services in the country. They serve the people of Zambia from diverse cultural and ethnic backgrounds. Midwives irrespective of gender are the frontline skilled birth attendants at all levels of health care in the country. We need to promote more males to get trained into this profession as this is a clear mark of gender achievement. Those against male midwives are stereotypes that ignore that gender roles are socially assigned and as such can change. He called for all interested parties to work together and address with seriousness the high maternal and infant mortality rates in Zambia*(The Post, May, 13th, 2013).

The above statement was a reaction to the 2nd May, 2013; media report that Senior Chief Nsokolo in Mbala Northern Province confirmed having ordered a male midwife to leave the health institution, Nsokolo Rural Health Centre. The chief indicated that traditionally, it is not acceptable for a man to attend to a pregnant woman. He appealed to the government to consider sending a female officer to the area, with which mothers will be comfortable (Zambia Daily Mail, 2013).

Senior Chief Nsokolo's action prompted the opposition political party, the Movement for Multiparty Democracy (MMD) Vice President for Politics to ask

government to do away with male midwives in the country. He said this during a press briefing at their party's secretariat in Lusaka. In support of the chief's action he said that as somebody informed in culture, allowing men to serve as birth attendants was not part of Zambia's cultural practice, stressing that it is important to uphold fundamental cultural norms in the midst of new development and trends. He said that women must be protected and he wondered why those who are gender sensitive were quiet about the issue (The Post, May 7, 2013).

On the 8th of May, 2013, Community Development Mother and Child deputy minister reacted to both the chief's action and the MMD's call. She warned of stern action against some traditional authorities that were reportedly sending away male midwives from attending to deliveries. The minister described the MMD vice president's line of thought as retrogressive and that the vice president was taking the country 30 years backwards by his suggestion. She said that male midwives seem to be stable and remained in the country whereas female midwives undergo maternity leave; male midwives are available at all times. She went on to say that studies have shown that most expectant women preferred being attended to males as opposed to their fellow women because they are tender and caring. That is if the government has to achieve the Millennium Development Goal number six. It needs not be selective as who can attend to women in child birth (The Post, May 8, 2013).

Amidst this debate it is important to have a look at the substantive reports about the male midwives in the nation in order to get a clear picture about how the nation is fairing on the matter from 1999 to date.

2.10 Substantive Reports

In 2001, it was reported that the community in Kan'onga in Ndola rural rejected male midwives and male clinical officers from conducting childbirth deliveries (Mubiana, 2001).

In 2006, a man in Lusaka Province, Chongwe district at Shikabeta village went to confront a male midwife upon discovering that his wife who was in labour was being delivered by him (Mugala, 2007).

In Kaoma in the Western Province of the country, it was reported by Muvi television in June, 2008 as a place where women were shunning using a health centre because of the presence of a midwife (Chilumba, 2011).

On the Copperbelt Province, Ndola rural, in the chiefdom of chief Mushili, it is also on record together with chief Lesa of Mpongwe district of having chased two male midwives from their chiefdoms. The same reaction from the two chiefs saw the stoppage of midwifery practice by student trainees from the Ndola Central Hospital School of Midwifery at Fiwale Health Centre and Mpongwe Mission Hospital respectively (Ndola DHMT 2008, Data Base).

In March, 2014 it was reported on the Zambia National Broadcasting Corporation (ZNBC) broadcast that pregnant women in Solwezi were shunning a rural health centre for them to be delivered of babies because of the presence of a male midwife.

Besides the debate and the substantive reports there is also need to briefly review some of the studies conducted from 1999 to date concerning male midwives in the country.

2.11 Studies conducted

Considering Imasiku's (1999), study of Factors Contributing to the Low Utilization of Institutional Based Delivery Services in Kalabo District, it was established that 50 percent of women in the area do not utilize the health facility provided by the government hence exposing themselves to maternal morbidity and mortality. She advanced two reasons for this: first, long distances to health facilities and the second was that their husbands did not like the idea of their wives being delivered by male midwives.

The study conducted in Chadiza, Eastern province of Zambia by Mutemwa (1999), showed that only 23 per cent of pregnant mothers in the area were delivered at health centers. It was discovered that 77 per cent preferred being delivered by TBAs because of the presence of male midwives at the health center.

Nsemukila (1988), studies conducted in urban areas of Lusaka, Livingstone, Kabwe and Ndola showed that most deliveries occur in health institutions.

However, studies conducted in Mongu, showed that male midwives were being chased away from the delivery rooms. The husbands totally refused their wives to be delivered by male midwives.

Mugala (2007), studies conducted in Chongwe district on "The Attitude of Pregnant Women towards Male Health Care Providers." It was observed that of the average 20 per cent of supervised deliveries by skilled personnel, for a period 2003-2005 only 1.1 per cent was delivered by male midwives while 18.9 were supervised by female midwives.

Chilumba (2011), studies conducted in Ndola an urban setting on the "acceptability of male midwives in birth and delivery care" revealed that 73.2% of the respondents were in support of male midwifery practice. 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.

Further, in 2013, Community Development, Mother and Child health minister revealed that 47 percent of births are handled by skilled workers at health institutions. Speaking during the launch of Safe Motherhood Action Groups (SMAGs) Radio Distant Learning (RDL) program, he said that 53 percent in rural areas deliveries take place at home because of either access to health centre or shunning male manned health centers (The Post, 31st May, 2013).

Zambia is one country in the region that has been practicing male midwifery since 1987. Though not many studies have been undertaken on the attitude of the rural community towards male midwives, there are quite a number of substantive reports on community's reactions together with studies undertaken on the midwifery issue in the country of which some are ones presented above.

2.12 Theoretical Framework

The consensus is that a theory is feminist if it can be used to challenge a status quo that is disadvantageous to women (Farrell et al, 2008).

The research and theory associated with studying gender issues propelled the sociology of gender from the margins to become a central feature of the discipline. Accounting for this, gendering has reshaped the theoretical and empirical

foundations of sociology. On the theoretical side, gender awareness has modified existing sociological theory and led to the creation of a new feminist paradigm. On the empirical side, gender awareness has led to innovative research strategies and opened up new topics for sociological inquiry (Liddington, 2008).

This study intends to approach the attitudes and perceptions of rural communities towards male midwives using functionalism theory also known as 'structural functionalism.' The theory seeks to identify the basic elements or parts of the society and determine the functions the parts play in meeting the social needs in predictable ways. Functionalism emphasizes values surrounding gender roles, marriage and the family as central to functionalist assertions regarding social equilibrium. However, functionalism asserts that in the case of disruptive social change, society can be restored to equilibrium as long as built in mechanisms of social control operate effectively and efficiently (Enmaji, 2005).

CHAPTER THREE: STUDY METHODOLOGY

3.1 Research design

This study used a case study design. A Qualitative Inquiry was implied to identify attitudes inherent in rural communities towards the practice of midwifery by males The researcher recognizes that critical research traditions differ from other forms of research, as they recognize that claims to truth are always discursively situated and implicated in relations of power. As such, since the research problem is about power inherent within the local culture and the directions to reject or eject male midwives stem from the traditional leadership, the topic calls for the researcher to be a criticalist rather than a mere descriptor of events or what is spoken. This is because the ejection and rejection of male midwives is a fact and it stems from regulatory rules and the rules must be met (Kincheloe and McLaren 2003). If these rules are not met, then truth has no meaning, and, as a result, libratory praxis has no purpose. Therefore the researcher believes that critical qualitative research seeks to do more than merely reconstruct reality. Rather, in this study, critical qualitative research seeks further to understand the relationship of culture to social structures like chieftaincy and Indunaship, and although these mostly escape the awareness of the actors, they influence how they act (Georgiou and Carspecken, 2002).

3.2 Research Site

The study was conducted in Mpongwe district. The district has a total population of 93, 097 (CSO, 2010). There are six chiefdoms and six chiefs in the district. These are Chief Malembeka, Chief Lesa, Chief Kalunkumya, Chief Ndubeni, Chief Mwinuna and Chief Machiya.

The district has two hospitals and sixteen health centers. Ibenga Mission Hospital has no male midwife while Mpongwe Mission Hospital has two male midwives. All the sixteen health centers offer antenatal and postnatal services. However, by September, 2013, of the sixteen health centers in the district, only 6 had midwives. Kanyenda and St. Anthony health centers had female midwives while Kalweo, Machiya, Mikata and Kanyenda; health centers have male midwives. (It should be noted that Kanyenda had two midwives a male and a female). Of the two male midwives at Mpongwe Mission Hospital one male midwife has been seconded to

go and assist in lecturing trainee nurses at the newly opened School of Nursing in Luanshya. The other one has gone for post nursing degree programme.

3.3 Reason for choosing the study site

The study site was selected due to its stance on midwifery being a practice reserved only for female nurses and not male nurses. It is one area with the highest frequency of rejection and ejection of male midwives in the rural areas of the Copperbelt Province.

3.4 Organization Structure of the Mpongwe Chiefdoms.

Traditional leadership setting in Mpongwe chiefdoms of the Bulima people is that as usual there is a chief per chiefdom. There are Indunas in the chiefdoms that come second to the chief in the seniority of rank and file of traditional leadership. For the convenience of governance, a number of villages are grouped to form a section. One headman or headwoman in a section is chosen to head the section and therefore automatically resuming the title of Induna. Among the Indunas are the Palace Indunas. These are the most senior of the Indunas. The number of Palace Indunas range from four to six. Among the Palace Indunas are; the Palace chairman, the Woman Induna, the Chief Advisor and the Palace Secretary in the order of seniority.

3.5 Study population

Traditional leaders, couples and male midwives in four chiefdoms form the study population in this study. Traditional leaders include chiefs, Indunas, headmen and headwomen whereas couples comprise of women and men.

3.6 Inclusion Criteria.

The qualification for a chief to be included in the study was as long as one is a chief in one of the chiefdoms of Mpongwe district qualified to participate in the study.

Indunas, qualified for selection because they are the closest to the chief in leadership and are usually consulted in decision making.

Headmen/headwomen, one officially recognized by such a title in one of the six chiefdoms. They are in leadership.

Couples, only those who have had an experience with a male midwife were eligible. These were identified with the help of headmen and headwomen who were tasked to find them in their villages using snowball sampling.

Male midwives were those working or once worked in Mpongwe district.

It should be noted that the opposite of one of the five characteristics was the criteria for exclusion.

3.7Sample size.

The total participants who took part in the study were 116. They are broken down as follows. Chiefs 4.Indunas 16 (four per chiefdom). Headmen 24 (six from each selected chiefdom). Headwomen 24 (six per selected chiefdom). Male midwives 4. Women were 24 and men were also 24 as couples (six couples per selected chiefdom).

3.8 Sampling procedure and Selection.

Purposive sampling was used to select chiefs, Indunas and headmen/ headwomen while snowball sampling was used to select male midwives and couples.

To begin with, four chiefdoms were picked to be a representative of the six chiefdoms because the research was designed for only that number due to availability of financial resources. Chiefdom selection was based on seniority of the chiefs, gender of the chiefs and population of the chiefdom. Chief Ndubeni was purposely sampled being the senior chief of the six chiefs because he is usually consulted on matters affecting the Bulima tribe. Chiefs Lesa and Malembeka were purposely sampled being the two female chiefs in Mpongwe district for the number of chiefs to be gender balanced. Chief Kalunkumya was sampled because it was the most populated chiefdom with 21 544 people (CSO, 2010).

Four Indunas were purposely picked; the first four per selected chiefdom in the order of seniority. They are the custodians who transmit and perpetuate values, norms, beliefs and cultural practices through their teachings.

Headmen and headwomen were purposely sampled following the order of population of their villages for a wider representation. This was done with the assistance of the Palace Secretary who keeps village records which also includes the number of people in a village.

Women and men as in couples were purposely sampled using snowball sampling. Only those who had a birthing experience with a male midwife qualified to participate in the study. It is assumed that only those who have experienced it may give a balanced version of male midwives.

Male midwives were sampled using snowball method. One male midwife was identified at Mikata Health centre. This pointed out two male midwives and gave out contact numbers for the one at Roan School of Nursing and another one who was at Kanyenda but transferred to Gondwe Clinic in Masaiti District. The midwife at Gondwe Clinic pointed out one at Kalweo Health Centre. This is how the male midwives were traced.

3.9 Data Collection Technique.

Data was collected by using face to face in-depth interview with chiefs, Indunas and Male midwives and focus group discussions (FGDs) with headmen/headwomen and couples.

3.10Pilot Study

The pilot study was done in Chief Mushili's Kingdom of Ndola rural which was not part of the main study. It had similar characteristics with the chiefdoms 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.

Initially it was planned that there would be two focus group discussions per chiefdom, one for headmen and headwomen and another one for couples. But this arrangement proved a failure as manifested in the pilot study. A bitter quarrel erupted between men and women in the first FGD. When women said that a male midwife is preferred than a female midwife, they were likened to prostitutes by men. They said that only prostitutes allow different men to see their private parts.

This made the researcher to recall one of the characteristics of a FGD that it must be homogenous. The researcher separated women from men so that both groups are free to discuss. Therefore this new arrangement made 4 FGDs per chiefdom. This is how the FDGs where numbered; focus group discussion for headwomen as FGD 1, focus group discussion for women in couples as FGD 2, focus group discussion for headmen as FGD 3 and focus group discussion for women in couples as FGD 4.

3.11 Data Collection Tools.

Data was collected by using unstructured In-depth Interview Schedule and Focus Group Discussion Guide.

Unstructured in-depth interview schedule was used to collect information. Standardized pre specified questions were used. The same words used to each interviewee with questions given in the same order. The advantage is that it enables responses from different individuals to be compared.

Focus group discussion guide was developed to collect detailed information in trying to identify the attitudes of the rural communities towards male midwives. The advantage is that debate was encouraged and the group dynamics became the integral part of the procedure as the participants engaged in discussion with one another. Focus group discussion guides and interview guides were used in the study

Both focus group discussions and in-depth interviews began abductively "almost from a point of complete ignorance." Carspecken (1996:4) and Blaikie (2000: 69) advice that qualitative researches who want to set aside personal experiences imaginations and theories ought to use open ended loose questions by recommending that the researcher compile thick descriptions to "sharpen one's awareness of events that may occur routinely. This required on the part of the researcher an attitude of openness and acceptance of whatever was experienced. This allowed then bracketing or putting aside what the researcher already knows about the experience being investigated and approaching the data with no

preconceptions about the phenomenon (Husserl, 1963; Dowling, 2004; Lopez and Willis, 2004).

3.12 Data Collection

The acceptance of the study by the chiefs and Indunas commenced the data collection activity. The first was Malembeka Chiefdom, followed by Kalunkumya Chiefdom, then Lesa Chiefdom and lastly but not the least Ndubeni Chiefdom.

The researcher made appointments with the palace chairman after consultations on when to meet the chief, the Indunas, the headmen/headwomen and couples. It was easy to make appointments with the chiefs and Indunas. Sampled headmen/headwomen were written to and summoned to a meeting at the palace on a particular date signed by the palace chairman and the palace secretary. No summoned headman/women missed the meeting (FGDs), only on two occasions where instead of headmen, assistant headmen came as the letters had stated. After the meeting each headman/headwomen was asked to go and identify a couple in their village that had a birthing experience with a male midwife and serve them with a letter of summon to meet at the palace on a particular date signed by the palace chairman and the palace secretary. Again, no summoned couple failed to attend the meeting (FGDs). It was an indication that people in villages respect their chiefs. There was one headwoman who was sampled because her village was the 6^{th} largest populated. The village is situated 78 kilometers away from the palace. She cycled 78 kilometers in order for her to attend the meeting (FGDs). In the same manner, a summoned medium aged couple from her village travelled the same distance in order to positively respond to the chief's call. This arrangement facilitated the researcher to meet respondents when called upon.

Couples inclusion criterion was verified by them mentioning the male midwife who delivered them. Indunas knew the names of the male midwives who had served the chiefdoms.

Five in-depth interviews were conducted per chiefdom; one for the chief and four for the Indunas (an interview per each Induna). This added up to twenty in-depth interviews plus four of the male midwives made a total of twenty four in-depth interviews conducted.

Four group discussions were conducted per chiefdom; for headwomen, for headmen, for women from couples and for men from couples giving a total of sixteen focus group discussions.

In-depth interviews and focus group discussions were recorded and complimented with field notes, journaling, and researcher reflections, in which focused and dense records of daily routines, and social interaction were constructed in keeping with Carspecken's (1996) approach of critical ethnography.

Data were collected over a period of 8 weeks after approval to proceed with the study.

3.13 Data Analysis

The data were initially transcribed verbatim in Lamba or Bulima. Several scripts were typed in these local languages. Back to back translation from the two languages to English was done with the help of three assistants to verify recordings and the translation. The transcriptions in English were entered into the database of the computer, coded, and categorized so that patterns and themes that emerged could be analyzed as recommended by Carspecken (1996), Blaikie (2000) and Claire (2012). However, as more information was collected than expected, categorization took a further two months than expected and the database became saturated with data to manage. In order not to lose data, the analysis skipped the development of meaning units and concentrated on writing memos to self about what was emerging in the data. This provided a bird's eye view of coded themes that the researcher was enabled to be "in touch" with. Much of what was spoken was retained by using this method.

The researcher then got involved in a dialogical approach to gain an "insider's position" (Georgiou and Carspecken, 2002: 690) with respect to the culture of birthing. The researcher was more open to reflexivity by allowing the participants and what was being spoken to determine the research process. For instance the research question that required documenting" how knowledgeable the men and women were towards safe motherhood" was not studied because the respondents did not have competency to comment on a domain. As such, relying on Burns and

Grove (2001) who stress that qualitative researchers must be flexible not only in their research design but also in how they view the world, this researcher therefore was ready to change his perspectives as new aspects of the world were unveiled or original intentions would not be achieved. As a result, critical research has an emancipatory intent not only for the researched but also for the researcher (Street, 1992). Self-reflection assists in the maintenance of critical theory principles, as its purpose is to expose the researchers' personal constructions of the world, their values, beliefs, strengths, and weaknesses that mold the research journey and the choices made (Mulhall, Le-May, & Alexander, 1999). Furthermore, a reflexive account increases "the plausibility or rigor of ethnographic research" (Pellatt, 2003: 29).

3.14 Ethical Consideration

Verbal permission was sought from the area member of parliament. The parliamentarian linked the researcher to the traditional chief. A description of the study was presented to the Royal Highness. A meeting was called by the Royal Highness for chiefs and Indunas. Acceptance of the study was by way of mouth to the researcher after the presentation of the letter from the University of Zambia.

Consent was obtained from each of the respondents after explaining the purpose of the study assuring that the information would be held in confidence. The purpose and nature of the study was explained to the study participants. Study participants were assured of anonymity and confidentiality and no other person apart from the research team was allowed to have access to the research data.

CHAPTER FOUR: RESEARCH FINDINGS

4.0 Introduction

Just like all research calls for the description of findings, this chapter is ascribed to the description of the lived experiences of men and women who have authority on reproductive matters in the chiefdoms in Mpongwe. It should be noted that all description entails interpretation and in this study, interpretation shall be reflexive as well as hermeneutic. This requires the researcher to allow personal interpretations as well as contextual literature cited in order to render full meaning of the experiences. Descriptions always depend on the perceptions, inclinations, sensitivities, and sensibilities of the describer (Emerson et al., 1995; Giorgi, 1992; Wolcott, 1994). "There is no pure looking with a naked, innocent eye" (Pearce, 1971: 4), and there is no "immaculate perception" (Beer cited in Wolcott, 1994: 13). Researchers seeking to describe an experience or event select what they will describe and, in the process of featuring certain aspects of it, begin to transform that experience or event.

The descriptions that the researcher presents below whether in the form of descriptive summaries of interview or observation data entail the choices about what to describe in line with the research questions. These descriptions accurately convey events in their proper context and have the meanings participants attributed to those events, or have interpretive validity according to Maxwell (1992). Although researchers can never, and will likely never want to, describe everything that is "there," what this researcher has chosen to describe will be something that most observers would agree if they read all the transcriptions. The description in this study will contain the presentation of the facts of the case in everyday language and the researcher's own interpretive spin on what he saw and has come across (Strauss & Corbin, 1998: 181; Van M, 1990: 101).

4.1. Theme I: Views of women and men towards male midwives.

When men and women were asked to advance their views towards male midwives, it was generally observed that women were ambivalent whereas men were decisive in terms of the stand they had on male midwives. The ambivalence in the women sample was that the higher in a position a woman was in decision making in the

kingdom, the more the woman looked at things like a man (women exerting hegemony on matters about their bodies) and this implying not supporting male midwives as practitioners in the chiefdom.

4.1.1. Women's Views.

Hegemonic Views by Women

The lower a woman was in decision making in the kingdom, the less the woman looked at things like a man and this could be considered by other women as subjugation of the feminine body by the medical life world. Below I first present the views of women and these are followed by the views of men. The views of women are presented as hegemonic, subjugation and acceptance.

Two excerpts involving an Induna and a chief demonstrate hegemony. One excerpt is about an Induna from Kalunkumya and the other is about a chieftainess. This is what a female Induna had to say about women's bodies:

> *"In our opinion as leaders, our culture demands that we can only accept male midwives because they are imposed on us by the government. We would not want to be at logger heads with the government by rejecting male midwives. If we were given a choice, we would not allow male midwives to assist in the delivery of mothers. This is because our tradition does not allow. As a woman, I feel disrespected, humiliated and demeaned for another man other than my husband to see my nakedness. It's us in leadership who should come out as a voice to speak on behalf of the common villager to the government that our own feminine value system has been eroded….."*

The chieftainess had this to say:

> *It is not permissible that a married woman should parade herself in labour before a man not her husband. In some instances, imagine male midwives happen to be younger than the women they assist to deliver. This is complicated by the fact that some male midwives are not even married to be engaged in such work.*

Subjugation of the woman's body by the medical life world

Women leaders' and some women believed that women were not happy that male midwives attended to them. The women leaders unlike ordinary women claimed that there was a false consciousness perspective operating that posits that although women appeared to freely choose to be delivered by male midwives, what they sought had been constructed by men and served them men in government and only men's interests. Therefore, women were in a new setting culturally coerced. When the women traditional leaders were asked to comment about women who went freely to the health centres to be examined and delivered by male wives, the responses by the female Induna was as follows:

> *"You will see when you interview our women…They will tell you that they are not happy at all to be attended by these men".*

> *"It is all because the government through men desires and some misplaced educated women who have lost the original culture just have some political agenda….I mean self-interests. Our women are just forced in the name of development and reducing maternal mortality".*

In a focus group discussion, two village women aged 38 and 42 narrated what they felt about male midwives attending to pregnant women. The 38 year old woman who was delivered by a male midwife narrated that it is culturally bad for a male to attend to a pregnant woman. This is what she said:

> *"There are so many things not good about this whole state of affairs. Some male midwives are younger than the pregnant women they attend to. It is difficult for her to open legs for him to examine and determine how far the baby is by pushing his two fingers inside the vagina by someone who is supposed to be her son by age. Male midwives have no secrecy about what happens in the labour ward. They talk about it in bars. For instance Mr.Kwaku (not real name). You see rural communities are small. Women are not free to live and interact with someone who sees their nakedness as long as they are bearing children".*

The 42 year old woman who was twice delivered by a male midwife observed that some male midwives go far than what duty demands in a negative sense. Sometimes they are sarcastic to pregnant women while at the same time derive pleasure out of it. However, she was quick to point out that not all male midwives have bad behaviour towards their clients. She said that male midwives of such character are the ones who make pregnant women to shun health centres. She had this to say:

> *"What I see not well is that though the government sends us these young men or they may not even be young, sometimes their language is bad during pre-natal clinics…they will tell you to shave instead of just keeping quiet on these matters. Sometimes they just touch you for nothing or for pleasure because we are able to differentiate between fingers genuinely doing their work and those deriving pleasure out of it. That part is an erogenous zone to arouse sexual feelings as long as the one touching you is of the opposite sex, it is only during labour that those feelings are latent but before that you are your own body with feelings. Some male midwives mean well in terms of language and examining touches but these who are like what I have just described like Mr Kwaku (not real name, but same name mentioned by woman 38). So because of male midwives like Mr.Kwaku pregnant women have stopped going to health centres to give birth".*

Acceptance

Some traditional leaders and a Chieftainess gave contrary views on male midwives. Many women opted to be seen by male midwives because female midwives were not helpful and were rough on pregnant women. The Chieftainess did not see it as a taboo but acceptable to be attended to by a male midwife. She had this to say:

> *"The issue of male midwives is not new, I remember my fifth pregnancy, in 1977 my pregnancy was a breach a male midwife attended to me and I gave birth very well. Since I took long to give birth, the child passed away few minutes after birth. In 1984, I had*

another breach. The female midwives had tried to help me but they had failed until a male practitioner was called in. His name was Simukoko, he came to my bed side and checked me, he realised that the pregnancy was a breach, so he put on cloves and pushed his hands inside my birth canal and pulled out the legs of the baby and then advised how to finally push the baby out. I gave birth to a baby boy who is now an adult and is working in accounts section at the district council. Basing on my experience, I have totally no argument against having a man as a birth attendant. The perception women have is that men in the delivery wards will disparage them to the public once she is discharged from the labour ward. It doesn't work like that; it doesn't mean that men keep pictures of all the women they assist in child birth. I believe that they do not keep count of each incident and use it against women in public. …"

One female Induna had this to say about accepting to be delivered by a male midwife. When asked as a parent, and if ever she had been delivered by a male midwife, she answered….

"No except being checked for malaria…and what else…..I was quite well pregnant but it was not labour time. It was a kind of checking where they had to examine the position of the baby in the womb. But I remember of one woman I was with. She was actually older than I was I think about 39 or so… she entirely refused to be delivered by a male midwife she could only be attended by a female midwife."

When quizzed … Suppose it was her time of labour, if she could have accepted to be delivered by the same male midwife who was rejected, she responded,

"Yes I would have accepted, because what is needed that time is to be saved. And the way it is, at that time you don't mind who is around to help whether man or woman, all you want is to be delivered of that pain."

One Induna in recounted her positive experience with a male midwife

" At one stage, I worked as a maid in a hospital and sometimes they used to ask us to render assistance if it was a male midwife on duty in the labour wards and they used to see women private parts but it was not a problem for them to use what they saw to gossip about pregnant women in public…..There are rules at places of work, even for male midwives including doctors are not permitted to divulge how they work to the public; if they begin to do that, it will imply that they are not fit for the job and must be removed. In my opinion it is not true that only females are good in assisting a woman in giving birth, it depends on the temperament of a person; there are women who are so canning and ruthless when attending to a woman in labour whereas men are so kind and tender in performing the job. I worked in the hospital so I used to see and could tell the difference. Of course there may be some bad male midwives but on the overall men make better midwives?"

One woman remarked positively and said:

"In western culture, husbands are in fact allowed to accompany wives in child birth to soothe their wives to ease his wife's child birth experience. By so doing, it helps the woman to speed up delivery. I believe there is no problem having a male as male midwife I don't know how others look at it."

When asked about the negative part of being attended to by a male midwife, she responded:

"I don't have a problem. I am puzzled about those complaining by saying it is traditionally wrong to gaze at female private parts. I believe that everyone knows how a man or woman is made like. The talk of ukutambila (seeing the nudity) cannot hold because everyone knows that a man has a penis and a woman has a vagina. So what would surprise a man or a woman when the opposite gender renders help to the needy? What I know is that God made two sexes and we

all know it, so what makes it a problem when the opposite sex helps a female".

Woman aged 37

A 39 year old woman who had three deliveries at the hand of a male midwife expressed her support of male midwives. More especially when the discussion got heated there were sentiments like this:

"The government's decision in my view of introducing midwifery for men has advantages. These men I am told go to learn about helping pregnant women to have safe delivery. There are not so many educated women to take up the challenge so if there are men to take up the position and save women from dying in labour, then it is good. Those who become midwives often run away from our rural areas and fake marriages. So what is the option? It is the men to fill in the gap as midwives. And in this region a lot of women die in labour more especially at Ibenga hospital. This month is May and already about four people have died in labour. It is like a woman dying in labour every month just at Ibenga alone. These men save two lives at the same time, that of the mother and the baby. So they deserve respect other than ridicule. Please understand that they are there to save us. They don't follow you after seeing your nakedness."

Woman aged 41

Nearly every woman from among the couples in the study had discussed choosing a male midwife even when a female was available. One woman had this to say about a female midwife:

"During labour on my second pregnancy there were two midwives on duty a male and a female. I was given the choice and of course I chose a woman but being examined by her was a nightmare, she was really, really rude and insensitive. She was literally shouting at me to stop screaming and keep quiet, that she was not there when I was having sex with my husband and that those the results of the sex you like, so be strong. I couldn't just bear it. No wonder people beat

nurses. So I changed the choice and demanded for a man instead because of the insensitivity and rudeness of the female midwife.

Woman aged 34

However, there were few divergent views like:

"I wonder what just the thinking is for these men who go to train as midwives. Why? Do they delight in what they see? Make it normal and call it a profession? A profession of seeing nudity! A profession! And even if I did not go far in my education, why should a man be called wife? There is something wrong with this men-wife. Me I can't allow."

Woman aged 27

Contrary to what most of the women leaders have said and supported by Foucault (1973; 1978), these actions by male midwives demonstrate an innocent exercise of men and not the system of coercive power over women through the body. These women leaders perceive these male midwives as judging them and encouraging them to meet men's standards of safe motherhood in form of a prescription by the government or just a mere gaze. A male gaze according to feminists was a concept developed by Mulvey (1989) to explain how feminine visual appearances are seen as pleasures for men or like narrative cinema. The gaze from the point of view of women highlights the failure of interaction between male midwives and women in Mpongwe to affirm whether that is the thinking of men. The centrality of looking and being seen naked in the social construction of gender and maintenance of oppressive social relations (Chandler, 2000) as agued by women is far from the ethics of midwifery. This is not understood by women in Mpongwe. In this way, looking and being looked at as a woman and naked are fundamental steps in the process of working towards breaking feminist hegemony or challenging the traditional social order which is contributing in one way to raised maternal mortality in this setting. The problem with the perceived male gaze is not the notion that looking is enjoyable but the problem is with patriarchal and heterosexist premise that hypothesises men as the sole agents and beneficiaries of the gaze. It is the women who are beneficiaries amidst this lack of female midwives in rural areas.

4.1.2. Men's Views

Most of the views presented by men in the study were decisive. Men were more indignant than women to have male midwives attending to the women in Mpongwe. The men spoke as though they were women. The men also believed that there were exceptional circumstances when male midwives could attend to women. Their rejection or strong views bordered on the fact that it was prohibited culturally to see a woman naked whom you are not married to. Women's nakedness was shrouded with sacredness and the men felt that it was extremely embarrassing to see another man checking or touching a woman intimately. This is in essence a kind of intimate care which is supported by the literature (Lawler 1991, Timmerman 1991, Routasalo 1999, Williams 2001, Bassett, 2002). Below are the illustrations of these four subthemes about men's views:

Cultural Prohibitions

One Chief, an Indunas and a headman had this to say about cultural prohibitions:

When the chief who throughout the interview supported the work of male midwives was asked about culture had this say:

> *"No, traditions do not allow, but we are now living in an enlightened world. There is now formal education and we cannot be educated and continue living in an informal manner. We just have to accept that education has to change some of these traditions."*

The Induna had this to say:

> *"From old according to our traditions, another man should not see the nakedness of another man's wife….though we see male midwives attending to our wives, there is no goodness. And I would not allow even my wife to be attended to by a male midwife. From experience, even doctors do not allow other doctors to deliver their wives in childbirth. This shows that it is not in order because those are supposed to be examples to us."*

The headman's contribution was as follows:

> *"It is not allowed in our culture that another man should have an intimate relation with a woman not his wife….I mean undressing a woman to see under garments, examine the space between the legs and worse still touching the private parts in the name of health care."*

When asked about the need to be flexible by doing away with some harmful practices, the headman replied:

> *"It's only educated people who are turning away from our traditions and customs that can support male midwives, but people from villages who cherish traditions see nothing good about changing."*

An Induna had this to say about prohibitions

> *Those who give us reports complain about male midwives attending to pregnant women, including our own wives. To begin with, a woman may not be free to undress before a man who is not her husband. Some women say that they are not free with male midwives such that they even fail to tell them they are in labor, hence they struggle alone. Male midwives only find a child already delivered. This is what others tell us.*

In order to buttress the point of maintaining tradition one Induna from Malembeka gave an example and argued against as follows.

> *If you have heard what I am explaining, people have feelings and the way they are brought up. For instance I have a small girl who refuses to be bathed by me. She does not even pass urine where people are present to see her nakedness as it is common here in villages. The girl is growing up with this mentality even when she grows up may not allow men to see her nakedness.*
>
> *Among other reasons one reason why women loath prostitution is because they don't want men to see their nakedness. This is what makes pregnant women to refuse to be attended to by male midwives*

more especially in the small communities where people mingle from time to time. This is what makes pregnant women in labor not to alert the male midwives in labor because of the alleged fears……That is where I said when there are difficulties, let the male midwife do the job. And this is only on special occasions because it is difficulty, and only at a time, but not daily on routine. It disturbs pregnant women to find a male midwife in attendance when they did not prepare psychologically.

Exceptional circumstances

The Lamba and Bulima tribes do not permit women to be seen by a male midwife save a female midwife or traditional birth attendant (who is always a woman). However, the men just like some women gave options in form of exceptional circumstances when tradition could be violated and allow male midwives attend to an expectant woman. As one man in our study observed:

"Sometimes it happens that the female midwife is on leave or not available for some reasons or the other. It becomes very necessary to be seen by a *male midwife because it* i*s very dangerous for your wife. Under such circumstances you have no option but to see the male midwife…..to save the pregnant woman and child's life."*

Man, aged 47 from Kalunkumya

Another headman was agreeable that under special circumstances, male midwives may render help to a pregnant woman in labour:

"For me, I have seen that you can allow him to attend to women when you are in a T in a very remote area where women TBAs may not be available or not identified…. a man can pitch up to help; and in another instance if there is an emergency, a child delivery problem and the man is the only one to help, I can request for his hand but that should not be adopted as a routine."

Sacredness of a woman's nakedness

The Lamba and Bulima tribes consider women and birthing sacred. The sacredness rests on the premise that all life rests on mothering and as such, it is not expected

that pregnancy and the birth process could be exposed to every Jim and Jack. Two elements of the woman can be identified as regards to sacred elements of a woman, namely the pregnancy and birthing.

"The woman's private parts and the pregnancy are held in high esteem by us as divine, hence its sacred quality...

In our community for example, sex with a pregnant woman is prohibited if not your wife. The gods will inflict harm on the woman and even the man in some way…..A pregnant woman must stick to one man because by engaging in sex with multiple partners while pregnant will result into difficulties at giving birth…. we believe that a woman who had multiple sex partners during her pregnancy will have to encounter what we call 'incila'" (a complication in giving birth due to unfaithfulness of either partner during pregnancy).

The headman elaborated further on the sacredness of a woman as regards to '*incila',*

> *"Whenever there were complications, traditionally these could have meant three things: Incila of the woman, Incila of the husband or Foul play by anyone in the community*
>
> *For incila of the woman, the woman was talked to by the fimbusa (women in marital matters) and upon her admitting that she had sex with other men and upon mentioning them, she was medicated before she delivered rest she dies after delivery upon her seeing the child.*
>
> *For incila of the man, he was called and talked to by the fimbusa and upon him admitting that he had sex with other women and upon mentioning them or simply breaking sticks, the number of sticks symbolizing the number of women he had sex with, she was medicated and she delivered. Men feared that if they don't admit the wife would die.*
>
> *If they both refused that they had never had sex with anyone apart from themselves, then they would know that it is foul play by anyone in the community. She was medicated upon, fortunately she delivered unfortunately she died or the baby or both.*

> *If the woman died in labour, the husband was to blame. Before the wife was buried, he had to open the womb using a sharp stick and traditionally the blood had to sprinkle to him and he was required to exclaim, "I have killed two." He was subjected to a lot of mockery, beatings and humiliation.*

When men were asked about their understanding of the sacredness of a woman's nakedness, this was the response from FGD 3:

It's not difficult to understand the word 'sacredness' if we think what happens in the body of the woman during pregnancy…..Normally this task, so uniquely feminine, is not understood in its mystery, its fullness and its true meaning, a meaning which is so miraculous that only God understands. This is probably due to the fact that the woman, because of her makeup is important for procreation. Nature has given carrying a baby or the generation especially to her alone. This role is so immense that not taking it into consideration what she is like not to expose her anyhow seems to offend the wonderful strength that manages this extraordinary function given by God.

Over the years, we have allowed the sacredness of a woman's nakedness to be seen by male midwives. We will try now to do an attempt in order to recover the sacredness that existed in ancestral cultures. We must return something that has always belonged to the woman….I mean dignity and reverence. The Lamba woman effectively lost most of it on the way: the value of maternity. This was observed by FGD 4.

FGD 3 emphasized that from time immemorial it is against tradition to use a man to attend to woman in child delivery. A man, even if he is a husband were asked to stay away from a woman giving birth. It is a domain for women and it is divine.

Embarrassing

The men felt that it was embarrassing for them and their wives to be attended to by male midwives. This was one of the reasons they disliked in the health care services in Mpongwe. As one male from FGD 3 noted:

When we say we do not like these men see our women we mean it. "It is not about education no ... All women are embarrassed being seen by men…" There is this appearance planned or unplanned which can only be tolerated by a fellow woman.

Another man from FGD 3 expressed some discomfort of seeing another male seeing the nakedness of his wife and had this to say:

> *"I tried one day to escort my wife to the Clinic. It is quite uncomfortable because it is not like a lady touching and seeing your wife, it is a man and she is wearing the maternity dress and then she has to get her tummy out which you alone see for a man… It is uncomfortable... It is just the feeling of it. I was not even allowed in the labour room. 'I do not like it and I do not like these men too."*

But another male respondent from FGD 4 had contra views and said

> *"As for me, I do not see any claim for embarrassment. The good performance of the male midwives gets overlooked because of this extremely sensitive issue [having a male midwife]. When a baby is born and the mother is well, the issue is generally not noticed and we are generally made to feel guilty when we hear calls of rejection of male midwives even on flimsy or concocted grounds."*

A traditional ruler raised some concerns that define morality in a community.

"As a people in the chiefdom we live in the shyness of not seeing the nakedness of the opposite sex anyhow. This is the strength of society as far as morality is concerned….. Now if this shyness is removed …. and freedom is given to them the freedom to see at will, then we create a big problem in the chiefdom because this will be a breakdown of society's morality. Women have not stopped going to school just like men. Let the government give jobs to men that suits them and likewise for women. If a man be trained as a midwife, let it be on part time and only be used in difficult situations."

Infidelity

Men speculated that their women were in danger of being proposed for sex by male midwives after they have seen their nakedness. One man from FGD 4 said this,

"When women are about to give birth their nakedness are seen severally by a male midwife. Even after giving birth they still go to these male midwives to show their nakedness in the name of review There is a belief that when a man sees the nakedness of a woman, it is easy for a woman to give in should he later demand for sex. In a village set up, it is possible for a male midwife to deliver a woman up to 3 children plus review. Our women are plain before these midwives. This indeed this brings familiarity and intimacy and as we all know familiarity breeds contempt. 'Elokalyakantunikamulyaweka'" (meaning a wife is one man's person for sex). Sex is the core of marriage because even if a couple doesn't bear children, they still enjoy marriage because of sex. It is not good for a male midwife to make such a wonderful private part his playing ground."

Women were asked in their focus group discussions to comment on the possibility of male midwives proposing them or them being prone to sexual abuse when male midwives examine or deliver them because that is the view of many men. The female participants did not see it as an issue because it is unlikely. The women narrated:

"It has not happened in my experience that a woman has fallen in love with a male midwife following a delivery…no, unless in towns but not in villages because everyone would know. It is difficult to hide a love affair in a village. Our men are just jealous which is normal but should not take us cheap because us trying to deliver their children."

"These men are disciplined…Yes they will touch you and will see what our husbands love and cherish in the process and end as a professional encounter. I actually have no regrets. Unless the pregnant woman is just a prostitute, then it can happen".

"The problem with our men is that they think it is easy for a woman to undress before a man anyhow, no. We respect our bodies so much and any woman definitely feels bad to undress before a male

midwives but that's what the situation demands at that time. So they should not be thinking of us otherwise, no. We are faithful to them and that's what we want them to be to us."

4.2. Theme II: Cultural practices that promote or hinder acceptability of male midwives

The traditional attitudes, norms, values, shared meanings, and patterned ways of behaving in relation to pregnancy and birth were varied as will be shown in this section. There were factors promoting the use of male midwives and factors inhibiting the use of male midwives. There were however more reasons addressing inhibitions than promotions and most of the reasons disfavouring the use of male midwives came from the men.

4.2.1. Sub-theme I: Inhibitors

Both men and women identified inhibitors or hindrances to accepting or rejecting male midwives. These included taboos insecurity, slander and lack of confidentiality. The most spoken about was men's insecurity and slander and lack of confidentiality.

Taboo

Lamba and Bulima culture in Mpongwe like any other culture is not only governed by rational decision making, but society has shared values and standards of acceptable behaviour that its members are encouraged to follow. The people have a list of behavioural guidelines in form of social norms and taboos that regulate pregnancy and delivery. Though the cited taboos can be repugnant and appalling actions or behaviour, some respondents have come to appreciate that some of the held taboos and their importance need to change with time. In some households, the taboos around birthing have weakened or even disappeared, while others have become stronger and more dominant depending on varying experiences. There were no clear explanations for the origin and effects of taboos among the Lamba and Bulima. The typical anthropological argument that was advanced was that the origin of taboos was cultural experience. The alternative explanation is psychoanalytical, emphasizing the strong subconscious prohibitions that pass

through generations. These norms and taboos have a huge effect on some of the respondents' lives. This is what men and women had to say.

Male participant contributed by saying:

> *"We know that the male midwives do not belong to our culture. If they did, they would not agree to work in this land. They are unlikely to suffer the consequences of breaking the rules…I mean insisting to examine and deliver pregnant women. I know for sure that some may have had some bad luck of one kind…..We cannot destroy our traditions as if there are no women who cannot train to do the job. It is women who give birth, not men. As for me, the time when men will start giving birth, that's the time the government should start training men as male midwives."*

The female participant contributed by saying:

"As for us as women, it is not in order for a man who is not the husband to be seeing the nakedness of another woman. We do not indulge in breaking the secrecies of child birth to any one….it is a taboo but male midwives tell women afterwards of what was happening in labor when they meet elsewhere. That you were crying, urinated, you killed the baby because instead of opening the legs you were closing."

The female participant further added

> *"Just as we have complained to the chiefs about African doctors that it does not give respect to us women according to our experiences and the sayings of our ancestors being touched on our private part by them. Male midwives too must not because it has been forbidden since time immemorial. It is there in their minds we tell them once they just arrive in our land."*

A male participant narrated that

> *"Traditionally, it is completely wrong, because we regard women as our mothers we men should not disparage them by gazing at their nakedness and touching their private parts in the name of birth assistance. It's improper traditionally for a man to fidget with the private parts which brought us here on earth. Even in marriage when*

it comes to shaving pubic hair, it was advised by elders that a woman would shave pubic hair of the husband but husband should not. The wife would shave herself or should request the help of her grandmother to shave her."

Another male participant felt that times had changed and responded by saying:

"According to the time in which we are today, I would allow my wife to be attended to by a male midwife. There is no rule which is being broken here and I do not see negative consequences. It is science at work. I would also want to learn so that I can I be in position of helping my wife in labor."

Insecurity

The majority of male participants felt that if another man saw their wives nakedness, then the state of nakedness would make their women vulnerable to engage in infidelity with male midwives. This was hotly contested by men though the women as well as the male midwives saw it to be an unlikely event.

The men narrated a story about a male midwife who was chased from the chiefdom that, "There was a male midwife who seemed to have liked looking at the nakedness of pregnant women. This was because every time there was a woman in labour he always wanted to be the one helping in child delivery. So people complained as to why he always wanted to carry out the work. Indunas sat down and wrote to the hospital administration, who responded by transferring him from Mpongwe mission hospital".

Another male participant just like the earlier one reported recounted of how frustrated he felt when he took his wife who was in labour to the health centre for delivery. He had this to say:

"Why we feel bad is that, I as the husband take my wife to the health center for delivery. Upon reaching there, I'm asked to go out and only be called in after she has given birth. It is better they let me in there because I'm the husband of the woman who is giving birth. But this should not be with the male midwife present because it is just too

difficult a scene to watch with another man. You also do not know what relationship will be hatched from this seeing and touching."

Another male participant added and said:

"According to us Africans, when you see the nakedness of another woman, the thought never leaves you until you propose love to her and the resistance from her from her is next to zero knowing there is kno secret private part about herself to you. The same happens to male midwives because women are weak before them."

However, women discounted this insecurity as they held a very strong belief that they would not just fall for a male midwife because they were naked.

One woman who was delivered by a midwife had this to say

"There is a male midwife at our health centre not far from here whom we all know and he knows us all. Does he not know nearly every woman's private part? Whom has he followed demanding for sex? To the best of our knowledge he hasn't slept with anyone to take advantage. We know that it is traditionally or humanly unacceptable for a man to gaze at the private parts of a woman who is not his or wife or girl friend. We undress before a male midwife because at that time that is what the situation demands. However, this does not cheapen women that they will be undressing anyhow before him."

Slander and lack of confidentiality

It is recognised that confidentiality is a fundamental part of professional ethics that protects human right. According to the male and female participants in the study, they all women, they all believed that everyone has the right to respect of their private life. The men and women believed that information given to a nurse or midwife is only used for the purpose for which it was given and will not be disclosed without permission. This covers situations where information is disclosed directly to the nurse or midwife and also the information that the nurse or midwife obtains from others. This one part men and women complained about vehemently. The illustrations below show the reasons for rejection and ejection of male midwives.

For example, one chief explained that

> *"People have complained to us leaders that male midwives tell stories about women they deliver in drinking places. More especially when they get drunk. People ask us to intervene because it is bad for them to be talking about it in public places. This shows that other people also see it as a bad thing."*

One female participant also added by saying:

> *"We have seen that some male midwives have no secrets at all about their work. They bring out the labor activities out to the public concerning the actual behavior of certain women in labor. This happened here in Ibenga. Women who deliver their friends in pregnancy keep secrets of what they see about women in labour. They do not brag about it like male midwives do. These male midwives bring out the labor activities out to the public concerning the actual behavior of certain women in labour. Male midwives have no secrets. But doctors keep secrets about their work."*

4.2.2. Sub-theme II: Promoters

Despite the reservations that were raised on the need to reject or eject male midwives, this type of health worker was appreciated by nearly all echelons of the Lamba and Bulima leadership. Women than men were more appreciative of the roles male midwives played. The majority of the women felt that both the government and the traditional leadership needed to support the roles male midwives were playing as it was very unlikely that they will have more female midwives in the near future. The subthemes representing promoters were hard work and reduced mortality rate. The majority of the participants were of the view that their work was exemplary.

The following was an excerpt from one of the chieftainess:

> *"At present the male midwives must be supported in their most immediate maternal task. They do more work when the Clinical Officer is not around. This does not necessarily mean consigning them to helping in giving birth, but acting in family, society and any*

environment. He is the one who loves, takes care, educates, joins, protects, tolerates, consoles, helps; as the one who brings peace and serenity from the noble job."

Reduced mortality and morbidity

The general comment may be summed as follows: "We have all seen that if it was not distant, there would have been very few deaths of our pregnant women and children. These male midwives have made easier for our women and their lives are saved, they have contributed in reducing maternal mortality and morbidity."

4.3. Theme III: Experiences of male midwives in these rural communities

There were numerous experiences that the four male midwives shared with the researcher. The subthemes that emerged included emotional experiences, challenges of nudity, gender image, protection, rejection and support and sexual feelings and advances and support from the Ministry of Health and cooperating partners. Each one is described and presented below:

Emotional experiences

The male midwives confessed that working as a male midwife was not an easy job. Because the job was associated with providing intimate care, they faced personal, interpersonal as well communal emotional challenges. The men were aware of the hostile environment they worked in, the gender difference during the delivery of intimate care for women clients. Male midwives were aware of gender difference during the delivery of intimate care. They explained that they often felt uncomfortable, embarrassed or experienced difficulties both when they encountered exposed parts of women clients' bodies, such as genitalia and breasts, or when topics related to sexual health were raised during care delivery. Although participants' interactions with clients were professional encounters, women clients' nudity was often perceived to have sexual connotations. One lamented as follows:

"I have been working here for five years. Everyone knows me and I really know everyone. Working in Lamba land is not an easy thing. You are constantly monitored to see if you are making mistakes. The

men will come innocently to spy on you. The older women as well keep watching of every examination or delivery you do. One moment you are summoned to the palace for a review…It is not an easy job."

Participants reported greater levels of embarrassment and discomfort when providing intimate care for young women. In this situation, they were even more aware of sexual issues and one stated:

"It is probably tougher for guys, especially when you've got a younger and [an] exceptionally pretty patient. Despite all of your training and the experience that you have, you feel embarrassed…I think I am more aware of my sex because they [women clients] don't look at me as a nurse."

The male midwives explained that working in Mpongwe and especially in a midwifery setting was particularly difficult and challenging area because the clients were mostly young women, and most of the care delivered was intimate. One male midwife added and said:

"You can't really get more intimate than [the] midwifery settings. In midwifery, people expose themselves in such a way and [their] family is always there. I've found that's why [providing intimate care in midwifery] it is difficult and challenging for male nurses."

Challenges of Nudity

Although the male midwives' interactions with expectant mothers and fathers were professional encounters, women clients' nudity was often perceived by especially by expectant fathers to have sexual connotations. One male midwife described his feelings in this way:

"You may ask a husband to witness the examination or delivery in the absence a female colleague. Whether they agree or refuse, you have made a mistake. If [providing this care] this way is the only way to ensure morality and transparency and people take every step you do as wrong or with suspicion, it is disheartening. You really know that it is a health requirement for this person to be there. I have felt hopeless

as a practitioner because I knew that I was trying my best and it was my duty. Our job as nurses and midwives is about the health of the body of a person. It implies that we will have to do the uncovering of the body to check for the affliction being complained about. Of course we always do it with due respect for personal dignity and privacy."

Another male midwife added by saying:

"There is nothing that comes to mind like admiring nakedness and planning to sexually abuse the client/patient."

Another male midwife explained:

"The actual act of penetrating women is not a pleasant thing because it has professionally huge implications. So I wasn't comfortable…All kinds of things are just embarrassing. Imagine explaining the whole examination…and then asking a woman to undress...it makes you sick."

There are times when older as well as younger mothers have reported greater levels of embarrassment , discomfort and even resentment when examining them or conducting a delivery.

One veteran male midwife explained that,

"Working in midwifery setting was particularly difficult and challenging areas because the clients were mostly young women, and most of the care delivered was intimate."

Another male midwife summed it up, by saying that,

"You just have to be humble, re assuring and gentle."

He further observed that:

"You cannot get more intimate with a pregnant woman than work within the confines of the midwifery settings. Pregnant women expose themselves in nudity and usually a family member is present. I've found that it is not possible to provide intimate care in midwifery, it is difficult."

The Gender Image

It is a well-known fact that nurses are more of females than males. This is one area of concern related to the public image of male nurse. When working in a female-dominated environment like the delivery room, male midwives are possibly excluded from compliments.

One male midwife summed up this perceived gender discrimination as follows:

> *"When colleagues and patients are going home they will say, to my colleagues thank you, sister' and automatically you feel you are not part of the group."*

Another male midwife narrated this

> *'One older woman showed me that she did not want me to get any closer after the vitals. She was happy with the history as long as it wasn't intimate like examining her tummy or assessing the presence of cephalo pelvic disproportion. I asked her to lie on the bed and she said, "No, I don't want to [have] any care given to me because you are a man!' Please ask the female nurse to come and examine me.'*

Protection

Almost all midwives in the area felt insecure. It is not possible in Mpongwe to have an assurance that you will last at a health centre. One male midwife had this to say:

> *"I did not have complaints from the chiefs or the community. When I moved to maternal health section a female midwifery volunteer from Germany whom I found working in the department was against males practicing the career. She influenced the staff, the church and some community to resist our service in labour wards. So I was redeployed to work in outpatients of the maternal section. However, during emergencies, I would be called upon to attend to mothers in the delivery room. When the Germany lady left, things settled and I moved into the labour ward to fully practice the trade."*

Rejection and Support

While male midwives tend to face rejection, there are instances when they get support from locals or colleagues. When one male midwife was asked to comment

about any support following a complaint about the German lady who resisted his work, he replied.

> *"Workmates have been very supportive. I have had an experience of workmates rejecting me because of my profession."*

The male midwife also confirmed about support

> *"There are women such as those coming from the remotest areas; they feel so shy to find a man in the labour ward to attend to them. In such an instance I ask for the help of female counterparts to take over so that the woman can be free in the delivery process. That is if there is a female nurse to assist but if there isn't you leave them alone. Then like instances experienced, it will be those who brought her to the clinic who convinces them to accept male midwife's assistance and then they will call you to assist. Or the pregnant woman will start calling for you upon experiencing the severe birth pang."*

The general attitude of the rural community towards health workers and male midwives especially was generally described as not all that good. There were some notable incidences which happened to prove the existence of negative attitudes of the community towards health workers and not only male midwives. The following observations of unfairness were made.

> *"In 2009 September, the district Medical office posted a young registered nurse namely Mr Kwanu (not real name) who had just graduated from Kabwe nursing school to Mikata Health centre. The officer barely worked for 3 months and the community began to complain about him by saying the officer was too young to operate as a nurse and conduct child birth services looking at the nakedness of our women. The community was resenting the young health care provider because of his age and for being unmarried…..Another case of victimization by the community involved a Mr Kwapa who was posted to a health centre as an environmentalist suffered resentment by the community. He was the only staff at the health centre before a nurse was posted there but the community expected him to attend to all health related things and somehow caused his transfer. Mr Kwapa was a health environmentalist."*

Mr Kwasa (not real name) graduated from Chilonga Mission and was posted to Mikata in 2012. People raised concern about his drinking habits and the community accused him of discussing male circumcision issues in the public at bars. He was unceremoniously transferred from this community. Here, tradition leaders are very powerful especially the Indunas. The chiefs are okay, especially the senior chief, he is very supportive. But of course Indunas have a strong voice and are usually feared. Nevertheless I have never experienced any victimization from any of them but I wouldn't hide to you that in rural areas we work under camera. We are not like you people in Lusaka where you are free with people, no. You have to be strong and courageous to work in a rural area, 'yalikabakuno' (its hot here).

Another male midwife had this to say about his experience and that of his predecessor.

I had also had some undue pressure from the area councillor who persistently accused me of not doing enough at work.

My colleague who has since retired was once victimised as well at one of the funerals and accused of causing so many deaths at the clinic.

Sexual feelings and Advances

The male midwives were asked to explain their experiences about the intimate examinations that they conduct. When asked to comment about the talk that was there that male midwives were just fond of looking at the nakedness of women, the responses were as follows:

"… Having sex with a woman in labour is not possible because women undergo terrible pain in child birth and thus the issue of having sex with them will be unfair. It is not possible, work of delivering a life safely is what lies at stake when a woman is placed in the labour ward. To start planning and making strategies to strike intimate relationships with the woman does not come to mind. Our obligation is far greater than sex. We try as much as possible to safe-

guard our profession so that we do not bring our career to disrepute. Don't forget that at this stage, a midwife is occupied with the saving of two lives, that of the baby and that of the mother."

Support from the ministry and cooperating partners

Themale midwives were asked to explain their experiences with the Ministry of Health in terms of support from them. In rural areas there are Non-Governmental Organizationswhich are providing health services to the rural communities. The male midwives were also asked to comment on these other stakeholders.

These were there comments in terms of support from the Ministry of Health which is their employer:

"…well we have no complaints with our employers. The salaries are now good atleast for us in the rural areas and we receive them on time. We receive rural hardship allowance which we feel is not much comparing to the hardships we face in rural areas. However, we have our concerns without employer. And this is that we feel it is not doing much to sensitize the community about the importance of our role in the health sector. It is like we are posted and left to fend for ourselves in terms of acceptance by the rural community. We feel that our employer should improve on this one."

In terms of health equipment, they went on to say:

"Health equipment in rural areas is a problem. For instance, this Mikata Health Centre is one of the big health centers here in Mpongwe District. It caters for more than9000 people with a daily attendance of not less than 125 patients to the clinic. Yet electricity is not provided for the clinic. The power line is very close. It is difficult to store medicine which is supposed to be refrigerated.If the ministry could look into it because it makes our work difficult in terms of improvisation."

Concerning working in partnership with the other stakeholders, the male midwives had this to say:

"… yes there are Non-Governmental Organizations like the World Vision and the Peace Corps who are working in providing health

services to the rural community. We appreciate their work but we feel that we should work in harmony because we are service same people. It is like our colleagues are working in isolation. We don't know whether their programmes are approved by the government which we feel they are but should partner with us who are on the ground in carrying them out."

CHAPTER FIVE: DISCUSSION AND CONCLUSION

5.0 Introduction

Before discussing these findings, answers to the research questions are presented. These are followed by a gendered synthesis of the findings. The data are then discussed, reflecting on what previous research has articulated on the matter. A conclusion and recommendation follows from the discussion.

5.1 Answers to the Research Questions

All research must begin with a question or questions (Punch, 2005 Creswell, 2007, 2009; White, 2009; Blaikie, 2010) and this study was premised on the following as research questions:

a) What are the views of men and women towards male midwives?
b) Whatfactors promote or hinder acceptability of male midwives by rural communities?
c) What are the experiences of male midwives who have worked in these rural communities?

The answers to these research questions are:

To Research question 1: **What are the views of men and women towards male midwives?**

Women were ambivalent whereas men were decisive in terms of the stand they had on male midwives. The ambivalence in the women sample was that the higher in a position a women was, the more she objected to the role of a male midwife. These women had hegemonic views just as the men had. Unlike women who had ambivalent views, men seemed to be more authoritative on pregnancy and delivery matters than women. The views of women were categorized in three ways as hegemonic, subjugation and acceptance. The men's views were full of indignance. The men spoke against male midwives as though they were women. Their rejection or strong views bordered on the fact that it was prohibited culturally to see a woman naked whom you are not married to. Women's nakedness was shrouded with sacredness and the men felt that it was extremely embarrassing for

them.Women also found it embarrassing to see another man checking or touching their private parts.

To Research question 2:**Whatfactors promotes or hinders acceptability of male midwives by rural communities.**

There were variations in traditional practices, attitudes, norms and values, shared meanings, and patterned ways of behaving in relation to pregnancy and birth were varied as will be shown in this section. There were factors promoting the use of male midwives and factors inhibiting the use of male midwives. There are however more reasons addressing inhibitions than promotions and most of the reasons disfavouring the use of male midwives came from the men. The men and women who were against male midwives cited behavioural guidelines in form of social norms and taboos that regulate pregnancy and delivery. It was not an accepted practice to touch or see the tummy or private parts of a woman who was not one's wife. The men unlike women believed that the practice of attending to women promoted infidelity, punctuated with male midwife slandering and their lack of confidentiality. However, more women than men acknowledged the roles male midwives played in reducing mortality and morbidity.

To Research question 3: **What are the experiences of male midwives who have worked in these rural communities?**

There were numerous experiences that the four male midwives shared with the researcher. The subthemes that emerged included emotional experiences, challenges of nudity, gender image, protection, rejection and support and sexual feelings and advances. The male midwives confessed that working as a male midwife was not an easy job. Because the job was associated with providing intimate care, it exposed them to personal, interpersonal as well communal emotional challenges. Although the male midwives' interactions with expectant mothers and fathers were professional encounters, women clients' nudity was often perceived by expectant fathers to have sexual connotations. It is a well-known fact that nurses are more of females than males. This is one area of concern related to the public image of male midwife.

5.2 Discussion

From the findings, it is evident that this study has contributed to existing literature in Zambia that examines how women are both objectified by and complicities in the construction and a proliferation of hegemonic gender from both males and female. The women objectify themselves rather different from men. While it is the woman's body which is the subject, women are not into so much of rejection or ejection of male midwives except when a serious wrong is done. Men on the other hand are into maintaining hegemonic masculinities of controlling the woman's body by objectifying it as a sexual machine for their own gratification ignoring the value of life and power of procreation inherent of being a mother and not a woman. The findings point to a false consciousness in the men surrounding insecurity or negative traditions bordering on false assumptions that a woman is nothing but a male gazeincomplete as Foucault (1979).This is the concept according to Mulvey (1989), that explains how some people look at the visual appearances of private parts as pleasures for men or like narrative cinema. The gaze from the point of view of men and some women highlights the failure of interaction between male midwives and women in Mpongwe.

In addition, the centrality of looking and being seen naked in the social construction of gender and maintenance of oppressive social relations (Chandler, 2000) as agued by women is far from the ethics of midwifery. This is not understood by women in Mpongwe. In this way, looking and being looked at as woman and naked are fundamental steps in the process of working towards breaking feminist hegemony or challenging the traditional social order which is contribution in one way to raised maternal mortality in this setting. The problem with the perceived male gaze is not the notion that looking is enjoyable but the problem is with patriarchal and heterosexist premise that hypothesises men as the sole agents and beneficiaries of the gaze. It is the women who are beneficiaries amidst this lack of female midwives in rural areas.

It should be remembered that women are expecting and are seeking the services from a health care provider, but they do so within the confines of hegemonic gender norms inherent inMpongwe. The heterosexual standards of feminine infidelity for instance have been created by men, and within this heterosexist, ageist, and patriarchal society. The society in Mpongwe is primarily very

traditional. Men exercise power to mete out personal and institutional sanctions on perceived truant or deviant male midwives.

It is evident that men exercise power interpersonally, by virtue of the visual attentions they devote to women who are deemed to be physically attractive. Interpersonal interactions between a man and a woman when naked in Mpongwe are one area among many where the power of the male gaze is exercised. However on the contrary even though the traditional standards of the male gaze are recognized /and internalized by men, women are not likely to fall for men and be led into infidelity following the male gaze. Women are not powerless and are able to exercise an insidious form of power over heterosexual men, whether they seek to conform to or resist hegemonic standards of men (proposals for sex or a sexual relationship).

In this study, women have demonstrated that they exercise considerable power and self-control in disciplining themselves from acts of infidelity after the male gaze. The researcher finds the attitude of women on male midwives significantly positive despite the limitations of the sample. This is supported by the fact that every one of the women, especially Indunas the researcher interviewed knew at least one other woman who had been examined and delivered by a male midwife and there was no infidelity or slander and loss of confidentiality.

The study has shown that there is concentration of power to eject or reject a male midwife in the community. Although power and authority are evident in Mpongwe at a personal and group level, it cannot be divided neatly into power among men and power among women. Identifying who has power between men and women or in the hierarchies of leadership position simply masks how power is dispersed in a gendered way and throughout the social structures. For example, concentrating on the male gaze blinds us to how the gaze emerges through other sites. This includes the women's gazes (during initiation ceremonies or other rites of passage) at one time or another (Winkler 1994). The clinical gaze (Foucault, 1973), is one in which women's bodies are constructed through the lens of medicine while self-gazing is one in which women look at themselves (Brush, 1998). The sexualised gazesare those through which male supremacy and heterosexism are constituted. A more comprehensive approach to understanding power in Mpongwe is to seek to identify

not who has the power but how this power operates and the consequences of those operations (Dreyfus and Rabinow 1982; Foucault 1980; Ransom 1997; Sawicki 1991). The benefit of such an approach is that it allows for critical intervention into multiple sites of power.

All the male midwives who participated in this study in this study reported that they found the experience of providing intimate care to women clients challenging. Like other studies, this study saw that close physical proximity to women clients and the necessity of seeing and touching their genitalia evoked feelings of discomfort and embarrassment. When they were required to provide such care for young female clients, they were more aware of gender than when dealing with older clients. What the men and some women do not know about intimate care is that it includes emotional closeness and working closely with a woman client in a therapeutic relationship. Timmerman (1991: 20) defined emotional closeness as 'a quality of relationship' which includes understanding and acceptance of the other. Mattiasson and Hemberg (1998) stated that emotional closeness is essential for fulfilment of human need in care settings. This traditional definition is supported by the literature (Lawler 1991, Timmerman 1991, Routasalo 1999, Williams 2001, Bassett, 2002).

5.3 Conclusion

What could be concluded from this study is that providing midwifery care to women clients in Mpongwe has placed male midwives in a challenging dilemma. The traditions in form of taboos, norms values and practices have placed serious challenges on these practitioners. Though the challenges are very few from the women who are their clientele, the men and traditional leaders irrespective of sex, create a hostile working environment for them.

The experiences of care of these midwives remained relatively unexplored and further studies beyond Mpongwe are recommended. Thus, while this study provided valuable insights into male midwives' experiences and the power inherent of the rural communities, they raise similar questions that need to be addressed such as: 'What is the experience of female nurses providing intimate care for men

clients?' and 'What is the position of traditional leaders on such intimate carefor men clients?

The lack of enquiry into the experiences of providing intimate care is mirrored by its relative absence from many health care intervention education programmes for community awareness and acceptance of care. Consequently, the majority of community members have often not been adequately prepared to manage the feelings associated with this experience.

Many of the strategies used by male midwives in this study were 'learnt on the job', rather than as part of their educational programmes. This lack of formal preparation and support may impact on the recruitment and retention rates of male midwives. It is therefore essential that nursing education programmes should provide information, guidance and support to assist them in the developing effective strategies when providing intimate care.

5.4 Recommendations

1.Since the views of men and women in Mpongwe have been established in depth, it would be ideal to have a holistic approach to change in culture and attitudes towards intimate care provided by male midwives to pregnant mothers in Mpongwe district and other rural communities in Zambia. The Ministry of Health is trying by conducting programmes like Safe Motherhood Action Groups (SMAGs) to inculcate a change in the mind set of our communities. However, the Ministry of Health alone may not manage; therefore the holistic approach should involve other stakeholders like the nongovernmental organisations who are said to be working in isolation to come on board. Besides, SMAGs is a pilot programme being conducted in few selected parts of the country but the holistic approach should be country wide. This is because the identified attitudes inherent in rural communities towards the practice of midwifery by males are not for Mpongweonly but are country wide as evidenced from the substantive reports.

2.The research has brought out factors that promotes or hinders acceptability of male midwives by rural communities. It would be necessary in the immediate future to let the media start talking about it. Drama on gender should be organized in order to give information to the community members not only in Mpongwe but

also to other rural communities for sensitization.Make the topic of procreation in relation to male midwives being at the centre to be part of part of community education and empowerment. This will not only inform the adults but also younger generation in general. The knowledge obtained will enlighten them with new values that are part of the reproductive life. It must be remembered that 'Functionalism' emphasizes values surrounding gender roles, marriage and the family as central to functionalist assertions regarding social equilibrium. As long as built in mechanisms of social control operate effectively and efficiently what may be seen as a disruptive social change to the rural communitiescan still be restored to equilibrium under such programmes.

3.Carry out sensitisation programmes in the Ministry of Chiefs Affairs for ank2authoritative voice that traditional leaders should work with the government in trying to reduce morbidity and child mortality.The research has shown that the maternal mortality is quite high as reported about referral cases at Ibenga Hospital.Since most of the women do not find it difficult to be attended to by male midwives then their husbands and the traditional leaders should not make difficult for. They are the ones who should be in the forefront of making the difficulty life easy for male midwives working in the rural communities. In this way the information will be spread in a convincing form.

4.It is recommended that a furtherwider quantitative research be conducted so as to establish the acceptable and non-acceptablelevels of the study population.

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Appendix I–

IN-DEPTH INTERVIEWS THEMATIC QUESTIONS

(For Chiefs and Indunas)

1) Theme I: Please tell me about yourself.

   Probe for the following if not covered in the self-description:

- Education
- Religious affiliation
- Probe for level of influence in the chiefdom, village.
- Probe for illness rate related pregnancy.
- Probe for death rates related to pregnancy.
- Probe whether this is worrisome.

2) Theme: II Cultural attitudes in the chiefdoms which are applied to midwifery

   Please describe for me your personal view on men attending to women in pregnancy, labor or even after delivery.

- Probe for negative points by asking to describe more.
- Probe for positive points asking to describe more.
- Probe for illness types and explore what the personal position is regarding men treating such women.

  Please describe for me the views of men attending to women in pregnancy, labor or even after delivery.

- Probe for negative points by asking to describe more.
- Probe for positive points asking to describe more.
- Probe for illness types and explore what the personal position is regarding men treating such women.

  Please describe for me what the local beliefs and practices are regarding men attending to women in pregnancy, labor or even after delivery.

- Probe for negative points by asking to describe more.
- Probe for positive points asking to describe more.
- Probe for illness types and explore what the personal position is regarding men treating such women.
- Probe women's views in view of the culture

3) Theme III: Strategies are gender sensitive that could be employed to mitigate the acceptance of male midwives

- Give a background of illness and death rates to probe then ask what he personally thinks could be done.
- Probe the response if it is in agreement with the local culture.
- Probe for the sticking or departure from the local culture.

Appendix II-

FOCUS GROUP DISCUSSIONS THEMATIC QUESTIONS
(for Headwomen, Headmen, women and men in couples).

4) Theme I: Please tell me about your traditions relating to pregnancy and labour

- Probe for illness rate related pregnancy (What do you see among women in terms illness related to pregnancy).
- Probe for death rates related to pregnancy. (What do you see among women in terms illness related to pregnancy).
- Probe whether this is worrisome.

5) Theme: II Cultural attitudes in the chiefdoms which are applied to midwifery
Please describe for me your personal view on men attending to women in pregnancy, labor or even after delivery.

- Probe for negative points by asking to describe more.
- Probe for positive points asking to describe more.
- Probe for illness types and explore what the personal position is regarding men treating such women.

Please describe for me what the local beliefs and practices are regarding men attending to women in pregnancy, labor or even after delivery.

- Probe for negative points by asking to describe more.
- Probe for positive points asking to describe more.
- Probe for illness types and explore what the personal position is regarding men treating such women.
- Probe women's views in view of the culture

6) Theme III: Strategies are gender sensitive that could be employed to mitigate the acceptance of male midwives

- Give a background of illness and death rates to probe then ask what he personally thinks could be done.
- Probe the response if it is in agreement with the local culture.
- Probe for the sticking or departure from the local culture.

Appendix III –

IN-DEPTH INTERVIEWS THEMATIC QUESTIONS
(for male midwives)

Theme I: Please tell me about yourself.

Probe for the following if not covered in the self-description:

- Education
- Religious affiliation
- What prompted you to become a male midwife?

Theme II: Tell me about your working experience.

Probe for the following emotional experiences, challenges of nudity, gender image, protection, rejection and support and sexual feelings and advances

Probe for illness rate related pregnancy and for death rates related to pregnancy.

- With the pregnant women you deliver.
- With the community in terms of
  (i) Traditional leaders like chiefs, Indunas, headmen and headwomen
  (ii) With the husbands of the pregnant women you deliver.

Them III: Tell me about your working experiences with the Ministry of Health in the provision of health services in rural areas.

Probe for

- Conditions of service
- Moral support
- Health equipment

Theme IV:Tell me about your working experiences with other cooperating partners in the provision of health services in rural areas.

Probe for cooperation with other cooperating partners

Effectiveness of work by other cooperating partners

The relevance of the work of the cooperating partners to the rural community in terms of reducing maternal mortality.

Appendix iv-

INFORMED CONSENT

TOPIC: THE ATTITUDES OF RURAL COMMUNITIES TOWARDS MALE MIDWIVES IN MPONGWE DISTRICT

INTRODUCTION

PURPOSE OF THE STUDY

VOLUNTARY PARTICIPATION

RISKS AND DISCOMFORTS

I, Chimimba Osborne, a student of Master of Arts Degree in Gender Studies at the University of Zambia, kindly request you to participate in the above mentioned research. This study will assist to obtain information on community views about the work of male midwives. 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.

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 the health centre. Feel free. 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 30 minutes.

BENEFITS

CONFIDENTIALITY

INFORMATION AND CLARIFICATION

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 not hinder the work of male midwives in rural communities. This will in turn improve 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. Your research records and any information that will be collected from you will be kept confidential to the extent permitted by law. Any personal information will not be released to any one without your permission unless required by law. Confidentially, the Ministry of Health, theSchool of Humanities and Social Sciences or the University of Zambia Research Ethics Committee may review your records again.

Kindly be informed that any time you seek clarifications or want to ask anyquestions about the attitude of rural communities towards male midwives, we will be more than obliged to give you the required information.

For any further clarification, with due respect contact:

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School of Humanities and Social Sciences
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