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# The Context of Male Midwives Among Rural Communities

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**Abstract** Midwifery is a profession that provides care for women, especially during pregnancy and childbirth. Despite the increasing number of men finishing a degree in midwifery, many people assume that only women can be midwives. Thus, this study aimed to identify the context of rural communities toward the practice of midwifery by men. Further, it explored the reasons for whether they will avail of the services of male midwives. The study was conducted on 14 women and four men residing in the rural areas of Ilocos Sur, Philippines. Respondents were accessed through purposive sampling based on the inclusion criteria: A researcher-made interview guide was used in obtaining qualitative data from the respondents. The responses were elicited through a semistructured, individual in-depth interview. Data collection was continued until data saturation was met. Ethical principles were followed throughout the process. Data were transcribed, coded, and categorized to obtain the results of the study. In this study, although male midwives are perceived as professionals and well trained, women still prefer female midwives and express their doubts about the men's capability to provide care, especially during delivery and childbirth. The respondents also expressed feelings of embarrassment on showing their bodies to a man other than their husband or partner. On the contrary, their willingness to avail of their services depends on whether they can perform and provide quality care. From these findings, the Department of Health and local government units may increase the presence of male midwives by hiring them in different health facilities. This may eventually help them be well known and accepted in the healthcare profession.

**Keywords:** acceptance; care; childbirth; man; midwifery; woman.

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## 1. Introduction

Midwifery is a profession of providing care for women, especially during pregnancy and childbirth. According to the [International Confederation of Midwives \(2014\)](#), a midwife is a person who, having been regularly admitted to midwifery educational program and is duly recognized in his or her country, has completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. The educational program may be an apprenticeship, a formal university program, or a combination. The midwife is recognized as a responsible and accountable professional

who collaborates with women to give the necessary support, care, and advice during pregnancy, labor, delivery, and postpartum. Midwives provide care to women and families from a variety of socioeconomic origins, racial and ethnic backgrounds, and sexual orientations. They want to meet these families' and women's needs with individualized treatment (Pilkenton & Schorn, 2008).

Midwifery is one of the oldest professions in the world from the inception of human life, and it was recognized in ancient Egypt as a female occupation as attested by Ebers Papyrus from 1900 to 1550 BC (Bwalya et al., 2015). The practice of midwifery was exclusively a female profession in ancient times. Since the beginning of time, women have assisted each other in giving birth. In fact, until quite recently, men hardly ever assisted women in giving birth. The midwife was typically the oldest woman in the neighborhood and was frequently a married or recently widowed woman. Over time, these women would learn their trade from more experienced midwives. Midwives in Athens should have been required by legislation to have had children during the time of Hippocrates (460–410 BC) (Osborne, 2014).

Midwifery began to change in the early modern period from a female art to a male occupation. The shift was not smooth, and it began in 1522 when Dr. Werdt of Hamburg dressed up as a woman to observe midwives and learn about childbirth. However, Dr. Werdt was burned alive when discovered to be a man. The renowned surgeon Pare set a firmer foundation for men practicing in the delivery room later in the mid-16th century. He helped deliver kids by yanking them out of the womb by their feet during a challenging birth. A significant factor in this transition in gender roles was Louis XIV. To deliver his illegitimate offspring, he hired male midwives. Male midwives became more well-known as they helped their mistresses give birth to their babies. More notably, at this time, Europe saw a fast population explosion that coincided with these social changes. Universities expanded their studies of anatomy and reproduction as the population increased. In addition to being medicalized, childbirth also became a more masculine activity (Nelson, 2008).

However, the Midwives Act of 1952 prohibited men from training and practicing as midwives. In the late 1960s and early 1970s, a few male nurses began challenging the idea that men cannot be midwives. In 1975, a bill to abolish sex discrimination in employment was introduced. This bill made it illegal for a man to practice as a midwife. Later that year, an amendment to the bill removed the barriers for men to enter the profession; however, there are still some restrictions on their practice. As a reaction, a British lying-in hospital was allocated for training male midwives, but these male midwives were monitored to ascertain their suitability as midwives. In 1982, the Royal College of Midwives recommended that midwifery

should be opened to men. On March 16, 1983, the Secretary of State announced the removal of barriers contained in the Sex Discrimination Act of 1975 relating to male midwives, and men were free to train and practice as midwives (Shavai & Chinamasa, 2015).

At present, the nursing and midwifery profession, as observed, is still mostly dominated by women. It is supported by the NHWDS 2016 Fact Sheet of the Department of Health in Australia on the registered and employed nursing and midwifery workforce in that 89.1% of the workforce comprised women. Many people assume that only women can be midwives. Further, at present, men make up approximately 10% of the nursing workforce in the USA (Bly et al., 2020). Further, according to the Nursing and Midwifery Council in the United Kingdom, of the 43,168 registered midwives in the UK at the end of March 2017, 188 were men. Nevertheless, that is still a minuscule 0.4% of the total. At a systemic level, despite excessive demand for midwifery care, there are not enough midwives to cover these demands (Behruzi et al., 2017).

Additionally, midwifery still predominantly belongs to women because of the widespread misconception that it is fundamentally a female-female connection. In order to establish a close-knit and trustworthy relationship with another woman, women seek out midwives. According to midwives, midwifery is about providing care to other women. (Osborne, 2014). According to Jones (2017), midwifery has predominantly always been a female profession, and before the mid-70s, it was illegal for men to practice as midwives.

Bwalya et al. (2015) revealed that 134 (67%) of their respondents agreed with the statement “Midwifery was a career for women” and 125 (62.5%) agreed with the statement “It is okay for women to work as midwives than males.” Beverly Beech, the Chairwoman of the Association for Improvements in Maternity Services, said that she would still not encourage men to enter the midwifery profession. She said, “The male midwives in this country (United Kingdom) are excellent, very gentle people and like helping women, but you do not find many men like that around.”

Even if midwifery has long been perceived as a profession for women, the scenario has changed as men continue to enter the profession (Bwalya et al., 2015). An increasing number of male midwives have delivered infants and provided other gynecological services. The first “man midwives” were guys who began working as midwives. According to Donnison, an English man midwife was frequently an unsuccessful medical student or an apothecary posing as an unlicensed doctor. According to William Seon, who reported in 1971 that men midwives believed they were superior practitioners: “The English midwife believed that a good midwife was one who sent for a male practitioner when labor became difficult.”

According to [Shavai and Chinamasa \(2015\)](#), even though male midwives gained popularity, their acceptance was not unanimous. Some people believed that men do not belong in the birthing room since men did not experience childbirth. Some believed that childbirth is beyond the realm of male expertise.

The rise in the number of male midwives emphasized changes in female culture, with elite women trying to set themselves apart from their poorer sisters by employing men and those of lower classes then trying to emulate those of higher classes ([Ross, 2014](#)). In Cameroon, part of Central Africa, the view of the male entrance to midwifery practice has created much controversy over the preferences of sex when it comes to a midwife's practitioner.

Because it is customary to prefer a female midwife than a male midwife, healthcare professionals frequently instill the perception that working with male midwives is uncomfortable. Some of the reasons why women did not want a male midwife were religion, culture, acute shame, a history of physical or emotional abuse in or outside of a relationship, or just not wanting a man holding their external reproductive organs. Nevertheless, according to the same source, studies carried out in San Francisco, Austin (TX), Washington, and Columbia found that women felt more at ease with a male midwife who would let them deliver the baby their way than with a female midwife who has delivered babies and would expect women to deliver the baby her/his way.

In the Philippines, the delivery of health services comprises of the public and private health sectors. It has a decentralized system, with the Department of Health (DOH) serving as the governing agency over local government health units (LGU) and private health sectors. Human resources manning these agencies are central to the health system in the country. Health professionals in the Philippines include doctors, dentists, nurses, and midwives ([Savella, 2018](#)). Other health personnel include sanitary inspectors; nutritionists; medical technologists; physical, occupational, and speech therapists; dental aides; and non-technical staff. At the grassroots level, the provision of health is also assisted by volunteer barangay health workers and birth attendants. In 2018, there were 4,9351 nurses and midwives (per 1,000 people) in the Philippines according to the World Bank collection of development indicators, compiled from officially recognized sources. In 2019, a total of 1,673,923 live births were registered, which is equivalent to a crude birth rate of 15.6 or 16 births per thousand populations ([Philippine Statistics Authority, 2021](#)).

With the above number of births, the number of midwives may not be enough to provide the health services needed by mothers and their newborns. In a report by the DOH in 2019, Philippine provinces employ 98% (79 of 81) of nurses, 74% (60 of 81) of midwives, and 25%

(20 of 81) of physicians (DOH, 2019). Although the number is adequate, the decreasing trend from 2016 to 2019 can be attributed to the constantly increasing population in the Philippines. In response, a steady supply of health professionals in the primary care and clinical settings was ensured to provide essential health services to the increasing population in the country.

However, the community, as the end user, shapes the implementation and/or utilization of such services. Community people have the wisdom and are active agents to change the lives of their people. They utilize local knowledge as much as they could for the well-being of their community/family and are considered experts who knew appropriate solutions to their community problems (Ross, 2014). In countries such as Ethiopia, rates of skilled birth attendance are still only 28% despite a recent dramatic national scale up in the number of trained providers and facilities. Concerns have been raised that women's perceptions of poor quality of care and fear of mistreatment might contribute to this low utilization (Burrowes et al., 2017).

In maternity nursing, it is perceived as an unwelcoming specialty by many nursing students who are men (Mitra et al., 2018). Opportunities for male midwives may be limited based on their sex. Communities, especially in rural areas, still prefer women to attend to them during delivery. Family members, particularly husbands, also express their hesitation to allow male midwives and nurses to participate and render service to their wives. In a study by Raza (2020), utilizing participatory action research, he highlighted community strengths, local knowledge, and wisdom. The study emphasized the importance of building community trust to increase motivation among community members to ensure their engagement and participation to work toward achieving project goals. Therefore, a trusting relationship between male midwives and their clients must be established for their services to be accepted.

The study's findings in the aforementioned situation will advance the field of sex and cultural studies. The DOH will probably use study findings to develop community-based treatments and health education programs. The results of the study might make mothers, fathers, and the community more aware of the existence of male midwives and the services they can offer to clients. Male midwives would benefit from this study, as this would inform them of the ideas of women and men regarding their services and care. Such information would also make them understand better their clients for the provision of quality care. For higher education institutions (HEIs), the study results would serve as their guide in the preparation of their students to become successful professional midwives.

This study is anchored on concepts and studies that were useful in understanding the perceptions of male midwives. According to the *social role theory*, gender stereotypes are

dynamic constructs influenced by actual and perceived changes in what roles women and men occupy (Sendén et al., 2019). In 1943, Ruth Cowan became one of the first two women with official US Army credentials to report on World War II. Applying the theory of “gender judo,” which demonstrates how women have used traditional gender roles to get themselves further into masculine roles (Olson, 2017). However, studies on the relationship between employees’ perceptions of gender discrimination and outcomes at work such as job attitudes, physical health outcomes and behaviors, and psychological health is negatively related. Therefore, implications for research and practice include the need to consider the influence of the country context in organizational decisions to prevent and address gender discrimination and its consequences for employees and ultimately, for employers. (Triana et al., 2018).

In the Philippines, despite its effort to be an egalitarian country, issues on gender roles are still observed, especially in the workforce. The Philippines remains the top country in Asia in terms of closing the gender gap, according to the Global Gender Gap Report 2020 of the World Economic Forum. The report shows that the Philippines has closed 78% of its overall gender gap, garnering a score of 0.781 (down by 1.8 percentage points from .799 in 2019). With this, it ranked 16th of 153 countries with the narrowest gap between men and women, dropping by eight notches from its place last year (Philippine Commission on Women, 2022).

In a study by Banerjee and Doshi (2020), women perceived considerably greater job demands than men both in the USA and India. In terms of workplace support, both studies found that workplace culture and supervisors’ support influenced the perception of job demands. Moreover, as influenced by the media, the observed trend among medical school graduates today is one where men are overrepresented in surgical specialties and women are overrepresented in obstetrics and gynecology and pediatrics, practices typically associated with the maternal role. Hence, throughout history and up until recent years, the male role in gynecology has been absent, indirect, or directly overlooked by a third party (Balayla, 2020). Achieving equal opportunity for all was one of the driving forces behind the creation of the European Union in the mid-20th century. Member nations are thus expected to comply with the principles outlined in them. The key to this arrangement is that countries are empowered to choose their way of meeting equality objectives. Where gender equality in the context of work is concerned, progress has been minimal.

The functionalism hypothesis, also known as structural functionalism, served as a further guidance for this investigation. The idea aims to pinpoint the fundamental components of society and identify the roles they play in resolving social problems in predictable ways. Functionalist claims about societal equilibrium place a strong emphasis on values related to

gender roles, marriage, and the family. The built-in system of social control must function effectively and efficiently for society to be able to return to equilibrium in the case of disruptive social change, according to functionalism. (Osborne, 2014).

Childbirth is a life-changing experience within all cultures and ethnic groups. It provokes a wide range of responses that are influenced by a complex interaction of different religious beliefs, culture, education, social status, economy, and perceived position of women within the society. The perception of women is influenced by social class, education, religious beliefs, and the degree to which the group has been exposed to different value systems (Shavai & Chinamasa, 2015). Filipino women, particularly Ilocanos, have been described as conservative, modest, and shy. Relative to this, the acceptability of male midwives may be influenced as giving birth entails the exposure and examination of the reproductive organs.

Consequently, the midwifery structural model of care, proposed by the Queensland Nursing Council I 2000, was used to guide the present study. The midwifery structural model of care is used to inform an assessment of expectant mothers' preferences for the midwife's gender and includes nurturing, hands-on care before, during, and after birth. It identifies four elements in midwifery: the woman as the central focus, the midwife as the provider of care, the professional partnership, and the environment in which care occurs. The midwifery model acts as a benchmark for midwives on areas to be deliberated on when changing a practice model. Midwives ought to develop trusting relationships with their clients, which will in turn result in confidence, trust, and cooperation from expectant mothers. As such, the use of the midwifery model essentially encourages midwives in the recognition that the quality of client care is dependent on various factors such as satisfying expectant mothers' preference of the midwife's gender and respect for patient preferences, values, and expressed needs.

The main objective is to identify the context of rural communities toward the practice of midwifery by men. Further, it explored the reasons whether they will avail of the services of male midwives.

## **2. Methods**

### **2.1. Design**

Qualitative research investigates relationships, activities, situations, or materials (Fraenkel et al., 2012). It is an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem (Creswell, 2012). Qualitative inquiries focus on respondents' perceptions, experiences, process that is occurring, and the outcome.



This research design followed the three-step process that [Streubert and Carpenter \(2011\)](#) outlined, including intuiting, analyzing, and describing.

- a. *Intuiting*: this is considered the first step. It is when the researchers become immersed in the experience being studied. In this phase, as much as possible, the researchers avoid an in-depth literature review, opinions, and other statements that might influence to any degree the interpretation of the phenomenon being studied. Instead, the researchers served as an instrument to uncover an accurate description of the phenomenon.
- b. *Analyzing*: in this step, the researchers make sense of all the data presented, including the relationships, connections, and clustering of themes as necessary. To do this, the researchers should be immersed in the data.
- c. *Describing*: this step covers communicating or writing down all the elements critical to convey an accurate description of the phenomenon being studied.

## **2.2. Participants and study site**

The study was conducted on 14 women and 4 men residing in the rural areas of San Juan, Magsingal, Bantay, and Salcedo, in the province of Ilocos Sur, Philippines, in 2021. Respondents were accessed through purposive sampling, and they were willing to participate in the study. The study considered the following participants based on the inclusion criteria: a) women and men of reproductive age (15-45 years), b) married, c) living in rural areas, and d) capable of expressing themselves.

## **2.3. Instrumentation and data collection**

A researcher-made interview guide was used in obtaining qualitative data from the respondents. The responses were elicited through a semi structured, individual in-depth interview. The schedule of the personal in-depth interview was arranged according to the respondent's convenient time and place. Data collection was continued until data saturation was met, which means until the time when there was no more new information extracted from the interviews. The researchers recorded the interview; thereafter, the recordings were transcribed and analyzed for data interpretation.

## **2.4. Data analysis**

Colaizzi's strategy was used for analysis, which was done through the following steps: 1) Each transcript file was read and re-read to obtain the overall sense of the whole content. 2) For every transcript file, the significant statement was extracted on another sheet. 3) Meanings were

formulated from the noteworthy statement. 4) The formulated meanings were organized into groups, cluster of themes, and themes. 5) The conclusions of the study were combined into an exhaustive explanation of the phenomenon under study. 6) The fundamental structure of the occurrence was described. 7) Validation of the findings was sought from the participants to compare the researchers' descriptive outcomes.

## 2.5. Ethical Consideration

Ethical considerations were observed before the study. This study was subjected to review and approval by the Ethics Committee of the University of Northern Philippines (Approval No. 0300). The ethical principles observed in the study include privacy and confidentiality, principle of informed consent, principle of vulnerability, recruitment, benefits, and compensation.

The researchers have no conflict of interest for the study. The findings derived from the study are all for the benefit of the respondents and other concerned institutions.

## 2.6. Establishing Trustworthiness

In the conduct of this study, establishing trustworthiness is vital to represent the responses of the participants accurately. Trustworthiness was observed through data saturation and thick description, enabling the findings to apply the findings in other contexts. In addition, the dependability and confirmability of the findings were observed using audit trials and bracketing of biases and beliefs.

## 3. Results and discussion

### 3.1. The context of male midwives among rural communities

The major themes uncovered in this objective were: (1) Theme 1: Educational Preparation, (2) Theme 2: Participation during delivery, and (3) Theme 3: Gender Ascription. The themes reflect a cognitive or mental process that the participants have built within and experienced in defining their context of male midwives. Verbal responses, codes and general descriptions of the theme is shown in table 1.

Table 1. The context of male midwives

Theme	Verbal responses	Codes	General description of the theme
Educational Preparation	“They are professionals and trained to assist during delivery” “They were trained”	Professionals trained	Male midwives are professionals as they have finished a degree from a

Theme	Verbal responses	Codes	General description of the theme
Participation during the birthing process		finished a course	The participants view male midwives as one who delivers a baby or assist doctors and nurses during
	“It is the course that they took up”		
	“Well experienced”	experienced	
	“They went to school and learned how to deliver a baby”	learned in school	
	“They went to school to be trained and use it to earn money”	trained in school	
	“Assist the doctor during delivery”	Assist the doctor	
	“Assist the nurse during delivery”	Assist the nurse	
Gender Ascription	“Attends to the mother during delivery”	Attends to the mother	The participants perceive male midwives as effeminate. More so, they are in a profession intended for women.
	“They know how to deliver a baby”	Delivers a baby	
	“Performs delivery”	Performs delivery	
	“They are mostly effeminate”	Effeminate	
	“They are doing a woman’s job”	They are in a profession for women	

### 3.1.1. Educational preparation

In this study, the participants see male midwives as professionals, went to school, and are trained. This is supported by statements such as “It is the course that they took up,” “They are professionals and trained to assist during delivery,” and “They went to school and learned how to deliver a baby.” The participants recognize that being a midwife requires formal preparation in a HEI offering the midwifery education program and has undergone training through intensive clinical practicum.

The practice of midwifery in the Philippines is stipulated in the Commission on Higher Education Memorandum Order (CMO) No. 33 Series of 2007. Under the CMO, a person who wishes to practice midwifery must enroll and finish the 2-year program diploma in midwifery or the 4-year degree program Bachelor of Science in Midwifery. Further, he/she must be able to pass the Midwifery Licensure Examination to become a licensed midwife. Midwifery practice in the Philippines has been recognized as one of the primary healthcare services for the people. The role of midwives has been expanded to address the basic health service needs of mothers and their children. Midwifery education must be able to respond to those needs by producing midwives who have up-to-date knowledge and skills and appropriate attitude necessary to render midwifery services with competency and dedication.

Therefore, it is a declared policy of the CHED that midwifery education shall be relevant and responsive to the emerging national and global midwifery practice and development. Hence, quality educational standards shall be attained through accreditation (CHED, 2017).

Moreover, clinical academics provide key contributions to positive outcomes in the delivery of high-quality health and social care; however, building capacity and capability for these roles for nurses, midwives, and allied health professionals within contemporary healthcare settings is often complex and challenging (Cooper et al., 2019).

### **3.1.2. Participation during the birthing process**

The World Health Organization (2021) defines midwifery as the care of women during pregnancy, labor, and postpartum, as well as the care of the newborn. It encompasses measures aimed at preventing health problems in pregnancy, detection of abnormal conditions, acquiring of medical assistance when necessary, and execution of emergency measures in the absence of medical help. In the Philippines, the practice of midwifery is defined in Republic Act 7392, otherwise known as the “Philippine Midwifery Act of 1992.”

The practice of midwifery has now broadened from rendering care of women during pregnancy, labor, and puerperium management of normal deliveries; health education of the patient, family, and community; and primary healthcare services in the community, including nutrition, family planning, and nutrition to the administration of immunization, including oral and parenteral administration of oxytocic drugs after the delivery of the placenta, suturing parietal lacerations to control bleeding, giving intravenous fluid during obstetrical emergencies provided they have been trained for that purpose; and injection of vitamin K to the newborn.

However, despite the more comprehensive work of midwives, the participants still perceive them as aide or helping hand during delivery. This is supported by statements such as “trained to assist during delivery,” “assist doctors during delivery,” and “assist the nurse during delivery.”

### **3.1.3. Gender construction**

Gender norms in profession and employment have always been a social issue, as people still assign certain profession to a specific gender. This holds true as law enforcement is more appropriate for men, whereas nurses and midwives are ascribed for women. In the USA, nearly 99% of midwives are women, and little attention has been given to gender diversity (Bly et al., 2020).

The participants adjudge male midwives as effeminate. More so, they are in a profession intended for women. Statements such as “they are mostly homosexuals” and “they are doing a woman’s job” hold up to their insight. According to the *social role theory*, gender stereotypes

are dynamic constructs influenced by actual and perceived changes in what roles women and men occupy (Sendén et al.,2019).

### 3.2. The reasons for refusing the services of a male midwife

The participants were asked if they will avail of the services of a male midwife during delivery. Refusal to avail were backed up with these reasons: (1) Doubts on their capability, and (2) Woman to woman care. Verbal responses, codes and general descriptions is shown in table 2.

Table 2. Refusal to avail of the services of a male midwife

Theme	Verbal responses	Codes	General description of the theme
Doubts on their capability	“I have doubts on males performing delivery”	Doubts	The participants express their doubts on male midwives performing delivery
	“It is different if a male will perform the delivery”	Different if male	
Woman-to- woman care	“I might have difficulty of delivering if the midwife is a male”	Difficult to deliver	The participants prefer a woman to attend during delivery
	“It should be a woman who will assist me during delivery”	Should be a woman	
	“It must be a woman”		
	“I prefer a woman like me”	It must be a woman I prefer a woman	
	“It is not good to see a man performing delivery”		
	“I will have difficulty if I give birth when assisted by a male midwife”	Not pleasant to see a man Difficult to give birth	
	“I choose a woman, if possible, to assist my wife”		
Embarrassment	“I feel reluctant because he is a male”	Chooses a woman	The participants feel embarrassed to show their body parts to another man
	“I feel ashamed showing my body to another man”	Ashamed	
	“I feel awkward because he is a male”	Awkward	
	“My wife might be ashamed”	Ashamed	
	“I feel shy and ashamed to show my private parts”	Shy and ashamed	

#### 3.2.1. Doubts on their capability

Men have been allowed to work as midwives for decades, but many expectant mothers remain unsure about availing them during birth. There have been those who question their motivation and ability for all that time. This is also true among the participants, as they express their doubts of men taking part during the delivery of their baby. This may be especially due to the intimate nature of maternity care and occurrence of sudden unpredictable emergency pregnancy or birth-related complications (Kumar & Sweet, 2020).

This is supported by the following statements: “I have doubts on men performing delivery,” “It is different if a man will perform the delivery,” “I might have difficulty of delivering if the midwife is a man.” However, according to Jones (2017), the philosophy “Men, they believed

could not provide this type of care” was challenged by various studies. The research found out that women cared for by male midwives described them as gentle, calm, sympathetic, and more understanding than some female midwives.

Some women preferred a man’s care, whereas 10% of women requested a male midwife. It became clear that male midwives had a role to play in midwifery and were an asset to the profession even in the early days of men entering the profession. This is supported in the study of [Bly et al. \(2020\)](#) in which the respondents disclosed their beliefs that men belong to midwifery (71.4%) and gender does not affect the quality of care (74%).

### **3.2.2. Woman-to- woman care**

Midwifery remains a female territory, largely due to the commonly held belief that in essence, midwifery is about a female relationship. Women seek out a midwife in the hope of building a close and trusting relationship with another woman. Further, according to [King et al. \(2017\)](#), one-third of women describe their childbirth as traumatic, and between 0.8% and 6.9% develop posttraumatic stress disorder.

It is supported by statements that they prefer women like them. As expressed, “It should be a woman who will assist me during delivery,” “It must be a woman,” “I prefer a woman like me,” and “I will have difficulty if I give birth when assisted by a male midwife.” Even the male participants favor a woman to attend to their wives during delivery stating, “It is not good to see a man performing delivery” and “I choose a woman, if possible, to assist my wife.”

Furthermore, because it was customary to prefer a female to a male midwife, the attitude of not feeling comfortable with male midwives is typically instilled by healthcare professionals. Women did not want a male midwife for a variety of reasons, including religion, culture, acute shame, history of physical or emotional abuse in or outside of a relationship, or just not wanting a man to look at their reproductive parts. The depth of intimate care required for psychological support during a woman’s pregnancy is perceived to be best given by another female. These concerns that stereotypes, gender bias and societal attitudes are stopping men from training as midwives. These perspectives could be a cause behind the disparity between male and female students entering midwifery and nursing courses. This is supported by the high share of employment of women in the health and social sector, with an estimated 67% of the health workforce in the 104 countries analysed being female ([Boniol et al., 2019](#)).

Additionally, because it was customary to prefer a female to a male midwife, healthcare professionals typically instill the perception that working with male midwives is uncomfortable. Women didn't want a male midwife for a variety of reasons, including religion,

culture, great shame, a history of physical or emotional abuse in or outside of a relationship, or just not having a guy looking at their reproductive parts.. The depth of intimate care required for psychological support during a woman's pregnancy is perceived to be best given by another woman. These indicate that stereotypes, gender biases, and societal attitudes are stopping men from training as midwives. These perspectives could be a cause behind the disparity between male and female students entering midwifery and nursing courses.

This is supported by Jones (2017) that healthcare providers should respect the choice of a woman if she prefers a female midwife to provide her care. Moreover, according to Allison, as cited in Shavai and Chinamasa (2015), even though male midwives gained popularity, their acceptance was not unanimous. Some people believed that men do not belong in the birthing room since men did not experience childbirth. Some believed that childbirth is beyond the realm of male expertise.

In contrast, respondents who reported feeling extremely safe when receiving care from male midwives in the Ndola urban zone of Zambia showed higher rates of acceptance (87.1%) than those who reported feeling uneasy, embarrassed, and bashful (39.8%). This suggests that the majority of women do not have any issues with male midwives during labor and delivery. 13 out of 15 participants in Chifubu preferred male midwives because they are stronger than women and can work longer hours by giving the care that the women need, whereas only 2 out of 15 participants in Kavuu said they would prefer a male midwife because he is more consoling and caring and does not shout at women as women do. There won't be any fabricated shortages (Bwalya et al., 2015).

### **3.2.3. Embarrassment**

The respondents have narrated that they feel self-conscious and ashamed to show their body parts to a man other than their husband. Further, the feeling that another man is touching their private parts is unacceptable to them. This is supported by statements of the participants that they do not like because they are men: "I still prefer a woman like me, I feel reluctant because he is a man," "I feel ashamed specially I am giving birth," and "I feel shy and ashamed to show my private parts."

Participants felt that it would be extremely embarrassing for male nurses or midwives to provide or execute personal care. Patients' assessments of their level of shame while receiving care from a male or female nurse about taking off their underwear, talking about personal

hygiene, bathing, delivering a bedpan, checking sanitary pads, talking about sexual activity, and talking about disease varies significantly.

When dealing with some cultures, a male midwife may be unacceptable to the woman, her husband, and her family. This is also comparable to maternity nursing perceived as an unwelcoming specialty to many male nursing students. Perhaps the deepest level of vulnerability in an examination is the genital and pelvic examination. A glimpse into history demonstrates that, until very recently, pelvic examinations in women were handled by women, likely to ensure comfort and privacy all the while preventing improper interactions from men (Balayla, 2020).

### **3.3. Will avail of the services (as long as he performs his duty effectively)**

Participants expressed their willingness to avail of the services of a male midwife when he is the only one on duty and that he will do his work to care for the mother and deliver the newborn safely. This is supported by the following statements of the participants:

- a. Participant 7: “If they have the knowledge and the baby will be safely delivered.”
- b. Participant 9: “It is his job and as long as he is licensed, I will agree to be attended by a male midwife.”
- c. Participant 14: “There is nothing wrong if a man will be attending my delivery, I do not even have the chance to choose especially on an emergency situation and my baby is delivered safely.”

Surprisingly, even some of the male participants agree with a male midwife if he can perform his task during delivery: “It does not matter if he is a man as long as he will be able to do his job and my wife and baby are safe.” Competency of the healthcare providers, effective communication, mother’s active participation during delivery, high gestational age, and normal vaginal delivery are the most important factors associated with a positive childbirth experience (Zamani et al., 2019). Perhaps, this is the time to recognize the profession of midwives for men and women who can perform the tasks as lifesavers and life-changers and carry on alongside women to achieve reproductive and sexual health.

## **4. Conclusion**

Midwifery is still a female-dominated profession. Although male midwives are perceived as professionals and well trained, women still prefer female midwives and express their doubts



about the capability of men to provide for care, especially during delivery and childbirth. Women express a feeling of embarrassment on showing their body to a man other than their husband or partner. On the contrary, their willingness to avail of men's services depends on whether they can perform and provide quality care.

The context that midwifery is absolutely for women has long been embedded since ancient history. To cultivate acceptance, male midwives ought to develop trusting relationships with their clients, which will in turn result in confidence, cooperation, and unguarded faith from expectant mothers. The cultural complexities and personified concepts of perspectives of society have created a progressively multifaceted psychoanalytic intersubjective ground. Cultural, class, racial, and familial dimensions of experiences can never be disconnected in the analytic relationship of communal beliefs and standards, moral laws, and norms. Embarrassment, as one of the main reasons for non-acceptance because of being ashamed to show one's body to another man other than her husband, is anchored on cultural roots and is linked with a deep understanding of social flourishing. A deeper study then on culture, familial dimensions, and personal experiences may be undertaken, as this is the limitation of the present study.

The following recommendations are based on the different findings and conclusions of the study. These are addressed to people and institutions that can help enhance the value of male midwives in society. The DOH and LGUs may increase the presence of male midwives by hiring them in different health facilities. The *Midwifery Journal* should regularly publish the accomplishments, capabilities, and good qualities of male midwives, and copies should be distributed to mothers and all health facilities. The Integrated Midwives Association of the Philippines should encourage male midwives to become regular members of the organization. This may eventually help them be well known and accepted in the healthcare profession. The Commission on Higher Education and HEIs may go over the midwifery program to provide equal training opportunities to all students, develop a climate of acceptance, and enable career development of male students.

### **Author Contribution**

Conceptualization, methodological framework, and analysis was done by Marlou R. Savella. Data collation, review and editing was done by Glicerio A. Savella.

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## **Conflict of Interest**

The authors have no conflict of interest to declare. The research has undergone review and approval by the Ethics Review Committee of the University of Northern Philippines.

## **Short Biography**

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