Acceptability of Male Midwives in Ethiopia : Findings of a National study

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Acceptability of Male Midwives in Ethiopia:

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Yeroam Consultancy
Office address: Piassa - Ras-Mekonen Bridge to Afincho-ber Enhas Building G-001,
Tel: +251 -111-117550 (office) +251-30033384 (Mobile)
E-mail: yeroam.consultancy@gmail.com

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LIST OF ACRONYMS

ANC	Antenatal care
CSA	Central Statistics Authority
EDHS	Ethiopian Demographic and Health Survey
EMA	Ethiopian Midwifery Association
EC	Ethiopian Calendar Year
FGD	Focus Group Discussion
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
FP	Family Planning
HC	Health Center
HRD	Human resource Directorate
HRH	Human Resource for Health
HSDP	Health Sector Development Plan
IUCD	Intra-Uterine Contraceptive Device
Gyn/Obs	Gynecology and obstetrics
KII	Key informant interview
L&D	Labor and delivery
MDG	Millennium Development Goal
MNH	Maternal and Newborn Health
PNC	Postnatal Care
RHBs	Regional Health Bureaus
SNNP	Southern Nations, Nationalities and Peoples Region
SPSS	Statistical Package for Social Sciences
SRH	Sexual and Reproductive health
TBA	Traditional Birth Attendants
UAE	United Arab Emirates
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
WHO	World Health Organization

EXECUTIVE SUMMARY

Objectives and Methods: The objective of this study is to assess acceptability and retention of male midwives in Ethiopia. The study was a national study and it was implemented in all the nine regional states and two city administrations and used both qualitative and quantitative data collection methodologies..

Overall the study was conducted in 40 health facilities (18 hospitals and 22 health centre), 30 Woreda health offices and 25 Midwifery training institutions. In addition data was collected from 11 RHBs, FMOH, UNFPA and Ethiopia Midwifery Association (EMA). Exit interview was conducted with 401 women attending MNH service at forty health facilities. In addition 13 FGD sessions were conducted with 90 women attending MNH services. Key informant interviews were conducted with 110 stakeholders (4 Federal stakeholders, 25 tutors of midwifery schools, 11 RHBs, 40 facility heads, 30 Woreda health office representatives). FGD and KII was conducted with 75 male and female midwives. In addition FGDs and KIIs were conducted with 34 male partners of MNH clients and 11 community representatives. HRH related secondary data was obtained from Woreda health offices and training institutions using structured checklist. In addition five case studies were developed.

Key informant interview and Focus group discussion tape records were transcribed and thematic content analysis was done using Atlasti-5.0. Quantitative data was analyzed using SPSS. Data from various sources were triangulated to outline key findings, conclusion and recommendations.

Key findings: About half (48%) of women prefer to be attended by female midwives during labor and delivery. Women were more sensitive to provider's gender especially for IUCD insertion, labor and delivery services.

Women from rural area, pastoralist communities and Muslim Women were more likely to prefer for female providers (midwives) than their counterparts. Acceptability of male midwives vary among the different regions. Women in Somali, Oromiya and Afar were more likely to prefer a female provider during labor and delivery. Most women identified culture values and social norms as a factor that influence women's attitude towards male midwives.

Though most mothers prefer to be attended by a female midwife/provider it doesn't necessarily translate to their action to refuse male midwives. It is only about ten percent of mothers reported that they will refuse labor and delivery service from a male midwife.

Few stakeholders reported instances where male midwives became barriers to MNH care especially in pastoralist and Muslim communities. In addition, 12% of women believe that male midwives could be barriers to institutional delivery.

Key informants (midwives and facility heads) reported that, during the instances where mothers refuse to be attended by male midwives, usually the husband or

companion family members will be counseled and women get convinced to eventually accept services of male midwives. Few facilities reported that when women refuse the services of male midwives they automatically give them the option to be attended by a female midwife.

Most male midwives are happy being a midwife and expressed their satisfaction in caring for two lives 'the mother and the newborn'. However, male midwives have some concerns that includes the fact that Midwifery as a profession is not well known among community, a perception that midwifery is a female's career and scope of midwifery is limited to attending labor and delivery. Many midwives also feel bad about the Amharic name 'Awalaj Nurse' used for a midwife which means 'a delivery care nurse'.

Overall there is high turnover of midwives both male and female from facility in rural areas to urban settings and sometimes to private sector (NGOS). Data from Woreda health offices showed 26% of midwives left facilities in 5 years period (2002-2006 EC). Rate of retention and motivation of male midwives is not different from female midwives.

A range of factors influence midwives retention and motivation that includes:-limited educational opportunities to advance their career in midwifery at Bachelors and Master's Degree level; very poor incentive package (low salary, duty hour pay and risk allowance); risk of contamination during attending labor and delivery; stressful nature of the work and high work load.

Lack of adequate educational opportunities for midwives to upgrade their education from Diploma to BSc Degree and then to Master's Degree in midwifery related fields has forced some midwives to change their profession to clinical nursing, public health and other health and non-health related fields.

Data from 25 training institutions showed that male students constitute more than fifty per cent for BSc Degree level training programs under FMOE. On the other hand male students constitute less than a third of the Diploma level midwifery training programs.

Enrolment to BSc Degree level training programs of midwifery schools under universities of FMOE has been largely by assignment. The assignment process doesn't seriously consider gender and interest of students which let males dominate the training program. While the Diploma level training programs under RHBs enrolls students with competitive application process which needs interest, competence and gives priority for females. Therefore, females take lion's share of students enrolled to regional college's midwifery training program.

According to the data from 25 midwifery schools, majority of faculty members were male (79%). Midwives constitute less than a fifth (16%) of the tutors and of this majority were males.

Recommendations: Addressing issues related with less acceptability of male midwives and retention of midwives needs multi-pronged interventions at all levels:

FMOH needs to develop standardized directive on how to address mother's preferences for female or male midwives including how to treat mothers who refuse services from male midwives.

EMA and FMOH need to enhance the Media campaigns and awareness creation sessions conducted at national level and training institutions to promote midwifery profession.

Regional Health Bureaus should map communities in their region based on potential acceptability of male midwives particularly rural and predominantly Muslim and pastoralist communities and seriously consider deploying female midwives where male midwives are not accepted.

RHBs need to develop and implement incentive package (salary, duty pay, risk allowance) that attract and retain midwives.

Health facilities should use standardized clients gender preference management protocol that ensure women's preferences for male or female providers are properly entertained;

Woreda health offices should implement awareness creation interventions through health extension workers and development armies; community conversation and pregnant mothers' conference sessions;

Midwifery training institutions should make enrolment of students based on interest and give priority for females so as to gradually increase proportion of females at Degree level training programs of Universities under FMOE.

Recruitment of midwifery tutors should strongly encourage female applicants and apply affirmative action to employ more female midwives as tutors in the universities and regional colleges.

Midwifery training institutions needs to create training programs that give opportunities to practicing midwives to upgrade their education from Diploma to Degree and from Degree to Masters level education.

FMOH and development partners' needs to further workout and follow-up implementation of action points outlined above based on the study findings

1. BACKGROUND RATIONALE AND OBJECTIVES

Among the Health Millennium Development Goals, achieving the goal for maternal health (MDG-5) poses the greatest challenge to many sub-Saharan African countries. Ethiopia is one of such countries with high maternal and neonatal mortality. The 2015 target of maternal mortality ratio for Ethiopia is 267/100,000 live births. However, according to EDHS 2011, the maternal mortality ratio stood at 676 maternal deaths per 100,000 live births for the seven years preceding the survey (CSA 2012) the same level reported in the EDHS 2005 (CSA 2006). A number of factors feed the lack of progress towards the set target. Chief among these are the fact that only 15% of deliveries are attended by skilled birth attendants (CSA 2014), the limited access to Emergency obstetric care services and a weak referral system.

Human resources are the most important assets of any health system. For health institutions to function effectively and efficiently, a well-trained, motivated and well-functioning health workforce must be produced, deployed, maintained and appropriately utilized. Ethiopia, like other countries with limited resources, has been suffering from an HRH crisis. In recognition of this, Ethiopia's Federal Ministry of Health developed an HRH strategy as a first step to addressing health workforce challenges and developing the health workforce strategy of the country (FMOH 2009).

There has been remarkable effort to address human resource for health crises in Ethiopia the past decade where there has been significant scale up of health workers pre-service and in-service trainings. The country has significantly scaled up production of health workers where HRH gap has been nearly closed for some health cadres such as nurses while there is still a lot to do for others such as Medical Doctors and Midwives (FMOH 2013).

Maternal and Child health is at the center of the Ethiopian Health policy and HSDP IV. Federal Ministry of Health in its Human Resources for Health Strategy has set a target of training 8,635 midwives by the year 2015 to reduce maternal and neonatal mortality and morbidity and achieve Millennium Development Goal number 4 and 5. Currently Ethiopia has achieved MDG 4 but a lot of work needs to be done to achieve MDG 5 (FMOH 2011).

Midwives are frontline workers that give care and support during pregnancy, labor and post -partum period benefiting not only the client and her immediate family but all members of the society and contributing to the country's human and economic development. They also provide other sexual and reproductive health services such as family planning. According to the State of the World Midwifery Report 2014, there are four domains which should be considered when providing midwifery services: Availability, Accessibility, Acceptability and quality of services. In most countries including Ethiopia, data on women's perception of midwifery care are scares and there is need for more robust research in this area. Issues of acceptability are strongly linked to both service users and health workers themselves. For midwives to be effective, they have to be culturally accepted and respected in the community in

which they work. This will ensure high uptake of sexual reproductive maternal and neonatal health services (UNFPA & WHO 2014).

The occupational role of the midwife is timeless in history. It emerged from the experience of being "with women" for childbirth, as a simple act of caring and compassion, that characterized the way of women regardless of culture or time. Midwifery as a profession has its origins in the 17th Century when European countries such as Sweden, France, Belgium and the Netherlands began to acknowledge that traditional attendants at birth required specialist education, assistance in skills development and appropriate supervision. Other European countries such as the United Kingdom, eventually followed suit later in the 19th and early 20th Century, educational opportunities opened for women. Midwifery institutes opened throughout Europe and, by extension, to developing nations. In ancient times; midwifery remained women's exclusive domain. Generally the midwife was a senior woman in the community, married or widowed who had given birth. In early 20th century some few countries started training male midwives. Midwifery 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. Male midwives are rare in most countries accounting less than 2% in countries like USA and France (Diana and Mavis 2008, Nicopoullus 2003).

Some argue that the overwhelming presence of men in obstetrics demonstrates the social acceptance of men in childbirth. 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 etal 2006).

Studies in developed countries documented refusal of care by a male midwife as high as 45%. For example in a study done In London, 17% of mothers booking at the Whittington Hospital and 15-45% of those booking at the City of London Maternity Hospital objected to male midwives. For inpatients, the rejection rates were 17% and 20% respectively. In another study in Scotland, only 57% said that the sex of the midwife made no difference to them, while 39% found the idea of a male midwife unacceptable to varying Degrees (Lake & Bramwell 1982).

Considering the issue of male midwife as a dilemma to gender equality, service quality and non-acceptance of a male midwife by women as a potential barrier to service access few studies explored acceptability of male midwives and factors influencing their acceptance. Some studies in Africa documented acceptability as high as 73 % (Chilumba J 2011). These studies also identified a range of factors to influence acceptability of male midwives that include women's economic and educational status; her value to socio-cultural believes; her previous experience with a male

midwife; male partners attitude to male provider as well as other socio-cultural and religious factors (Chilumba J 2011, Diana and Mavis 2008).
Though there is much reservation on male midwives among the wider community in both developed and developing world considering midwifery as "woman-to-woman" care some argue that the issue of gender fades if the male midwife provide care that exhibit quality and meets woman's expectations (Chilumba J 2011; Kennedy etal 2006). 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 (Kennedy etal 2006).

Ethiopia is one of the countries that have been training male midwives. According to 2012 Ethiopian Midwifery Association data base, Ethiopia had 1,063 male midwives and they constitute 30 percent of the midwifery workforce. In addition there were 7,767 midwifery students registered in both universities and colleges of which 2279 (29%) were males. There are some regions who are training female midwives only as this is culturally accepted (FMOH & UNFPA 2012).

Though there are no nationwide studies in Ethiopia, there are concerns on acceptability of male midwives among community and its role as barrier to MNH care access. There is also a belief and perceptions that after graduation male midwives like to work in managerial positions and not necessary provide maternal and neonatal health services and even those in training institutions do not like to instruct students in the clinical setting. Therefore this study was conducted to assess acceptability and retention of male midwives in Ethiopia (See Conceptual framework of the study as Annex Fig 6.1).

Objectives of the study
The study is intended to obtain reliable and relevant data on the acceptability of male midwives in Ethiopia and retention of male midwives the MNH service delivery outlets

Specific objectives of the assessment

- To gather information on how male midwives perceive their profession;
- To determine the proportion of male midwives who continue to stay in the service provision area
- To gather information on the numbers of male and female student midwives at high education training institutions undergoing Diploma, BSc and MSc programmes;
- To determine the number of female midwife tutors/instructors versus the number of male tutors/instructors in the training institutions;
- To identify the perception of antenatal , intra and postnatal clients and their partner towards male midwives;

- To gather information on community perception of male midwives and factors influencing their perception including the social, cultural, economic, religious, educational, parity and place of residents of community members.

2. METHODOLOGY AND APPROACH

2.1 Data collection methods, instruments and data sources

The study used both qualitative and quantitative data collection methodologies. The study was a national study implemented in all the nine regional states and two city administrations. Overall the study was conducted in 40 health facilities (18 hospitals and 22 health centre), 30 Woreda health offices and 25 Midwifery training institutions. In addition data was collected from 11 RHBs, FMOH, UNFPA and Ethiopia Midwifery Association (EMA) see list of study sites annexed as Table -1.

Data collection was conducted by a team of ten professionals (Master of public health and MA) with ample experience in qualitative and quantitative research. Two senior researchers trained data collectors on the study objectives, methods of data collection and data sources. In addition the two senior researchers supervised and coordinated data collection.

Data collection instruments were developed through a review of literatures and brainstorming exercise with the research team. The draft data collection instruments were reviewed by UNFPA and FMOH and feedbacks were duly accommodated. Finally the data collection instruments for client exit interview and Key informant and Focus group discussion guide was tested at Yekatit 12 Hospital and Arada health center in Addis Ababa and refined based on the findings from field testing. The following data collection instruments were used in the study:

- KII guide for stakeholders
- KII interview and FGD guide for male and female midwives
- KII and FGD guide for MNH/SRH clients, partners and community representatives
- MNH/SRH service clients exit interview questionnaire
- Case study guides

- Checklist to review training institutions and heath sectors data base

The following qualitative and quantitative data collection methodologies were used to collect qualitative and quantitative data:

Key informant interview with key stakeholders: In-depth interviews were conducted with stakeholders using key informant interview guide with respondent-specific themes. A total of 110 key informants were interviewed: four national stakeholders (1 FMOH-HRD, 2 UNFPA and 1 EMA), 11 RHBs, and twenty five Midwifery Schools / department heads. In addition thirty Woreda health office heads/MNH focal person and forty facility heads/MNH focal person were interviewed (see Table -2 annexed).

Key Informant interviews and FGD with Midwives: key informant interviews was conducted with male and female midwives in 40 health facilities selected from all the nine regions and two city administrations. In addition three FGDS were organized with male and female midwives at Addis Ababa, Harar and Gondar towns. A total of 75 midwives were participated in the KII and FGDs.

Focus group discussions and key informant interviews with MNH service clients their male partners and community representatives: Thirteen FGD sessions has been conducted with mothers attending sexual and reproductive health, ANC, labor & delivery and PNC services in hospitals/health centres selected from the nine regions and one city administration. FGDs were organized with MNH/SRH clients at Debrebrhan, Woreta, Wukro, Kofele, Gelemso, Sekoru, Wolayta Sodo, Pungido, Bambasi, Dubti, Degehabour, Harar and Addis Ababa town. In each FGD there were around 6-8 MNH clients participated and a total of Ninety MNH clients participated in the thirteen FGD sessions.

Four FGD sessions were organized with male partners of MNH clients at Debrebirhan (representing agrarian and predominantly Christian communities), Gelemso

(representing agrarian and predominantly Muslim communities), Jinka-South Omo (representing Chirstian Pastoralist community) and Dubti town (representing Muslim Pastoralist community).In addition nine key informant interviews were conducted with male partners at Dejen, Worota, Kola Temben, Wukro, South Omo-Jinka, Bambasi and Pugnido Woredas. A total of thirty four male partners participated in the study.

Eleven key informant interviews were conducted with community representatives at Diredawa, harar, Dejen, Enderta, Wolyta Sodo, Dila, Jinka, Dubti, Fafem Bambasi and Pugnido Woredas. Community representatives includes religious leaders, women representatives and community leaders.

Exit-Interview with MNH care clients (Cross-sectional survey): A total of 401 Mothers Exiting ANC, Labor & Delivery, PNC and FP services in the health facilities were interviewed using structured questionnaire. In each of the 40 health facilities selected for the study 10 mothers were randomly selected and interviewed using structured questionnaire up on exit from the service outlets (See Table- 1 annexed).

Case Study: Five case studies have been developed from interviews with four male midwives career experiences and an MNH client attended by male midwives (See case studies annexed).

Review of Secondary data: Data base of 25 training institutions was reviewed using structured checklist to document students enrolment trends over five years period (2002-2006 EC) and Tutors profile desegregated by gender (see list training institutions annexed as Table -1). Similarly, HRH data base of 29 Woreda health offices was reviewed for the five years period (2002-2006 EC) to determine rate of retention of midwives disaggregated by gender.

2.2. Data collection, organization and Management:

FGD & KII field notes, socio-demographic data sheet, Digital tape records were given the archival number and packed in a heavy duty enveloped and stored under lock in canvas bag. Return from the field all hard and soft copies of data were submitted to Yeroam Senior researcher who led the data collection. Researcher's field note and digital records verbatim from each session of FGD &KII were transcribed into Microsoft Word based on a standardized transcription guideline. Transcripts were thoroughly read to identify recurrent themes and to develop a coding tree. KII and FGD transcripts was coded and analyzed with the assistance of computer aided qualitative analysis software (Atlasti-5.0). A content-driven analysis was used to summarize key findings of the qualitative data along study major themes.

Data from the cross-sectional survey - exit interview of MNH clients was cleaned, coded and fed to SPSS. Then descriptive analysis was done to determine rates and ratios along key study variables. In addition bivariate analysis was done to identify determinants of acceptability of male midwives.

Data from review of secondary data at the Woreda health offices and midwifery training institutions was cleaned, coded and fed to SPSS. Data was analyzed to determine retention rate of midwives disaggregated by gender and student enrolment trend over five year period (2002-2006 EC) and Tutors profile desegregated by gender.

Finally findings from client exit interviews, review of secondary data at training institutions and Woreda health offices, key informant interviews and Focus Group Discussion were triangulated and key findings were synthesized in text, tables and graphs. Then conclusion and recommendations were outlined in line with the study questions.

2.3. Limitations of the field work data collection

Major limitation of the study that data collectors/researcher faced during field work were lack of well-organized data base at the Woreda health offices and training institutions.

3. FINDINGS

3.1. Acceptability of male midwives

A total of 401 mothers attending MNH services at 40 health facilities (22 health Centers and 18 hospitals) were interviewed. Two third were interviewed at ANC, labor and delivery, PNC service outlet while 29% were interviewed at family planning and other SRH services outlet. Sixty one percent were from urban community and the rest were rural residents. Majority (62%) were Christians and the rest were Muslims. About a third (38%) of women were illiterate and the rest majority had some literacy (Table-3).

Table-3: Socio-demographic characteristics of MNH clients interviewed (N=401)

Socio-demographic characteristics	Frequency	Percent
Health Facility Attended		
Health Center	219	55
Hospital	182	45
Service outlet interviewee recruited		
ANC	170	42
Labor and Delivery	28	7
PNC	87	22
FP & other SRH services	116	29
Age		
≤19 years	49	12
20-24 years	117	29
25-29 years	143	36
30-34 Years	50	12
>/=35 years	42	10
Residence		
Urban	243	61
Rural	158	39
Religion		
Christian	250	62
Muslim	151	38
Educational status		
Illiterate	152	38
Elementary Education (Grade 1-8)	123	31
High School (Grade 9-12)	77	19
Certificate/Diploma/Degree and above	49	12
Household monthly income		
</= 500 birr	114	28
501-1000 birr	106	26
1001-2500 birr	104	26
>2500 birr	77	19

Of 401 mothers interviewed at MNH/SRH service outlets in the 40 health facilities, majority (59%) were attended by midwives. About 18% of mothers were attended by Male midwife and 41% by female midwife while the rest 41% were attended by nurses (31%) Medical Doctors and health officers (10%). Overall a third (33%) of MNH services was provided by a male provider (Fig 3.1).

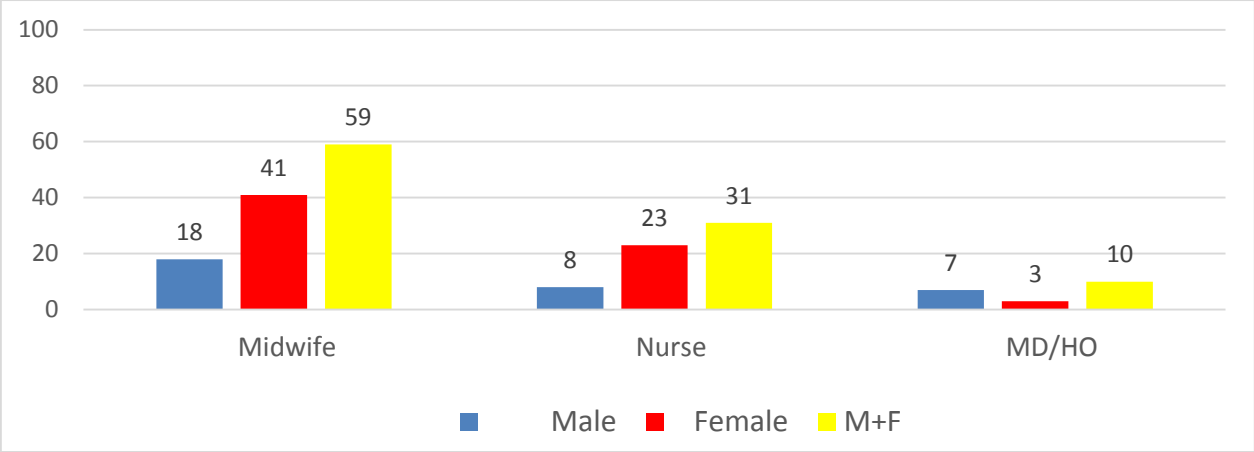

Fig 3.1: Women response of the service provider profession and gender who attended to them during their visit at date of interview (N=401)*

Of the 401 mothers interviewed 334 mothers (83%) ever had child birth. Of this 334 mothers who ever had child birth 227 mothers (68%) reported that their last child birth was at the health facility and the rest 107 (32%) reported that their last birth was at home. Of the 227 mothers who delivered their last baby at the health facility 41% of mothers reported that midwives assisted them at their last delivery in fact about 15% reported that male midwives assisted them during their last delivery. However, half of these women reported that they didn't know the profession of the provider.

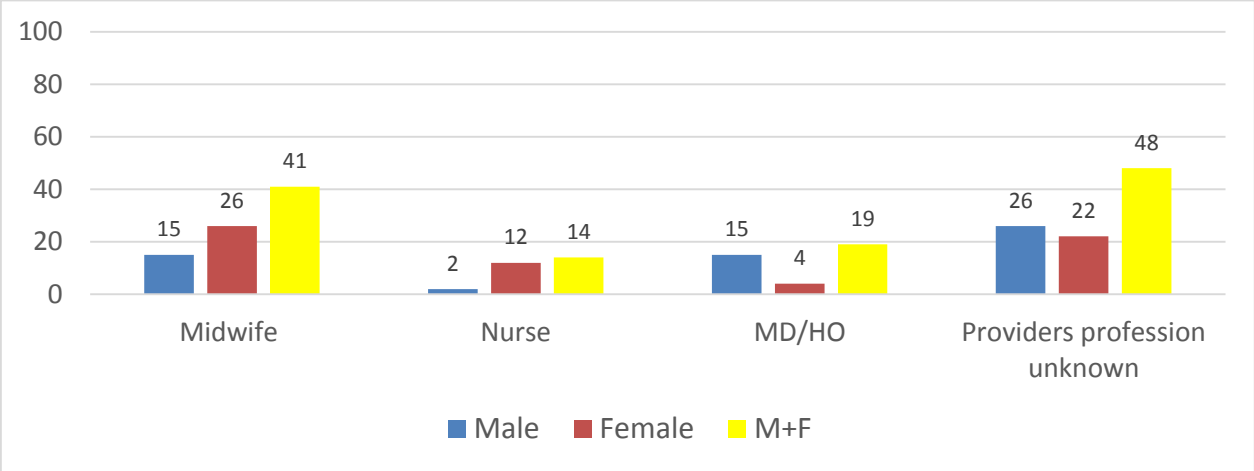

Fig 3.2: Proportion of Women who had been assisted at the health facility during their last birth disaggregated by service provider's gender and profession (N=227).
*Note that percentage don't add up to 100% because some of the mothers reported two or more health professionals who assisted them

Of the 334 women who had child birth 162 (48%) women reported that they were assisted by male service provider during labor and delivery where majority (84%) were comfortable or did not see any difference in the service received from a male provider. While 16% of the women reported feeling discomfort or were shy or afraid of the service they received from a male provider.

A total of 260 mothers reported ever receiving at least one MNH/SRH service (ANC, PNC or FP) from a male provider and majority (85%) reported being comfortable or neutral of a service received from a male provider while only 15% reported feeling discomfort of shy of the service they received from a male provider.

The 401 women were asked if they have preference for providers gender when they come for MNH/SRH services and half (48%) of mothers reported that they prefer to be attended by a female providers (Midwives). While 39% of mothers reported having no preference for providers gender and a tenth (13%) of the women reported that they prefer a male provider. Women were more sensitive to provider's gender during labor and delivery as compared to other services where majority (51-58%) of women have no preference on provider's gender for ANC, PNC, FP and other SRH services (See Fig 3.3).

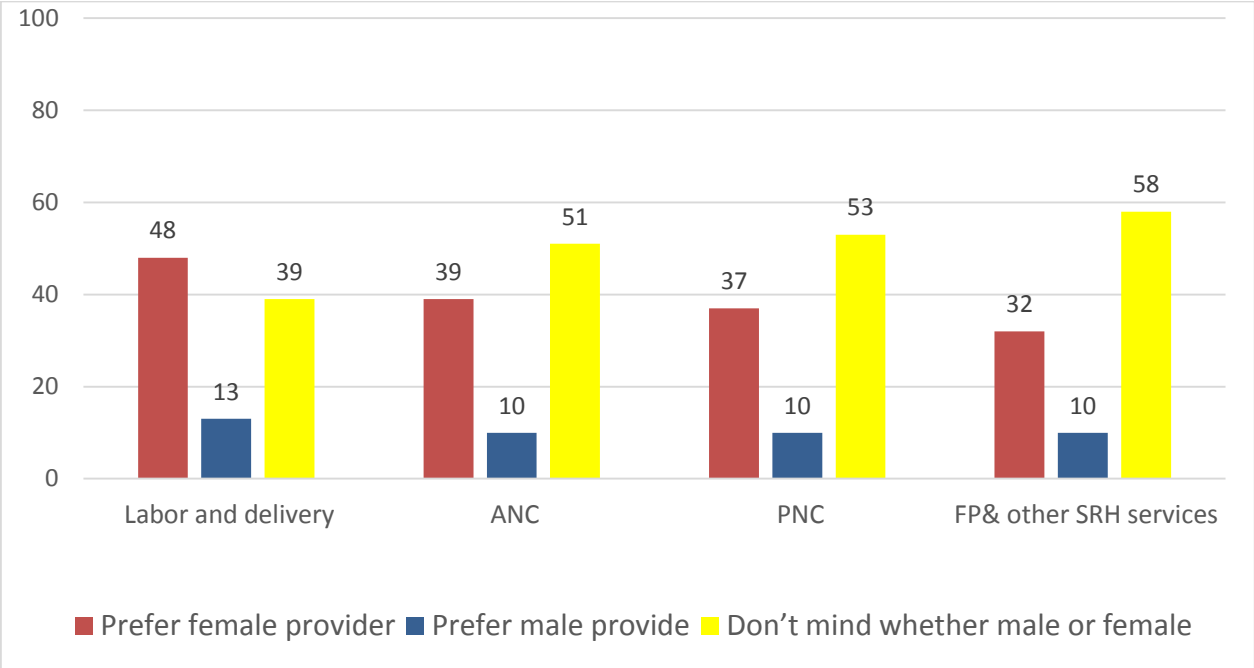

Fig 3.3: Women preference on provider's gender when they came for MNH and SRH services (N=401)

Even though majority of the 401 mothers interviewed prefer to be attended by female provider/Midwife when asked what they would do if male midwife is the only option available to provide them labor and delivery service, only 10% of women said they will refuse the service of the male midwife. Similarly majority of women reported their willingness to be attended by male midwives for ANC service (94%), PNC service (95%), FP & other SRH services (95%).

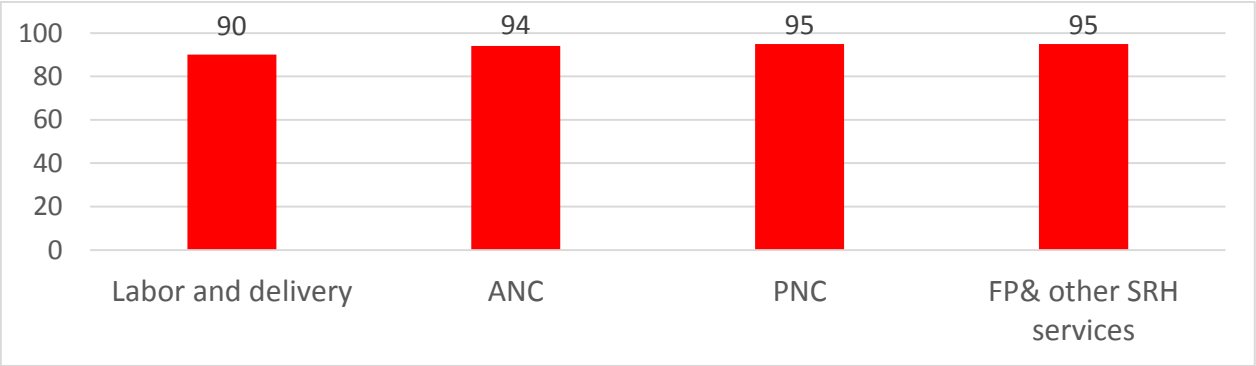

Fig 3.4: Proportion of Women who reported to be willing to be attended by male midwives if male midwife was the only option available for different MNH

Nearly half (47%) of the women reported that women in their community have preference on provider's gender (prefer female providers). They also reported that women in their community are more gender sensitive especially for labor and delivery service. Women were asked if they would recommend male midwives for their friends and a quarter (25%) of the women reported that they wouldn't recommend male midwives to attend their friends. Moreover, 12% of women believe that male midwives could be barriers to institutional delivery. When asked about the reason why women prefer female provider during MNH especially labor and delivery services; most women mentioned cultural values and social norm (60%) as reasons while the rest mentioned religion (26%), male partners attitude (7%) and women past experience with male provider (8%) as reasons for women's preference for a female provider.

The study examined factors influencing acceptability of male midwives or provider among women. Women preference on provider's gender when they came to labor and delivery services was taken as a parameter to determine acceptability of male midwives. Women from rural areas, pastoralist and Muslim communities were more likely to prefer female midwives assisting them during labor and delivery as compared with urban women and Christian women ($P < 0.05$). However, women past labor and delivery experience, age and household income showed no statistically significant association with women preference for female or male midwives ($P > 0.05$).

Table-4: Women preference on provider's gender when they came for labor and delivery services disaggregated on their socio-demographic profile (N=401)

Determinants	Prefer female provider	Prefer male provide	Don't mind male or female	P -value
Region				
Addis Ababa	17	30	53	
Afar	48	19	32	
Amhara	46	8	46	
Benishangul	24	7	69	0.000
Diredawa	35	15	50	
Gambella	21	5	74	
Harar	60	5	35	
Oromiya	61	13	27	
SNNP	60	12	28	
Somali	97	0	3	
Tigray	30	23	48	
Residence				
Urban	39	17	44	0.000
Rural	60	7	33	
Community livelihood				
Pastoralist	75	8	17	0.000
Non-Pastoralist	43	14	43	
Religion				
Christians	39	14	47	0.000
Muslims	62	10	28	
Educational status				
Illiterate	63	8	30	
Elementary (Grade 1-8)	46	13	41	0.000
High School (Grade 9-12)	34	18	48	
Diploma/Degree and above	27	18	55	
Age				
≤19 years	57	6	37	
20-24 years	44	16	40	
25-29 years	48	13	39	0.623
30-34 Years	48	16	36	
>/=35 years	48	7	45	
Household monthly income				
</= 500 birr	43	14	43	
501-1000 birr	57	11	32	0.444
1001-2500 birr	46	10	43	
>2500 birr	45	16	39	
Parity				
Premi-Para	44	16	40	
Multi- para	47	13	40	0.500
Grand multi-para	60	7	33	

Acceptability of male midwives vary among the different regions. Women in Somali, Oromiya and Afar were more likely to prefer a female provider during labor and delivery. On the other had majority of women from Tigray, Benishangul Gumuz, Gambella and Dire Dawa reported that they don't mind if the provider assisting them during labor and delivery is a male or a female. Interestingly significant proportion (30%) of women in Addis Ababa reported that they prefer to be attended by a Male midwife (P=0.00).

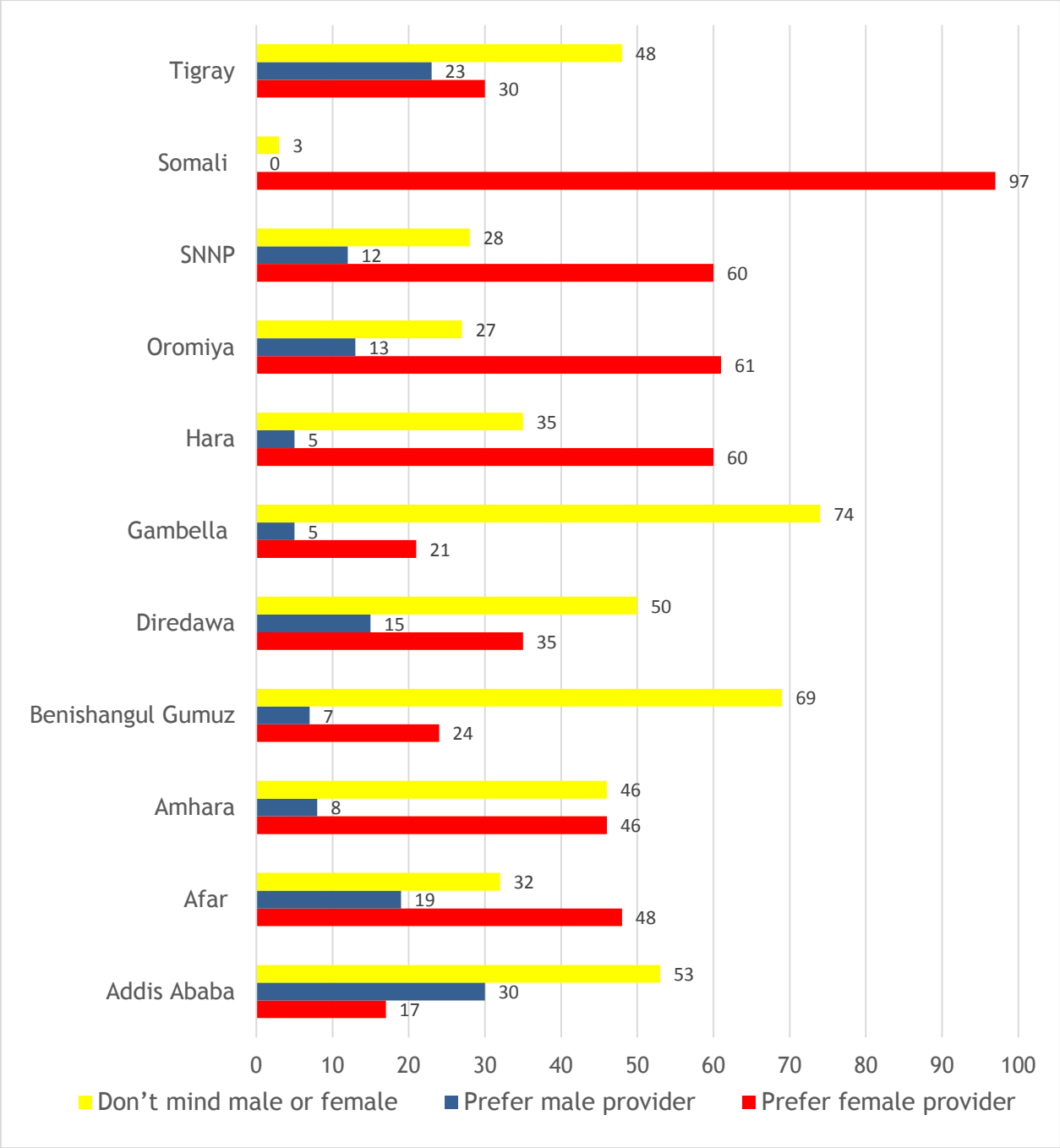

Fig 3.6: Women preference on provider's gender when they come for labor and delivery service disaggregated by Region

Women from rural areas were more likely (60%) to prefer a female provider during labor and delivery as compared with women from urban areas (39%) P=0.00 see figure -3.5.

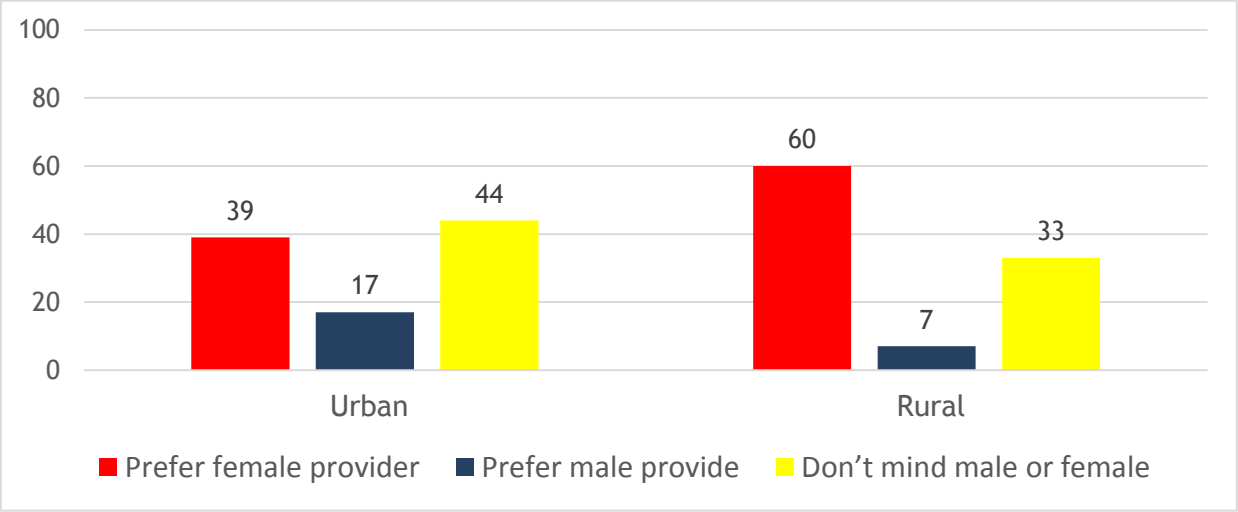

Fig 3.5: Women preference on provider's gender when they come for labor and delivery service disaggregated by urban rural residence

Women from pastoralist community were more likely (75%) to prefer a female provider during labor and delivery as compared with women from non-pastoralist community (43%) P=0.00.

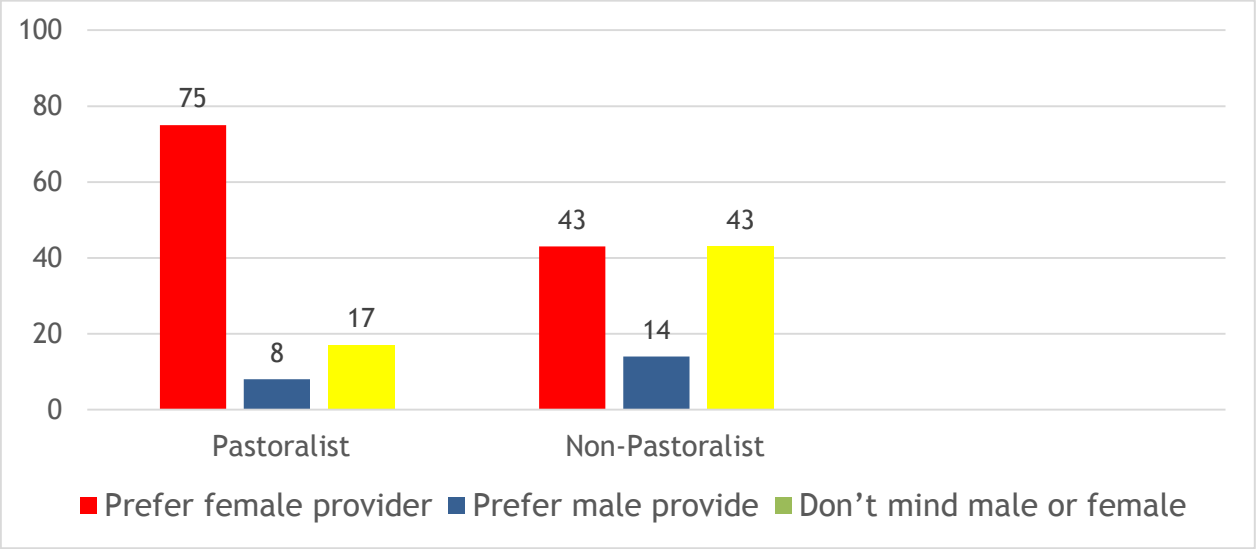

Fig 3.7. Women preference on provider's gender when they come for labor and delivery service disaggregated by community livelihood

Muslim women were found to be more sensitive to providers gender who provide labor and delivery service. Higher proportion (62%) of Muslim women were reported to

prefer female provider when they came for labor and delivery service as compared to Christian women where only 39% expressed preference to female provider (P=0.000).

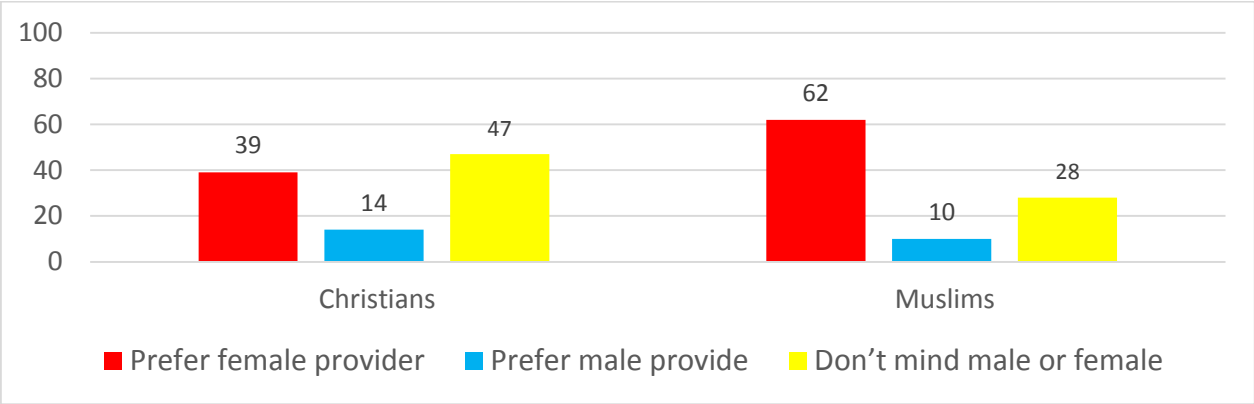

Fig 3.8: Women preference on provider's gender when they come for labor and delivery service disaggregated by religion

Women's literacy was found to influence her sensitivity to provider's gender. The more educated the women the less sensitive she becomes for providers gender. Higher proportion (63%) of illiterate women expressed preference for female provider when they came for labor and delivery as compared to women who had a Diploma or Degree level education (27%) P=0.000.

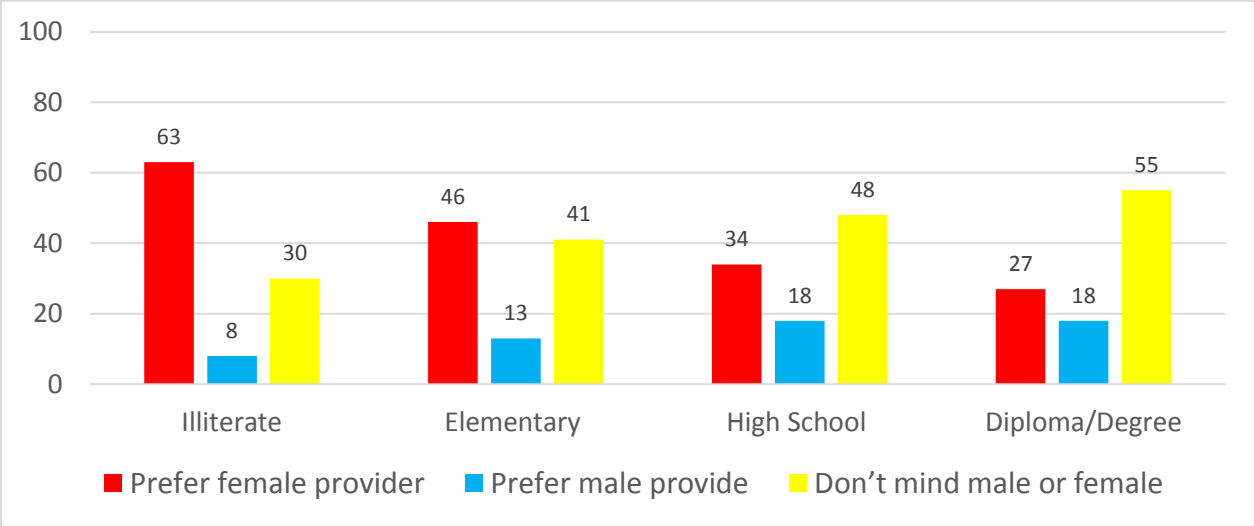

Fig 3.9: Women preference on provider's gender when they come for labor and delivery service disaggregated by women's educational status

Though there were five variables (Region, urban-rural residence, pastoralist livelihood religion and Education) that showed statistically significant association with women's preference for female providers during labor and delivery on bivriate analysis, it's only two of the five variables (Region and urban-rural residence) that continue to have statistically significant association on a multivariate analysis (See Table -5 annexed).

Interestingly, qualitative study (FGD and KII) findings were consistent with the survey data results. Interviewed key informants at RHBs, Woreda health offices and facility level as well as FGDs with clients and Male Midwives anonymously reported that mothers generally prefer female provider to assist them during MNH care services. Majority of the key informants and FGD discussion participants believe MNH care is a women to women care.

> A women attending MNH care service at Kofele Health Center in the FGD said "*Most of us prefer female health providers...we just feel scared to be seen by a male health provider....we feel more comfortable to openly discuss our health problems with the female health workers*". Similarly, a male midwife at Assosa hospital also said *"some mothers feel female providers would share and feel their pain and problems better than the males. Because they have the same sex and may have the same experience"*.

Mothers and midwives participated in the study were asked for which MNH care service women are more sensitive about provider's gender and majority of them identified IUCD insertion and labor and delivery services. Women need these services to be delivered by female midwives.

> Head of a Health Center said *"women usually refuse male midwives during labor and delivery as well as IUCD insertion"*. Similarly a women participated in the FGD at Dubiti hospital said *" … ANC since the examination is done only in the abdomen we don't have problem if the provider is male. But for labor and delivery we prefer female midwife*.

However, FGDs conducted with women in Addis Ababa reveled notable difference with women in other regions. Significant proportion of women in Addis Ababa reported that they prefer a male midwife because male providers are caring and disciplined than the female counterparts. Some women reported in the FGDs that the female providers working at labor and delivery services are verbally abusing and mistreating women during labor and delivery.

> A women attending MNH care service Woreda 17 Health Center in the FGD said *"I prefer male provider to assist me during delivery. I have experience with both male and female providers. The males are more caring and tolerant but most female providers insult you and treat you badly especially in MNH services of government health institutions"*.

Discussions with key informants revealed that acceptability of male midwives is low among women from rural area, Muslims and pastoralist communities of Afar and Somali Region. Most key informant interview and FGD participants said rural women feel shy to be attended by male provider. Most also said it is 'haram' prohibited by sharia law for a Muslim women to be naked or show her private parts to a man other than her husband and Muslim women prefer to be attended by a female midwives especial during labor and delivery. Stakeholders, midwives and women participated in the qualitative study in Afar and Somali region said it is culturally unacceptable for women from this communities to be attended by male midwife or provider.

A female midwife at Agaro Health Center said *"Most Muslim women believe that 'Sharia law' do not allow a woman to show her sexual parts to a man including male service providers. Therefore Muslim women don't want services from a Male provider unless she has no any other choice"*. Similarly a Woman participated in the FGDs at Kofele Health Center said *"… in the 'Sharia' law it is totally forbidden for a woman to expose private parts a man other than her husband"*.

Expressing reservation of rural and pastoralist women to services of a male provider, a male Midwife at Dubti Hospital said *"…there is a firm opposition from those who come from rural areas to accept MNH services delivered by male providers especially labor and delivery. Rural women get surprised to see a male midwife. They believe only females are suitable to be a midwife"*.

In addition to the socio- cultural and religious context of women some qualitative study participants identified male partner's attitude as one important factor that influence women reaction to services of Male midwives especially in rural area and among pastoralist communities. Some said as Men in this communities don't approve of services such as labor and delivery to be provided by a male provider it influence their wives views and attitude towards male midwives. Elaborating this a woman participated in the FGD at Degehabur hospital said *"our husbands don't feel comfortable when we are attended by male service providers they prefer if female health professionals examine their wives therefore we just want to make sure that we go with their feelings"*.

FGD with MNH clients showed that most mother's preference for services by female midwives doesn't translate to refusal of services from a male midwives. Most Mothers from rural, Muslim and pastoralist communities participated in the FGDs reported that even though they prefer female midwives they will use services of male midwives if they don't have option. Most feel that the situation of labor and delivery is a life and death issue where a mother don't have a privilege to argue for female provider.

MNH client at Sekoru Health Center said: *"...though it is 'haram', we use services of male providers when that is the only option. I am not going to die refusing the service. We usually say let me give birth and relive the pain then I will confess to Allah"*. Similarly, a Midwife at Asita Hospital said *"….in Afar women don't want to be seen by male providers. At beginning most will refuse male midwives but latter on they will feel that they don't have any other option and when the pressure keeps going they will accept service of the male midwife"*.

During key informant interviews facility heads and male midwives were asked what they do when women refuse services by male midwives and most said women and her accompanying family members will be counseled to accept the service of male midwife if she persisted refusing female service provider is assigned whenever possible. Most said that usually the husband or companion family members will be counseled and women get convinced to eventually accept services of male midwives.

Few providers said when women refuse the services of male midwives they will be automatically given the option to be attended by a female midwife.

> A Male Midwife at Asita said *"there are women who refuse services from us. What we do is we will counsel her and the families accompanied her. Then eventually she will accept and cooperate…we don't let her to go"*. On the other hand head of Woreta health Center said *"rural women are usually afraid of male midwives, when they refuse we assign female midwife or nurse available"*

Though few, there were key informants who shared experiences that illustrate situations where male midwives become barriers to MNH services particularly for rural, Muslim and pastoralist women.

> For example head of Agaro Woreda health office said *"the community in one of our catchment kebele signed petition requesting to replace the male midwife assigned in the Labor ward with female. At this facility the delivery service users was already low and when a new male midwife was assigned to the facility, the number of institutional delivery dropped dramatically. The problem is worse when male midwives are deployed in a facility where female midwives were previously providing service"*. Similarly MNH client participated in the FGD at Woreta Woreda said *"… women do not want to be seen by male providers …because of this unless the labor becomes complicated some Muslim women prefer to deliver at home"*.

Surprisingly Some Male midwives and facility heads in pastoralist communities of Afar and Somali noted that male midwives trained from the same tribe and deployed in the community they came from are less likely to be accepted by women.

> *Head of Degehabur hospital said "When the male midwife is from the same ethnic group the acceptability is very low. When a male midwife from same tribe is assigned in the delivery room the information will instantly reach the community and the institutional delivery will drop dramatically. I remember once I (male midwife) was assigned in the delivery room and I remember that time women started to make home delivery"*.

Though there is consensus on most mother's preference to a female provider especially when it comes to labor and delivery, some male midwives and facility heads argue that gender of the provider will became less concern to a women when male midwives deliver services that satisfy mothers. Some mothers, facility heads and male midwives reported that even though male midwives face some resistance at the beginning if the male midwives is caring, competent and hardworking mothers will accept the service of male midwives overtime. Capitalizing on this a Male Midwife at Awash health Center said *"What matters is the quality of care delivered. If you approach the mothers with passion and provide good clinical care you will be accepted gradually"*.

Even though qualitative study participants have a consensus on the fact that acceptability of male midwives is a notable concern for communities of rural areas, pastoralist and Muslim communities, most KII and FGD participants underscored that

over the years there is an improvement on the acceptability of male providers in general and male midwives in particular. In line with this a Matron at Dubti Hospital said *"some years back there was firm resistance from mothers when they find a male midwife. But nowadays through continuous counseling and discussion, the problem is decreasing"*.

Even though issue of male midwives acceptability has not been well articulated at national or regional levels to design comprehensive interventions, Woreda health offices and facilities serving rural, pastoralist and Muslim communities were implementing some interventions. Mentioning some of the interventions facility heads reported assigning male and female midwives together during both regular working hours and duty hour. For example MCH focal Person at Asaita Hospital said *"Due to the resistance, we assign a male and female midwives for night time and weekend duty shifts"*. Some also mentioned transferring male midwives from areas where there is firm resistance to urban facilities where their acceptability is better.

These key informants also reported community level awareness creation interventions such as educating community members through community conversations, health extension workers house to house education sessions, mother's conferences, and development armies one to five social development activities.

> Head of Degehabour Woreda health office said *"we are working on community mobilization so the community is accepting male midwives"*. Similarly head of Gelemso Woreda health Bureau said *"Now days we are on the way to mitigate the problem of male midwives acceptability using 1 to 5 mothers organization and by giving continuous education by health extension workers. Even if there are remaining works when we compare it from the previous times we have improvement in this issue"*.
>
> Head of Kofele Woreda health office said *"…currently our Woreda has monthly pregnant women conferences in each kebele where we discuss a range of issues that are identified as service barriers. As a result previous misconceptions are now changed related to male midwives and institutional delivery*.

3.2. Male Midwives Perception to their Profession and Retention

Male Midwives participated in FGDs and KIIs anonymously expressed their appreciation to their profession. Most midwives noted that they feel no different being male and working as a midwife from other male health care professionals. Most midwives expressed their satisfaction caring for two lives 'the mother and the newborn'. A male midwife in Harar said "…..*Midwifery is interesting because you are dealing with two souls [The mother and the baby] up to now I am happy*". In line with this a Male Midwives at Gandhi Hospital said "I *am happy for being a midwife. You will become happy when you see a mother get her baby by her side after passing through the stressful laboring process*".

However, some midwives mentioned challenges and concerns they had related with being male and working as a midwife, that includes the fact that Midwifery as a profession is not well known among community, a perception among community and some professionals that midwifery is a female's career and see scope of midwifery narrow and limited to attending labor and delivery. Many midwives also feel bad about the Amharic name 'Awalaj Nurse' used for a midwife which means 'a delivery care nurse'.

Key stakeholders (Woreda health offices and facility heads) and midwives were asked about retention and motivation of midwives in general and male midwives in particular. There is a consensus among the key informants that rate of retention and motivation of male midwives is not different from female midwives. Overall the key informants at Woreda and facility level reported that there is high turnover of midwives both male and female from facility in rural areas to urban settings and sometimes to private sector (NGOS).

Midwives participated in the FGD and KIIs identified a range of factors that influence midwives retention and motivation especially in public facilities that includes:-limited educational opportunities to advance their career in midwifery at Bachelors and Master's Degree level; very poor incentive package (low salary, duty hour pay and risk allowance); risk of contamination during attending labor and delivery services; stressful nature of the work and high work load".

Most midwives capitalized that lack of educational opportunities for midwives to upgrade their education from Diploma to Bsc Degree and then to master's Degree in midwifery related fields is a very serious challenge. Some noted this situation has forced some midwives to change their profession to clinical nursing, public health and other health and non-health related fields. Elaborating this point a key informant at Arsi University said "*Previously there was very limited access to bachelor and*

postgraduate level training in midwifery. Due to this midwifery professionals were forced to study other discipline even those with the interest to continue in midwifery profession. There is actually some improvement in the past few years due to the opening of Bachelor Degree programs in many universities and Master's Degree in few universities. I'm sure majority of midwives will continue in the same field if this opportunity gets more accessible".

Even though most key informants believe that acceptability of male midwives has no any bearing on retention of male midwives, key informants in Somali region consider low acceptability of male midwives play a role in their retention and motivation.

Midwives and facility heads were also asked if male midwives avoid working in labor and delivery wards and prefer other MNH care services because of their low acceptability by women and almost all participants said male midwives are working in all MNH care services as the female midwives including labor and delivery services.

Health human resource (HRH) related data was obtained from 29 Woreda health offices in the 11 Regions to assess rate of retention of male midwives and findings were consistent with the qualitative data. According to the HRH data obtained from the 29 Woreda health offices there are a total of 366 midwives registered working in the 29 Woredas in the five year period from 2002 to 2006 EC. Of the 366 midwives 93 (25%) were Male and 273 (75%) were female midwives.

Out of the 366 midwives were assigned in the 29 Woredas and 87 midwives (20 Male and 67 female) were left or transferred out in the five year period from 2002 to 2006 EC. Overall retention rate of midwives was 76% with attrition rate of 24%. There was no statistically significant difference on rate of retention of male and female midwives (78% Vs 75%).

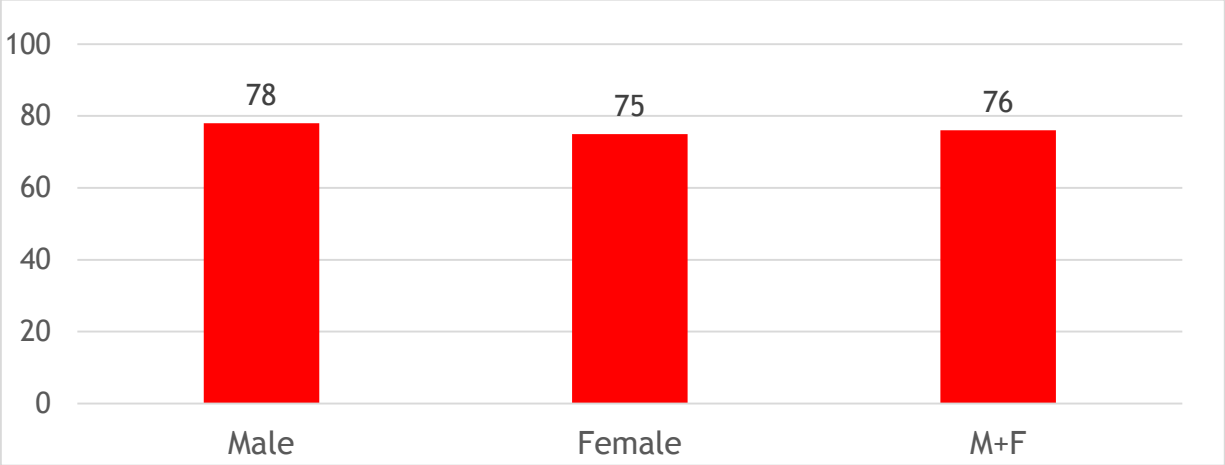

Fig 3.10: Proportion of midwives retained in the MNH care delivery in the past five years disaggregated by Gender

Midwives participated in the study were asked if they have a career plan to continue practice midwifery and out of the 75 midwives who participated in the study 68 (91%) midwives reported to have a plan to continue work as a midwife while the rest 7 (9%) midwives reported that they don't want to continue work as a midwife in the future.

In the 29 Woreda health offices data was obtained on the number of midwives working on MNH clinical service delivery and program management. Out of the 279 midwives currently available in the 29 Woredas only 5 midwives (2%) were working in the program management. Out of the 5 midwives reported to be working on program management three were female and two were male. Similarly, the 75 midwives participated in the study were asked their current place of assignment and 73 (97%) midwives were working in the health facilities MNH service delivery and only 2 (3%) were engaged in public health program management activities at Woreda health office. The above two data sources showed that Majority of midwives are working in actual MNH clinical care delivery and its only 2-3% of the midwives that engage in public health programs where both male and female midwives participate equally.

3.3. Male Midwives and Midwifery Training Program

Student enrolment and tutors data was collected from 25 training institutions. Of these 12 were Universities under Federal Ministry of health, 11 were Health Science Colleges under RHBs and two were private health Science colleges (See Table -1 annexed). Data was collected from 29 training programs (16 Degree level and 13 Diploma level training programs). Note that four colleges (Alkan, Harar, Jijiga and Minilik HSC) had both Diploma and Degree level programs. Looking the data between 2002 and 2006 E.C the number of midwifery students enrolled to the training program has increased significantly from 750 in 2002 to 1816 in 2006 EC.

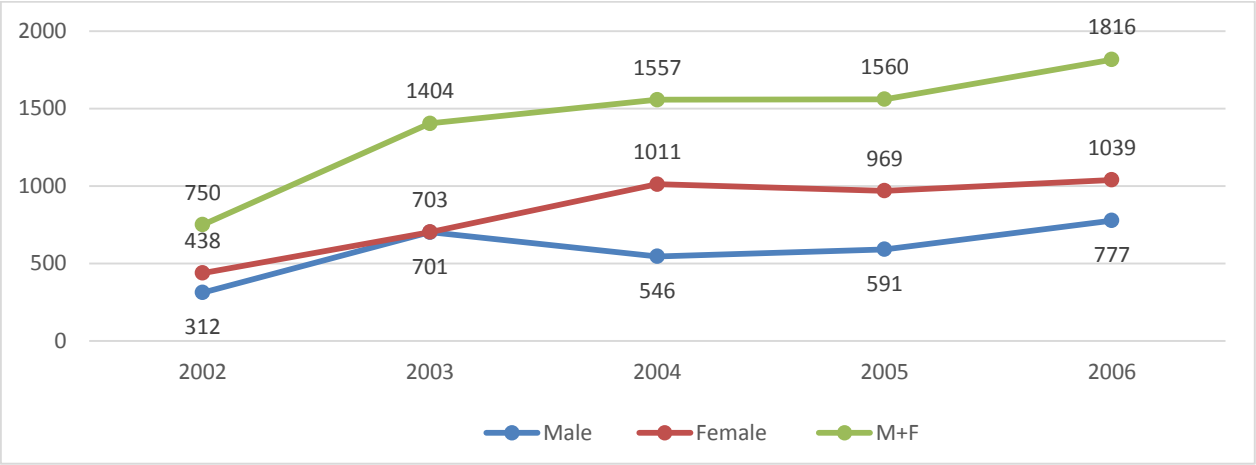

Fig 3.11: Number of midwives students enrolled to Bsc Degree and Diploma level training programs between 2002 and 2006 EC

The increment in the number of students enrolled to midwifery training program between 2002 and 2006 EC was marked for the BSc Degree level training as compared to the Diploma level training program see Fig 3.12 and 3.13 below.

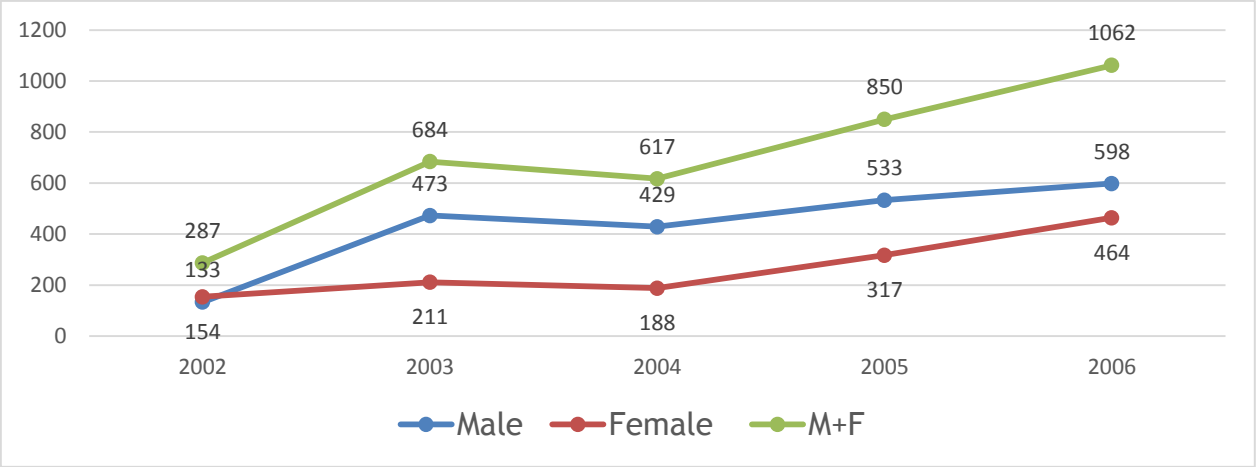

Fig 3.12: Number of midwives students enrolled to Bsc Degree level training programs between 2002 and 2006 EC

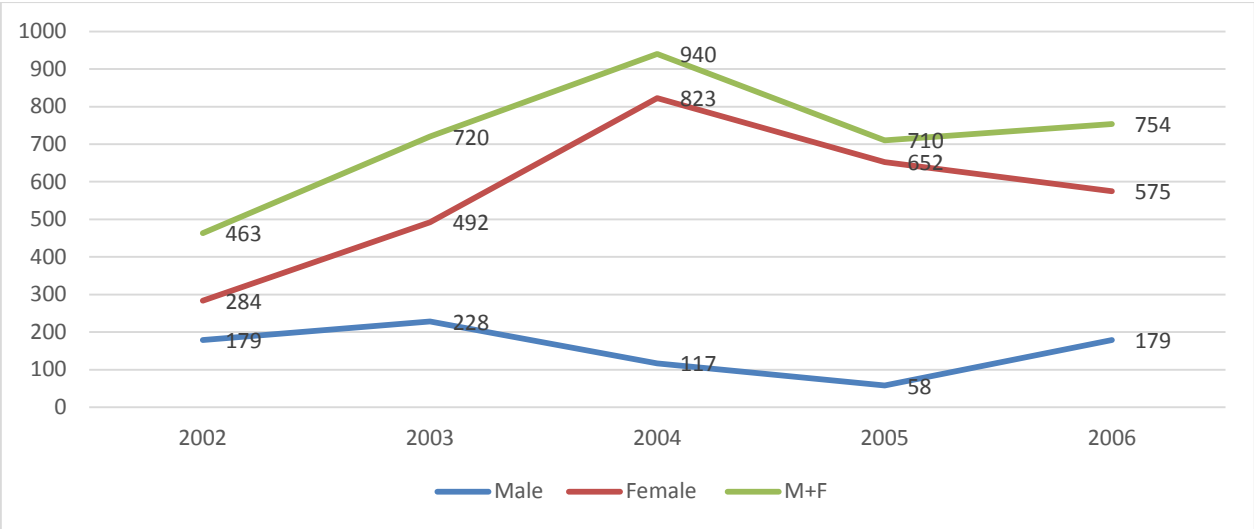

Fig 3.13: Number of midwives students enrolled to Diploma level training programs between 2002 and 2006 EC

Midwifery student's enrolment to Bsc Degree and Diploma level training programs between 2002 and 2006 EC reveled interesting findings on proportion of male students enrolled to Bsc Degree and Diploma level training programs. Overall male students constitute more than fifty percent for Bsc Degree level programs while male midwifery students constitute less than a third of the Diploma level midwifery training program students. Looking at the trend between 2002 and 2006 EC the proportion of Male midwives enrolled to Bsc Degree training program has increased from 46 % in 2002 to 70% in 2004 and 54% in 2006. On the other hand the proportion of Male midwives enrolled to Diploma level training program has decreased from 39 % in 2002 to 8% in 2005 and 24% in 2006 (Fig 3.14).

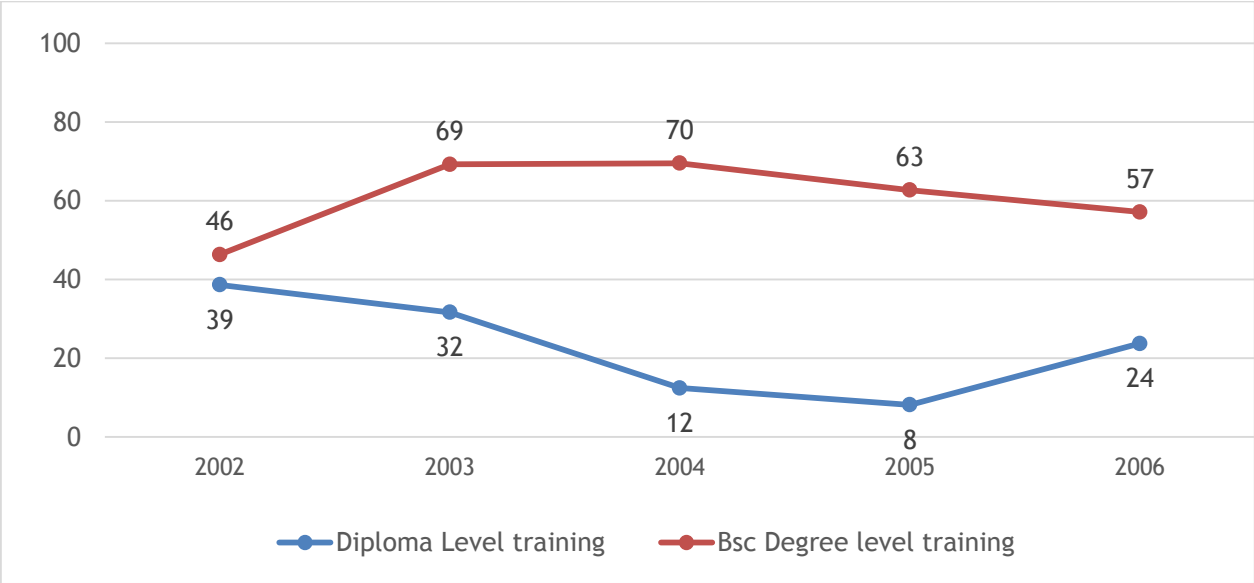

Fig 3.14: Proportion of male midwifery students enrolled to Bsc Degree and Diploma level training programs between 2002 and 2006 EC

Data from the 25 Midwifery training institutions showed that there are 1278 tutors (1015 Male and 263 female). Of these 540 (58%) of tutors were teaching basic science and biomedical courses coming from the respective departments while the rest 538 (42%) were teaching clinical courses and coaching clinical skills where most belong to midwifery department. Of 1278 tutors only 209 (16%) were midwives (Table -5).

Table-6: Number of tutors available to teach midwifery students in 25 midwifery training institution

	Male	Female	Total
Total Number of teaching Staff	1015	263	1278
Total number of staff who teach clinical courses and coach students in clinical settings	383	155	538
Total Number of Staff who are midwives	132	77	209
Total number of staff who teach clinical courses and coach students in clinical settings and who are midwives	131	76	207

Looking on gender of tutors in midwifery schools the data from the 25 midwifery schools showed that the academic staff of the midwifery schools is male dominated. Of 1278 tutors available in the midwifery schools females account only a fifth. Similarly female instructors account small proportion of tutors who teach clinical skills and coach students in clinical settings (Fig 3.15)

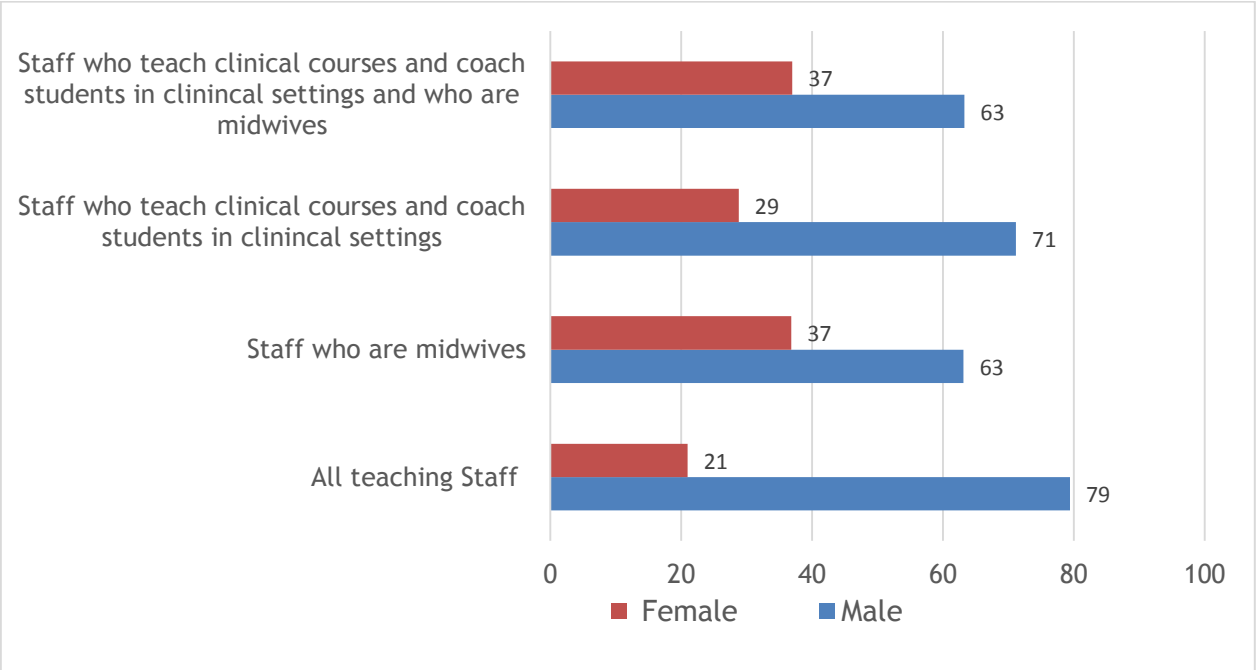

Fig 3.15: Proportion of male and female tutors teaching midwifery students in 25 training institutions

Midwives and faculty of midwifery schools were asked about student enrolment process and the finding shows different enrolment process applied for university level training institutions under FMOE and training colleges under RHBs that mostly train midwives at Diploma level. Midwives and faculty reported that the enrolment to midwifery schools at Degree level training universities has been largely by assignment to the training rather than choice of the students. Most midwives reflected that they were assigned to midwifery school while it was not their primary choice to be a midwife. Most believe that since gender and interest was not seriously considered in the assignment to the training males happen to dominant in the Degree level training program.

Though not joined the training on their choice most midwives participated in the FGD and KII reported that they like the profession once they joined the training. They have noted that they were treated in an encouraging manner by their tutors and have all the privileges as the female students.

Some noted the situation has been changed in recent days due to FMOH, UNFPA and EMA promotion of the midwifery profession through mass media and awareness creation programs held at training institutions and high schools. Midwives and tutors reported that pool of students applying to the department is increasing significantly and recently students enrolled to midwifery department is mostly those who had good score and interest to join the profession.

On the other hand Midwives who graduated from regional colleges and faculty at regional training institutions reported that they enroll students with competitive application process which needs interest and competence. In addition some stakeholders at regional training institutions reported that it is females mostly encouraged and accepted to the training which make majority of students enrolled to regional colleges to be females.

In the Key informant interviews and FGDs midwives and faculty reflected that increasingly high number of students to faculty and case ratio has been a serious challenge to skills training in the midwifery schools that affects the quality of training.

4. DISCUSSION

The mid 70s witnessed growing interest of researchers and health care managers to explore if women had preferences for health care provider's gender. Specifically, many studies examined if women prefer female gynecologists and midwifery care providers for MNH services and most of this studies documented that many women had preferences for female MNH care providers. Therefore, one of the most frequently asked questions in maternal and newborn health care practices today is whether women generally prefer female MNH care providers and how health care organizations respond to this needs (Hill CJ 1991, Elstad JI 1994, Kerssen et al 1997, Amir H, et al 2011, Victor et al 2012 and Audu et al 2014).

Our study aimed to assess acceptability of male midwives in Ethiopia and half (48%) of women participated in the study prefer to be attended by female midwives during labor and delivery. Women from rural area, pastoralist communities and Muslim women were more likely to prefer for female providers (midwives) than their counterparts. Acceptability of male midwives vary among the different regions with different socio-cultural values and contexts. Cultural values and social norms was identified as important factors that influence women's attitude towards male midwives.

Findings of this study is consistent with many studies done in developing countries that endorsed women preference for female MNH care providers and identified religious beliefs and cultural traditions as most important reasons underling women preferences for female providers. For example In 2014 Audu et al found that 59%, of Nigerian women prefer to be attended by female gynecologist, whereas 22% didn't have any sex preference and 19% preferred a male gynecologist. In 2006 Lafta et al. found that 74% of Iraqi female patients preferred female gynecologists, 8% preferred male gynecologists and 18% had no gender preference. In 2005 Bashour et al. reported that more than 85% of Syrian women preferred their obstetrician to be a female. All this surveys demonstrated an association between gender preference and social tradition and religious beliefs. Similarly In 2005, Rizk et al carried out a survey in the United Arab Emirates (UAE) providers gender was one of the important factors women consider while selecting provider attending them at Gynecology and Obstetrics clinics.

Religion particularly Muslim religion, social values and traditional believes were found to have strong influence on women choice of MNH care providers gender in developing countries (Bashour et al. 2005, Amir et al 2011, Audu et al 2014). Muslim modesty (hejab) is described as one of the five pillars of the Islamic faith and includes restrictions on: dress (hair, body, arms, and legs must be covered any time a woman may come into contact with men who are not family members), privacy, the mention

of anything related to bodily functions, direct eye contact with the opposite gender and opposite gender medical care providers, except in cases of extreme medical necessity (Scheinberg AC 2006). Islam clearly demonstrates any interactions between opposite sexes as illegitimate human relationships. Physical contact between members of the opposite sex is strongly discouraged. Societal laws exist to aid Muslims in abiding by this framework. This framework explains why many prefer to see a same-sex clinician, particularly in consultations necessitating examination of the genitalia (Scheinberg AC 2000).

Growing influence of women preference for female health care providers has demonstrated its effect shaping male to female ratio of physicians joining Gynecology and Obstetrics residency training in developed countries where health care system is consumer driven. In the last two decades, the proportion of men who wish to become gynecologists worldwide is decreasing steadily. For example in the US since 1970 the percentage of women pursuing specialty practice in obstetrics and gynecology has more than quadrupled, leaving men in this specialty practice area in the minority (during the period between 1990 and 2001 portion of female Gynecologists (Junior fellows) in the residency program has grown from 44% in 1990 to 67% in 2001 (Jonson et al 2005).

However, in developing countries where the health care system is mainly public financing, effect of women preference for female MNH care providers has not been observable to influence Male to female ratio of candidates joining the midwifery and gynecology training programs. For example our study finding revealed that male students constitute more than fifty per cent for BSc Degree level midwifery training programs under FMOE where enrolment is largely by assignment to the department and active effort to enrollee female students was not a trend. On the other hand training programs under RHBs were more or less actively gearing the training towards women growing need for female skilled birth attendants or midwives. Male students constitute less than a third of the Diploma level midwifery training programs under RHBs which enrolls students with competitive application process and gives priority for females.

Overall this study finding shade light on women preference for female health care providers for services such as labor and delivery or services that involve exposing their private parts. Heading towards client centered care urges health care services to consider addressing women preference on provider's gender for services such as MNH care. Health professional training particularly midwifery and Gynecology and obstetrics training programs needs to respond to such facts and enrollee more female candidates to such trainings.

5. CONCLUSION AND RECOMMENDATIONS

5.1. CONCLUSION

- About half of Women prefer to be attended by female midwives especially during labor and delivery services. Women from rural area, pastoralist and Muslim communities are more likely to prefer female midwives.
- Acceptability of male midwives vary among the different regions. Women in Somali, Oromiya and Afar were more likely to prefer a female provider during labor and delivery.
- Most women identified cultural values and social norms as a factor that influence women's attitude towards male midwives.
- Though most mothers prefer to be attended by a female midwife/provider it doesn't necessarily mean that they will refuse the services of male midwives. Most mothers said though they prefer females they will use male midwives service when that is the only option available. It is only about ten percent of mothers reported that they will refuse labor and delivery service from a male midwife.
- In pastoralist communities of Afar and Somali, male midwives who are members of the same tribe or ethnic group are less accepted than those from other tribe or ethnic group.
- Though few there were stakeholders who reported instances where male midwives became barriers to MNH care especially in pastoralist and Muslim communities. Twelve per cent of women also believe that male midwives could be barriers to institutional delivery.
- Women were more sensitive to provider's gender especially for IUCD insertion, labor and delivery services. Most women don't mind if the provider is male for ANC, PNC and other FP services.
- During instances where mothers refuse services from male midwives, usually the husband or companion family members will be counselled and women get convinced to eventually accept. . Sometimes when women refuse the services of male midwives, they will be given automatically the option to be attended by a female midwives.
- Even though the issue of male midwives acceptability has not been well articulated at national or regional levels to design comprehensive interventions there were interventions implemented to address acceptability of male midwives by Woreda health offices and facilities serving rural, pastoralist and predominantly Muslim communities. Some of the interventions include assignment of male and female midwives together during both regular working hours and duty hours; transferring male midwives from areas where there is firm resistance to urban facilities where their acceptability is better; awareness creation among the community through health extension workers and development armies.

- Most Male Midwives are happy being a midwife and expressed their satisfaction caring for two lives 'the mother and the new born'. However, male midwives have some concerns that includes the fact that Midwifery as a profession is not well known among community, a perception among community and some professionals that midwifery is a female's career and see scope of midwifery narrow and limited to attending labor and delivery. Many midwives also feel bad about the Amharic name 'Awalaj Nurse' used for a midwife.

- Overall there is high turnover of midwives both male and female from facility in rural areas to urban settings and sometimes to private sector (NGOS). Data from Woreda health offices showed 26% of midwives left facilities in 5 years period (2002-2006 EC). Rate of retention and motivation of male midwives is not different from female midwives.

- A range of factors influence midwives retention and motivation that includes:- limited educational opportunities to advance their career in midwifery at Bachelors and Master's Degree level; very poor incentive package (low salary, duty hour pay and risk allowance); risk of contamination while attending labor and delivery services; stressful nature of the work and high work load".

- Lack of adequate educational opportunities for midwives to upgrade their education from Diploma to BSc Degree and then to Master's Degree in midwifery related fields has forced some midwives to change their profession to clinical nursing, public health and other health and non-health related fields.

- Data from 25 training institutions showed that male students constitute more than fifty per cent for BSc Degree level training programs under FMOE. On the other hand male students constitute less than a third of the Diploma level midwifery training programs.

- Enrolment to BSc Degree level training programs of midwifery schools under universities of FMOE has been largely by assignment. The assignment process doesn't seriously consider gender and interest of students which let males happen to dominate the training program. While the Diploma level training programs under RHBs enrols students with competitive application process which needs interest, competence and gives priority for females. Therefore, females take lion's share of students enrolled to regional college's midwifery training program.

- According to the data from 25 midwifery schools, majority of faculty members were male (80%). Midwives constitute only a fifth (18%) of the tutors and of this majority were males.

5.2. RECOMMENDATIONS

Addressing issues related with less acceptability of male midwives and retention of midwives needs multi-pronged interventions:

FMOH, EMA, UNFPA and Other development partners needs to:-

- Develop standardized protocol on how to address mother's preferences for female or male midwives when they come to MNH services particularly labor and delivery including how to treat mothers who refuse male midwives
- Enhance the Media campaigns at national level and awareness creation sessions conducted at training institutions to promote midwifery profession
- Further workout and follow-up implementation of the following action points outlined based on the study findings

Regional Health Bureaus should

- Map communities in their region based on potential acceptability of male midwives particularly rural and predominantly Muslim and pastoralist communities and seriously consider deploying female midwives where male midwives are not accepted.
- Develop and implement incentive package (salary, duty pay, risk allowance) that attract and retain midwives

Woreda Health Offices and Health Facilities should

- Apply standardized clients gender preference management protocol that ensure women's preferences for male or female midwives are properly entertained
- Implement awareness creation interventions to improve acceptability of male midwives through health extension workers and development armies; community conversation and pregnant mothers' conference sessions
- Create a working environment that improve midwives motivation and retention at the MNH care services

Training institutions should:

- Make enrolment of students to training institutions to be based on interest of students and give priority to females so as to gradually increase proportion of females at Degree level training programs
- Recruitment of midwifery tutors should strongly encourage female applicants and apply affirmative action to employ more female midwives as tutors
- Create training programs that give opportunities to practicing midwives to upgrade their education from Diploma to Degree and from Degree to masters level

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7. ANNEX

7.1. Case studies

Case - 1: Male Midwife refused by rural and Muslim community and transferred to urban center

Regassa is a 25 years old male midwife working at Kofele health center in a delivery case team, found in Kofele town, Oromiya regional state. He graduated from a private health science college in 2012 with a Diploma in midwifery.

Just after Graduation from midwifery school Regassa was deployed to Elka Health center, one of the facilities in Kofele woreda serving Muslim Communities. Regassa was assigned to provide MNH care services of Elka Health Center including labor and delivery service he was fresh and energetic.

However, communities around Elka health center were Muslims and few women came for institutional delivery. Even these women who came to Elka health center for labor and delivery services were not willing to be attended by a male provider.

Indeed he tried a lot of mechanism to convince mothers to receive the service he was providing. Unfortunately, all such efforts didn't bring much improvement with regards to mother's perception on male midwife.

Regassa never attended a single laboring mother for one year period where he stayed at Elka health center. Finally Regassa felt idle and lost his motivation to continue work at Elka Health center. Then he requested the Woreda health office for transfer to another facility where he can be accepted.

The Woreda health office positively entertained his request and transferred him to Kofele health center which is serving relatively urban communities and he face no serious challenge.

Case study -2: Male Midwife who is awarded as best midwife of the year

Wondimu is 24 years old male midwife who has been working in Kombolcha Health Cebter for the past five years. He graduated from Bahirdar university midwifery school. Wondimu joined midwifery on his interest and he would like to peruse his career as a midwife.

Wondimu is one of best performing health personel awarded as best midwife of the year in Kombolcha Woreda last year. He used to receive appreciation and recognition by mothers and community at mother's conference and meetings. He believes that this is because of the quality service that he is providing. Wondimu reported that he makes all possible effort to make mothers happy of the MNH/SRH services they received at the health center. The health center is awarded three or four trophies due to the quality service provided in Kombolcha Woreda.

Wondimu reported that he go home to home to encourage pregnant women attend AND and Labor and delivery services. He feels that this effort has brought a visible change on the delivery coverage of the health center. He believes being male and working as a midwife has no bearing to enjoy his career.

Case 3: Male Midwife shifting from clinical practice to academic role

Kassu graduated from a midwifery school in 2011. He was assigned to a health Center 20 km away from Debark town. The health center is serving rural communities of Amhara around Debark. Kassu was interested to practice midwifery skills and working in all MNH care outlets including labor and delivery. However, he felt challenges when some of the rural women were refusing his service at labor and delivery unit.

He somehow became frustrated of the rural women attitude towards male providers and no one gave attention to the problem. No intervention was done to create awareness to rural women by woreda health office.

Worsening the situation he had worked for over 3 years and there was no hope for opportunity to upgrade his Bsc Degree working at this health center. On top of this though his friends working in health facilities in other area were paid risk allowance and duty hour pay his woreda had no such incentive package which made Kassu look for other employment options.

News of Gonder University announcing for interested applicants to work as a tutor at the midwifery school reached Kassu and he never thought for second time when he submitted his application and eventually ended up to be a tutor. Kassu loves to work on clinical practice and help women but he feels the situation is difficult to stay with.

Case 4: Male midwife who had joined the profession without interest and demotivated to continue work as a midwife

Kebede is a male midwife working in Asita Hospital Afar region. He has 2 years' work experience working as a midwife.

Kebede feel that he joined midwifery training not on his choice but through assignment by the university. He said he has been trying to convince himself to work as a midwife while in school and in clinical practice for the past two years. However, Kebede felt tired trying to stay in the profession. He said women around here don't accept male midwives and we don't have enough incentives and I am not sure if I want to continue working as a midwife. He has a plan to pursue public health in the future.

Case 5: MNH client in Somali expressing community preference to female midwife

Fatuma, a 30 years old woman who reside in a place called Fafem, a rural village found in one of Woredas in Somali Region. She is a mother of two and has no formal education. She came to Fafem health center for her third child birth. She gave her last birth in the same health center attended by a female midwife. . She described that there are "very good" services regarding maternal health care in the health center. As per her description she does not prefer male providers given that she is a Muslim follower and showing her private part to male provider is forbidden in Muslim religion. Previously mothers preferred to give birth in their homes in the rural villages as per Fatuma explanation because of the fear that they may be forced to be attended by a male provider. She expressed that during those earlier days mothers were embarrassed to receive delivery care from male providers as a result mothers were not much interested to attend the services provided by the Health Center. She described that it was after the deployment of female provider at the HC that mothers started to come to this facility to give birth. Now she is happy to have a female midwife in the health center. Fatuma described that, now Mothers want to get immediate care from this health facility when they feel even minor labor cramp. Even mothers come alone to the health facility without seeking help from other people if the labor is not serious as Fatuma described the current situation.

7.2. Annexed Tables

Table -1: List of Woredas, health facilities and training institutions visited by region

Region	Woreda	Health facilities	Training Institutions
Amhara	DebreBirhan Kombolcha Dejen Woreta Tarmaber Bahirdar Gonder	Debirebirhan Hospital Kombolcha Health Center Dejen health Center Woreta Health center Tarmaber health center Gonder university hospital	Debrebirhan HSC Bahirdar University Gondar University
Oromia	Wuchale Kofele Chiro Habru Arjo Agaro Sekoru	Muka Turie Health Center Kofele Health Center Chiro Hospital Gelemso Hospital Arjo Health Center Agaro Health Center Sekoru Health Center	Arsi University Haromaya University Jimma University Wollega University Shashemene HSC Nekemte HSC
Tigray	kolla Temben Wukro Axum Enderta Mekele	Kola tembn Health Center Wukro Hospital Enderta Health Center Axum Health Hospital	Mekele University Axum University Sheba Univesity Dr.Tewelde HSC Araya HSC
SNNP	Humbo Chencha Homicho Dilla Hawasa South Omo-Jinka	Humbo Health Center Chencha Health center Homicho Health Center Dila Hospital Jinka Hospital	Hawasa University Wolayta Sodo University Arbaminch HSC Hossana HSC Dilla University
Somale	Degehabour Kebrebeya Fafem/Gursum Jigjiga town	Degehabur Hospital Kebrebeya Health Center Fafem Health center	Jijiga Health Science College
Afar	Awash Dubti Asita	Awash Health Center Dubti Hospital Asita Hospital	
Benishangul Gumuz	Asosa town Bambasi Pawe	Asosa Hospital Bambasi Health Center Pawe Hospital	Pawe Health Science College
Gambella	Pignewedo Abobo Gambela	Pignewedo Health Center Abobo Health Center	
Diredawa	Dire-Dawa	Dilchora Hospital Adisketema Health Center	
Harari	Harar town Sofi Woreda	Hiwotfana Hospital Sofi Health Center	Harar Health Science College
Addis Ababa	Addis Ababa	Gandi Memorial Hospital Bole Woreda 17 health centre BGM MCH Hospital	Addis Ababa university Minilik Health Science college Alkan Health Science college

Table -2 Summary of data source, data collection methodology and study participants enrolled to the study

Study design	Study population	Sample size
Review of data base at training institution Review of Woreda health office data base	Training institutions Woreda health offices	25 institution 29 Woreda health offices
Key informant interviews with stakeholders	UNFPA, FMOH and EMA RHBs Woreda Health Offices Health facility heads Training institutions	4 11 30 40 25
KII and FGD with male and Female Midwives	Male and Female Midwives	75
FGD & KII with MNH clients, Male partners and community representatives	FGD with MNH clients FGD & KII with male partners KII with community representatives	90 MNH clients 34 male partners 11 community rep
Survey of Maternal Health care clients	Mothers attending SRH, ANC, Labor and delivery PNC services	401 MNH clients
Case studies with male midwives and MNH clients	MNH clients & Male midwives	3 Male Midwives 1 MNH client

Table-5: Women preference on provider's gender when they came to labor and delivery services a multivariate analysis on selected demographic variables (N=401)

Determinants	Prefer female provider		Adj OR	Adj OR (95% CI)	P -value
	Yes	No			
Region					
Addis Ababa	5	25	Ref.	Reference	
Somali	29	1	36.7	(2.6 - 519)	
Tigray	12	28	1.3	(0.3 - 4.8)	
Afar	15	16	1.9	(0.3 - 10.7)	
Amhara	28	33	3.4	(1.1 - 10.7)	0.000
Benishangul Gumuz	7	22	0.7	(0.2 - 3.0)	
SNNP	30	20	5.5	(1.7 - 18.3)	
Dire Dawa	7	13	2.2	(0.5 - 9.0)	
Gambella	4	15	1.0	(0.2 - 4.8)	
Harari	12	8	3.6	(0.8 -15.6)	
Oromiya	43	28	3.8	(1.2 - 12.4)	
Residence					
Urban	96	147	Ref.	Reference	0.007
Rural	96	62	2.2	(1.2 - 3.9)	
Community livelihood					
Pastoralist	44	15	Ref	Reference	0.507
Non-Pastoralist	148	194	1.6	(0.4 - 6.0)	
Religion					
Christians	98	152	Ref	Reference	0.115
Muslims	94	57	1.8	(0.9 - 3.0)	
Educational status					
Illiterate	96	56	2.7	(1.1 - 7.2)	
Elementary (Grade 1-8)	57	66	2.0	(0.8 - 5.0)	
High School (Grade 9-12)	26	51	1.4	(0.6 - 3.5)	0.178
Diploma/Degree and above	13	36	Ref	Reference	
Age					
≤19 years	28	21	Ref	Reference	
20-24 years	51	66	1.8	(0.6 - 5.6)	
25-29 years	69	74	0.8	(0.3 - 1.9)	0.319
30-34 Years	24	26	0.9	(0.4 - 2.2)	
>/=35 years	20	22	0.7	(0.3 - 1.9)	
Household monthly income					
</= 500 birr	49	65	Ref	Reference	
501-1000 birr	60	46	1.5	(0.8 - 2.8)	0.454
1001-2500 birr	48	56	1.2	(0.6 - 2.3)	
>2500 birr	35	42	1.7	(0.7 - 4.1)	
Parity					
Premi-Para	28	36	1.5	(0.5 - 4.8)	
Multi- para	139	156	1.5	(0.6 - 3.6)	0.700
Grand multi-para	25	17	Ref	Reference	

Table -7: Total Number of Midwives available_per region between 2002 and 2006 EC

Region	Sex	2002 EC	2003 EC	2004 EC	2005 EC	2006 EC
Tigray	Male	46	36	57	61	155
	Female	124	152	197	222	418
Afar	Male					240*
	Female					
Amhara	Male					850
	Female					813
Oromyia	Male			376	429	817
	Female			1594	2036	2302
Somali	Male	16	12	16	29	48
	Female	71	40	39	129	202
Benishangul-Gumuz	Male		9	21	35	45
	Female		19	78	68	136
SNNP	Male			106	129	131
	Female			823	1095	1500
Gambela**	Male					
	Female					
Harari	Male			4	9	13
	Female			36	34	40
Addis Ababa	Male					338*
	Female					
Dire Dawa	Male				24	24
	Female				20	22

*data disaggregated by gender not available
** Data not available at the RHB during the data collection period

7.3. Conceptual Framework

This conceptual framework defines socio-cultural, demographic, women status, previous experience with male midwives, male partners attitude to male provider and other determinants of the acceptability of male midwives. Considering acceptability of male midwives as intermediate factor it also outlines proximal and distal outcomes of acceptability of male midwives that includes motivation and retention of male midwives in clinical care delivery, quality of MNH care, MNH care uptake and maternal and newborn health outcomes. Note that this assessment measures only acceptability of male midwives among MNH clients and its determinants not the other outcome variables i.e quality of care and maternal health outcomes (Chilumba J 2011, Diana and Masvis 2008).

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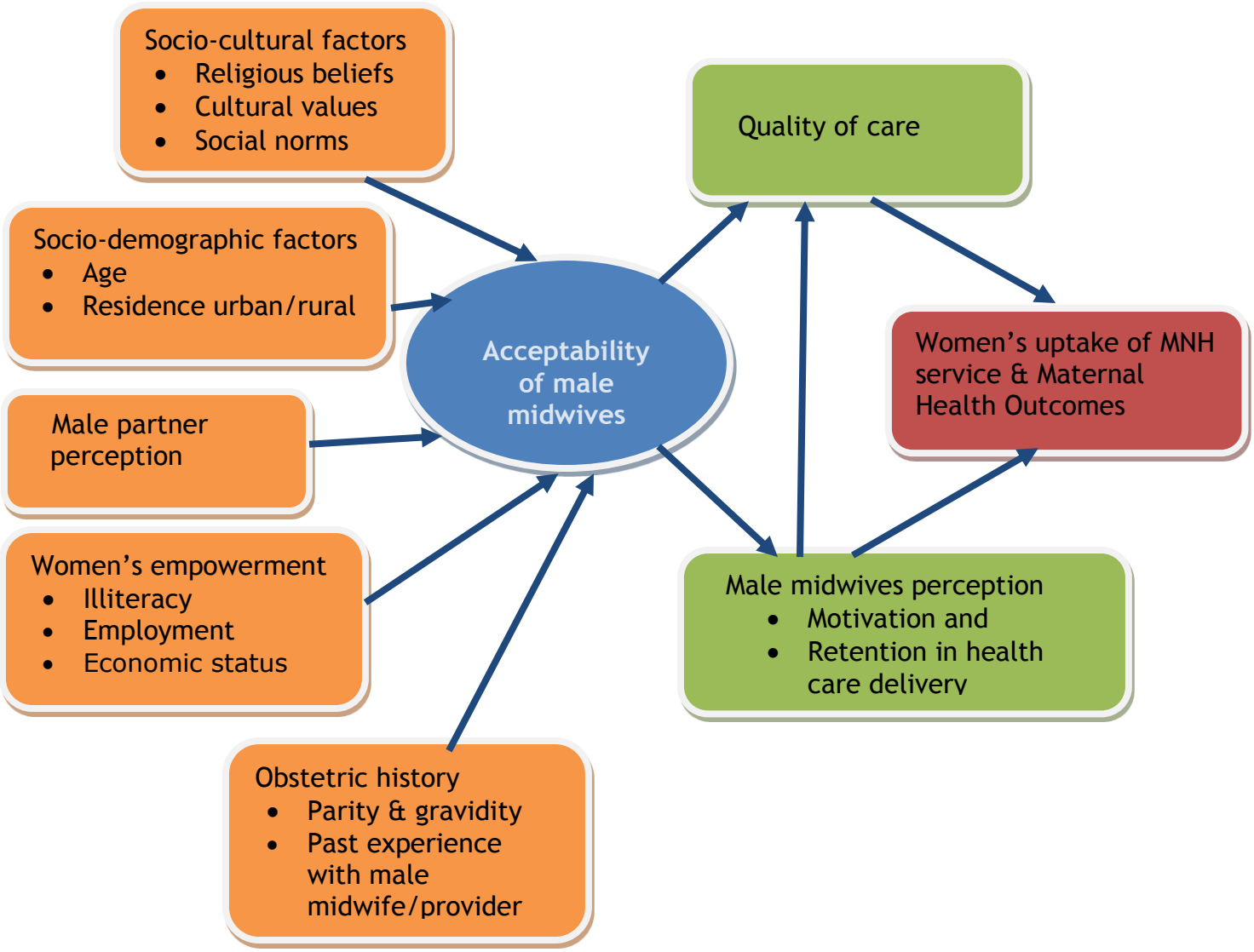

Figure 6.1: Conceptual framework determinants of acceptability of male midwives and its outcome