Publisher: Centre for Behaviour and Wellness Advocacy, Ghana
Co-publisher: Cherkas Global University, USA
Has been issued since 2014
ISSN 2410-4981. E-ISSN 2508-1055
2024. 11(3): 301-308

DOI: 10.13187/jare.2024.3.301

Journal homepage:
http://kadint.net/our-journal.html

"How Can a Male Too Want to Do This Work?" Exploring the Challenges Faced by Male Midwives in Ghana's Midwifery Practice

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Abstract

Workplace challenges can be daunting and hinder the provision of quality services, especially for a professional such as the male midwife who spends the entirety of his work life in an environment in which he can be termed the minority. Heavy workload, harassment, and intimidation are some documented challenges of the male midwife. The study sought to explore the challenges faced by male midwives in midwifery practice in Ghana. Using the qualitative study design and purposive sampling, data were collected within 30 to 45 minutes for each participant and reached saturation by the 14th participant. Thematic analysis was employed for data analysis. Findings revealed two major themes of current practice and training period challenges from which four sub-themes emerged: the attitude of female midwives, the heavy workload and unfavourable duty schedule, and the clinical supervisors' attitude. In conclusion, male midwives are trained maternal and neonatal health care providers working in various aspects of midwifery to reduce maternal and neonatal morbidities and mortalities; however, the challenges in the workplace pose unbearable barriers which impede the aim of practice.

Keywords: Challenges, Ghana, Male Midwives, Midwifery Practice.

1. Introduction

The environment in which an individual works can be a motivator or demotivator. The male midwife working in a field where he can be termed as the minority among female colleagues and female clients may raise concerns for both parties. The external environment where most, if not all, of the midwifery life is spent significantly impacts the practice of the male midwife. These experiences may determine whether the male midwife will remain in the profession or not. An environment filled with difficulties, such as a heavy workload, may negatively impact an individual's health and even affect the decision to remain or exit the practice (Rajan, 2018).

The work environment must be conducive enough for the male healthcare provider to develop good coping strategies, as indicated in past studies (Inoue et al., 2006); however, the practice environment is one primary source of burnout among midwives (Thumm, 2022). According to Piddleton (2015), most challenges in the field for male midwives stem from within the profession, especially their female counterparts, as the men are seen as emotionally incapable of handling the care of pregnant women and managing the childbirth process. Some of these challenges can be attributed to the male midwives being the minority in the field of practice, and it

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Received: 10 April 2024 2024 Revised: 29 August 2024 Accepted: 28 October 2024
Published: 31 December 2024

has been confirmed in studies that minorities in the workplace are reported to experience bullying and harassment (Fine et al., 2020; Folke, Rickne, 2022).

The education of health care professionals, especially nursing and midwifery, is interspersed with theoretical and practical sessions focused on building a rounded individual who is knowledgeable in both aspects. However, Meyer (2012) reported that male midwives experience external challenges even before the completion of their training. The training sessions and the clinical ward practice sessions are filled with the rejection of service provision by female patients based on culture (Chan et al., 2013), including unfriendly attitudes from clinical supervisors. The lack of supervision during the training periods in the work environment increases the male midwife's frustrations (Mthombeni, Phaladi-Digamela, 2015).

Few studies focus on male minority issues in nursing and midwifery, typically within the African context. Gender roles and biases are noted to compound challenges that male midwives face in the clinical environment, a place that is traditionally female-dominated. Male midwives are often singled out as different and excluded from some clinical activities, mainly based on gender (Ayu, Yasin, 2022; Kantrowitz-Gordon et al., 2014). Other studies report male rejection in clinical care in the Northern part of Ghana, where women were not ready to accept or receive midwifery care from male midwives, and even those who were prepared to receive care from them do so when there is an accompanying female midwife (Nachinab et al., 2022). Similar findings are shared by Bwalya et al. (2015), reporting that most women think it is traditionally wrong for male midwives to provide intimate care to women. Furthermore, additional challenges escalate when there is poor availability of required resources to provide the necessary standard of care.

Just like female midwives, male midwives provide quality maternal and neonatal care to reduce maternal and neonatal mortalities and morbidities, thereby contributing to SDGs 3.1 and 3.2The Gulf of Guinea lies southbound in the region. With a total land area of 9830 km^2, the region has the longest coastline (150km) . However, it is particularly challenging, especially in developing countries; these challenges range from a shortage of staff and inadequate infrastructure to logistics issues, including a lack of basic medical logistics (Adatara et al., 2021; Kafulafula et al., 2005). Numerous studies have focused on challenges faced by female midwives in Malawi, Ethiopia, South Africa, and some Asian countries; however, data on the challenges faced by male midwives in Ghana are scarce. It is crucial to explore these challenges and understand the implications on midwifery practice.

2. Materials and Methods

Study design and setting

The study utilised a qualitative approach underpinned by the constructivists' worldview (Creswell, 2014) to explore male midwives' experiences of clinical practice in Ghana. This research adopted an exploratory, descriptive design (Cropley 2021) to gain an in-depth understanding of the challenges faced by male midwives in practice in Ghana, considering the gaps in the evidence on male midwives' experiences of practice in Ghana. Due to the limited existing knowledge about the phenomenon under study, a qualitative explorative descriptive was chosen (Creswell, 2014) to explore the factors influencing male midwifery practice in Ghana through an inductive approach to develop rich narratives of the participants' experiences. This approach is considered appropriate as researchers sought a comprehensive understanding of the phenomenon and participants' subjective experiences of it (Grove et al., 2015).

Male midwifery in Ghana is a comparatively recent development and with very limited research data. Historically, male midwives have not been universally accepted. Ghana's efforts to expand maternal/newborn and reproductive health care access required male inclusion in midwifery training as a measure to improve coverage of skilled care delivery. However, male midwives and their acceptance in clinical care have met resistance in practice, culminating in low numbers, though male nurses are relatively common in general nursing practice. In view of the scarce population of male midwives in Ghana, a purposive and snowballing sampling method (Lopez, Whitehead, 2013) was used to recruit male midwives who met the inclusion criteria. The participants were engaged in in-depth interviews until data saturation was reached (Lewis, 2015) by the 14^{th} participant, and no new information emerged from the interviews. The collection of data spanned from March to September 2023. Male midwives are few across Ghana, especially at the tertiary level of health care. In this study, we recruited male midwives from two regions of

Ghana, where male midwives are primarily common. Inclusion criteria: male midwives who had a professional licence in good standing with the Nursing and Midwifery Council of Ghana, had practised for at least one year and expressed willingness to be part of the study were included in the study. Male midwives with less than one year of work experience and male student midwives were excluded from the study.

Data collection method

In-person interviews were conducted using a semi-structured interview guide, which was developed based on the evidence from the literature. The tool focused on sections on demographic data and questions related to the study's objectives. The interview guide was pre-tested with two male midwives in the Eastern Region to refine the data collection tool; the data generated from the pre-testing were not included in the analysis for the current study. To gain voluntary informed consent, the study's information sheet, which included the objectives of the study, was shared and explained to eligible participants; questions raised were duly addressed. The principal investigator (DBBA), who is an expert in qualitative studies, conducted the interviews in a quiet environment at a date, time and venue convenient for the study participants. The interview session lasted for about 30-45 minutes for each male midwife, which was audio-recorded. Several probing and follow-up questions were used during the interviews to elicit deeper responses and expantiation of information from the participants. The data were transcribed verbatim.

Data analysis

The data was analysed using thematic analysis following steps outlined by Clarke and Braun (2016). Data collection was concurrent with analysis. The audio recordings of the interviews were transcribed verbatim and validated with the interview transcripts. The transcripts were initially read and re-read to identify similarities in the familiarisation process. Similar concepts are grouped and coded considering key concepts related to the study objectives; the condensed codes were subsequently placed into sub-themes. All researchers reviewed the data, and sub-themes were accurately and collaboratively formed to ensure accurate representations of the data. The researchers then compiled a comprehensive thematic analysis report when a consensus was reached.

Ethical consideration

The research was approved by the Ghana Health Service Ethical Review Committee with number GHS-ERC: 036/01/23. After obtaining consent from the participants, the objectives and benefits of the study were explained, and they were made aware of the right to withdraw from the study at any point. Written and verbal informed consent was obtained from the male midwives before data collection. Confidentiality and anonymity were ensured during data collection by using pseudonyms for each participant.

Methodological Rigor

It was established through credibility, dependability, confirmability, and transferability (Lincoln, Guba, 1985). To ensure credibility, member checking was done by engaging participants in the review of the transcript and confirming the themes derived from the analysis. Triangulation was carried out with support from participants' primary data sources, clinical observations, and field notes. Dependability was attained through the use of the same interview guide along a similar line of questioning used across all participants to ensure uniformity. The research team engaged in peer debriefing sessions during the concurrent data collection and analysis process to discuss data issues, common concepts, and emerging themes to enhance the study's credibility. Confirmability was achieved by maintaining an audit trail and documenting all processes involved in participant selection, data collection, and analysis. In addition, transferability was addressed by providing a comprehensive account of all experiences during data collection, including details about the location and context within which the interview was conducted.

Reflexivity

In qualitative studies, researchers engage in reflexivity to account for their biases and how subjectivity shapes the inquiry and its entire processes, considering this as fundamentally intertwined (Finlay, 2002). In this study, researchers engaged in reflexivity by identifying our

abilities, familiarising with the context, and communicating nuanced decisions in generating real-world data to reflect participants' experiences.

3. Results

Table 1. Demographic Characteristics of Study Participant

Pseudonym	Age	Health facility	Number of male midwives
P1	36years	Hospital	One
P2	33years	Health center	One
P3	42years	Health center	One
P4	37years	Hospital	Two
P5	39years	Health center	One
P6	35years	Health center	One
P7	35years	Hospital	Two
P8	34years	Community Health Planning and Services (CHPs)	One
P9	38years	Health center	One
P10	35years	Hospital	One
P11	39years	Hospital	Two
P12	49years	Hospital	One
P13	34years	Hospital	One
P14	41years	Hospital	Two

Themes and subthemes

Demonstrated in Table 2 are the themes and subthemes developed from the collected data.

Table 2. Theme and Sub-Themes

Themes	Sub-themes
1. Current challenges	a. Attitudes of female midwives
	b. Heavy workload
	c. Unfavorable duty schedule
2. Training Related challenges	a. Supervisor attitude

Current challenges faced by male midwives in practice.

This theme relates to the challenges in the participants' work environment and how they impact midwifery practice. It relates to all the physical and tangible surroundings of the participant in which he performs his daily activities as a midwife.

Subtheme 1: Attitude of Female Midwives

Some participants expressed a little challenge with their colleague midwives when explaining the external environment and its effect on their experience as midwives. The participants acknowledged that even though they had excellent relationships with their female colleague midwives, they were not particularly enthused by some of their actions, such as making petty, unwelcoming comments and favouring male doctors over male midwives.

P11 bitterly expressed:

You know, in the line of work, you come across so many challenges, one or two, but mainly in this one, I am not going to be biased. I am being frank with you, it is our colleagues who make us sometimes feel uncomfortable, our colleagues, as in the female midwives. Some will say that I do not want you to be present when I am in labour, but will allow a male doctor to be present while she is in labour. Some are too lazy and will not do anything immediately after they realise you are on duty with them. (39 years).

P6 also stated:

The problem is just our counterparts who are female. Some of them will behave like you are a man, and I do not want you to be there when I deliver with other similar comments (35 years).

Sub-theme 2: Heavy workload

Some participants expressed that they are, more often than not, burdened with the heavy-duty aspect of the practice as compared to their female counterparts, which is a factor in the decision to divert from the profession or move into academia.

P9 said:

Oh, I am moving into academia, the midwifery training school, because the workload on us, the male midwives in the ward, is hefty. (34 years).

P1 stated:

The only challenge I have is from my colleagues. They always think that because I am a male, I have to do all the menial jobs, and then sometimes, when we are for the night, we have to take a small nap in turns. When it's time for them to wake up so that I take my nap, they do not, so I will end up doing everything. (36 years).

Subtheme 3: Unfavorable duty schedule

Some participants, apart from those working in one-man health facilities, stated that sometimes it is a challenge for them when they have to run unfavourable duties.

P11 narrated his experience:

It's serious because I'm the only male, the way they can use me, the thing is they will draw the duty roster [rota], and someone will get up and say I can't come to work, and when they look around, they will say as for this person (me), he is a man and will be less busy so let's put him there or let's call him. So, I can be sleeping and they will call, or they will call the day I am off and resting saying, we are begging you, this person says she cannot come, and about 4 or 5 females who are supposed to go for that shift have an excuse, so I will have to fill in for her. (39 years).

P3 added:

The days are mostly busy, and sometimes, when you leave the workplace and get to the house, someone will come for service, they will call you and you will have to return. That is what makes it difficult. (42 years).

Theme 2: Training Period Challenges

Most participants had significant periods interspersed with minimal setbacks about acceptance during their clinical attachment days. They, therefore, had to put in more effort to prove that they were capable of the work they were being trained.

Sub-theme 1: Supervisor Attitude

P10 recounted:

On Campus was good. But when we went to the field, some directors and supervisors were against it. And some midwives, these old ladies, were against it. Some were not against it, but they were like, oh, this thing, it won't yield good results. It's a pilot program. They will cancel it, those negative thoughts. And you know, as normal human beings, hearing those negative thoughts weighs you down, but when we come back to campus, our tutors encourage us. (35 years).

P2 stated:

You know, it was such a challenging moment. Because, you know, people didn't know about male midwifery, people used to tell us that they knew only males who were gynaecologists. So once you go and introduce yourself as a midwife, they are like, mmmm..., how can a male too want to do this work? But you know, it doesn't take one day to change someone. As we started talking with and interacting with them, sometimes, when we can carry out only one procedure on a client, do it very well, and let the clients understand very well, their concern that the male midwives come to look at their vulvas started to change. (33 years)

4. Discussion

Challenges in an individual's career may be within or outside the practice or career environment. For these male midwives, the prominent challenge stemmed from within the practice environment. This study identified that female midwives posed a challenge to male midwives to some extent. Most of the male midwives reported poor recognition from their colleague female midwives, expressing that some of the female midwives underestimated their competence by

refusing care from the male midwives, while others thought they would not be capable of the task as midwives. This is consistent with findings from Piddleton (2015) and Chinkhata and Langley (2018), who reported that most challenges in the field for male midwives stem from within the profession, especially their female counterparts, as they see the men as emotionally incapable of handling the care of pregnant women and childbirth. Again, supporting this is a study by Folke and Rickne (2022), which indicated that gender minorities are at high risk of experiencing harassment in the workplace.

The workload on these male midwives cannot be underestimated. This study identified that heavy workload and unfavourable shift system were challenges the male midwife faced in the field of practice. The male midwives acknowledged the midwifery profession in general to be one that is fraught with stress and heavy workload, and as such, based on their gender as men and seen as the stronger, are put in positions where they carry out all the heavy-duty aspects of the midwifery work, unlike their female counterparts. Furthermore, male midwives are always made to run double or extended shifts when colleague female midwives are on maternity leave or when the female midwife does not report to work or is exhausted from the plights of pregnancy or nursing a child. This aligns with a study that indicates that gender minorities in the workplace may experience some forms of bullying (Fine et al., 2020). Again, Rajan (2018), on the causes and negative impacts of heavy workload, identified long leave of co-workers and co-worker absence.

Another finding of this study is the minor setback related to the periods of training. Participants reported varied challenges from directors and supervisors doubting their competence and intent for practice, which is in tandem with a study that indicates that male midwives experience challenges during training periods even before completion from both clients and supervisors (Chan et al., 2013; Meyer, 2012).

5. Conclusion

Male midwives are trained maternal and neonatal health care providers working in various aspects of midwifery to reduce maternal and neonatal morbidities and mortalities, and if the challenges in the workplace become unbearable, then this aim will not be realised. These challenges must, therefore, be addressed to improve work harmony and enhance client outcomes. Again, the clinical session during the training period must be a period of teaching and support to build the confidence of the male midwives even before they graduate and begin working.

6. Strengths and Limitations

The different workstations (health facilities) of the participants provide rich data that enhances the understanding of the challenges experienced by male midwives. The qualitative design and its corresponding sample size may impose on the generalizability of the work.

7. Implications

Continuous sensitisation and addressing of these challenges faced by male midwives in practice must be paramount to achieve workplace harmony aimed at improving maternal and newborn infant outcomes. Male midwives must undergo well-planned training with adequate support and clinical preceptorship to enhance the transition. There is also the need to draw policies that enhance awareness creation and visibility of the male midwives. Future research may be conducted to explore the experiences of female midwives working with male midwives.

8. Declarations

Ethics approval and consent to participate

The Ghana Health Service Ethical Review Committee granted ethics approval for the study (GHS-ERC: 036/01/23).

Consent for publication

All authors read and approved the final version of the manuscript for publication and agree to be accountable for all aspects of the work, ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Availability of data and materials

The data supporting this study will be made available upon reasonable request to the corresponding author (Mani-amponsah@ug.edu.gh).

Conflict of interest statement

The authors do not have any personal or financial interest in this study.

Funding

The study had no funding from any institution or persons. However, the authors sincerely thank the Centre for Behaviour and Wellness Advocacy, Ghana, for providing financial support through the Institutional Open Access Publication Fund.

Authors' contributions

DBBA conceptualised the study. DBBA designed the study with input from MAA and EA. DBBA collected data from participants. DBBA analysed and interpreted the data. DBBA drafted the initial manuscript. MAA and EA contributed to the revision and finalisation of the manuscript. All authors read and approved the final version of the manuscript.

Acknowledgements

We acknowledge all participants of this study.

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