DDC Professional Journal
Vol. 7, No.1, January 2026
ISSN 1908-3130

# ON COMFORT AND TRUST: WOMEN'S PERSPECTIVE OF MALE NURSES IN MATERNAL AND FAMILY PLANNING CARE

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## Abstract

This study aimed to explore the lived experiences and perceptions of women receiving maternal and family planning services from male nurses in San Isidro, Davao Oriental, where cultural beliefs and gender expectations continue to influence comfort and acceptance during intimate care. A descriptive-phenomenological design was employed, with seven women undergoing in-depth interviews and another seven in focus group discussions to capture diverse perspectives. Data were analyzed using Colaizzi's method. Three themes emerged: (1) Moving from Gender-Based Discomfort to Gender Acceptance, (2) Transitioning from Initial Discomfort to Developing Trust, and (3) Relying on Faith and Social Support for Emotional Coping. Initially, participants expressed modesty, embarrassment, and hesitation due to cultural norms about gender-appropriate care. Over time, repeated encounters with professional, respectful, and empathetic male nurses contributed to a shift from discomfort to trust and eventual acceptance. These findings suggest that professional conduct, empathy, and therapeutic communication were perceived as important factors in building rapport and trust. Implications for nursing education and practice include integrating gender sensitivity and inclusivity into training, and normalizing the roles of male nurses in maternal and family planning care. Such efforts can strengthen patient-centered, culturally sensitive, and equitable healthcare in rural communities, with broader relevance for policy and future research on gender-sensitive health services.

**Keywords**: *Comfort, Trust, Women's Perception, Male Nurses, Maternal Care, Family Planning Care, Descriptive Phenomenology, San Isidro, Davao Oriental*

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## Introduction

The increasing visibility of male nurses in maternal and family planning care has challenged traditional gender expectations in healthcare. While their presence was growing, many women continued to feel discomfort when receiving intimate care from male providers, particularly in reproductive health contexts where modesty, privacy, and emotional sensitivity were paramount. These perceptions were shaped by cultural norms and gender role expectations that often-equated caregiving in maternal settings with women's work (Whembolua & Tshiswaka, 2024; Espinoza & Dakessian, 2024).

Globally, women's responses to male involvement in reproductive care reflected deeply embedded cultural boundaries. In Ghana, male participation in antenatal care was often perceived as intrusive (Anamege et al.,2023). Similar discomfort was documented in Southeast Asia and the Middle East, where religious and traditional beliefs reinforced female-only caregiving in maternal health (Raghavan et al., 2023). Even in Japan, where health systems were more inclusive, traditional gender roles continued to limit women's acceptance of male nurses (Fujioka et al., 2024). These examples underscored that discomfort with male nurses was not confined to one region but was a global phenomenon shaped by cultural expectations.

In the Philippines, maternal and family planning care had historically been the domain of female professionals. Filipino women often reported greater comfort and openness with female nurses, particularly during reproductive health services and intimate examinations (Robles & Baquiano, 2021). Cultural modesty, religious beliefs, and personal privacy reinforce hesitancy toward male nurses, and in some communities, their presence in family planning programs may discourage participation (Savella & Savella, 2022). These realities underscore the need to examine local perspectives to inform culturally sensitive and inclusive health practices.

Although gender dynamics in healthcare have been widely studied, significant gaps remain that limit our understanding of women's experiences in maternal and family planning care. (1) Limited attention to women's voices, resulting in an underrepresentation of their perspectives in gender-related health research (Salvador & Ebrahim, 2024). (2) There is lack of studies examining Filipino women's perceptions of male nurses in maternal care, despite the cultural and social importance of this issue in the Philippine context (Yip et al.,2021) and (3) current literature provides little insight into the coping strategies women employ to manage discomfort and build trust when receiving care from male providers (Alshammari et al., 2023b). Addressing these gaps was essential to advancing culturally competent, gender-sensitive care.

Two theoretical frameworks guided this study. Mercer's Maternal Role Attainment Theory (Mercer, 2004) emphasized the importance of supportive nurse-patient relationships in maternal identity formation and how professional conduct and empathy can shape women's experiences of care. Eagly's Gender Role Theory (Eagly, 1987) explained how societal expectations influenced perceptions of gender-appropriate roles, providing a lens for understanding women's discomfort and eventual acceptance of male nurses. Together, these frameworks situated women's responses within both emotional and cultural contexts, offering a nuanced basis for interpretation.

The research questions were: (1) What are the perspectives of women on male nurses in maternal and family planning care? (2) What are their experiences receiving care from male nurses? Moreover, (3) How do they cope with challenges in these encounters?

By foregrounding women's narratives in San Isidro, Davao Oriental, this study contributed to the development of gender-sensitive policies and practices in maternal and family planning services.

It also informed nursing education by highlighting the importance of inclusivity and cultural competence, ultimately fostering patient-nurse relationships that respected both professional competence and cultural expectations.

**Methods**

This study employed a descriptive-phenomenological approach to explore the lived experiences of women who had received maternal and family planning care from male nurses. The design was chosen to capture the meanings women ascribed to their encounters with male nurses during intimate and critical moments of reproductive health care, within the context of prevailing cultural beliefs and gender expectations. Both in-depth interviews and focus group discussions (FGDs) were conducted to balance individual disclosure with collective reflection. Interviews allowed participants to share sensitive experiences privately, while FGDs provided opportunities to explore shared norms and community perspectives. To minimize social desirability bias, FGD were held in small groups and facilitated in a manner that emphasized confidentiality and respect.

The study was conducted in San Isidro, Davao Oriental, where maternal and family planning services were commonly delivered in barangay health stations and a municipal birthing home. These facilities serve as primary access points for women seeking prenatal care, contraception, birth spacing, and family planning consultations. Staffing patterns in the study sites included both female and male nurses. Due to the limited number of healthcare personnel in barangay health stations, male nurses were often the first to provide maternal and family planning care, including initial consultation and routine services. In a municipal birthing home, male nurses were also assigned to maternal and reproductive health duties when staffing shortages required their involvement. Their participation in these settings reflected both the scarcity of healthcare workers in rural areas and the necessity of flexible role assignments, which positioned male nurses a primary provider of intimate and culturally sensitive care.

Fourteen (14) women of reproductive age participated in the study. Eligible participants were women aged 18-49 years who were residents of San Isidro, Davao Oriental, and who had direct experience receiving maternal or family planning services from a male nurse in recent years. All participants were willing and able to provide informed consent and to openly share their experiences during the data collection process. Women were excluded if they had no direct encounter with a male nurse in maternal or family planning care, were outside the specified age range, and were not resident of San Isidro. Purposive sampling was used to select participants who could provide rich and relevant insights into the phenomenon under investigation. Seven participants took part in in-depth interviews, while the remaining seven participated in focus group discussions, enabling both individual reflection and shared discussion of experiences.

Data were collected using semi-structured interview guides designed to encourage participants to openly describe their experiences, perceptions, and coping responses related to receiving care

from male nurses. Interviews and FGDs were conducted in Cebuano, the local language, and later translated into English. Translation accuracy was ensured through back-translation and review by bilingual researchers. Individual interviews lasted 30-40 supplemented by field notes capturing nonverbal expressions, emotional responses, and contextual details.

Prior to data collection, ethical approval was obtained and signed by the Program Chair of the Graduate School, which is part of the Master of Arts in Nursing program at a private university. All participants were provided with a clear explanation of the study's purpose, procedures, potential risks, and benefits. Written informed consent was obtained, and participants were assured of confidentiality, anonymity, and their right to withdraw from the study at any time without consequence. Pseudonyms were used in all transcripts and reports, and identifying information was removed to protect participants' identities.

Data were analyzed using Colaizzi's (1978) phenomenological method. Audio-recorded interviews and discussions were transcribed verbatim, read repeatedly to achieve immersion in the data, and significant statements were identified, extracted, and organized into a cluster of meanings. These clusters were then synthesized into themes that captured the essence of participants' experiences. The process continued until data saturation was achieved, with no new themes emerging from the analysis

**Results and Discussions**

This chapter presents the lived experiences of fourteen women from San Isidro, Davao Oriental, who received maternal and family planning care from male nurses. Participants varied in ge, marital status, parity, and reproductive health needs, providing a rich understanding of different phases of

minutes, while FGDs lasted about 90 minutes. Each participant engaged in one session; however, clarifying follow-ups were conducted with three participants to ensure in-depth narratives. All sessions were audio-recorded with consent and

(Creswell & Creswell, 2022). To strengthen the credibility and address potential bias, peer debriefing was conducted to review coding decisions and thematic interpretations. To validate the findings, participants were asked to review the thematic interpretations to ensure that the results accurately reflected their experiences. These strategies ensured that the findings were trustworthy and faithfully represented participants' voices.

The rigor of the study was ensured through strategies that enhanced trustworthiness. Credibility was established through prolonged engagement with participants, member checking, and triangulation of data from in-depth interviews and focus group discussions. Dependability and confirmability were supported through peer debriefing and reflexive journaling to minimize researcher bias. At the same time, transferability was strengthened by providing a rich and detailed description of the research context and participants. Reflexivity included acknowledging the researcher's positionality as a health professional familiar with maternal care but excluded from the study community, which helped balance insider knowledge with an outsider perspective.

womanhood and motherhood. Some sought parenteral care while others accessed contraception, birth spacing, or family planning consultations. Their experiences were shaped by both the intimate nature of reproductive care and local cultural expectations regarding gender.

**Table 1. Participants Profile**

| Participant Code | Age | Number of Children | Frequency of Encountered with Male Nurses | Study Group |
|---|---|---|---|---|
| P1 | 30 | 2 | 4 or more | IDI |
| P2 | 34 | 2 | 2-3 times | IDI |
| P3 | 26 | 2 | 2-3 times | IDI |
| P4 | 35 | 3 | Once | IDI |
| P5 | 30 | 3 | Once | IDI |
| P6 | 33 | 3 | 4 or more | IDI |
| P7 | 25 | 2 | Once | IDI |
| P8 | 26 | 1 | 4 or more | FGD |
| P9 | 18 | 1 | 4 or more | FGD |
| P10 | 24 | 1 | 4 or more | FGD |
| P11 | 49 | 9 | 4 or more | FGD |
| P12 | 35 | 5 | 4 or more | FGD |
| P13 | 40 | 2 | 4 or more | FGD |
| P14 | 25 | 3 | 4 or more | FGD |

These fourteen (14) participants had varying experiences of maternal and family planning care delivered by male nurses. The number of children ranged from one (1) to nine (9), indicating diverse maternal backgrounds. Most participants reported multiple encounters with male nurses, particularly four or more times, while a few experienced only limited interactions. These differences reflected the unique reproductive journeys each woman had gone through and the varying ways they experienced care from male nurses.

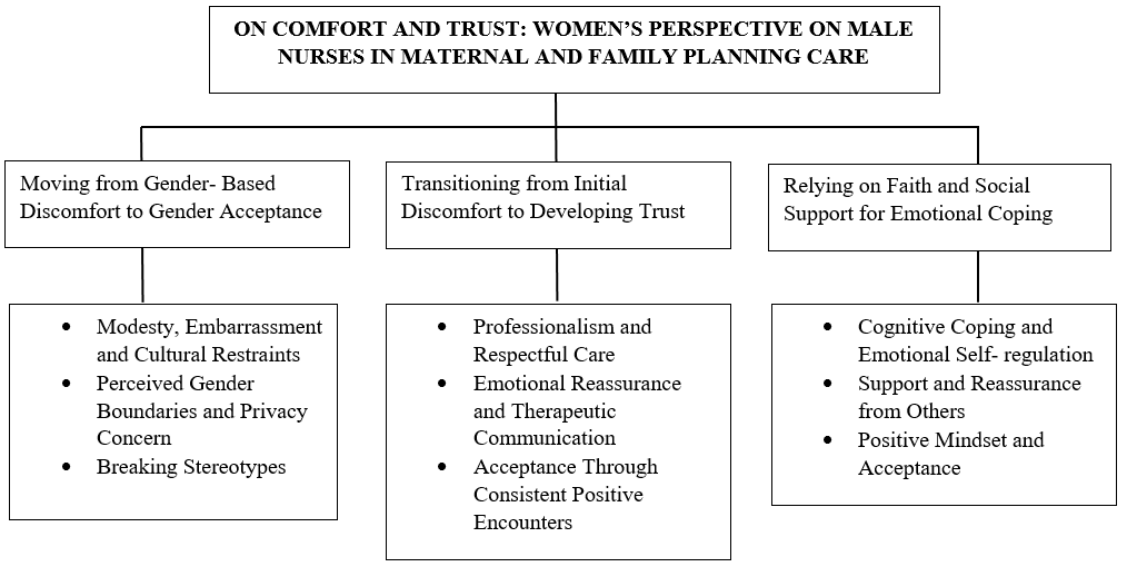


**Figure 2: Thematic Map**

The thematic map illustrated the lived experiences and evolving perspectives of women regarding male nurses in maternal and family planning care, showing how initial discomfort evolved into trust and acceptance. It highlights the relationships between themes, demonstrating how modesty and cultural boundaries gave way to trust through professionalism and communication, and how faith and social support sustained coping. Beyond simply organizing the themes, the map provided an analytical lens that revealed the progression of experiences as interconnected stages rather than isolated findings. This helped visualize how cluster themes built upon one another, revealing the overall trajectory from gender-based hesitation to eventual acceptance and empowerment. It clarified the dynamic interplay between cultural norms, professional care, and coping strategies in shaping women's perspectives.

**Emergent Theme 1 Moving from Gender-Based Discomfort to Gender Acceptance**

Women initially experienced *ulaw* (shame), anxiety, and hesitation when receiving maternal and family planning care from male nurses. Several participants expressed feeling "uncomfortable," noting that caregiving roles were traditionally associated with women. Male nurses were sometimes perceived as intruding into a space considered feminine, which heightened unease and reluctance to engage.

However, repeated encounters with male nurses who demonstrated empathy, competence, and respect reshaped these perceptions. Participants reported that their focus shifted from the nurse's gender to the quality of care provided. One woman explained that:

> ***Verbatim: "****Walaon na lang ang kaulaw kay gi-atiman man pod ko sa lalaki nga nurse og gitarong og pasabot" ( P7,T19,L80-81)*
> ***Translation:*** *"I chose to set aside my feelings of embarrassment because I was properly cared for by the male nurse, and he explained everything clearly to me" ( P7, T19, L80-81)*

Others highlighted how professional conduct and compassionate communication fostered trust and reduced anxiety.

This progression reflected a redefinition of comfort and trust in maternal care. Acceptance emerged not from the erasure of cultural norms but from the consistent experience of professional, client-centered care that transcended gender expectations.

This shift from discomfort to acceptance can be understood through Gender Role Theory (Eagly, 1987), which highlighted how cultural norms shaped caregiving expectations. Women's initial unease reflected incongruence with these norms, but positive experience prompted renegotiation. It also resonated with Maternal Role Attainment Theory (Mercer, 2004), which emphasized trust and confidence in caregiving relationships. Acceptance of male nurses illustrated how professional care could transcend gender expectations. Recent studies confirmed that patient trust often stemmed from relational quality rather than provider identity (Nabirye, 2022b; Al-Hilou&Suifan,2023)

**Cluster Theme 1.1 Modesty, Embarrassment, and Cultural Restraints**

Women's early encounters with male nurses were marked by modesty, embarrassment, and vulnerability, shaped

by cultural teachings that discouraged exposure to men outside one's spouse or partner. Intimate procedures such as internal examinations heightened these experiences, creating emotional tension between clinical necessity and cultural propriety.

Emotional reactions ranged from hesitation to anxiety:

> ***Verbatim***: *"Ulaw siya pamalandungon kay lalaki ang motan-aw sa imoha, unya private part pa gyud na" (P2, T5, L15-17)*
>
> ***Translation***: *"It is embarrassing when you think about it, because it is a man who will look at you, and it is your private part." (P2, T5, L15-17)*
>
> ***Verbatim:*** *"Kay sympre kong babae ang nars, komportable kay ta kay same lang me, then ang lalaki natural murag maulaw ka".(P6,T15,L5-6)*
>
> ***Translation***: *"Of course, if the nurse is a woman, we feel comfortable because we are the same; but if it is a man, naturally, you feel shy or embarrassed toward him." (P6.T15, L5-6)*

Participants did not question male nurses' competence; rather, they struggled to reconcile professional care with cultural beliefs. Respectful conduct, privacy measures, and sensitive communication gradually reduced embarrassment and facilitated trust.

**Cluster Theme 1.2 Perceived Gender Boundaries and Privacy Concerns**

Women's sense of emotional safety was closely linked to same-gender care, particularly during intimate maternal procedures. Cultural traditions reinforced gender boundaries, leading participants to perceive female nurses as more relatable and emotionally safer.

Participant expressed:

> ***Verbatim:*** *"Di pod makarelate si sir sa akoa isip usa ka babae" (P1, T1, L17)*
>
> ***Translation:*** *"He also cannot fully relate to me as a woman." (P1, T1, L17)*

Despite these boundaries, women showed openness to professional care that upheld privacy, respect, and informed consent. This cluster reflects early hesitation where gender defined comfort, but respectful engagement gradually blurred boundaries and fostered acceptance.

**Cluster Theme 1.3 Breaking Stereotypes**

Repeated positive interactions with male nurses gradually normalized their presence in maternal care. Familiarity reduced discomfort and reframed male nurses as legitimate and capable caregivers.

Narratives captured this shift:

> ***Verbatim:*** *"Sa akoa ma'am, okay ra gyud siya ma'am normal ra siya ma'am kay nars siya… bisan pa lalaki siya" (P14, T22, L128-129)*
>
> ***Translation: "****For me, it is really okay; it is normal because he is a nurse, even if he is a man." (P14, T22, L128-129)*
>
> ***Verbatim:*** *"Dili man ka makaingon nga maulaw ka niya tungod lalaki siya. kay daghan na man kaayo'g mga buntis ug manganakay na iyang naatiman"*

> ***Translation:*** *"You cannot really say you feel awkward with him just because he is a man, since he has already taken care of many women who were pregnant or giving birth" (P6, T15, L21-24)*

This cluster illustrated how repeated exposure challenged traditional gender roles. Findings suggest that trust and consistent positive experiences gradually reshaped perceptions, leading to greater openness and acceptance of male nurses in maternal care.

**Emergent Theme 2 Transitioning from Initial Discomfort to Developing Trust**

Women described early encounters with male nurses as marked by embarrassment and fear. Over time, however, these feelings shifted as nurses consistently demonstrated professionalism, empathy, and ethical conduct.

> ***Verbatim****:"Sa sugod, medyo gibati ko'g kaulaw ug dili ko kaayo komportable, pero maayo man niya pagka-explain sa tanan, maong gibati ko nga luwas ug kampante ko niya" (P8,T24,L18-19)*

> ***Translation****: "At first, I felt shy and uncomfortable, but he explained everything clearly and made me feel safe." (P8, T24, L18-19)*

Clear explanations, calm reassurance, and compassionate communication gradually transformed during consultations. What began as gender-focused discomfort evolved into human-centered trust, where women felt emotionally secure and respected.

Empathy was shown to significantly enhance patient trust and satisfaction, underscoring the importance of relational quality over provider identity in shaping care experiences. (Maudatsou et al., 2020)

**Cluster Theme 2.1 Professionalism and Respectful Care**

Participants frequently described professionalism as a key factor in building trust. Professional behavior, maintaining respectful boundaries, providing clear explanations, and demonstrating competence, helped shift attention away from the nurse's gender and toward the quality of care delivered.

Rather than focus on personal attributes, participants emphasized observable behaviors and clinical competence.

> ***Verbatim****: "Nagsalig man ko sa iyaha kay kabalo ko nga iyaha gyud ng gitun-an og naa gyud siya sakto ana iyang profession o trabaho"(P7,T18,L8-9)*

> ***Translation****: "I also trusted him because I know that he really studied for it and is truly qualified in his profession or job". (P7, T18, L8-9)*

> ***Verbatim****: "Okay ra pod, kay si Sir bootan man sad. Dili bastos ,so komportable ka"(P5,T14,L33-34)*

> ***Translation:*** *"It is okay because he is kind; he is not rude. You do not feel any form of disrespect, so it is comfortable." (P5, T14, L33–34)*

Women described feeling reassured when procedures were explained clearly and carried out confidently. Professional conduct reduced tension and helped normalize the interaction, reinforcing dignity and respect. Trust in this context emerged not from emotional closeness alone, but from consistent demonstration of skill and ethical behavior.

**Cluster Theme 2.2 Emotional Reassurance and Therapeutic Communication**

Participants described how empathy, humor, and an approachable manner helped lessen their anxiety and embarrassment during intimate maternal and family planning consultations. They shared that when the male nurse initiated light conversation and explained procedures clearly, they felt less awkward and more at ease. For many women, simple gestures such as smiling, speaking gently, and maintaining a respectful tone made the encounter feel less formal and less intimidating.

As the participant stated:

> ***Verbatim:*** *"Si Sir kay storyahon man pod ka niya dili ka mailang niya"(P10, T25, L244)*
>
> ***Translation****: "He talks to you so you do not feel awkward with him" (P10, T25, L244)*

Women described that through these interactions, the care experience became more emotionally supportive. Clear explanations, friendly conversation, and respectful engagement helped them feel acknowledged and valued during procedures that could otherwise feel embarrassing.

In sum, empathetic communication enables women to move from guarded silence to open trust, gradually overcoming feelings of vulnerability and building confidence in the care relationship.

**Cluster Theme 2.3 Acceptance Through Consistent Positive Encounters**

Repeated encounters played an important role in transforming discomfort into acceptance. Several participants shared that although they initially felt uneasy being attended by a male nurse, their perspective changed after multiple positive experiences.

> ***Verbatim****: "Sa una ma'am, dili gyud ko komportable kay lalaki man gud, unya kadugayan maanad ra man ko kay wala man tay choice. Si Sir ra man gud, nakomportable ra kadugayan" (P13, T27, L362-363)*
>
> ***Translation****: "At first, I honestly did not feel comfortable because he is a man. However, over time, I got used to it since we did not really have a choice, and he was the one assigned. Eventually, I became comfortable with it." (P13, T27, L362-363)*

Consistently strengthened familiarity and reduced uncertainty. As women repeatedly experienced respectful and competent care, their attention shifted from the nurse's gender to the effectiveness of the service provided.

However, some narratives also revealed that limited choice influenced acceptance. In certain cases, participants noted that they were attended to by the assigned nurse, with no alternative options. It suggests that comfort sometimes developed within existing institutional arrangements rather than through full patient autonomy. While repeated positive encounters fostered trust, the context of limited choice highlights underlying power dynamics within health care settings.

**Emergent Theme 3: Relying on Faith and Social Support for Emotional Coping**

Women described turning to both personal faith and supportive relationships to manage feelings of discomfort when receiving care from male nurses. These sources of support were expressed in two distinct but related ways:

internal coping through faith and external coping through social support.

Several women shared that prayer and trust in God helped them feel calmer during consultations. They described silently praying before or during the procedure, asking for strength, or reminding themselves that the situation was part of their health care needs. For these participants, faith served as an internal source of reassurance, helping reduce anxiety and maintain emotional stability.

In addition to faith, social support from family members and peers played an important role in emotional coping. Encouragement, reassurance, and shared experiences helped validate their feelings and normalize their experiences. This external support reinforced their confidence and helped them overcome initial discomfort, allowing trust to develop over time.

Aligned with Mercer's Theory (Mercer, 2004), this mechanism facilitated emotional adaptation and sustained trust (Zhou, 2025; Acoba, 2024)

**Cluster Theme 3.1 Cognitive Coping and Emotional Self-Regulation**

Participants described using internal strategies, such as prayer, maternal reframing, and emotional regulation, to manage discomfort. Faith functioned as both a spiritual and psychological resource, helping them reframe modesty concerns and anxiety. Rather than asserting definite outcomes, these strategies appeared to support emotional steadiness and acceptance.

Statements reflected how participants used faith and spirituality to reframe their feelings of discomfort.

> ***Verbatim:*** *"Magrelax lang gyud ko ma'am, og kailangan hunahunaon nga kinahanglan lang gyud ni maagian hangtod sa ikasiyam na bulan" (P11, T29, L437)*
>
> ***Translation:*** *"I just really try to relax, and think that you just need to get through it until the ninth month." (P11.T29, L437)*
>
> ***Verbatim****: "Ako gyud gi-ampo sa Ginoo na malampasan nako to bisan pag lalaki ang nars, unya naa'y lain pa motan-aw sa imong private part" (P2, T6,L69)*
>
> ***Translation:*** *"I really pray to God that I can get through it, even if the male nurse and other personnel can see your private part." (P2, T6, L69)*

Supporting literature confirms that integrating spirituality strengthens emotional support and culturally sensitive care (Saad & De Medeiros,2025; Balay-Odao et al., 2024).

**Cluster Theme 3.2 Support as a Source of Strength**

This cluster highlighted how social support from family, friends, coworkers, and Barangay Health Workers (BHWs) reinforced emotional stability and acceptance during maternal care involving male nurses. Emotional reassurance helped women normalize their experiences and reduce anxiety.

Social reassurance helped mitigate anxiety and reframed their perspectives toward comfort and acceptance.

> ***Verbatim:*** *"Ginacomfort man pod ko sa akong family ug sa mga ka workmates" (P1, T3, L149-150)*

***Translation**: "My family and workmates also comforted me." (P1, T3, L149–150)*

***Verbatim**: "Sa higala, nangutana ko sa ilaha unsay angay buhaton na first time pa gyud nabuntis unya lalaki pa gyud nga nurse" (P9, T29, L467-468)*

***Translation:** "I asked my friends what I should do since it was my first time being pregnant and the nurse attending to me was a man." (P9, T29, L467-468)*

***Verbatim:** "Nagpangutana ko sa mga BHW, kay lahi ra man gud ning lalaki ang mohandle" (P13, T29, L483-484)*

***Translation:** "I asked the Barangay Health Worker (BHW) because it really feels different when a man handles the care." (P13, T29, L483–484)*

Literature supports that social support during pregnancy reduces emotional strain and enhances maternal well-being and satisfaction (Al-Mutawah et al., 2023); Koçoğlu et al., 2025)

**Cluster theme 3.3 Positive Mindset and Acceptance**

This cluster reflected women's culmination of earlier coping processes. Through cognitive reframing and accumulated reassurance, participants gradually adopted a gender-neutral perspective, valuing competence and compassion over the nurse's gender. This mindset appeared to foster resilience and emotional independence**.**

***Verbatim:** "Akong mindset ato kay ibutang gyud nako permi sa akong huna-huna, nga kailangan gyud ni para gyud ni sa akoa. Kailangan magpaprenatal bisan lalaki o babae ang nars kay para ni sa akoa dili mag ulaw-ulaw" (P8, T30, L487-490)*

***Translation: "**My mindset at that time was always to remind myself that this was really necessary for me, I need prenatal care whether the nurse was a man or a woman. It was for my own good, so I should not feel embarrassed about it." (P8, T30, L487–490)*

Supporting evidence shows that reflective practice and gender-responsive education reduce stereotypes and promote inclusive, patient-centered care (Prosen, 2022; Saquing-Sellers,2025)

**Implications**

This study provided important insights into how culture, gender, and professionalism influenced women's experiences of maternal and family planning care provided by male nurses. Guided by Mercer's Maternal Role Attainment Theory (Mercer, 2004) and Eagly's Gender Role Theory (Eagly, 1987), the findings showed that initial discomfort rooted in cultural gender expectations can gradually shift toward trust and acceptance when nurses demonstrate empathy, respect, and professional competence. Authentic nursing care was found to transcend gender and be grounded in compassion, trust, and humanity.

The three emergent themes highlight key implications for practice. Gender-based discomfort was reduced through respectful behavior, privacy protection, and empathetic communication. Trust developed over time through consistent, honest, and sensitive interactions, emphasizing the importance of therapeutic communication in intimate care. Faith and social support served as vital emotional resources, helping women cope and feel secure, underscoring the value of holistic care that

addresses emotional and spiritual needs alongside physical care.

Overall, the findings emphasized that professionalism, cultural awareness, and empathy were essential in building trust, improving patient satisfaction, and promoting inclusivity in nursing care. For nurses and students, reflective practice, gender sensitivity, and cultural competence were crucial. For administrators, supportive policies, clear guidelines on privacy and consent, and inclusive institutional cultures were necessary to normalize male participation in maternal care and ensure respectful, patient-centered practice.

This study explored women's subjective experiences and perceptions of receiving maternal and family planning care from male nurses in a rural health unit. Findings indicated that cultural expectations of modesty and traditional gender roles often influenced initial discomfort related to gender. However, participants described gradual adjustment facilitated by internal coping mechanisms such as faith and cognitive reframing, as well as external support from family, peers, BHWs, and structured health practices.

Acceptance did not appear immediately; rather, it developed through sustained reassurance, visible professional conduct, and system-level safeguards. Ultimately, participants emphasized competence, respectful communication, and quality of care over the nurse's gender. These findings highlight the importance of culturally sensitive, patient-centered practices to promote trust and equitable professional recognition for male nurses in maternal and reproductive health settings.

Based on the findings of this study, several practice, education, policy, and research recommendations were proposed to strengthen patient-centered and gender-inclusive maternal healthcare.

In clinical practice, healthcare facilities were encouraged to institutionalize structured safeguards that enhanced patient comfort and trust, particularly during intimate examinations. Clear consent protocols were recommended, including explicit verbal explanations prior to the procedure and proper documentation of informed consent. Facilities were advised to ensure the availability of a chaperone, such as a female Barangay Health worker (BHW) or a significant other who accompanied the patient, whether requested or deemed appropriate. Privacy measures were recommended to be consistently observed, including adequate draping techniques, private examination spaces, and minimizing unnecessary exposure. Additionally, they are encouraged to adopt structured communication strategies, such as explaining the procedure step-by-step before physical contact and acknowledging the patient's discomfort in a respectful, validating manner. Embedding these practices into standard operating procedures was suggested to help normalize professionalism and reduce gender-based apprehension.

At the administrative and policy levels, healthcare leaders were encouraged to develop clear institutional guidelines on chaperon use, consent procedures, and privacy standards to ensure consistent practice across providers. Continuing professional development programs focusing on empathy, cultural competence, and therapeutic communication were recommended for all nursing staff. Administrators were also advised to establish a formal patient feedback mechanism to monitor comfort levels and identify areas for service improvement.

Policymakers and nursing leaders were encouraged to promote inclusive staffing policies that normalized the role of male nurses in maternal and reproductive health, thereby addressing occupational stereotyping and supporting equitable professional opportunities.

For future research, studies were recommended to include participants from diverse cultural, religious, and geographic backgrounds to enhance the transferability of findings. Comparative research between rural and urban healthcare settings was suggested to provide deeper insight into contextual differences in patient perceptions. Further exploration of male nurses' own experiences in maternal care was also recommended to provide a more comprehensive understanding of the phenomenon. Longitudinal and mixed-method studies were proposed to examine how structured privacy measures, communication strategies, and institutional policies influenced patient comfort and acceptance over time.

Together, these recommendations were intended to strengthen culturally sensitive practice, improve education preparation, enhance institutional support, and advance research promoting inclusive and patient-centered maternal healthcare.

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