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Original Article

Do Our Women Prefer Female Obstetricians and Gynecologists? - A Cross-Sectional Survey at A Tertiary Hospital in Southwestern Nigeria

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Abstract

Objective: To evaluate the provider gender preferences of obstetricians and gynecologists by female attendees at the University of Medical Sciences Teaching Hospital (UNIMEDTH) in Ondo city, south-western Nigeria. **Methods:** This was a cross-sectional study involving 500 consenting attendees at the site's out-patient unit of the department of obstetrics and gynecology. Selection was by systematic random sampling technique using pre-tested, structured, self-administered questionnaires. Data was analyzed using Statistical Package for Social Sciences (SPSS) Version 26. Descriptive analysis was presented as tables and charts and summarized as means and standard deviation, proportions and percentages. Chi-square analysis was carried out to determine the association between variables, and regression analysis carried out to identify determinants of gender preference. P-value of ≤0.05 was considered as significant statistically. **Results:** Of the 498 respondents' data analyzed (response rate of about 99%), 62% had past pelvic examinations by female specialists and 58%, by males. In addition, 53% of total respondents preferred female specialists, 28% were gender indifferent and remainder preferred males. Furthermore, clinical competence was chosen by 41% of respondents as the most important attribute for a specialist performing pelvic examinations while only 7% selected gender. Finally, when subjected to tests of association, the differences in respondents' socio-demographic characteristics and provider gender preferences were predominantly statistically insignificant. **Conclusion:** Most of this cohort prefer pelvic examinations by female specialists with no dominant associated socio-demographic characteristic. However, a great majority chose attributes of clinical competence, empathy and friendly bedside manner of the provider in preference to the latter's gender. It is recommended that specialists of both genders be made available to female health seekers to improve accessibility and reproductive health indicators in Nigeria.

Keywords: Provider gender preference, obstetrician/ gynecologists, out-patient clinics, Ondo state

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Introduction

According to the 2018 Nigeria Demographic and Health Survey, only 67% of women aged 15 – 49 years received antenatal care from a skilled provider.[1] The same survey revealed that less than 40% of live births took place in health facilities. Furthermore, an abysmal 17% was adjudged the contraceptive prevalence rate among married women. Therefore, it stands to reason that sub-optimal utilization of maternity services in health facilities might be partly responsible for these worrisome national statistics. Indeed, several studies on the sub-utilization identified individual and household causative factors such as ages of clients, levels of education, poor economic statuses and harmful socio-cultural beliefs.[2 - 5] A Port Harcourt study singled out unpleasant care experiences by health seekers (e.g., poor attitude of staff, etc.) as influencing non-utilization of facilities.[6]

Out of all the factors relevant to Nigeria, one of the most contentious and inadequately evaluated might be healthcare provider gender preference. This brings to the fore the trado-cultural and religious implications as well as the sensitive nature of subjecting female patients to intrusive physical examinations of their genitalia. Some local studies in the Muslim-dominated northern region of the country indicated that majority of female respondents preferred female specialists over their male counterparts.[7, 8] This was further corroborated in studies conducted in some Muslim-dominated countries.[9, 10] A systematic review and meta-analysis on the topic also concluded that about half of the population analyzed preferred female specialists closely followed by gender indifferent respondents.[11] However, a study conducted in Kano metropolis of northern Nigeria affirmed that more female respondents were indifferent to provider gender preference compared to those that were not.[12] The findings of this latter study were similar to those from Turkish and British surveys which also showed that majority of their female respondents had no provider gender preference.[13, 14]

A dual study was conducted among female health seekers in primary centres located in the Muslim-dominated north-eastern Bauchi and Christian-dominated south-southern Cross River states of Nigeria in which there was a sharp contrast in findings.[15] It showed that majority of respondents in the former preferred female providers whereas those in latter had no gender preference. In another study from a public hospital in Calabar to assess women's awareness, acceptance and practice preference of transvaginal ultrasound scans (TVS), majority either chose a female sonologist or were indifferent to gender.[16]

In view of the contrasting results as well as sparseness of surveys from south-western Nigeria, it is imperative to fill the knowledge gap on healthcare provider gender preference. Since it seeks to address gender interactions between health seekers and their providers, the findings of this study have the potential to drive policy changes at all facility levels.

Research Objectives

1. To determine the proportions of obstetrics and gynecology (O&G) clinic attendees that have had pelvic or vaginal examinations by either male or female specialists.
2. To evaluate the healthcare provider gender preferences for O&G clinic attendees.
3. To identify important attributes specialist doctors performing pelvic or vaginal examinations on O&G clinic attendees should possess.

Methodology

This descriptive, cross-sectional study involving consenting out-patient clinic attendees was conducted between 13th May and 30th June, 2024, in the O&G department of the University of Medical Sciences Teaching Hospital (UNIMEDTH), Ondo city, Ondo state, south-western Nigeria. The sample size was computed using the Leslie Kish formula, $n = Z^2p(1-p)/d^2$, where n was the required minimum sample size; Z, standard normal deviation corresponding to 95% confidence level (1.96), and p, estimated proportion of women attending O&G clinic as reported by Audu et al.[7] The latter study revealed 59.2% of respondents preferred female healthcare provider and d, was margin of error (5%). Therefore, the calculated sample size, n, was equal to 371. To account for non-response, 10% of the sample size was added to give a total of 408 participants, which was rounded up to a minimum of 410.

A systematic random sampling technique was used to select respondents based on the average monthly attendance of 1000 per month at the combined O&G clinics of UNIMEDTH, Ondo. The sampling interval (K) was every 4th attendee successfully selected until the sample size was reached. Pre-tested, structured, self-administered questionnaires, developed by the researchers after detailed review of relevant literature, were used to gather the required information from the respondents under the supervision of trained research assistants.

Data obtained were analyzed using Statistical Package for Social Sciences (SPSS) Version 26. Descriptive analysis was presented as tables and summarized as means and standard deviation, proportions as well as percentages. Chi-square analysis was carried out to determine the association between variables, and regression analysis, to identify determinants of gender preference. P-value of ≤ 0.05 was considered as statistically significant. Ethical approval was obtained from the Health Research Ethics Committee (HREC) of the University of Medical Sciences (UNIMED), Ondo state.

Results

Five hundred respondents were eligible for this study out of which 498 fully cooperated and had their responses analyzed, giving a response rate of 99.6%. The respondents' age range of 28 to 37 years formed the largest bloc at 40.4% followed by that of 18 to 27 years (25.7%). In addition, the majority were married (84.1%), of Yoruba ethnicity (81.7%) and Christians (85.1%). Furthermore, 43.8% had completed tertiary education and 75.5% had between 1 and 4 previous pregnancies or deliveries. Details of the socio-demographic characteristics of the respondents are illustrated in Table 1.

The responses by respondents on past pelvic examinations by male specialists revealed that 58% answered in the affirmative whereas 62% had been examined by female ones. Table 2 further highlights these.

In our study, 265 (53.2%) respondents preferred that female specialists perform their pelvic examinations while 96 (19.3%) preferred males. The others were simply indifferent. In addition, clinical competence (41.4%) was chosen as the most important attribute for a specialist performing pelvic examinations.

Table 1: Socio-demographic characteristics of respondents

Variable	Frequency N=498	Percent (%)
Age (years)		
18-27	128	25.7
28-37	201	40.4
38-47	97	19.5
48-57	45	9.0
58 and above	27	5.4
Ethnicity		
Yoruba	407	81.7
Ibo	49	9.8
Hausa	19	3.8
Ijaw	5	1.0
Others	18	3.6
Marital status		
Single	58	11.6
Married	419	84.1
Separated	8	1.6
Divorced	4	0.8
Widowed	9	1.8
Education		
Primary	48	9.6
Secondary	170	34.1
Tertiary	218	43.8
Postgraduate	62	12.4
Religion		
Christianity	425	85.3
Islam	73	14.7
No of past pregnancies or deliveries		
0	77	15.5
1-4	376	75.5
>4	45	9.0

Table 2: Pelvic examination History and Preference

Variable	Frequency N=498	Percent (%)
Previous pelvic examination by male specialist doctor		
Yes	289	58.0
No	209	42.0
Previous pelvic examination by female specialist doctor		
Yes	309	62.0
No	189	38.0

Only 7.4% of respondents selected gender as an important attribute. Table 3 showcases these responses.

Table 3: Gender preference

Variable	Frequency N=498	Percent (%)
Choice of gender of specialist doctor to perform pelvic examination		
Male	96	19.3
Female	265	53.2
Indifferent	137	27.5
Most important attribute of specialist doctor performing a pelvic examination		
Ability to empathize with patient	115	23.1
Clinical competence	206	41.4
Friendly bedside manner	99	19.9
Gender whether male or female	37	7.4
Number of years of experience	41	8.2

Table 4: Factors Associated with Provider Gender Preference

Variable	Provider Gender Preference			Chi-square	p-value
	Male n (%)	Female n (%)	Indifferent n (%)		
Age(years)				10.925	0.206
18-27	23 (18.0)	71 (55.5)	34 (26.5)		
28-37	42 (20.9)	109 (54.2)	50 (24.9)		
38-47	22 (22.7)	52 (53.6)	23 (23.7)		
48-57	4 (8.9)	22 (48.9)	19 (42.2)		
58 and above	5 (18.6)	11 (40.7)	11 (40.7)		
Ethnicity				15.966	0.043*
Yoruba	78 (19.2)	209 (51.4)	120 (29.4)		
Ibo	10 (20.4)	28 (57.2)	11 (22.4)		
Hausa	4 (21.1)	14 (73.7)	1 (5.2)		
Ijaw	3 (60.0)	1 (20.0)	1 (20.0)		
Others	1 (5.6)	13 (72.2)	4 (22.2)		
Marital status				8.485	0.388
Single	14 (24.1)	30 (51.7)	14 (24.2)		
Married	77 (18.3)	229 (54.7)	113 (27.0)		
Separated	2 (25.0)	2 (25.0)	4 (50.0)		
Divorced	1 (25.0)	2 (50.0)	1 (25.0)		
Widowed	2 (22.2)	2 (22.2)	5 (55.6)		
Education				5.376	0.497
Primary	5 (10.4)	28 (58.3)	15 (31.3)		
Secondary	30 (17.6)	96 (56.5)	44 (25.9)		
Tertiary	45 (20.6)	111 (50.9)	62 (28.5)		
Postgraduate	16 (25.8)	30 (48.4)	16 (25.8)		
Religion				4.864	0.302
Christianity	82 (19.3)	221 (52.2)	121 (28.5)		
Islam	14 (19.2)	44 (60.3)	15 (20.5)		
Traditional	0 (0.0)	0 (0.0)	1 (100.0)		
No. of past pregnancies or deliveries				3.664	0.453
0	12 (15.6)	48 (62.3)	17 (22.1)		
1-4	76 (20.2)	196 (51.9)	105 (27.9)		
>4	8 (17.8)	22 (48.9)	15 (33.3)		

When respondents' provider gender preferences were subjected to tests of association with their ages, marital statuses, education, religion, parities and ethnicity, only the latter showed differences that were statistically significant ($p = 0.043$). The statistical tests and p values are illustrated in Table 4.

Discussion

To the best of our knowledge, our study on provider gender preference among 498 female clinic attendees conducted in Ondo west, a semi-urban local council of Ondo state, is among the largest sample sizes in literature and is one of the few emanating from south-western Nigeria. A study on a similar topic among 204 respondents in the capital city of Cross River state, south-southern Nigeria had similar socio-demographic patterns to ours.[16] In the north-west, two facility-based publications among 419 and 424 O&G clinic attendees were conducted in Kaduna and Kano, respectively.[8, 12] Both revealed an expected preponderance of Muslims i.e., 56% and 81%, respectively. However, their patterns of attained educational levels differed from each other; the Kano respondents had majority of 52% at tertiary (like our study) while Kaduna had only 25%. Nevertheless, the age ranges and marital statuses were both similar in patterns to ours. Another facility-based survey among 300 respondents this time in Maiduguri, north-eastern Nigeria showed similar socio-demographic patterns to ours except in ethnicity (with Kanuris dominating theirs at 29%) and religion (Muslim majority of 62%).[9] These varied patterns reflect the expected social and ethno-religious distributions in the southern and northern regions of the country.

Prior to the conduct of our study, more respondents had been examined vaginally by female specialists compared to male ones i.e., 309 to 289, respectively. These support the subsequent finding that majority of the respondents requiring pelvic examinations prefer female specialists followed by gender indifference and lastly, male providers. These proportions corroborated provider gender preference in the Zaria study i.e., 59%, 22% and 19% for female, indifference and male, respectively.[7] It was less so in the Maiduguri study which revealed 37%, 33% and 30%, respectively.[8] Interestingly, a similar study conducted in Kano showed that indifference to provider gender had the highest number closely followed by female i.e., 45% and 43%, respectively.[12] The latter findings were also seen in the study on gender preference for sonologists performing TVS which showed 46% and 45% for indifference and female, respectively.[16] The dual study in Bauchi and Cross River states on gender preference at primary health care levels showed the former's respondents preferring female at 59% while the latter were majorly indifferent (64%).[15]

On the international level, a Saudi Arabian study on provider gender preference among 418 O&G clinic attendees revealed an overwhelming choice of female specialists at 77% followed by gender indifference (15%).[9] These proportions were almost replicated in a similar publication from Pakistan involving 280 respondents.[10] Comparatively, Tobler et al in their systematic review of 23 publications showed a lesser proportion preferring female providers at 50% and indifference, 41%.[11] However, when Turkey-based researchers specifically targeted 710 Muslim female attendees, they got a majority of 54% being indifferent to provider gender followed by female preference at 32%.[13] Interestingly, the latter findings corroborated a British study involving majorly Christian Caucasian populace with almost 52% being indifferent and female preference at 45%.[14] The summary of these varied findings suggest that female and indifferent provider gender dominate choices of female health seekers. These might partly be explained by the distinct socio-demographic patterns of the environment where the studies are conducted, with a few exceptions as earlier elucidated.

Despite most of our study respondents preferring female specialists, the top attributes for a clinician were competence (41%), empathy (23%) and friendly bedside manner (20%). Gender as an important attribute was selected in only 7% of respondents. When asked the same question, about 58% of the Kano-based respondents singled out religion as the most important factor influencing either choice of gender.[12] In Maiduguri, 36% of respondents that preferred female providers identified religion as their main reason.[8] For those based in Kaduna, it was the provider's communication ability at 79% followed by religion (73.4%).[7] Among those who preferred female providers in the British study which had similar socio-demographic patterns as ours (except ethnicity), the main attribute was good understanding at 48% and religion was a minority at 5%.[14] These findings could be explained by the preponderance of Muslims in their respective cohorts, unlike ours.

In our study, tests of association between respondents' socio-demographic traits and gender preferences were not statistically significant. The exception was ethnicity, which showed a statistically significant difference for male specialists. However, the relatively small number of respondents of Ijaw and other minor ethnic extractions in our study makes it difficult to draw a deduction from the analyses. When compared to the results from the conservative Muslim-dominated northern regions of Nigeria as well as those from Saudi Arabia and Pakistan, it should not be surprising that religion is a dominant factor in choice of female providers by O&G clinic attendees. Nevertheless, the exceptions in studies from Kano and Istanbul metropolises that revealed a preponderance of indifferent respondents suggest it is not a universal trend among Muslim-dominated populations.

The limitations of our cross-sectional study include the fact that it was conducted in a hospital environment and so cannot be extrapolated to the general population. In addition, despite use of clear language and careful supervision by research assistants, a significant number of respondents might have chosen not to or been unable to differentiate specialists from other professional cadre especially nursing staff therefore giving rise to an over-estimation of the female gender conducting pelvic examinations prior to the study. Furthermore, there might be other variables that might have been factored in by respondents but were not studied e.g., role of spouse. Nonetheless, the relatively large sample size and one of the few expositions on specialist provider gender preference in the south-western part of Nigeria make our study worthy of

impacting policies to enhance facility utilization. This could facilitate the removal of additional impediments militating against accessing reproductive health services towards reversing the current unwholesome indicators in the country.

Conclusion

In conclusion, our cohort of clinic attendees have had more pelvic examinations by female specialists and prefer the latter if given a choice as compared to male ones. However, a great majority readily sacrifice their gender preferences on the altar of attributes of clinical competence, empathy and friendly bedside manner of the provider. In addition, there were predominantly no statistically significant differences between respondents' socio-demographic characteristics and their provider gender preferences.

It is recommended that facility managers and policy makers ensure availability of specialists of both genders to cater to the teeming populace of female health seekers. This strategy could enhance facility utilization especially as relating to improving reproductive health indicators in Nigeria.

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