University of Derby

DOCTOR OF HEALTH AND SOCIAL CARE PRACTICE (NURSING)

An exploration of the lived experience of male Health Visitors: An interpretative phenomenological analysis.

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Why this study? Sadly, my inspiration-

Dear …,
I never really thanked you and Suzanne enough for your support during my HV (Health Visitor) course. Both of you showed kindness and support, where it was really needed. I practiced as a HV for a few years. I left after my own 'Baby P'. Hearing praise from the chair of the SCR (Serious Case Review), did not really feel right. I am now an 8A ACP (Advanced Clinical Practitioner) in … and still doing bank … work. I always remember you and Suzanne's support and that this course will open doors.

Ref. Email from previous anonymised male HV student received March 2022

Abstract.

The government drive to increase the national health visitor (HV) numbers in 2011 (Department of Health (DH), 2011) encompassed targeting all entrants on the Nursing and Midwifery Council (NMC) register, from all disciplines and genders. There was a specific drive to recruit men, resulting in men coming forward for the first time to train locally as HVs. The catalyst for this study was a male HV student having a challenging time within the placement setting. This made me wonder what it must be like for the male HVs undertaking the HV programme of education and subsequently working in the community, both as a colleague, to the predominantly female workforce and as a professional, delivering a traditionally female service to the community population.

The research design, following a constructivist methodology, was chosen to acquire the lived experience of the male HV through an interpretative phenomenological analysis (IPA) lens. Semi-structured interviews for data collection were conducted, verbatim transcription was completed and the six-phase approach to analysis, advocated by Smith, Flowers and Larkin (2009) was used to extrapolate findings.

The findings provided fourteen themes and four superordinate themes as follows: Gender as a factor in health visitor service delivery, The cultural marginalisation of fathers in England: health visitor service impact, Progressive career choice and Evolutionary health visitor practice and eclectic workloads. The discussion considers the theories of gender role conflict and novice to expert against the findings.

Conclusions drawn together, from the personal insightful narratives, demonstrate that male health visitors do have an impact on and are impacted by HV service delivery. Many of the participants entered the HV profession initially to find a better way of working but then embraced the role advocating for children, families and raising the profile of fathers.

This is an original contribution toward the development of knowledge as there are no other studies looking at the lived experience of male health visitors. This study can be seen as a benchmark toward future study around the subject matter.

Abbreviations

CPD = Continued professional development

DH = Department of Health

FaHV = Fathers who were also Health Visitors

GP = General Practitioner

GRC = Gender Role Conflict

HCP = Healthy Child Programme

HEI = Higher Education Institution

HRA = Health Research Authority

HTM = High Traditional Masculinity

HV = Health Visitor

HVIP = Health Visitor Implementation Plan

HVs = Health Visitors

iHV = Institute of Health Visiting

L = Line

LA = Local Authority

MH = Mental Health

MW = Midwife

NHS = National Health Service

NICE = National Institute for Health and Care Excellence

NMC = Nursing and Midwifery Council.

P = Page

PT = Practice Teacher

QNI = Queens Nursing Institute

RCT = Randomised Control Trial

RGN = Registered General Nurse

RSCN = Registered Sick Children's Nurse

SCPHN = Specialist Community Public Health Nurse

SLAIP = Standards to support learning and assessment in practice

SOT = Superordinate Theme

SSSA = Standards to support supervision and assessment

STEM = Science, Technology, Engineering and Mathematics

T = Transcript

TL = Team Leader

UK = United Kingdom

Glossary of terms

The glossary of terms enables the reader to see the perspective of the writer in using such terms.

Discrimination. This term denotes a difference, that does not usually carry a negative connotation. Within this study the term discrimination is used as in legal terms as an unfair process or treatment due to difference that leaves someone disadvantaged or at detriment due to their gender, racial, sexual, or other difference (Thompson, 2012).

Fore-structure. The researcher's previous 'experiences, assumptions and preconceptions' used reflexively before, during and after the interpretation, while maintaining focus on the phenomenon at hand (Smith, Flowers and Larkin, 2009, p.25).

Gender. "*Describes the characteristics of women and men that are socially constructed, while sex refers to those that are biologically determined. People are born female or male but learn to be girls and boys who grow into women and men. This learned behaviour makes up gender identity and determines gender roles*" (World Health Organisation (WHO), 2022).

Health Visitor. An NMC registered nurse and/or midwife with additional training in specialist community public health nursing. HVs provide an evidence based professional public health service for individuals, families, groups and communities; enhancing health and reducing health inequalities through a proactive, universal service for all children 0-5 years and for vulnerable populations targeted according to need (Institute of Health Visiting, (iHV), 2022a).

Health Visitor Implementation Plan-A Call to Action (DH, 2011). A specific Department of Health recruitment drive to build the HV workforce by 4,200 over a four-year period.

Hegemony. The social, cultural, ideological, or economic influence exerted by a dominant group (Agnew, 2005).

Intersectionality. Any or all of the following overlap: "Ethnicity, socioeconomic status, disability, age, geographic location, gender identity and sexual orientation, among others. This is referred to as intersectionality." (WHO, 2022)

Oppression. The outcome of negative discrimination on those affected be it isolation, marginalisation, reduction in life chances and self-esteem for example (Thompson, 2012).

Nursing and Midwifery Council (NMC) - Professional regulatory body for nurses and midwives**.**

Sex. "Sex refers to the different biological and physiological characteristics of females, males and intersex persons, such as chromosomes, hormones and reproductive organs." (WHO, 2022)

Specialist Community Public Health Nurse (SCPHN)- A qualified nurse and/or midwife who has completed a post graduate specialist course and is registered on the 3rd part of the Nursing and Midwifery Council register.

Chapter One. Introduction

1.0 Introduction

This chapter will introduce the researcher, noting their fore-structure also known as positionality that is influential in every aspect of this research and the interpretation of the findings. My fore-structure or positionality is based on my previous 'experiences, assumptions and preconceptions' used reflexively before, during and after the interpretation, while maintaining focus on the phenomenon presented (Smith, Flowers and Larkin, 2009, p.25).

The rationale for the research will be presented together with fundamental information to set the scene for the thesis ahead, including a reader map to identify where to find content within the thesis.

1.1 My Fore-Structure and Positionality Statement: Motivation for the Study.

I qualified as an Enrolled Nurse-Adult in 1985, as a Registered General Nurse-Adult in 1991 and later as a Specialist Community Public Health Nurse (SCPHN)-Health Visitor (HV) in 1996. The research problem resulted from my experience both as a practice teacher (PT) within the field of a SCPHN-HV and subsequently taking up an educational role as a lecturer within the Higher Education Institution (HEI) setting. Previously, within the community as a student HV, I came across one HV that happened to be a man. To my knowledge, he was fully integrated as part of the wider team and was given respect and acceptance by both staff and clients. On reflection this may not have been the case but nothing adverse came to my attention during that time. During my time as a qualified HV and subsequently a PT, I did not personally come across any other male HVs for approximately 16 years. Then came a government drive to increase the national numbers of HVs by 4,800, over 3 years, known as the Health Visitor Implementation Plan: A Call to Action (HVIP) (Department of Health (DH), 2011). During that time, the Specialist role of the HV was marketed, targeting all entrants on the Nursing and Midwifery Council (NMC) register, from all disciplines and genders with a special push on recruiting men, resulting in men coming forward for the first time to train at the local HEI as HVs. Interestingly there has been a consistent history of men training to be Specialists in District Nursing (DN) locally, but not men training to be HVs. I found it intriguing, considering the different dynamic that having a man in the group brought to the learning environment. The catalyst for

this study was a male HV student being given a challenging time within the placement setting. This made me wonder what it must be like for the male HVs undertaking the HV programme of education and going into the community, both as a colleague, to the predominantly female workforce and as a professional, delivering a service to the community, who traditionally experienced working with female HVs.

The research presented in this thesis was undertaken as part of a professional doctorate award. My employing organisation helped to support some of the funding, related to Continuous Professional Development (CPD) expectations, with the rest funded personally, but no external funding was attached to this study.

1.2 The origins and history of the role of the Health Visitor: a gendered context.

The 1848 'Act for Promoting Public Health', the first Public Health act of its kind, was aimed at environmental factors such as dwellings and drainage, rather than personal health and hygiene (While, 1987). The health of the general population was in a desperate condition, due to poor overcrowded housing, unsafe working practices and malnutrition (Baggott, 2000). The charitable work of visiting the poor and voluntarily giving support by middle class women was a regular activity (While, 1987). It was this backdrop and particularly the high infant mortality rates (While, 1987), that set the scene towards the development and evolution of the role of the Health Visitor.

Health Visiting as a profession is recounted to have emanated from The Manchester and Salford Ladies Sanitary Reform Association, that was established in 1862 (iHV, 2022d; Adams, 2012). Thus, Health Visiting was engendered as woman's work from the outset (Peckover, 2013). Respectable women, were employed initially in a sanitary inspector role, known as Sanitary Visitors (Adams, 2012; Baldwin, 2012) and the ladies would visit less fortunate impoverished women and children at home and give educational advice on health-related matters such as nutrition, abstinence from alcohol, cleanliness and child welfare, while also offering practical support on maintaining comfort in the home (While, 1987; Heggie, 2011).

Appointing Medical Officers of Health (MOH) became a legal requirement following the inception of the 1872 Public Health Act (While, 1987). While (1987) highlights that while the MOH covered differing population sizes they were expected to cover a couple of communities in the less affluent, rural areas. At the same time the more able MOH saw the opportunity of home visiting as a way to influence individual health and

well-being factors (Haynes, 2006). This HV transition from a voluntary PH endeavour into paid employment by the local authorities (LAs) was a notable time, with 50 LAs employing female HVs by 1905 (While, 1987; Henshaw, 2021).

A Phd study by Haynes (2006) explored, through the inspection of published records, the role of the lady sanitary inspectors and visitors working in a public health role from 1890-1930. Haynes (2006, p14, p93, p95) provides citations of engendered narrative, suggesting that such public health visitation should be carried out by well educated women, who were ladies, with lady like characteristics, and the ability to communicate across all walks of life, regardless of their personal educational or financial standing. Critically, Haynes (2006) highlights the short comings of this arguably assertive female role of its time, suggesting that the lady Sanitary Inspectors and Visitors were acting upon the direction of notable male reformers, husbands and latterly MOHs (Haynes, 2006).

The 1907 Notification of Births Act (Parliament UK, 2023) added momentum to the role of the HV, as all births had to be notified within 36 hours of arrival. Subsequently the Notification of Births Extension Act in 1915 (Haynes, 2006) empowered local authorities to employ HV's from the rates income toward instigating home visiting for all new babies and mothers (Parliament UK, 2023). Notably, this increased the number of HVs to 1,355 full time equivalents by 1918 (Haynes, 2006).

Adams (2012) asserted Florence Nightingale's notion that while HVs required the same level of knowledge as nurses, a different qualification and knowledge base was required, and Florence provided some of the initial HV training. Subsequently, the recognised formal qualification for HVs in 1916 was launched by the Royal Sanitary Institute (Adams, 2012). Following this, the Ministry of Health in 1919 created the first statutory HV qualification (iHV, 2022d).

A change to the entry requirements for HV training instigated by the Ministry of Health in 1925 produced a midwifery qualification as a prerequisite (Adams, 2012). As such, at that time, critically the prerequisite of a midwifery qualification would have inhibited men generally from aspiring to enter the HV profession. Midwifery remains today a female dominated profession, with the NMC reporting that 0.3% of the midwifery workforce is male (NMC, 2023a).

The Health Visiting profession was legislated in statute from 1929 with a standardised qualification introduced, and the professional name of Health Visitor listed as a protected title up to 2004 (iHV, 2022e). Baldwin (2012) reports in 1945, the prerequisite toward HV training altered again and being registered as a nurse was an expectation to be accepted onto a programme, but HVs stayed under LA employment up to 1974 (iHV, 2022d). As nurse training included men and women this time could have been the point where more men entered HV as a profession, but no evidence could be found to suggest this. With the initiation of the NHS in 1948 a holistic inclusive approach began toward family and child health, through beginning to identify and recognise abuse and the requirement for some interagency work, causing some confusion between the role of the HV and that of the Social Worker (Baldwin, 2012). It was in 1974 that HV employment moved into the NHS from local authority, arguably moving the focus from community work, through being attached to General Practitioners (GPs), to a medical model of individualised care (Baldwin, 2012).

The legal status of the HV ceased and the HV specific register closed in 2004 (iHV, 2022e). All registered HVs were moved onto the third part of the NMC register and annotated under the latest protected title of Specialist Community Public Health Nurse (Health Visitor) (SCPHN, HV) (Legislation.gov.uk, 2023). The title does not sit in statute and as such arguably began the demise of the HV role (see section 5.5). The SCPHN nomenclature has struggled to gain traction and the term HV remains routinely used by the public and professionals today.

In 2010 the Department of Health published the ‘Equality Analysis Health Visiting Programme’ document that reported 1% of all HVs were male. As such the HV profession remained engendered at that time. A push to raise the numbers of HVs 2011-2015 (DH, 2011) aimed to recruit qualified nurses, from all fields, and midwives. A specific mention of men in the advertising campaign was hoped to entice more men into the specialist HV field. However, data on the numbers of HVs is difficult to find regardless of gender (Conti and Dow 2021).

As can be seen in this condensed historical narrative, the HV role has been voluntary, overseen by LA, transitioned into the NHS and more recently moved back to the LA in 2015. Despite this complex 160-year evolution of the HV role, few men have entered

the profession. This study aims to explore the lived experience of men who are nurses or midwives and chose to train and work within the HV profession.

1.3 Nomenclature

The nomenclature of men that work as nurses, midwives (MWs) and HVs is debateable. For this study, the term male was used in line with the World Health Organisation (WHO) (2022) definition, related to sex being biologically determined as male or female and gender as socially constructed and variable across different societies. For this reason, the term male nurse/MW/HV was deemed most appropriate. As with other traditional constructs, such as mother or father (see section 6.4), the world is always changing and this study is not able to cover all permutations related to being a parent, as the priority is to address the research question.

1.4 Male Nurse, Midwife and Health Visitor Demographics

There is presently a Health and Social Care workforce gap (UK Parliament, 2020), with a particular problem in nursing and community nursing. Male nursing numbers have remained around 10% of the workforce for many years with a relatively recent increase to 11% (Whittock, 2003; Herakova, 2012; NMC, 2021). Despite this, being of male gender correlates with heightened nurse training attrition rates (Salamonson, *et al*., 2014). Midwifery has the least notable number of men in the profession with 0.3% listed for 2021(NMC, 2021), whereas health visiting is thought to have around 1% of the HV workforce being male (DH, 2012b) although, specific HV related data is no longer provided in the NMC Equality, Diversity and Inclusion annual data tables for public scrutiny (NMC, 2021). Even if the numerical data of male HVs was available it would not mean that the number given would be reflected in the client facing workforce, as male HVs could be employed in other roles. This is the same situation for all the NMC registration statistics provided. However, the data could provide approximate growth or decline in overall numbers over the years. In this way, the government and commissioners would be able to effectively develop the workforce strategy over the longer term.

HV numbers had reduced pre-pandemic by a third, causing a national shortage of five thousand HVs (Day, 2022). During the pandemic 63% of HVs were redeployed with these jobs being lost altogether in some areas (Conti and Dow, 2021). Some HVs have caseloads of over 750 children under the age of five, when the recommended

number is 250 (Conti and Dow, 2021). With this information to hand it would seem important to rebuild the HV workforce, to provide the Healthy Child Programme (HCP) (DH, 2009) through the new delivery model (PHE, 2021a) and support children and their parents, (House of Commons Petitions Committee, 2022). Importantly, the recruitment of more men could help to achieve the HV workforce required.

1.5 Reader Map.

Chapter Two introduces the initial literature review, the design, execution and process of analysis before discussing the findings. The literature review did not identify any peer reviewed articles related to male HVs, resulting in the search being carried out on literature related to male nurses. From the review of the literature the semi-structured interview questions were formed and subsequently tested within the pilot study.

Chapter Three considers the epistemological stance and justifies the methodology and utilised methods that ensured a robust approach for the research study. This chapter applies the chosen approach to data collection and analysis which was a critical part of the qualitative research prior to presenting the findings.

Chapter Four presents the findings following the analysis of data using interpretative phenomenological analysis and being mindful of convergence and divergence within this qualitative study. Direct quotes are chosen and used with care to ensure the points made are clear to the reader.

Chapter Five updates the literature review on male nurses' experiences. A discussion is provided on how the new papers added to or altered the original themes from the initial literature review.

Chapter Six presents the conceptual framework and discussion of the findings, exploring triangulation with the literature and researcher positionality. Theoretical frameworks particularly pertinent to this study are presented and discussed throughout this chapter.

Chapter Seven draws from the research study, reported across the thesis, to form conclusions. How the aim and objectives have been met will be illuminated while identifying the answers to the research question. Limitations to the research approach and process are also discussed bringing the study to a conclusion.

Chapter Eight makes recommendations for future practice and research, following the conclusions of the research process and findings, to create the best impact. The dissemination of the research to date and the plans for future dissemination of the completed study are presented.

1.6 Summary

Chapter one introduced my background as the researcher, known as fore-structure or positionality, together with my rationale and motivation to undertake this study. An insight into the notion of masculinity is presented with demographic information of the numbers of men working in the fields of nursing, midwifery and health visiting. A reading map is then presented to guide the reader into the structure and content of the overall thesis.

Chapter Two. Initial Literature review

2.0 Introduction:

Due to the paucity of peer reviewed literature about male HVs and the prerequisite of all HVs being nurses and/or midwives (NHS Careers, 2022), it was deemed appropriate to illuminate the experiences of male nurses within this literature review. In this way the salient points could be captured, and the themes gathered would assist in constructing the questions for the semi-structed interviews within the study.

In recent times the quality of nursing care across the United Kingdom (UK) has been under scrutiny. Following the thorough investigation into the failings of the Mid-Staffordshire hospital, The Francis Report (Francis, 2013) and the National Institute for Health and Care Excellence (NICE, 2014) recommended that the number of nurses needed to grow especially regarding providing skilled nurses that can deliver the holistic care requirements of specific patients. Critically, for this to happen there needs to be a greater mix of diversity within the nursing profession, including the balance of gender, to mirror the rich mix of society that it serves.

Historically, men have been involved in caring for others through nursing activities (Macintosh, 1997). With Liminana *et al*, (2013) asserting that historically nursing was an acceptable role for men. During the Middle-ages, helping the sick and attending to the wounded was attributed to males such as the military or religious groups (Liminana-Gras *et al*., 2013). This situation changed during the Crimean War, in the 19th century, when Florence Nightingale radicalised the nursing profession portraying it as the work of choice for young ladies and as a result the nursing profession moved to female dominated workforce (Evans, 2004). Since this reduction of men in nursing the male nurse population has failed to regain its former figures (Oxtoby, 2003; Ford, 2019). Evans (2004) claims that for the men who took up nursing, it was initially in areas deemed less appropriate for women, such as asylums, to care for the mentally ill or violent patients. This is arguably as men are stereotypically and scientifically thought to be physically stronger, with a larger muscle mass and bone density than women (Blair, 2007) and as such would potentially address physically aggressive behaviour more easily than women. Leonard and Whittock (2003) state that violent patients are routinely placed with the male nurses due to the nurses' assumed strength. Milligan (2001) adds to this notion suggesting that the male nurses felt valued because of the physical contribution they could make to nursing care through lifting

and handling. Yet other male nurses found these repetitive manual tasks arduous, suggesting being like a crane or a removal man, which is not what they came into nursing for (Evans, 2004). Ford (2019) asserts that male nurses remain more prevalent in the professional fields of mental health and learning disabilities.

Williams (1995) highlights opportunities for men in nursing claiming there is a potential to fast track to the top, sometimes referred to as ladder climbing, into nursing management, where the responsibility and financial reward are higher. Despite this incentive, Dyck *et al*. (2009) report that demographically and culturally men remain in the nursing minority. Men represent approximately only 10% of nurses within the UK (Nursing and Midwifery Council (NMC), 2011b), 10% in America (United States Bureau of Labor Statistics, 2014) and 6.4% in Canada (Canadian Nurses Association, 2012). Interestingly a contributory factor toward the minority in male nurse numbers is the realisation that from the outset the attrition rate for male nurse students, who fail to complete their nurse education, is an ongoing issue (Stott, 2003, 2007; Whitfield *et al*, 2019). This early attrition of male nursing students is then further compounded by nearly double the amount of newly qualified male nurses leaving the occupation than female nurses within four years of qualification (Sochalski, 2002). The reasons for this lack of men and high attrition of male nurses are not clear and thus further investigation was required.

The following critical literature review aimed to establish why there continues to be so few men in the nursing profession.

The Literature Review

2.1 Aim:

The aim of this critical literature review was to explore the literature to investigate why there are so few men in the nursing profession.

2.2 Method:

A critical literature review was undertaken utilising the guidance of Aveyard (2010). To bring the relevant literature together and draw out the salient themes for analysis and discussion, a systematic and structured approach was required (Aveyard, 2010). The comprehensive picture drawn from the collated studies aims to elucidate the notions put forward that potentially could be lost when relying on evidence from one paper alone.

To report on the most up to date evidence available, the date parameters for the search were set from 2004 to 2014 as part of the inclusion/exclusion criteria (Table 1).

Table 1 Inclusion and Exclusion Search Criteria

Inclusion	Exclusion
Time frame 2004-2014	Dates outside of the time frame
Published in the English language	Not published in the English language
Research published in a peer reviewed journal	Unobtainable full articles
Full text research article	Non-research articles. Descriptive papers. Editorials
Discourse around being a male nurse	The experience of a man being nursed

The search engine EBSCO was used to search databases including, AMED, CINAHL Plus, MEDLINE, PsychINFO, PsychArticles and ebooks. After many false starts with the literature search, trying different terminology such as 'men in nurs*', 'men and/or nurs*' to find this permutation, led to identifying articles that involved men seeking medical support from nurses, and some explicit material, which were not appropriate for this study. It was recognised to retrieve appropriate articles, the search terms required were "male nurs*". By utilising the speech marks, it ensured the combined phrase was searched for. The asterisk* was used to identify all possible endings such as nurse, nursing and nurses. Boolean Operators: 'AND' was applied to include the United Kingdom (UK) 'OR' Ireland (Aveyard, 2010). Full text and peer reviewed articles were requested with other limiters including English Language, Sex-Male and Population-Male. The Assia database was reviewed separately, and no new papers were retrieved using the same search strategy.

The initial total of papers found was 2,529. Qualitative methodology, as inclusion criteria (McIntosh-Scott *et al*., 2014), was added to the search resulting in 512 papers. The database classification categories of professional education and training, health and mental health (MH), professional attitudes and characteristics were added together with the subject matter of nursing, nurses, health care service, education programmes, sexuality, health care policy, stigma and clinical practice bringing the final yield to 48 papers. Of these, three papers were unobtainable leaving 45 papers.

The titles, geographic location of the study and the abstracts of the final 45 papers were reviewed to ascertain content related to the subject matter, duplication, and the hierarchy of research. McIntosh-Scott *et al*. (2014) assert that it is as important to state why papers are excluded as well as included in the review to maintain credibility.

2.3 Results*:* Despite originally specifying papers from the UK and Ireland, only one paper was retrieved from each location. It became apparent that if the retrieved papers had been published in the UK or Ireland, regardless of where the research had been undertaken, they would be in the final yield even though the study could have taken place in any part of the world. As there were too few papers from the UK and Ireland to undertake an informative literature review, the geographical breadth of literature accepted was widened to include global papers. The 20 papers remaining were then critically appraised utilising the Guidelines for Critical Review Form-Quantitative Studies (Law *et al*., 1998) and the Guidelines for Critical Review Form-Qualitative Studies (Version 2) (Letts *et al*., 2007). This critical review facilitated the removal of a further 7 papers that did not meet the criteria or were not within the acceptable hierarchy of research (Aveyard, 2010). One of the excluded papers was analysing data related to male nurses that had been collected eight years previously (Romem and Anson, 2005). Arguably in the presently fast changing world the findings may not still be relevant. In addition to this notable point, despite specifying qualitative research as a methodology of choice in the literature search, critically nine of the final 13 papers used a quantitative research methodology. Aveyard (2010) suggests that if the initially desirable literature is not found it is still possible to answer the question with alternative literature. From a positive position this gap in qualitative research methodology identifies an opportunity for future research and the research papers retrieved gave a valuable insight into why there are so few men in the nursing profession.

The final 13 acceptable included papers are all research papers that have been published in peer reviewed journals (Table 2). There is value in raising here that 4 of the papers are from Taiwan and written by a core of authors, alternating as the lead author for each publication (Jiunn-Horng, Hsing-Yi and Sheng-Hwang, 2009; Jiunn-Horng *et al.,* 2010; Hsiu-Yueh *et al*., 2010 and Sheng-Hwang *et al.,* 2013). There are between 100-300 participants in each study all reportedly from National Union of nurses' Associations Republic of China Database. Arguably, they use different data but have a similar style for each piece of research and format for writing up the

research that is evidently successful with regard to the resulting number of publications. The response rate for all four studies (Jiunn-Horng, Hsing-Yi and Sheng-Hwang, 2009; Jiunn-Horng *et al.,* 2010; Hsiu-Yueh *et al.,* 2010 and Sheng-Hwang *et al.,* 2013) was routinely higher, ranging from 62%-86% than the 40-50% routinely expected for mailed questionnaires (Gray, 2014; McIntosh-Scott *et al.,* 2014), suggesting that contributing to research is culturally ranked more highly in different parts of the world.

Table 2 Included papers: A General Overview.

	Author/s	Year	Title	Sample Size	Methodology/ Design	Geographical Setting
1	Clow, Ricciardelli and Bartfay.	2013	Attitudes and Stereotypes of male and female nurses: The influence of social roles and ambivalent sexism.	n=145	Quantitative Cross sectional survey.	Canada
2	Dyck, Orliffe, Phinney and Garrett.	2009	Nursing instructors' and male nurse students' perceptions of undergraduate, classroom nursing education.	n=12	Qualitative Interpretive Ethnographic study.	Canada
3	Harding.	2007	The construction of men who are nurses as gay.	n=18	Qualitative A phenomenological approach, through in-depth interviews.	New Zealand
4	Herakova.	2012	Nursing Masculinity:	n=8	Qualitative	United States America

			Male Nurses' Experiences through a co-cultural lens.		Phenomenology through in-depth interviews.	
5	Hsiu-Yueh, Sheng-Hwang, Hsing-Yi and Jiunn-Horng.	2010	Job stress, achievement motivation and occupational burnout among male nurses.	n=121	Quantitative Cross sectional survey.	Taiwan
6	Inoue, Chapman and Wynaden.	2006	Male nurses' experiences of providing intimate care for women clients.	n=12	Qualitative A phenomenological approach, through in-depth interviews.	Australia
7	Jiunn-Horng, Hsing-Yi and Sheng-Hwang.	2009	Factors affecting the career development of male nurses: a structural equation model.	n=308	Quantitative Cross sectional survey.	Taiwan
8	Jiunn-Horng, Ren-Hau, Hsing-Yi and Sheng-Hwang.	2010	Relationships among self-esteem, job adjustment and service attitude amongst male nurses: a structural equation model.	n=284	Quantitative Cross sectional survey.	Taiwan

9	Liminana-Gras, Sanchez-Lopez and Javier Corbalan-Berna.	2013	Health and Gender in Female-dominated occupations: The case of male nurses.	n=196	Quantitative Cross sectional survey.	Spain
10	Loughrey.	2008	Just how male are male nurses?	n=104	Quantitative Non-experimental descriptive design.	Ireland
11	Salamonson, Everett, Cooper, Lombardo, Weaver and Davidson.	2014	Nursing as First Choice Predicts Nursing Programme Completion.	n=352	Quantitative Longitudinal Cohort Study.	Australia
12	Sheng-Hwang, Hsing-Yi, Hsiu-Yueh, Fang-Chen, and Jiunn-Horng.	2013	Organisational support, organisational identification and organisational citizenship behaviour among male nurses.	n=109	Quantitative Cross sectional survey Pilot.	Taiwan
13	Wallen, Mor and Devine.	2014	It's About Respect: Gender-Professional Identity Integration Affects Male Nurses' Job Attitudes.	n=178	Quantitative Web based survey.	United States America

2.4 Discussion*:* When evaluating the literature chosen for review, Griffiths (2009) suggests reading and rereading the papers while comparing the techniques and findings to ascertain similarities and differences and make decisions as to the reasons for commonalities and variance. Griffiths suggests initially looking at the key findings together to ascertain an overview (Table 3).

Table 3. Key findings from the identified research papers.

	Author/s and Title	Key Findings	Cited in paper
1.	Clow, Ricciardelli and Bartfay, (2013)	From this comparative study of nursing to non-nursing students there was evidence that the female nursing students held nurses of both genders in higher regard than the students from a non-nursing background.	3
2.	Dyck, J. *et al.* (2009)	Male nurse students demonstrated heightened traditional masculinities as a gender norm. The students did not see themselves as integrated, which demonstrates findings with other papers where the male nurse needed to feel a sense of belonging.	--
3.	Harding, (2007)	The gay stereotype of the male nurse persists, causing male nurses to experience homophobia at work causing heterosexual male nurses to use strategies against this assumption. Yet there is also a divide where the psychiatric nurse is deemed 'heterosexual' while the general nurse is perceived to be 'homosexual'.	--
4.	Herakova, (2012)	A sense of belonging is required for male nurses in order to normalise nursing as a profession for them. Participants reflected on trying to influence traditions in nursing to feel and be accepted as a male nurse within the female nursing arena. This sense of belonging mirrors the required sense of belonging in other papers.	--
5.	Hsiu-Yueh *et al.* (2010)	Job loading, role conflict and occupational burnout were related to the stress of the job resulting significantly in professional burnout.	--
6.	Inoue, Chapman and Wynaden, (2006)	For male nurses, the provision of intimate care, to women, proved to be a barrier requiring the construction of complex coping strategies.	--
7.	Jiunn-Horng, Hsing-Yi and Sheng-Hwang,	There was a statistical significance of emotional labour toward empowerment professionally, which in turn was significant in relation to the career development of male nurses. Although emotional	--

	(2009)	labour was not directly related to nursing career development when put with professional development it accounted for the variance of 75%.	
8.	Jiunn-Horng *et al.* (2010)	Adjustment to the job explained and influenced male nurse attitude toward the service. Service attitude was not linked significantly to self-esteem. This finding correlates with normalising the profession for the male nurse in other papers.	--
9.	Liminana-Gras, Sanchez-Lopez and Javier Corbalan-Berna, (2013)	The analysis showed that male nurses had better health than female nurses. Despite highlighting a usual pattern regarding the male health experienced by male nurses, the male nurses demonstrated other diminished male gender norms such as risk taking, winning and power over women, among others.	2, 3 6, 10
10	Loughrey, (2008)	The male nurse sample generally identified with more female than male gender norms. This study shows similarities to the findings in other papers in relation to the gender norms associated with some male nurses.	--
11	Salamonson *et al.* (2014)	When nursing was the primary choice of career for the student their chances of programme completion were doubled. However, the male nurse students or the students who had additional employment, over 16 hours weekly, showed higher rates of attrition. An undercurrent of sexism exuded which was similar in other papers.	11
12	Sheng-Hwang *et al.* (2013)	The analysis showed that organisational support through good work conditions and supervisor support increased the organisational citizen behaviour of the male nurses. However, this varied significantly across the types of organisations and related mostly to the organisational distinctiveness and identification which related to the ownership invested in the organisation as stated by the participant.	10
13	Wallen, Mor & Devine, (2014)	The job commitment and satisfaction were positively affected when there was integration of the male gender and the role of a nurse, when working as a man in the nursing profession. Male nurses tended to continue working in the female dominant career as the fusion of job role and gender increased. As the external admiration of nursing improved, the job satisfaction rose together with job commitment.	--

Table 3 above, highlights Liminana-Gras, Sanchez-Lopez and Javier Corbalan-Berna (2013) as a paper which is highly relevant to the inquiry regarding the scarcity of men working in nursing as a profession, cited in four of the final 13 papers. Harding (2007) and Loughrey (2008) have both been cited twice in the chosen 13 papers which suggest that their work is influential toward the specific discourse. Critically Harding (2007) and Loughrey (2008) were more likely to be cited in other papers retrieved in the search as they were published earlier, although the same cannot be said for all the earlier papers.

Many areas of interest were initially evident when reviewing the final papers and notes were made for future consideration. This part of the process was important to allow the commonalities and differences to emerge before being able to see the wider perspective of the developing associations and subsequent themes (Robson, 1997). When rereading the papers colour codes were given to the lines of text that housed the associated subject matter to clearly draw out the overriding points regarding the subject (Holloway and Wheeler, 2002).

Further rereading of the papers and consideration of the overriding points allowed them to be drawn together and become subthemes that then formed patterns under themes and overarching themes, as suggested by Polit and Hungler (1997) (Table 4).

Table 4. **Overview of the Themes and Overarching Themes from Identified Research Papers**.

Themes	Overarching Themes
Communication	Isolation
Minority	
Sexism	
Intimate Care	Work related stress
Workload	
Role model	

Eight of the final 13 papers reported findings related to the overarching theme of isolation, in relation to one or more of the themes and seven of the final papers related to the overarching theme of work-related stress, in relation to one or more of the

themes. This demonstrates that the mutual mapping of themes and overarching themes to the papers, reflects the papers mapping to the overarching themes and themes demonstrating congruence. The overarching themes will now be discussed.

2.4.1 Isolation

The overarching theme of isolation for the male nurse may not be a constant feature of their existence but could go some way to identifying the reason for so few men in the nursing profession. Clow, Ricciardelli and Bartfay (2013) put forward that the lack of men in nursing predisposes to the position of nursing being a female dominated occupation that is not wholly due to gender diversity. They continue that because of the large number of female nurses, the idea that nursing is a female role is perpetuated and so is thought to be gender specific. Critically as Clow, Ricciardelli and Bartfay (2013) only had three male nurse participants in their study, they chose to remove them from the sample. This could be argued as consciously negating the male nurse voice further. Another suggested weakness of the study is that the participants were given 20 minutes at the end of a lesson to complete the multiple scales, measures and dual favourability score. An incentive of $100 was offered which could potentially cause participants to rush to complete the activities in the allotted time scale. Time was notably in short supply as the participants with incomplete areas of data were taken out of that section of analysis, thus resulting in lack of clarity as to who completed which parts of the research (Clow, Ricciardelli and Bartfay, 2013).

Isolation was caused by multiple factors such as being in the minority gender, being assumed to be gay or being gay, being exposed to sexism and due to exerting an exuberant communication style to fit in (Harding, 2007; Loughrey, 2008; Dyck *et al*., 2009; Herakova, 2012; Salamonson *et al*., 2014 and Wallen, Mor & Devine, 2014). Harding (2007) identified that the gay stereotype of men in nursing was still evident and caused not only men that were gay, but also those who were heterosexual, to become victims of bullying and harassment. Harding (2007) expanded the complexity of this further as his findings portrayed the male general nurse as homosexual while the male psychiatric nurse was still deemed to be heterosexual demonstrating that despite all the participants acknowledging that most male nurses whom they knew were heterosexual, the notion of the gay male nurse was strong enough to marginalise reality. Harding (2007) put forward that this strong inaccurate stereotype of male

nurses would potentially stop men from entering or indeed stop them from remaining in the ironically named ‘caring’ profession. The feeling of ‘otherness’ prevented a sense of belonging developing and then perpetuated the feeling of isolation (Herakova, 2012).

Dyck *et al*. (2009), in an interpretive ethnographic study, referred to isolation in terms of the ‘token male’ and conversely, because of trying to fit in. However, due to the masculine characteristics of leadership and competitiveness spilling out at times rather than fitting in, this caused the man to stand out more from a majority female classroom (Dyck *et al*., 2009). It was noted that despite, at times, the men only making up 15% of the cohort they were noted to engage 75% of the time and this singled them out from the females (Dyck *et al*., 2009). It was noted that the classroom culture did not embrace diversity and made the men feel like outsiders yet, as noted above, they still contributed. This negative stance was tempered by suggestions that for a single guy nursing could be a gold mine (Dyck *et al*., 2009), although arguably this should not be a marketing strategy for the future of nursing or widening participation.

2.4.2 Work Related Stress

The overarching theme of work-related stress is underpinned with themes such as intimate touch, lack of role models, workload in relation to lifting and handling expectations and high levels of anxiety (Juing-Horng, Hsing-Yi and Sheng-Hwang, 2009; Hsiu-Yueh et al., 2010; Sheng-Hwang et al., 2013 and Salamonson *et al*., 2014). Dyck *et al*. (2009) noted limited access to a role model that was male both within the clinical setting and amongst the teaching staff. This point alone would potentially have a negative impact on a newly qualified male nurse that is looking for verification and inspiration for future practice. Sheng-Hwang *et al*. (2013) suggest that male nurses undergo more social stress within their nursing career and to retain male nurses there needs to be an organisational cultural shift toward supporting them through integration and involvement. This notion links to the overarching theme of isolation and at times it is difficult to unravel the complexity of not only retaining but increasing the numbers of the male nurses globally.

A clearly defined factor that caused stress among the male nurses within the final papers was the issue of intimate care. Herakova (2012) found that the male nurses formed strategies to negotiate intimate care with the least stress possible through

working with a female team or negotiating or delegating the task to another. Inoue, Chapman and Wynaden (2006) found in their qualitative phenomenological approach to in-depth interviews that the provision of intimate care was a challenge using emotional labour and causing them to encroach on the personal space of their client resulting in personal anxiety to them. While not wishing to minimise this notion, it could be argued that female nurses have the same anxieties when providing intimate care for clients but due to the scarcity of male staff the option of delegation may not be available.

2.5 Conclusion and recommendations

The critical literature review followed a systematic approach to explore the historically low numbers of male nursing staff in the profession. The findings suggest that the isolation of some male nurses is impacting both on recruitment and retention. The workload related stress is complex and potentially needs a cultural shift to overcome.

Recommendations include working toward reducing the gender divide by sharing knowledge and initially supporting male nurses to promote their role in nursing. In this way, the increased exposure of the male nurse will hopefully engender increased acceptance as suggested by Pettigrew and Tropp (2008) to lessen prejudice. The education of nurses needs to be reviewed to integrate the male nurse into the profession rather than singling them out as a token male. Sexism should be challenged at the point of contact and taken further with strong sanctions as appropriate for individual cases to lessen the threat to the rise of the male nurse within the female dominated nursing profession.

2.6 Summary

This chapter presented the systematic literature review using a recognised search strategy (Aveyard, 2010). The analysis helped to develop six themes and two overarching themes that were then instrumental in the formation of the research questions toward the pilot study of six male nurses working within a HEI. As there are so few men working as HVs it was important not to jeopardise those participants that could potentially take part in the main study, as such male nurses were chosen as the participants for the pilot study on which to test out the approach and the formulated questions.

Chapter Three. Research design and method.

3.0 Introduction

Chapter three discusses the methodology and methods used within the research design.

The chapter critically discusses my ontological position, epistemological stance, theoretical perspectives, and the methodology used.

The focus then moves to the research methods available and subsequently used, within the design, to enable participant recruitment, data collection, transcription and analysis to take place. The justification for interpretative phenomenological analysis (IPA), as the method of analysis, is made (See figure 1) by orientating IPA against other qualitative research methods.

Chosen Approach and Philosophies of the Research Design.

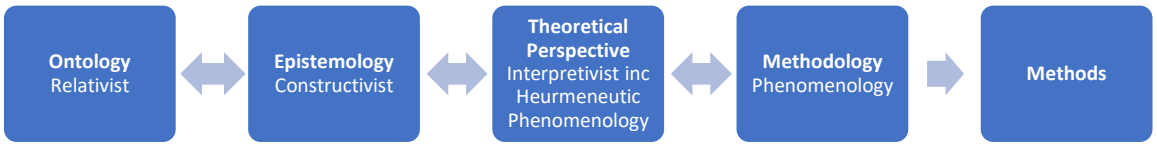


Figure 1. A diagram of the research process

3.1 Research Design.

A research design sets out the logical direction of travel from initial questions posed to the conclusions subsequently made (Yin, 2009).

Yin (2009) alludes to having a starting point for a research study. The starting point for this research was encompassed in the following research question, the aim and the objectives. The conclusions are discussed later, in the findings and discussion chapter and as a standalone chapter.

Research Question: Do men encounter any gender specific issues when working as a registered health visitor?

The question was formed using the specific qualitative format known as '**PEO**', suggested by Khan *et al*. (2003) and Schardt, *et al*. (2007), and helped to identify specific terms required toward the critical literature search.

Population; Men, Male, Man.

Exposure; employed or worked as Health Visitor/Specialist Community Public Health Nurse (HV).

Outcome or Theme; Personal experience.

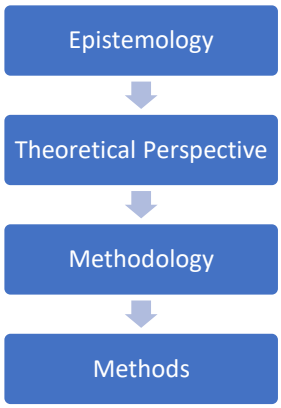
Aim: To explore the lived experience of being a registered male HV.

Objectives:

1. To collect personal experiential narratives of being a registered male HV.
2. To investigate why the participants chose Health Visiting as a profession.
3. To consider the impact on service delivery by male HVs.

Crotty (1998) underpins Yin (2009) by highlighting that when constructing a research proposal there is a need to be clear about what it is you want to know and how you intend to find out the answer. Crotty (1998) developed the four elements of research process as a way of distinguishing the research components that feed forward and back to influence each other. Crotty (1998) highlighted that the elements were organised into a process rather than existing in a myriad of disorganised parts with inconsistently applied terminology. Crotty's (1998) approach was used as an aid to develop this research design while acknowledging his omission of ontology from his process. See figure 2.

Figure 2. Crotty (1998, p 4). Four elements of the research process.



3.2 Ontology

Crotty (1998) suggests that ontology and epistemology are inter-dependant of each other and as such omitted ontology from his four-element model of research processes. Critically, rather than omit ontology he appeared to fuse it within epistemology. Crotty (1998) intimated that the paradigms work and develop meaning together, to know of existence (ontology) and how existence is known about (epistemology). However, within the structure of the research process presented by Crotty (1998, see figure 2), the term epistemology is used alone as the starting point with no reference to ontology. Rather than dismiss the framework I chose to build on it as the approach was otherwise helpful bringing clarity to the confusion of inferences and terminology experienced when exploring the literature. Critically, Corbetta (2003), Cohen, Manion and Morris (2011) and Creswell and Poth (2018), all put forward a five-stage process including ontology, relating to realities being multiple across the researcher(s) and participant(s). Crotty (1998) himself suggests that his framework is to be used as a base on which to scaffold further structures.

Creswell and Poth (2018), raise the importance of researchers' positioning themselves within the study. In this way philosophical assumptions are arguably highlighted from the outset of the study to be undertaken. This positioning is also known as the 'fore-structure' that considers previous researcher knowledge, experience and standpoints to reflexively keep the participant experience in focus rather than researcher's assumptions. My application of reality or positioning, within this study, will be through the knowledge and cultural experiential lens of being a qualified female HV (see section 1.1). The quotation of verbatim narratives will allow double hermeneutic interpretation (Smith, Flowers and Larkin, 2009) and subsequently enable the male HV participant narrative to be elucidated. The experience and personal interpretation will be unique to the participants (Creswell and Poth, 2018). As the researcher I imposed my interpretation on the participant interpretation, and this gave a different perspective with obvious bias that was tempered using existing theory or evidence at times generating new knowledge (Willig, 2008). The use of direct quotes assisted to raise the participant voice with the researcher interpretation then being offered. There is a clear process of evidence presented, demonstrating where inferences are made throughout the study.

My ontological positioning is based on the reality that humanity continues due to procreation, but the evolution of mankind is arguably constructivist in nature, constructed across political, social and cultural expectations and norms within a changing environment across the dimension of time. As such epistemologically, the understanding of personal experience and perspectives requires an interpretive stance to discover meanings applied to specific contexts (Matthews and Ross, 2010).

Arguably, in this study, it is known ontologically that male HVs exist. However, there is a gap in the evidence, epistemologically, regarding the reality of their personal professional existence and what their working life is like for them (see Chapter One). As there are no studies of the male HVs' lived experience it is important to hear their voices, to consider why their numbers are few, what impacts or supports their role and what impact they may have on service provision. However, Ashby (2011) rightly critiques the notion that the researcher can give voice to participants, as the perspective will be through the researcher interpretative lens rather than the participant's view. Ashby's (2011) research raises the notion of feminist research giving voice to women putting them central to the research being undertaken. The feminist construct was then applied to other minority groups. Ashby (2011) argues that the perspective of giving voice is flawed as the researcher assumes a higher-level authoritarian position and could subsequently add to the oppression of a particular group rather than raising the voice of the participants.

With these considerations the ontological paradigm is added to my study and features in the research design in figure 1.

Easterby-Smith *et al*. (2015) relate to ontology independently, discussing it from a natural science and social science perspective while acknowledging that there is confusion surrounding the terms ontology and epistemology, which in Crotty's (1989) approach are proposed together. It is prudent to understand various philosophical viewpoints to be sure of using a legitimate research design that validates the study (Willig, 2008; Gray, 2014).

The natural sciences discuss ontology in terms of realism, transcendental realism and internal realism suggesting that the world is fixed to varying degrees with one reality and only scientific observation/experimentation can assist progression. Therefore, this perspective did not fit with my need to gather rich qualitative data, in order to

understand the lived experience and look at individual realities, with relevance to the participant's choice of occupation. Realist and relativist ontological stances are based on developing scientific law and not merely finding it (Easterby-Smith *et al*., 2015) and therefore are not appropriate for this social science study where the aim is inductive, to draw out ideographic narratives as part of this research. Inductive reasoning intends to build theory from small pieces of information as a method of discovery toward generalisation (Gray, 2014). Inductive theory provides reasoned argument rather than scientific facts that are related to deductive theory and the acquisition of proof (Gray, 2014). Therefore, this study requires an inductive approach to discover the different perspectives and nuances that male HVs have about their lived experience that will be based on their subjective opinion rather than objective scientific fact. This individual perspective aligns itself with an ideographic approach which relates to the study of individuals, unique cases or specific event and is deemed appropriate for the aim of my study (see section 2.0). The opposing approach of a nomothetic study would benefit the scientific rather than social world in that it relates to discovery of truth, facts, and scientific laws (Cohen, Manion and Morrison, 2011), again not suitable for my study that is related to opinion and a social construction of a reality that is relevant to the individual.

The social science ontological perspective is pertinent for this study as it relates to people and their behaviour within their worlds (Hughes 1990, Crotty 1998, Easterby-Smith *et al*., 2015). Within social science the internal realist considers social structures, inequity and the outcomes for individuals acknowledging the difficulties in measurement of such concepts (Easterby-Smith *et al*., 2015). This is an example of where the same term, internal realism, can be used differently depending upon which ontological perspective the study is based.

The idealist paradigm discussed by Crotty (1998) talks of ideas put together in the mind confining it to a cerebral activity. This perspective arguably appears restrictive when seen in isolation and critically cannot be isolated from the external real-world environment. Crotty elaborates by citing Heidegger and Merleau-Ponty (1989, p. 44), 'the world is always out there' and as such objectivity and subjectivity should be combined and he then highlights that the paradigm of constructionism meets that agenda. Constructionism, often used interchangeably with constructivism, features

within the epistemological construct of Crotty's (1989) four-element research process and the ontological philosophy is inherent within there.

Nominalism is also pertinent to this study as I will be looking at the meaning of terms used by the participants and the feelings they relate to. The ontological position of nominalism questions the validity of the truth, highlighting the need for appropriate language to be used to support the importance of experiences as truth can change across places and time scales (Easterby-Smith *et al*., 2015).

For the purposes of this study, aiming to discover the lived experience of individuals, the relativist ontological paradigm discussed by Crotty (1998) and Easterby-Smith *et al*. (2015) is appropriate. Crotty (1998) suggests that relativism relates to multiple perspectives of people of their experience, depending on their individual circumstances. Easterby-Smith *et al*. (2015) give examples of socially constructed issues such as racism, sexism being a phenomenon that will be interpreted differently across countries, communities and social class systems. This point is important to my study as there will be different lived experiences across the participants who may face additional layers of discrimination. The relativist position will allow for the potential differences, of the male participants working within the same field of practice, to be draw out thus demonstrating their single relative reality.

Ontologically, my world and reality are constructed from a social science perspective, leaning more toward the relativist position (Crotty, 1998; Willig, 2008). This stance arises from being a female with thirty-five years of nursing experience. Arguably, my experience will be unique to me, my values, cultural positioning, gender and heritage. It is impossible to approach this research with a blank canvas. Ashby (2011) highlights that the participants narratives will be heard but their voices will be interpreted, through the lens of the researcher. My nursing experience includes twenty-four years as a HV and thirteen years as a senior lecturer in higher education and being directly involved in the education of HVs. I have met people from all walks of life and heard many stories/experiences and it has always been from their perspective and their individual reality of their 'lifeworld' (Crotty, 1998, p145; Smith, 2008, p29). It is important to acknowledge the background and approach of the researcher to enable transparency within the research process (see section 1.1). My professional and personal experience gives me direct insight, into the working practice and culture of the National

Health Service (NHS), the HV profession and the cultural practice of health visiting (NMC, 2004a/b; NMC, 2008; DH, 2011). However, as a woman it is not possible to align myself to the male HV narrative. Arguably, despite experiential insight into the lived experience of the female HV, this is unique to me and cannot be seen as the singular truth across the female HV service provision. As Norman, Denzin and Lincoln (2013) acknowledge, there is a co-creation of understanding forged between participant and researcher using a constructivist, relativist paradigm assuming there are multiple realities for individuals that are open to interpretation.

Of note, the HV service was traditionally commissioned by the NHS but now predominantly sits within the Department of Health and Social Care. The commissioning of public health for the under-fives and their parents moved to the local authority (LA) in October 2015 (Public Health England, 2018). This knowledgeable insight of HV service provision will influence the approach to the research design, methodology, methods and execution of the research project.

3.3 Epistemology

Gray (2014, p.19) illuminates the notion of epistemology saying,

> *Epistemology provides a philosophical background for deciding what kinds of knowledge are legitimate and adequate.*

The epistemological underpinning of a study often fundamentally informs the theoretical perspective and the methodology used with the subsequent methods selected. Yet, as Crotty (1998) highlights, this is not a trajectory but a complex multidirectional continuum. Carter and Little (2007) reinforce this notion suggesting the process is iterative with the methods and methodology also informing the methodology and epistemology. Gomm and Davis (2000) concur, suggesting through research interaction evolving ideas, challenges and perspectives will influence, restrict and consequentially create new perceptions that will influence the research process. This new way of thinking could result in a paradigm shift (Crotty, 1998).

Crotty (1998, p.5) refers to epistemological paradigms including, ‘objectivism, subjectivism and constructionism’. Objectivism relates to reality divorced from consciousness, negated of emotion (Gray, 2014). Epistemological objectivism aligns

to ontological realism in that they are both concerned with reality of what already exists in the world devoid of cognisant interpretations (Crotty, 1998). Therefore, the objectivist paradigm would not facilitate the meeting of this study's objectives (See section 3.3).

A subjectivist approach allows for the study of reality from the participant's perspectives including their views, values and feelings (Gray, 2014). Subjectivism is not divorced from constructivism but sits alongside it regarding the interpretation of perspective, rather than determining facts that are related to an objectivist epistemology (Crotty, 1998). Constructionism embodies the participant's construction of their experiences of phenomena, in their own way, and builds on this to make sense of it through a reconstructed perspective (Densin and Lincoln, 2003; Gray, 2014). Constructionism fits well with my study regarding the researcher insight into the workplace and educational standing of the participants. This specialist background will impact on the data collection, analysis and interpretation. Positively the theoretical perspective of hermeneutics embraces interpretation by the researcher. Smith, Flowers and Larkin (2009) talk about the use of double hermeneutics, within the method of analysis called Interpretive Phenomenological Analysis (IPA), where the researcher will interpret the participant, who is interpreting the phenomenon.

Crotty (1998, p.42) refers to his view of constructionism below.

> *all knowledge and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world and developed and transmitted within an essentially social context.*

This quote by Crotty (1998) acknowledges that a variety of perspectives exist about the same occurrence. Crotty (1998) attests that constructivism and the methodological construct of phenomenology are so closely entangled that the subjectivist and objectivist paradigm would not befit either epistemology. As Crotty (1998) suggested, the world meant nothing before it was interpreted through the mind. As such constructivists build meaning rather than create it through the notion of intentionality, moving toward the phenomenon and existentialism, the participant being situated within the world (Crotty, 1998). This means that my study cannot detach the

participants and my subjectivity from the objective world in which the phenomenon took place and constructivism will enable the interaction of both paradigms.

Denzin and Lincoln (2003) discuss a constructivist approach as having a relativist ontological perspective. This will be important when looking at the multiple perspectives to potentially arise from the participants within this study. It is also important to acknowledge the deep emic approach to the interpretive inquiry that arguably brings ethical considerations for protecting the participants of my study by ensuring a non-oppressive, facilitative social inclusion and the potential for liberation (Denzin and Lincoln 2003).

Interestingly, positivism was placed as an epistemological approach by Willig (2008), Gomm and Davis (2000) and in theoretical perspectives by Crotty (1998). As this chapter is based around Crotty's (1998, p.5) four-layer perspective of the research process, positivism will be discussed within the theoretical perspectives section of the chapter.

3.4 Theoretical Perspectives

The theoretical perspectives, as highlighted by Crotty (1998) require consideration to appropriately contextualise the methodology that will frame the research methods of the study to draw out the evidence base required.

Positivism was developed from the natural sciences, through deductive procedures and processes, to find fact and prove theory (Polit and Beck, 2006). Auguste Comte (1798-1857), arguably a reformist of the strictly numerical perspective of positivism, talked about certainty rather than absolute proof in relation to social science (cited in Crotty, 1998, p.22). Historically, within healthcare, randomised controlled trials (RCTs), systematic reviews of RCTs and meta-analysis have been deemed the best available scientific evidence (Sackett *et al*., 1996). Gray (2014) takes this further, talking of a positivist approach of hypothesis testing through experiment, measurement and quantifying results. It could be said that this standard of deductive evidence remains prudent to provide efficacious care that results in more benefit than harm for patients. More recently, Murad *et al.* (2016, p.126) have critiqued the influential 'evidence-based pyramid' commonly used within medicine and scientific

research, arguing that all designs can have flaws and limitation and that the research design alone is not proof of a high-quality study. They highlight that the approaches to randomisation, potential inconsistency with literature searches and use of meta-analysis to aggregate evidence could result in bias, poor evidence and error (Murad *et al*., 2016).

Therefore, it would seem fundamental that anyone with an extensive health and NHS background would have to justify why they were not going to take a positivist approach to their research. This defence is as follows; quantitative studies require a sample size that can be generalised to the population in question (Polit and Beck, 2006), arguably making economic sense. My study was qualitative with a purposive sample to ensure a rich vein of experiential narrative I approached participants with personal insight, specific knowledge, experience and in-depth information on the subject matter, of being a professionally registered male HV. Therefore, a quantitative study did not meet this need. When relating to the term quantifiable in relation to quantitative data there would be an expected structure for data collection so that the resulting data could be statistically analysed (Polit and Beck, 2006). As my study is a social qualitative inquiry, I collected narrative data, themes were collated resulting from noting repeated topics from different participants (Polit and Beck, 2006). There was no need for statistical analysis. The researcher's subjective decision, when generating themes, is deemed a valuable commodity in qualitative research and was important for my study (Polit and Beck, 2006).

My study explored the experience of men working in the field of Health Visiting and as such utilised a constructionist inductive epistemology (Crotty, 1998) that will not be generalisable to the population, or men from all origins, but will shed light on their experience, behaviour, emotions and beliefs. Again, a deductive approach would not meet the aim of my study (see section 3.0).

A mixed method design utilising quantitative and qualitative approaches was also considered, as deductive and inductive research designs have their place. Mixed method research designs are becoming more commonplace and are being used to compliment, progress, increase validity and provide the platform for other studies (Polit and Beck, 2006; Matthews and Ross, 2010). However, this study is relating to a minority group of men working in a traditionally female field. Meeting the research

objectives (see section 3.1) did not require comparison between positivist and interpretivist theoretical perspectives and therefore a mixed methodology was not suitable to meet the needs of my study.

Moving immediately away from the positivist paradigm associated with deduction, generalisability and testing of outcomes, an inductive qualitative approach was deemed most appropriate to identify patterns and themes across the data and generate meanings whilst discovering new perspectives and ideas (Gray, 2014). This will be discussed below.

The theoretical perspective of interpretivism evolved in contrast to positivism (Gray, 2014). Interpretivism allows discovery and understanding of the world through interpretation from a cultural and/or historical perspective. Interpretivism is linked to the epistemological stance of constructivism and considers social realities often through an idiographic lens (Gray, 2014). Interpretivist approaches include symbolic interactionism, hermeneutics and phenomenology. Symbolic interactionism explores what people do in their lives and what life is really like by studying what happens, is anticipated to happen and the results from their social interaction. As symbolic interactionism involves an insider perspective, time in the field can be required (Gray, 2014). Therefore, this type of study attracts ethnographers or grounded theorists (Gray, 2014). Symbolic interactionism could be used in exploring the lived experience of male HVs but in entering the field the confidentiality of the service user could be compromised while also affecting the therapeutic relationship. For these reasons, this approach is not appropriate for my study.

The next interpretive perspective is hermeneutics relating to the interpretation of scriptures and biblical texts also called exegesis (Crotty, 1998). Over time hermeneutics as a term covers a broader perspective of reading to evoke understanding, including the interpretation of meaning for human activity (Crotty, 1998). Wilhelm Dilthey (1833-1911) noted the need to study humans in relation to their reality, purpose and meaning and not as standalone objects (Hughes, 1990). This reality needed to identify the lived experience from personal perspective, not external observation, while retaining a robust method (Hughes, 1990). Polit and Beck (2006, p.215) expand on this concept suggesting that ‘hermeneutics uses the lived

experience of people as a tool'. The theoretical perspective of hermeneutics will be fit for purpose for this study that is all about the lived experience of male HVs.

Phenomenology sits within the epistemological stance of constructivism as, while constructivists believe reality is personally and socially put together, phenomenology seeks to explore and explain the human lived experience (McIntosh-Scott *et al*., 2014). However, there is also an acceptance of many realities that are constructed socially and thus they are subject to change (McIntosh-Scott *et al*., 2014). The founding phenomenologist, Edmund Husserl (1859-1938), referred to individual consciousness regarding the focus of inquiry (Smith, Flowers and Larkin, 2009, p.13). Husserl talked about 'epoche', which was putting into brackets the researcher's knowledge base and potential bias in order that only the specifics of the experience would be drawn out (Husserl cited in McIntosh-Scott *et al*., 2014, p.118). However, Husserl's student, Martin Heidegger (1889-1976) was interested in hermeneutic enquiry (Smith, Flowers and Larkin, 2009). Heidegger linked the two paradigms together forming 'hermeneutic' phenomenology also known as 'interpretive phenomenology' (Smith, Flowers and Larkin, 2009). Notably, with interpretive phenomenology the researcher is not able to detach themselves from the real world but needs to take account of 'being there' known as 'Dasein' (McIntosh-Scott *et al*., 2014, p.118). This approach is sensible as there is an acknowledged relationship between the participant, the researcher and the engagement with the real world (Smith, Flowers and Larkin, 2009). To explore the lived experience of male HVs from a theoretical perspective the interpretative phenomenological paradigm is the right approach. Phenomenology is both a theoretical perspective and a methodology (Crotty, 1998).

The methodological approaches will now be considered to ensure the most appropriate research design is used. When considering the methodology, the small numbers of male HVs would need to be kept in mind regarding sampling and potentially unwittingly compromising confidentiality.

3.5 Research Methodology

The research methodology is crucial as the basis for decisions about research tools and the overall implementation of the study design (Crotty, 1998). Miles and Huberman (1994) put forward that the researcher should utilise a research

methodology that is in keeping with the study, suggesting it is possible to adapt what is not useful and not stick meticulously to a given methodology. Despite this guidance, it is arguably prudent to follow a structure initially both to enable the study to be completed and to provide rigour to the process and subsequent findings. To be sure the most appropriate methodology of phenomenology was chosen, it was important to consider other qualitative methodologies regarding how they would fit with my epistemological and ontological position**.**

Consideration of other Qualitative Methodologies

3.5.1 Grounded Theory

Grounded theory was first published by Glaser and Strauss in 1967 as a move away from testing theory to creating it (cited in Birks and Mills, 2015, p. 2). Grounded theory uses data for repeated systematic analysis before constructing theory from the emergent themes (Glaser, 1996, cited in Cohen, Manion and Morrison, 2017). The data can come in a variety of forms including images, numerical data, literature and narratives (Strauss and Corbin, 1998; Cohen, Manion and Morrison, 2017). The constant comparison and analysis of the data generated with the new data collected enables data saturation, where no new information or categories are emerging, and theories are formed (Birks and Mills, 2015). Strauss (1987, cited in Birks and Mills, 2015, p. 90) reported that rather than being solely inductive, grounded theory used inductive and deductive reasoning in reaching the goal of developing theory. However, the objective of this study was not to form a theory, process or a conceptual framework but to understand, from a personal perspective, what the experience was like for the individual working as a male HV. Thus, grounded theory was not an appropriate methodology for this study.

3.5.2 Case Study

The case study approach can be single or multiple, and is used across many arenas such as health, social care, politics, education, the business sector and others (Yin, 2009). Yin (2009) highlights that case study methodology is used when there is a ‘why’ or ‘how’ question posed and that the posing of the research question is of importance. Indeed Stake (1995, cited in Cohen, Manion and Morrison, 2017, p. 289) states case

study is about the study of the ‘particular’. Yin (2009) suggests that a case study would be useful where the phenomenon needed in-depth inquiry within the situated environment. The case study also relates to exploring issues within a context while potentially drawing on a range of data sources including interviews, a variety of documents and observations (Baxter and Jack, 2008; Yin, 2009; Gray, 2014). Although a case could relate to the role of the male HV, it was not clear at the outset if the potential HV participants would be carrying out the same role or be employed by the same types of organisations across the country. This would make the case difficult to bring into a bounded phenomenon. In addition, the research question, ‘Do men encounter any gender specific issues when working as a registered Health Visitor?’, does not relate to the ‘how’ and ‘why’ question suggested by Yin (2009). Thus, a case study was not deemed the most appropriate approach for this study.

3.5.3 Ethnography

Ethnography is a research methodology that strives to study cultural perspectives from inside the field of interest. An ethnographic approach would mean immersion in the field often by ‘going native’ (Wolfe, 2012, p.285). Denzin (1989) suggests ethnographers should integrate into their subjects’ lives to gain an extensive perspective and subsequently retell the conceptualised narratives (cited in Denzin and Lincoln, 2003, p. 94). This immersion into the field is problematic due to maintaining the confidentiality of the limited numbers of male HVs nationally and confidentiality of the client. Health Visiting involves the substantial personal psychological support of parents (NMC, 2004a; DH, 2011). Potentially the therapeutic dynamic between the client and professional could be compromised by the ethnographic researcher entering the field (Flick, 2002). Noting the difference between ethnography and phenomenology, Tesch (1994, cited in Gray, 2014, p. 24) suggests that while both methods describe and interpret, ethnography is concerned with the study of culture through observation. Thus, ethnography is not a suitable approach for my study.

3.5.4 Phenomenology. The Chosen Research Methodology.

Phenomenology is both a theoretical perspective and a methodology (Crotty, 1998) (see section 3.3). When trying to understand the reality of social existence, Gray (2014) suggests the study should be situated in the participant’s experience,

phenomenology strives to do this. The founding phenomenologist, Husserl related to the inquiry being grounded in the participant's consciousness and to bracket off that which is not directly resulting from the specific phenomenon but may be from earlier acquired knowledge or assumption (Smith, Flowers and Larkin, 2009). This process allows for the engagement and absorption with the phenomenon being considered and puts to one side the distraction of wider issues (Smith, 2008). By doing this Gray (2014) claims there will be new meaning that is broader or more specific. Heidegger moved away from Husserl's perception of the bracketed experience toward a fully immersive engaged reality where it is impossible to separate out the object or phenomenon from the world and context (Smith, Flowers and Larkin, 2009). Heidegger's intersubjective perspective placed the individual within a complex enmeshed interaction with the world that cannot be separated for inquiry (Smith, Flowers and Larkin, 2009). Heidegger's philosophy is the approach that will be used for this study as the role of the HV is complex and cannot be bracketed off when examining their world. HVs working with children and families have knowledge of the biopsychosocial aspects of development that are affected by their relationship with the ecological system around them (Hayes, O'Toole and Halpenny, 2017).

3.6 Research Methods

The research methods are the practical procedures used to generate and analyse data (Birks and Mills, 2015). Within the research methods section there will be a discussion on the ethical procedure required for the study, consent, sampling, the tools used, data analysis, triangulation, validity and reliability and concluding with a critique of the method.

3.6.1 Ethical Requirements and Procedure

This study is unique as it explores the unresearched area of the lived experience of male HVs and as such it will make an original contribution to the subject area. When undertaking a research inquiry, it is important to consider the ethical perspectives including deontology (Duncan, 2010), as every care will be taken to fulfil the duty of completing and disseminating the research following commencement. In addition, from a consequentialist perspective it is imperative to seek out new findings to add to and improve what is already known (Duncan, 2010). Beauchamp and Childress (2012)

provide guidance on the four principles that underpin ethical morality within the biomedical sciences namely, autonomy: including respect for independence and choice, non-maleficence: related to doing no harm, beneficence: aimed toward doing the right thing for the good of others, and justice: observe and maintain the rights of individuals especially regarding confidentiality and respect for their wellbeing.

These ethical principles will be discussed here within the ethical process.

3.6.1.1 Consent

Two types of consent were required to undertake this inquiry as part of the Doctor of Health and Social Care Practice (Nursing) programme. The first consent or ethical approval was formally for the study to take place and the second was the informed consent from each participant agreeing to take part in the study. These two areas of consent will be discussed below.

A formal application for ethical approval for the inquiry to take place was submitted and obtained from the University of Derby Health and Social Care College Ethics Committee. This research approval was granted and the consent can be seen in appendix 1 and 2. Simultaneously, an ethics approval application was submitted to the ethics committee for the NHS, as it was thought to be a requirement to recruit HVs on a national scale. Of note, the University approval was reliant on the NHS ethics approval before the inquiry could commence and any participants could be contacted. The Health Research Authority website (HRA, 2015) guidance changed in November 2015 stating,

> *HRA Approval is open to studies that fit one of the following types: Health services research studies involving only NHS staff as participants and taking place in England only. These must be studies that are identifying participants by virtue of their NHS employment and that do not require review by the NHS Research Ethics Committee (REC). We refer to these as cohort 1 type studies (HRA, 2015).*

Therefore, this type of NHS ethics approval seemed to be the most appropriate for this study. This was a complex and time-consuming process due to my application

coinciding with a change to the organisational structure and procedural process for research ethics approval within the NHS. I was asked to contact the local NHS research and development unit (R&D) who advised to apply through the HRA, who subsequently suggested applying to the NHS IRAS approval who then returned my study to the HRA (see appendix 3, 4 and 5). I waited six months for a final reply and after initially being advised that I required NHS ethical approval, this was not the case. I received confirmation that I did not need NHS ethical approval as the participants were staff, not patients, and they were being interviewed off site (see appendix 3, 4 and 5). The formal research approach, towards attracting the sample, commenced only when all appropriate approvals above, were agreed.

3.6.1.2 Consent of Participants

Interested potential participants made contact for further information (see sampling section 3.6.2) and each one was sent the participant information sheet (see appendix 6) and consent form by email (see appendix 7). In this way they had the information required to make an informed decision. Streubert and Rinaldi Carpenter (2011) highlight that the information must be understandable by the participant and that they should not be coerced into deciding, but that it should be by their own free will. They were asked to reply if they were willing to take part. Once replies were received, a time and appropriate venue were mutually agreed to undertake the semi structure interview (see section 3.6.1.7). The participant information sheet (see appendix 6) and consent form (see appendix 7) were then reiterated face to face individually with the participant prior to the interview and the participant was then asked to read and sign the consent form. Clear explanation was given to ensure that the participants were fully aware of the research purpose and process giving them autonomy toward decision making and their choice to participate in the study (Beauchamp and Childress, 2012). Streubert and Rinaldi Carpenter (2011) add, to accept or decline the offer of taking part in the research study comprehensive information must be shared.

3.6.1.3 Deception and Debriefing.

When advising the participants that the research is part of the Doctor of Health and Social Care Practice programme it was explained that the data collected will be used toward the final thesis for the ‘Independent Study’ module (8DP001). It was reinforced

that the data will be used for conference presentations and publication within health-related journals. By ensuring the participants were fully informed this helped to mitigate any risk of deception to them and subsequently do no harm (Beauchamp ad Childress, 2012). Interestingly, Streubert and Rinaldi Carpenter (2011) point out that this will also protect the integrity of the researcher.

The participants were offered time to debrief after the interview or to make contact later if appropriate. They were provided with contact details so that they could seek psychological support later if required. To date none of the participants have chosen to make further contact following their interviews, other than to reply to the review of the transcribed text. Smith, Flowers and Larkin (2009) suggest that every study will have its own issues, but the participant needs should be anticipated where possible. The use of peer supervision, human resources or the line manager was discussed and established as first points of contact for participant support in line with Beauchamp and Childress (2012) ethical principle of beneficence-to do good.

3.6.1.4 Withdrawal from the investigation.

Smith, Flowers and Larkin (2009) highlight the good practice of the participants reviewing the transcripts for content and context and acknowledge the option of withdrawal usually coincides with the beginning of data analysis. The participants were advised both in the participant information sheet (see Appendix 6) and face to face, immediately before the interview, of the ability to withdraw from the study at any time until the researcher has started the data analysis process. To date none of the participants have requested to be withdrawn from this study.

3.6.1.5 Confidentiality and Data Protection.

Streubert and Rinaldi Carpenter (2011) relate confidentiality to the ethical principle of preventing harm (Beauchamp and Childress, 2012), by not openly or inadvertently identifying the participant. Streubert and Rinaldi Carpenter (2011) continue to stress that confidentiality can only occur when the data is unrecognisable to the researcher which they highlight is difficult for qualitative research data. While acknowledging this discourse all attempts to maintain confidentiality of the participants have been put in place as follows; a secure cabinet is used to lock the information and data collected,

no discussion or disclosure has taken or will take place related to the participants or their data except during supervision with the director of studies. Any personal data has been anonymised prior to any dissemination taking place. Names of places, people and identifiable features have been changed during transcription and agreed with the participant prior to the analysis commencing. The participants confidentiality and privacy has been and will be maintained in line with the University of Derby (2015), Guidance Notes for the Implementation of the Research Ethics Policy and Code of Practice, the General Data Protection Regulations (GDPR, 2018) formally the Data Protection Act (HM Gov, 1998) and The Freedom of Information Act 2000 (Amendment) (EU Exit) Regulations 2018 (HM Gov, 2018b), formally the Freedom of Information Act (HM Gov, 2000). All hard data is being stored in a secure locked cabinet. The digital recording of the interviews was transferred to electronic audio files within ten working days and then deleted from the digital recorder. The initial use of an encrypted data stick helped with securing data for travel purposes regarding analysis of the data and writing up the findings. With the arrival of an encrypted secure fire wall and password protected university one-drive technology storage system, the data was moved from the encrypted stick into the more secure data storage system supplied by the University of Derby. This is in line with the University guidance on data storage suggesting a minimum of six years to a maximum of ten years for post graduate research students (University of Derby, 2015, p.7). The electronic data will then be deleted, and the hard data shredded. Any discussion, related to the research participants or data collected, has been solely between myself and my director of studies for supervision purposes. The director of studies did not have access to the data before it was anonymised and transcribed. The transcribing was done predominantly by me (see section 3.7) as the chief investigator, as the only person to have access to the data before it was anonymised. Due to the relatively small sample size, the snowballing technique for the sample selection and the minority of male HVs nationally it may be that participants disclosed their participation inadvertently to each other. See section 3.6.1.6 below regarding further actions taken regarding participant protection.

3.6.1.6 Protection of participants.

Participant protection has been given priority throughout the study and will be regarding any subsequent publication or presentation taking place. 'The Code' (Nursing and Midwifery Council (NMC), 2018), gives professional standards required for nurses and MWs to follow. By adhering to 'The Code' (NMC, 2018a) the approach to the research study will be steadfast in protecting people, maintaining safety, being always honest and trustworthy while being an affective professional practitioner. The physical risk reflects that encountered in routine daily life. If the participant acknowledged distress or poor practice, they would have been offered support, advice and information regarding other agencies such Human Resources, Occupational Health and the line manager as required. Positively, nothing untoward occurred before, during or after the interviews taking place.

It was intended that all data would be anonymised by allowing each participant to choose a pseudonym at the point where informed consent is signed e.g., Zach for participant 1. From then on, that pseudonym/code would be used. However, some of the initial names chosen were the real names of later participants and as such all participants were given a pseudonym by the researcher. All participants were informed of their pseudonym when their transcription was returned to them for review. However, this plan met the same outcome and subsequently the interviews were renamed as transcript (T)1,2,3 rather than using any other identifier. The chronological order was also mixed up to further prevent identification of individual participants. As a registered nurse and HV, I have a duty of care to full fill under the NMC, 'Code' of practice (NMC, 2018a) and in line with the ethic principle of non-maleficence, to do no harm (Beauchamp and Childress, 2012). This responsibility has been kept in focus throughout the study.

3.6.1.7 Environmental protection.

When undertaking the research interviews initially a secure environment was perceived as optimal but with further consideration this could have put both the researcher and the participant at risk of harm or increased anxiety. Miller *et al*. (2012) suggest both safety and litigious ramifications should be considered and a plan of action created for potential risks. For this reason, I submitted a risk assessment, as

part of the application to register the research 12th May 2016. The risk assessment considered lone working and the safety of the participant and researcher. The risk was considered moderate and was aligned to no higher than the risk in everyday life. Professional standards have been adhered to throughout the study (NMC, 2018). I also have vast experience of lone working within the field of health visiting, working in the community across a range of diverse settings. This knowledge heightened my awareness that personal safety cannot be taken for granted. I left my phone number with a colleague and a relative and informed them as I entered the interview and left the location either by train or car. As the research was not able to take place on NHS property, some data was collected in LA buildings such as children's centres and others took place in public places such as library premises. This provided protection for both the interviewee and the interviewer while remaining secure and relatively quiet but where the interview could not be overheard. Other ethical considerations such as for observational research or carrying out research with animals did not apply in this instance.

3.6.2 Sampling

3.6.2.1 Purposive Sample.

Purposive sampling was the deliberate method of choice to gather rich data directly related to the phenomenon, which in this case was from male HVs with the experience of working in the field in the male HV role (Yin, 2016). Smith, Flowers and Larkin (2009), state the method of sampling used for qualitative studies should be aligned to the theoretical perspectives of the enquiry and is the method of choice to allow for insight into a specific phenomenon. They talk about the purposive sample being similar, known as homogenous, yet not identical so that the research inquiry is meaningful, but each participant brings their unique perspective (Smith, Flowers and Larkin, 2009). Cohen, Manion and Morrison (2017) support purposive sampling to allow participants with in-depth knowledge, experience and subject expertise to share vital information regarding the subject matter in question. When using interpretive phenomenological analysis, Streubert and Rinaldi Carpenter (2011) also acknowledge the value of the qualitative research participant having personal knowledge, experience and insight into the subject of the inquiry, to allow for rich data collection. This contrasts with scientific probability methods that often use large samples to allow

for generalisability (Gray, 2014). Generalisability was not the aim of this research, although there may be some synergies with other minority groups working within a majority workforce. As such, for a purposive sample, it was important to get the right inclusion criteria for this study.

3.6.2.2 Inclusion Criteria.

Study inclusion criteria
As a participant you would require to:

- Be a Nursing and Midwifery Council (NMC) Registered HV.
- Be male.

Streubert and Rinaldi Carpenter (2011, p.90) state 'information-rich' cases allow a depth of study around the phenomena. Thus, female HVs were excluded as it was the minority male HV voice that was needed for the study.

3.6.2.3 Process of Gaining the Sample

There is debate regarding the appropriate sample size as Smith, Flowers and Larkin (2009) suggest the question should be more around interviews than participant numbers to gather the rich data required. They suggest for degree students and/or Master students a small sample size of three to six participants for the in-depth analysis to take place. In addition, that with the smaller participant numbers, further interviews with the same participant can take place to gather the information required. As this inquiry is part of a professional doctorate a purposive sample of four to ten participants is suggested with the lower number being interviewed twice (Smith, Flowers and Larkin (2009). For my inquiry ten to twelve participants were sought with a specific knowledge base of being a man working as a registered HV being required. To generate a purposive male HV sample a structured email was forwarded to the local community NHS providers, Institute of Health Visiting (iHV) and United Kingdom Standing Conference (UKSC) for Specialist Community Public Health Nurse (SCPHN) education (see appendix 10), for which membership is held for the latter two. McIntosh-Scott *et al*. (2014) state that it is important that the right participants are recruited rather than focusing on getting the numbers. The structured email requested that an introductory email was forwarded to any male HVs known to the members of both organisations (see appendix 8). The email asked the potential participants to

contact the chief investigator if they were interested in taking part in the study. Once contact was made the participant was sent the information sheet (see appendix 6) together with the consent form (see appendix 7). In this way the participant had all the information required before making the final decision to engage or not with the research. Once agreement to take part was gained a date, time and venue were mutually arranged to undertake the interviews in a safe environment. In the event of oversubscription, it was planned that the first twelve applicants would be taken. This was not a consideration that needed to be actioned. One retired male HV, no longer on the NMC register, came forward and was respectfully declined and thanked for his offer, as he did not fit the inclusion criteria or aim of the study.

3.6.2.4 Difficulties in Attracting the Research Sample.

Engaging participants was initially difficult as only four came forward in the first six months. Therefore, I personally attended the next possible UKSC meeting, within the any other business section of the meeting, I requested that the email asking for participants should be resent to the members. The email was also re-sent to the iHV and this time there was heightened interest and when I engaged with two of the interested participants, they suggested contacting other male HVs who were known to them. This snowball technique increased the final number of participants to 11 participants. By chance, the spread of the 11 willing participants was England wide.

3.6.3 Tools used

3.6.3.1 Semi structured Interviews

Semi-structured interviews were the tool of choice used to gather the data (see appendix 9). Polit and Beck (2006) suggest that by using a guide the researcher ensures that all necessary areas will be covered while allowing the participant to recount their experience or opinion openly. After considering telephone, Skype or postal surveys the decision was made to conduct a face-to-face research interview.

The critical detail necessary to extract meaning from feelings and how they are influenced would be achievable through this qualitative method of data collection (Flick, 2002). Flick (2002) talks about an 'emic' position in that only the participant can

understand what being like that or doing that was or is like for them. Miles and Huberman (1994) also suggest that typical occurrences should be explored and the relationship to how people manage such occurrences studied from the insider perspective. The HV experience and knowledge that I took into the interviews gave me credibility and an insight into the lifeworld but not the specifics of what life was really like for each unique participant. Their story had to be told and the guidance of the semi-structured interview questions arguably allowed this to happen.

Cohen, Manion and Morrison (2017, p.423 cite Patton, 1980), in terms of keeping the interviewee engaged with the interview, suggest using everyday language to evoke data that is deep, vivid and original. The interviews were recorded and transcribed verbatim (Flick, 2002). The time requirements for transcription were extensive. Smith, Flowers and Larkin (2009) suggest that for every hour of interview, seven hours of transcription will be required. Thus, a minimum of 77 hours was required for 11 interviews to be transcribed. As can be seen in appendix 11 and 12 the time scales initially envisaged and the reality of time taken from the initial interview, transcribing, content checking, the six-stage analysis process and formation of the superordinate themes took around two and a half to three years.

3.6.3.2 Question formation and structure of the semi-structured interview schedule.

Phenomenology concentrates on human experience, mostly using interviews, usually with individuals (Tesch, 1994, cited in Gray, 2014 p. 24). Crotty (1998) suggests the best way to enter the participant's lifeworld, is through open non-leading questioning.

All questions were derived from the systematic literature review, that had taken place (see chapter 2) to both note the gap in knowledge and inform the construction of the semi-structured interview questions (see section 3.6.3.1) and these were checked for relevance through the pilot study (Le Blond, 2016). No alterations to the questions were found to be necessary. All the questions were open ended rather than allowing yes/no answers, as can be seen in appendix 9, to allow for the collection of rich verbatim data.

3.6.4 Data analysis- Interpretive Phenomenological Analysis (IPA).

As explained earlier in this chapter the research method of choice for data analysis was interpretive phenomenological analysis (IPA). The structured IPA approach followed is suggested by Smith, Flowers and Larkin (2009). IPA combines phenomenology with hermeneutics as the perspective of the person experiencing the phenomena is key from an 'emic', insider position (McIntosh-Scott *et al*., 2014). IPA was chosen as it is a qualitative method that tries to make sense of the lived everyday experience and why this should matter to the individual (Smith, Flowers and Larkin, 2009). Husserl asserted that the everyday occurrence should be explored, as for some this occurrence could be significant at that time but may not be apparent for others (Smith, Flowers and Larkin, 2009). It is the potential significance of being a male HV working in a traditionally female (DH, 2012b) role that this research aimed to explore. Critically, despite the commonality of the participants all being men who are HVs, their individual experiences and lifeworld within health visiting practice or service delivery was unique to each one of them. For this reason, the hermeneutic circle allows for a dynamic non-linear consideration of the parts and the whole, shown in table 5 below, to extrapolate and construct meanings from the participant and corpus accordingly.

Table 5. The Hermeneutic Circle: Concepts of the relationships.

The part	The whole
The single word	The sentence in which the word is embedded
The single extract	The complete text
The particular text	The complete oeuvre
The interview	The research project
The single episode	The complete life

Ref. Smith Flowers and Larkin (2009, p28)

Streubert and Rinaldi Carpenter (2011) suggest that by undertaking the research in the field, directed by the participant, the control moves to the participant allowing the researcher insight into the broader perspectives of the chosen approach to the research study. Smith, Flowers, and Larkin (2009) highlight that IPA studies are concerned with an idiographic ideation (see section 3.1) and as such take time to draw out individual context and phenomena thus utilising numerically smaller samples.

IPA was deemed the most suitable approach to get the richest source of data and subsequent analysis.

The data analysis consisted of the six-stage approach suggested below by Smith, Flowers and Larkin (2009, p.82-107).

Step 1. ‘Thorough reading’ of the transcripts, over and over, to submerse oneself in the data.

Step 2. The ‘Initial Noting’, considering concepts, description and linguistics, while noting in the left and right margins comments and themes, respectively.

Step 3. ‘Developing emergent themes’, by adding the transcripts and notes to create a substantive set of data then moving toward data reduction by merging, mapping and linking patterns through a synergistic process to create a new totality.

Step 4. ‘Searching for connections across emergent themes’ both similarities and diversities, significant events, frequently used references and purposes.

Step 5. ‘Moving to the next case’ and repeating the process to create individual themes and new themes.

Step 6. ‘Look for patterns across the cases’ potentially charting or mapping graphically.

The hermeneutic circle (Denzin and Lincoln, 2003; Smith, Flowers and Larkin, 2009; Pietkiewicz and Smith, 2014) (Table 5) of moving back and forth between the part or particular to the whole, both within transcripts and across the whole corpus required multiple lenses and helped to elucidate the key themes and SOTs.

Gomm and Davis (2000, p.14) point out that data analysis is about interpretation of the data while identifying personal bias and experience, to acknowledge assumption and to challenge it. In taking an integrated critically reflective approach, the researcher provides an open transparency and understanding that is authentic and trustworthy (Gomm and Davis, 2000) (see section 3.6.6). Importantly, as a HV, Community PT and academic lecturer, teaching HVs, I have insight into this field of study and come

with assumptions and experiences integral to the meaning applied to the participants' narrative and experience (Willig, 2008; McCormack & Joseph, 2018) (see section 1.1) that will be discussed within Chapters 4 and 5.

Initially, each individual transcript was viewed as a whole, reading and rereading, making notes and looking at parts of the narrative, through deconstruction and unique idiographic analysis into each participant's world to develop patterns or themes (Smith, Flowers and Larkin, 2009; Creswell and Poth, 2018). Smith, Flowers and Larkin (2009, p.3) advocate looking for 'convergence and divergence' in detail when analysing the data. Every line was numbered and each page numbered, to ensure that all verbatim quotes referred to could be found easily when returning to the scripts and to check out notions being drawn out during analysis efficiently. A large margin was created on both edges of the page for initial notations (left margin) and emergent themes (right margin) to be made as the analysis progressed (Smith, Flowers and Larkin, 2009).

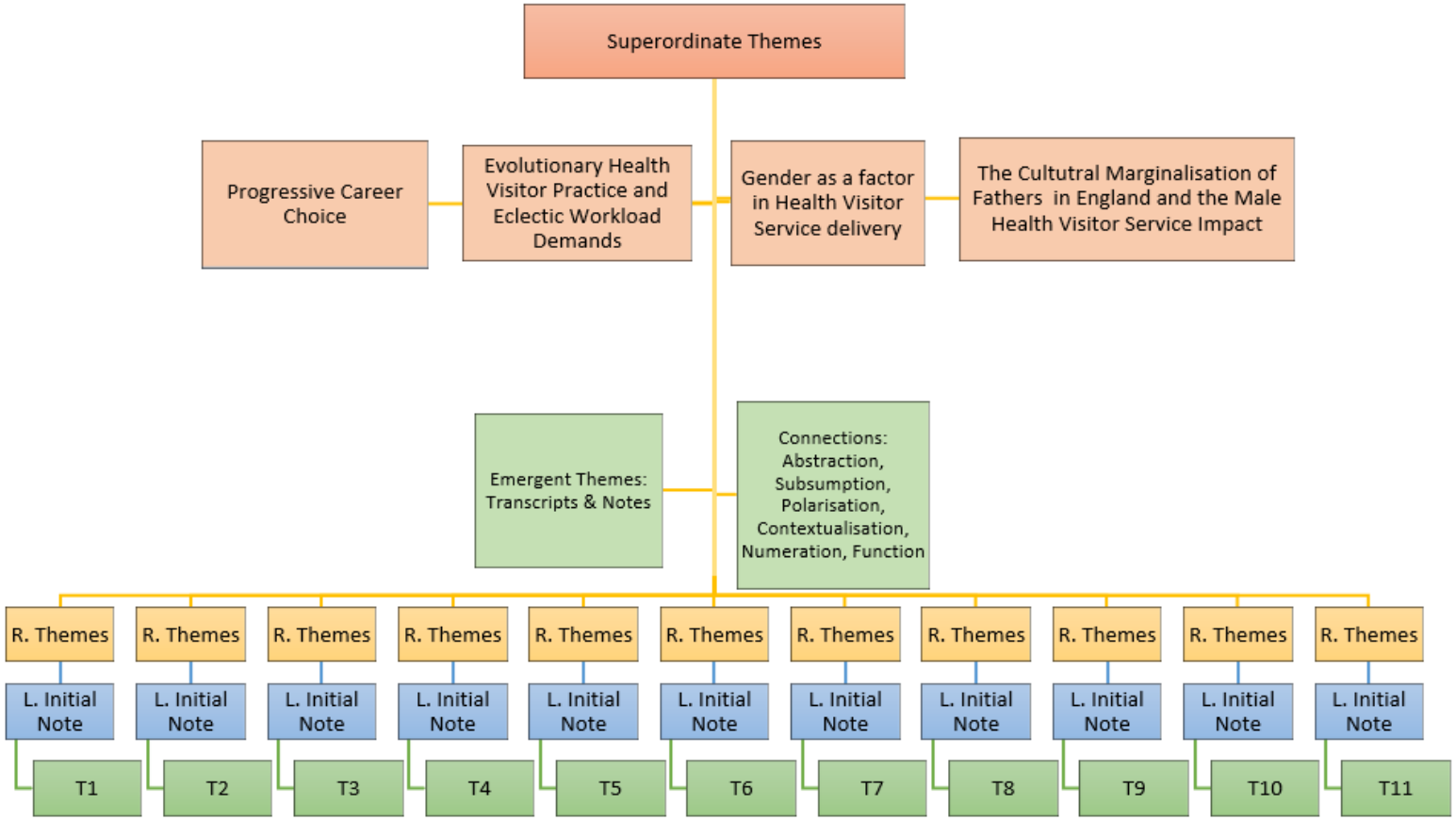
This approach subsequently illuminated in detail, the superordinate themes (SOTs), from the themes, across the individual narratives that were drawn together through a process of analysis including abstraction, subsumption, polarization, contextualisation, numeration and function (Smith, Flowers and Larkin, 2009). Ultimately, the SOTs were considered for each participant and time was taken to look for divergence and convergence across all the participants' transcripts, whilst still being mindful of individual experiences as well as group commonalities (see figure 3 below).

Importantly, Padgett (2012) suggests that following the interview and data analysis it is possible to generate new questions thus precipitating the need to interview the original participants again and this could have been the case. However, the original interviews were data rich and covered the questions asked, thus negating the need for further questions.

Crotty (1998) discusses the phenomenological term of intentionality, not used in the regular sense of intending to go somewhere or buy something but in the sense of veering toward or into something. This pull is related to the conscious being aware of the phenomenon and moving toward it. Crotty (1998) refers to the opposition of the subjective and objective realities yet highlights there cannot be one without the other

they are together. This is helpful when interpreting the lived world of the male HV perspective within their workplace.

Figure 3. The process of data analysis using Interpretative Phenomenological Analysis (IPA). (Created by author, 2021)



KEY

Carry out step 1-5 for each transcript.	Step 1 Listen to audio-recording	Read& Reread	Immersing self in the data
	Step 2 Left margin- initial notations	Step 2 Right margin-themes	Looking for key descriptive, linguistic, and conceptual points
	Step 3 Emergent themes	Map interrelationships	Large data set reduction by mapping patterns, abstraction, subsumption, polarisation, contextualisation, numeration, function
	Step 4 Superordinate themes	Search for connections	
	Step 5		Move to next case and repeat step 1-4 allow new themes
Across all transcripts	Step 6 Superordinate themes	Look for patterns of superordinate themes	Form Superordinate themes across all transcripts

3.6.5 Triangulation and Transparency.

The first approach to triangulation and transparency was to record the interviews and transcribe verbatim the participant narratives, then returning them to the participant for content checking. I met regularly with my director of studies and supervisor to discuss and explore the data retrieved and my developing analysis of the subject matter, while being mindful to ensure confidentiality.

The secondary theoretical approach to triangulation was achieved using academic theories from the literature, theories born out of the data analysis and the insider knowledge of the researcher (Munhall, 2012).

3.6.6 Validity, Reliability, Rigor and Reflexivity

Validity and reliability are synonymous with positivist scientific research measurements (Polit and Beck, 2006). Quantitative data can be measured for statistical significance and generalisability, as can some qualitative research studies (Gomm and Davies, 2000). However, this is not the case for all qualitative research. Gomm and Davis (2000) suggest that it is difficult to prove truth in subjective opinion such as personal life perspective. Gray (2014, p.150) suggests, 'to ensure validity a research instrument must measure what it was intended to measure'. Thus, a semi-structured interview (see section 3.6.3.1) potentially allows for rich data production resulting from personal detailed descriptions (Denzin and Lincoln, 2013). Polit and Beck (2006) suggest allowing enough time to collect the data and to develop understanding to know if the data is trustworthy and authentic. As this study is qualitative in nature, the evaluation relates to the concepts of trustworthiness and authenticity (Denzin and Lincoln, 2013). Munhall (2012) discusses reflexivity as a concept of the qualitative researcher being fundamental to the research both within data collecting and data analysis. As I am an expert within the field of health visiting, I am aware of the cultural norm associated with this profession as such the research is dependent on my positionality or fore-structure (Willig, 2008) (see section 1.1). This insider information can influence the inquiry, and this needs to be recognised through the reflexive process (Gray, 2014) to provide rigour.

Rigour is related to the quality of this qualitative research study, both the thoroughness and accuracy of the inquiry (Streubert and Rinaldi Carpenter, 2011). Rigour was evident throughout in several ways such as keeping a research diary, working within

the parameters of the ethical approval and following the structured analysis described by Smith, Flowers and Larkin (2009) (see section 3.6.4). Silverman (2000) suggested that research diaries are useful for reflection but there is no one way to keep them if the records kept are meticulous. My research diary has been used sporadically as initially I was unsure how to keep it or what information to keep. As an evolutionary process I could have kept more precise detail in one place. Critically the use of information technology has added another dimension to the diary keeping notion, with emails, folders and word documents all storing information toward a broader chronology of the research process. This is a way of maintaining an audit trail to demonstrate the credibility of the data and ensuring clear articulation of the research process in the final write up of the study (Streubert and Rinaldi Carpenter, 2011). Yardley (2000) looks at assessing the quality of qualitative research using four principles: sensitivity to context, commitment and rigour, transparency and coherence and impact and importance. All of which are addressed in Chapter 6. Triangulation is also associated with demonstrating rigour and this was discussed in section 3.6.5.

3.7 Critique of Method

The semi-structured interview questions previously tested in the pilot study worked well (Le Blond, 2016). However, question 3.1 and 3.2 (see appendix 9) regarding the delivery of intimate care met with unforeseen lack of insight. Despite providing a pre-question qualifying statement (see question 3 appendix 9) all eleven participants initially answered the questions from a provision of intimate physical care perspective. Noting that they did not provide physical care as they had during their nurse or MW delivery of care and initially negating any intimate psychological care that they provided. This is discussed further in section 4.1.1.6.

The interviews were recorded using a digital audio-recorder and some notes were taken during the interviews as a back-up if the recording failed. However, as the recordings were successful the notes added no additional value. The recordings were transcribed verbatim. As Silverman (2011) states, the transcribing is time consuming and can take years and this is reflected in Appendix 10 below. Kvale (2007) suggests an experienced secretary could take five hours to transcribe an hour of recording. However, for a novice typist listening carefully to every utterance in a variety of dialects the time exceeded this suggested timescale. To speed up the process a second transcriber was enlisted. However, being distanced from this narrative felt at odds with

my wish to be immersed in the data, therefore I continued to complete the rest of the transcripts independently. Ensuring ethical care and valuing the participant security (Denzin and Lincoln, 2013) made me question the decision to share participant data to save some time. While the participants were not identifiable within the recording, the priority of maintaining confidentiality supported my decision to continue personal transcription of the data. Kvale (2007) discusses the ethical dilemmas faced by the researcher and the need to be clear from the outset on how the information will be stored and managed to protect the participants. Confidentiality was further considered due to the population of male HVs being small (see section 3.6.1.6). Thus, it could transpire that some readers perceive wrongly that they know the participant. Therefore, a sensitive approach was taken, and all transcripts (T) were given a number in a different order to the chronology of the interviews (e.g., T4, T1 etc). This would help to mask which participant had provided specific information. When writing up the study and returning to the narratives and transcription, through reflection it became truly apparent the value of carrying out the interview, transcribing and analysing the interview yourself. Nuances of the interviews returned when revisiting the transcript, whereas others may construe some wording as negative when seen flat on the page, I recalled the irony through intonation within the voice. Another elucidated point was that of the researcher undertaking the analysis having command of the same language within the transcription, again to identify the speech patterns, vocabulary and insinuations from each utterance. This is not to say that a strong interpretative approach could not be taken by a researcher using a different language to the participant however, the notification of the particular, could be bought into question.

Another critique of the method included no personal consideration given to the financial cost or time required for data collection. As a novice researcher this was an oversight that will not happen again.

3.8 Summary

Chapter three presented the research design, methodology, methods together with the ethical approach toward participant protection. A variety of approaches were considered before justification for research methodology was made. The issues with gaining an appropriate sample were highlighted and approaches to ensure

triangulation and rigor were put forward. A critique of the methodology was provided. The results of the data collection and analysis will now be set out in chapter four.

Chapter Four. Analysis/Findings

4.0 Introduction and demographic information

This chapter will initially present the demographic data of the 11 participants (see table six). The demographic data provided will offer a sense of the participants backgrounds. Specifically detailed demographic data was consciously not collected and will therefore not be presented to retain confidentiality. Due to the nationally small number of male HVs there is the potential to compromise individual identity and it is imperative to protect the participants (see section 3.6.1.5 and 3.6.1.6) who were kind enough to share their experiences.

The chapter will then present the findings following the analysis of data collected across the 11 participants within this qualitative study. Silverman (2011) highlights the need to be clear of the approach toward data analysis, from the start. The IPA process of analysis (see figure 3 above) and in-depth consideration, through my eyes and experienced HV position, with insider knowledge of the culture and historical experiences (Creswell and Poth, 2018), facilitated the identification of four overarching SOTs underpinned by fourteen themes (see table 7).

Once data collection was achieved the IPA method provided a clear robust systematic process for data analysis (Smith, Flowers and Larkin, 2009) (see section 3.6.4)

This chapter will present the findings of my research, while addressing the aim, to explore the lived experience of registered male HVs in England and the following objectives**:**

1. To collect personal experiential narratives of being a registered male HV.

2. To investigate why the participants chose Health Visiting as a profession.

3. To consider the impact on service delivery by male HVs.

Table 6. Demographic information demonstrating the participants backgrounds and reasons for entering the specialist field of health visiting.

Transcript number for each participant (T)	Age	Ethnicity	Pre-Nursing roles	Why HV?	Father	Other men in their HV cohort	Qualified Practice Teacher	Plan for next 5 years
T1	44	White British	Had other jobs. Wanted to study something caring. Access course. Direct entry Midwife	Disillusioned with MW. Started a family. HV 9-5 hours.	Yes	0	Yes	Go into teaching
T2	30s	White British	Mental health support worker in care homes.	Adult Nurse A&E. Like working with children & families *Call to Action	Yes	1	No	Go into school nursing
T3	50s	White British	Had other jobs. Wanted mentally & practically stimulating role. Started Adult nursing age 28 P2K.	HV 9-5 hours. Band 6. Interest in Paediatrics	Yes	0	Wanted to be PT no funding	Retired
T4	50s	White British	Different jobs armed forces, engineering but never settled. Saw a Nursing TV advert. Adult branch.	Paediatric placement with HV placement. Worked on Paed ward-did Paed training. Needed new challenge. Had family. HV 9-5 hours.	Yes	0	Wanted to be a PT but no scope due to 2018 NMC education standards	Retired
T5	50	White British	Fell into adult nursing 29yrs ago. Did lots of jobs but kept returning to nursing auxiliary role. Decided to train as a nurse.	Did not want to be a manger and wanted to get higher with patient contact. Did a ENB Child protection course with HVs and they swayed me.	Unclear	0	No Designated Nurse Child Protection	Retired

T6	40s	White British	Long career in Civil service-worked in care home at weekends. Encouraged to do MH Nursing.	Straight from MH Nursing course into HV training *Call to Action	No	1	Want to be PT but no funding or training locally	lecturer
T7	50s	White British	Family in caring professions. At age 16 no idea about career options, so started Paediatric Nurse training	Paediatric nursing 17 yrs then starting family. Wanted better hours so HV felt natural move.	Unclear	0	Yes	Retired
T8	40s	White British	Health orientated retail 25yrs. Redundancy-career change. Care assistant working with families. Encouraged toward Adult Nursing.	Disheartened- lack of patient continuity, ward politics. Read HV job description -Enthused by Upstream thinking *Call to Action	No	2	No	HV in Multi-agency safeguarding team
T9	40s	White British	Travelled and studied Degree race relations- initially wanting green card for Australia but wanted a course with a guaranteed job at the end of it. Adult Nurse	Worked in theatres then selling theatre supplies, own diary, workload. Was interested in Child development and a student nurse suggested HV *Call to Action	Yes	0	No	Wants to complete Masters study but no funding or research career framework
T10	50s	White British	Hospitalised as a schoolboy. Thought about physiotherapist role but fell into nursing from school.	Wanted a change from being a Charge nurse but to take skills and knowledge forward. Spontaneously thought HV next	Yes	0	No Designated Nurse Child Protection	'Wherever I am'
T11	50	White British	Lots of different jobs & travelling. Liked caring and wanted a flexible job that gave job satisfaction. Trained as paediatric nurse.	Paed nurse acute and community. Disliked shifts then moved into HV.	Yes	Didn't say.	Yes	Do a PG Dip to be on same level as HV students

Table 7. **Superordinate Themes and Themes**.

	Superordinate Themes	Themes
1	Gender as a Factor in Health Visitor service delivery.	• Being male as an asset influencing acceptance, toward health visitor service delivery. • Male as a difference causing rejection: a notable lack of equality, through discrimination. • The potential vulnerability of the male HV and the need for constructive managerial input as a determinant of male health visitor role fulfilment.
2	The Cultural Marginalisation of Fathers in England: Health Visitor Service Impact.	• Invisible fathers: the hidden male voices within England's cultural norms. • Service delivery a double lens perspective for fathers who are male health visitors. • Gender bias health visitor service delivery.
3	Progression Career Choice.	• Pre-health visitor Career. • Health visitor training, the minority issue. • Practice teachers and their influence on student progression. • Being a qualified health visitor and career progression.
4	Evolutionary Health Visitor Practice and Eclectic Workload Demands.	• Health visiting: a hidden service. • Caseloads: challenges and continuity. • Evolving health visitor service versus demise of health visiting service. • Professional health visitor attributes and values toward service provision and caseload management.

McCormack and Joseph (2018) highlight nine potential pitfalls when undertaking an IPA study that bore resonance with my experience. Having ensured validity through the stringent application of Smith's IPA approach to analysis (Pietkiewicz and Smith, 2014; Smith, Flowers and Larkin, 2009), I then found it difficult to detach myself from the rich verbatim quotations, of each individual participant, for fear of not representing them honestly and fully. Silverman (2011) suggests the constructivist makes sense of

the participants recall of their lived experience but that it is difficult to detach oneself from the interview. The paper by McCormack and Joseph (2018), together with specific supervision around how to approach writing up the findings, enabled me to see past this barrier and address the analysis as an iterative process that will be evident throughout this chapter and discussed in chapter 6.

The analysis/findings section initially highlights each SOT and then presents the corresponding themes and the ways in which they relate to the SOT within specific summary tables (see appendix 16). Smith, Flowers and Larkin (2009) propose that enhancing the validity of the findings can be done by noting recurrence of the themes across the sample with at least a third to half or all transcripts capturing the same theme. This approach to demonstrating validity has been taken and is shown within the summary tables A, B, C and D (see appendix 16). This robust approach was supported using corresponding rich verbatim texts (Willig, 2008). The verbatim texts were chosen carefully, from the vast number available, to retain the participant voice and illustrate the context of the experience to focus the themes, while illuminating the interpretations made from the one-to-one semi-structured interviews. The priority of retaining the participant's meaning within edited quotes was uppermost and considered ellipses (…) were used to negate unnecessary words while remaining true to the experience of the participant.

Alongside each verbatim quotation the following key is applied to locate specific narrative accordingly: T= Transcript with the number (T1, T2 etc), P=Page Number, L=Line Number, for example T1 P2 L4-5.

4.1 Superordinate Theme One: Gender as a Factor in Health Visitor Service Delivery

Gender was raised as a factor, for all eleven male HV participants, that impacted on HV service delivery. Maleness as a notion evolved with nine male HVs finding their gender an asset and at other times eight participants found their gender a hindrance (see sections 4.1.1 and 4.2).

All 11 male HV participants talked about their gender in a variety of ways including both negative and positive perspectives of working in a female dominated profession. The notion of consent, both implied and verbal, was implicit throughout all the interviews regarding service delivery. Receiving implied consent by being allowed to

visit within the home, or have a clinic contact, was associated with acceptance, regarding professional and client interaction, as can be seen in this chapter. When working with a predominantly female client base with young children (NMC, 2004a; DH, 2009; DH, 2011; Public Health England, 2018), there was unanimous discourse that gender difference was a factor in service delivery from a variety of perspectives that are highlighted within the analysis and findings below.

4.1.1 Theme: Being male as an asset influencing acceptance, toward Health Visitor Service delivery.

All 11 participants were able to deliver the HV service. The articulation of acceptance varied across their professional lives as can be seen within this theme. Gender was not voiced as an issue for T3, who stated he carried out all aspects of the role that his female HV colleagues delivered. Across the 11 transcripts the notion of maleness had been an asset allowing them to support mothers more objectively than female HVs, by whom some mothers suggested they felt judged. The participants raised that their gender negated the ability to give birth or breast feed. As such T1, T2, T5, T6, T7, T8, T9 and T10 described being able to give evidence-based objective, non-judgemental support from a different perspective and that this was appreciated by the mothers. T4 acknowledged that while doing his UNICEF breast feeding training one mother was particularly helpful and had no problem with him being there while she breastfed her baby. This acceptance in attendance during the intimate time of breast feeding was echoed by T10. Critically this perceived male HV non-judgement may have also been the case for female HVs, but this view was put forward as a reason some mothers preferred seeing the male HV rather than the female HV.

> *I think my approach has been quite different. I think parents of families, probably like myself, didn't even think of a male in that kind of role (HV). So, I bring a different perspective, I think. A lot, especially mums, have said, it's really kind of nice to talk to someone, to somebody that can't empathise with certain things, because then you've got a different perspective, that perhaps can be slightly more objective at times.* ***T2 P3 L2-6****.*

Here T2 acknowledges, that as he is a man, he has no idea what parenthood is like for mothers and he has to try different approaches to explore their perspective rather than making assumptions about their experience.

This notion was similar for T10 who proposed he was accepted as it was obvious that he could not breast feed, but he could arrange other expert advice to support mothers if required. T10 reported he had come across Midwives who said to the mothers, if you are breast feeding, then you need to feed, and that struggling was normal and to get on with it. Here, T10 suggests that this dictatorial approach from other professionals resulted in mothers preferring his style of service delivery. T10 recounted that he immediately broke down barriers by acknowledging he could not tell mothers how to breast feed, adding, he did not see the need to be master of everything. Critically, Cowley *et al*. (2015) suggest, evidence-based information should be given to the client that is unique to the individual experience, rather than anecdotal advice. However, T10 uses the word 'barrier' noting that there are obstacles to overcome when first starting to interact with clients to be able to communicate effectively as time moves on.

Below T5 also gives an example where mothers have accepted him as they were willing to breast feed in front of him and were concerned that he could have been offended by their action.

> *You know in fact some women would say to me I want to feed my baby T5, are you alright if I feed my baby like, I don't want to embarrass you. I mean I'd say certainly not, don't worry about it.* ***T5 P20 L9-11.***

Here T5 sounds comfortable in his HV role and supportive in not wanting to raise the mother's anxiety while she was feeding her baby. Another participant, (T1) recounted other mothers' negative experiences of judgemental female practitioners who had tutted if asked for pain relief (midwifery) or when advising that the mother should breast feed, because that is what women should do (HV). Here, T1 uses the word 'tutted' to show that he thought the MW was exasperated having to give pain relief to someone giving birth which was deemed a natural occurrence and that the HV was perceived to lack empathy, stating that women should breast feed regardless of any problems they may have. This narrative from T1 promotes his perception that through not being judgemental like the MW and HV he described here; he was accepted by the mothers.

Adding to this perspective of acceptance, T9's quotation below, suggests that male HVs were not seen to exert as much social pressure on mothers as female HVs did.

> *We get a lot of mums feeling pressurised, you know, say for instance to breastfeed and then they talk to me about it quite often and they don't feel the same like, pressure, because I think they know I can't (breastfeed), they know I can't necessarily empathise.* ***T9 P12 L13-15.***

The notion of power related to some female HVs in the following excerpt from T7 related to pressure, where some mothers 'felt weak' when they asked a female HV a question that they, as females, thought they should know the answer to, potentially resulting from some genetic disposition.

> *Some of them (mothers) have actually said they quite like talking to a guy because they don't feel that they are being judged by a bloke, whereas, you know, they felt if they're a woman and they've got issues and they are trying to talk to another woman (female HV), they kind of feel that it's a kind of sign of weakness and they were being judged.* ***T7 P11 L1-4.***

Here T7 alludes to mothers feeling anxious about asking a female HV questions related to motherhood. The perception appears to be that all women will have the inherent knowledge required, to carry out or give opinion on motherhood, which from experience as a mother and HV is not the case.

From a unique perspective below T3 saw his role as valuable, noting the difference he could bring to younger mothers' psychological wellbeing, through being a positive male role model. This positive outlook appeared to inspire T3 in that his role was valuable and gave job satisfaction and that he was not judgemental like some of his female HV colleagues.

> *Having worked with young mums in supported accommodation, they saw it as being very positive, for two reasons; because they had not had any consistent advice from a male in their life, but also, they didn't feel judged.* ***T3 P25 L7-9****.*

4.1.1.1 *Families on the Caseload*

It became apparent that the participants expected more of a response about their gender from their clients when visiting in the home, as can be seen in the following examples. T6 highlighted that no one had refused his care that year and only a couple of people over his HV career had refused his service, which was in keeping with his female HV colleagues. As such T6 was comparing against the traditional female HV service delivery and as his rate of rejection by clients was on the same level, he perceived he must be doing his job well and this was important to him. Once parents got to know T8, they would request his care as they stopped seeing a male HV and saw him as an HV. This narrative, from T8, fits with the genderless connotation noted as meaning acceptance in section 4.1.1.4. Interestingly, T5 reflected that he had been initially accepted when working in a more deprived geographical area but then faced rejection when he moved to work in a more affluent locality. This polarised behaviour from service users would need further exploration to draw any conclusions but it obviously troubled T5. With a critically reflective lens, I could have delved deeper into the participant's view of why that was the case, but as a novice researcher I did not take the opportunity to divert at every opportunity from the pre-set semi-structured interview questions to hand. Equally, if asked, T5 may not have known why the service users, in a more affluent area, chose to reject him when others in the impoverished area accepted his visits. T5, also expressed that he had to justify himself to clients more than female HVs, to get credibility by saying how many children he had. Here T5 portrays himself as working harder than his female colleagues to be accepted and build a client facing relationship. This may or may not be the case but as my research was not a comparable study, further research would be required to assess T5's perspective.

Other male HVs reported not having an issue with visiting the service users and had faced limited rejection, if any, over their time as HVs (T1,T3, T9, T10, T11). Some male HVs acknowledged they knew they had been accepted as the mothers would open-up to them about relationship issues and domestic abuse (T6, T9). Such intimate trusting discussions demonstrated advanced communication skills (see section 4.4.4) and would be deemed a high achievement as it is well known that domestic abuse is a hidden crime with extensive underreporting (Women's Aid, 2022) (see section 4.2.2).

Acceptance by attracting more fathers to his clinic, than any other clinic, was seen as a triumph for T10, who alluded to his gender difference attracting other HV service users. T10 took his discussion on fathers further as follows.

> *Erm, I think there's two angles on fathers. There's the, oh my God actually there's a man coming into this house, and he is going to look at your boobs and bits. Classic who is he? He might be a nurse but what have you. I suppose you might get, a bit politically incorrect, but I'll get it out in the open, you might get that he's a male nurse, he must be gay, so we're all right because I think that definitely, I don't know if that even exists, but it definitely did exist that all male nurses must be gay because that's why they're in the nursing and all that kind of stuff. So you've got two sides, the guy who thinks fine and the guy who thinks all hang on a minute what does he know about this kind of thing…* ***T10 P40 L13-16. P41 L1-3.***

Being perceived as gay or effeminate, by clients and colleagues, due to being a man working in a female dominated role was also noted by T5 and as a stereotypical notion in the literature review (Loughrey, 2008; Dyck *et al*., 2009; Harding, 2007; Jiunn-Horng *et al*., 2010; Clow, Ricciardelli and Bartfay, 2013). This projection bore some resonance with my pilot study (Le Blond, 2016) where male nurses were stereotypically perceived as gay to be in their chosen job role. Although this perception is now outdated within a progressive society, there is prejudice related to gender and job roles (Stonewall, 2021) and this will be addressed as a point of convergence within the discussion chapter (see 4.1.2.4 and 4.2.1).

4.1.1.2 *Health Visitor Teams*

The asset of being a male HV had an impact on the team cohesion with colleagues and managers reporting they brought balance to the team and a different dynamic and or perspective (T2,T5,T6,T8). The acceptance of T2 went so far that he was included in office conversations about the menopause, as if the female team forgot he was there. This apparent ambivalence from the predominantly female team when discussing personal health issues demonstrates the trust, they shared in their male HV colleague. The welcoming received by T6 made him feel immediately accepted as part of the team. The notion of acceptance was also presented as being well supported by the management and team with the opportunity to progress and develop new skills

(T6, T8). T6 had also taken on low-cost team building activities, that were managerially supported, and appeared to give him a sense of pride and enthusiasm to help lift the spirits and cohesive nature of the HV team.

4.1.1.3 *Multi-agency Teams (MATs)*

Working across the broader multi-agency team, which is usual practice within the Child and Family landscape of Health Visiting (Department for Education (DfE), 2018), did not routinely pose any problems for the participants (T2, T10). However, T10 elaborated that his interaction, with a specifically difficult to engage male General Practitioner (GP), was different to that of the female HVs. Initially T10 questioned his manager as to why he should go to work with that GP which he recounts he may not have done as 'a fresh staff nurse' (T10 P9 L3). T10 states,

> *I was whisked into the practice nurse office and the practice nurse was one of those dominant characters in that practice, she had the power base. I was sort of interrogated interviewed, it wasn't an interview, I'd just gone to say tell me about it, I met with these doctors, and I met doctor X and actually thought I can really work with these guys, yes, he was challenging but so were surgeons where I came from.* ***T10 P9 L10-14****.*

T10 expands, "*there had been streams of HVs who had left the practice*" (T10P18L3) but explains that he would listen to what GP X had to say then give his HV perspective and allow GP X time to think about it. After this T10 and GP X generally came to a mutually agreeable compromise which allowed T10 to meet the GP practice needs and beneficially expand his practice acumen (see section 4.4) and as such T10 "*got things done*" (T10P27L15). T10 raised the notion that GP X was "*particularly good at using his power base against female staff*" (T10P28L1), which hindered their practice but assisted T10. This personal perspective of T10 alludes to the misogynistic undertones (see section 1.2) of the powerful hegemonic male GP who devalues the role of female staff. T10 also presents the notion of newly qualified or less experienced staff, as 'fresh faced', not having the courage to challenge the hierarchy of the health care system. As an extensively experienced practitioner with the capability and capacity to question decisions from those deemed more powerful and knowledgeable than himself, T10 was more in control of the situation and was able to redress the

power imbalance to his and the client's advantage and ‘get things done’. This is a powerful representation of patriarchal advantage for T10.

4.1.1.4 *Genderless Acceptance*

The concept of maleness was put across in several ways with a stark perspective of knowing, that as men, they were accepted and integrated when seen as a HV, rather than a male HV (T8, T1, T7). This concept related to achieving gender neutrality (T1) or being genderless within the role and being perceived as delivering the same service regardless of their gender. T1 related his gender neutrality to not having birth or parenting experience which allowed him to have an impartial outlook and be a subjective practitioner. However, this perceived acceptance came with a caveat, from T8, as when a young mother was struggling to breast feed, she requested a female HV to observe and give guidance. T8 then continued to deliver the service as the HV of choice. T8 came across as pleased the mother felt confident enough to raise her wishes and then continue with his service as this demonstrated he was doing a decent job. T6 refers to the lack of supportive services in his areas, so he gave independent breastfeeding advice without problem. Critically, the intimate nature of breast feeding gave rise to a range of experiences divulged by the participants and is shared across a number of themes within the study (See section 4.11, 4.1.1.6, 4.2.1, 4.4.3 and 4.4.4). Below, T7 sums up his elation that he was accepted as a practitioner regardless of his gender. T7 uses the term ‘asexual’ denoting he fits in and gives the appropriate guidance and advice regardless of his gender.

> *Oh yes, she told me you'd be giving me a ring and she said he's like an old woman, you can tell him anything. What I really took out of that is that asexual thing, people don't see me as a man, they see me as a healthcare professional and that was fantastic and actually you know it kind of reassured me a bit about, you know, how things is.* ***T7 P11 L8-11.***

Despite T7 aligning to a genderless connotation in the quotation above, it could be that T7 had diminished male traits allowing his seamless fusion into providing the HV service (Liminana-Gras, Sanchez-Lopez and Javier Corbalan-Berna, 2013). A slightly different view from T8 proposes that he was not alpha male or a rugby playing manly man and that working in a female dominated caring profession was not beyond his character boundaries. T8 elaborates on his view of developing acceptance.

> *They (the parents) see this male HV, and you give them your name, so they see T8 the nurse. Eventually they see you as you and the caring, the empathy that you give so you are no longer that gender anymore.* ***T8 P16 L13-15.***

Again T8's narrative suggests that by being caring and empathetic he is no longer seen as male, suggesting that a predisposition toward traditional masculinity would not be useful in such female orientated work. T8's thought process concurs with the work of Loughrey (2008) and Liminana Gras *et al.* (2013) who found diminished hegemonic masculinities such as risk taking with heightened predication toward female traits such as caring and understanding.

4.1.1.5 *Friends and Family*

Choosing to work in a female dominated profession was not an issue for friends who also worked in helping professions and who were supportive of the participant's career choice (T2, T11, T8). This acceptance of the male HV's chosen role was echoed across ten of the eleven transcripts, by friends and family. One of the participants (T8) was surprised when his brother-in-law, a painter and decorator, introduced him as someone who did an interesting job, realising that this 'manly man' who did sports and was in a traditionally male role, had not only accepted what T8 did for a living, but was proud to tell his friends. The reference to the sporty manly relative demonstrates the self-image held by T8 that he himself was not a stereotypical man and did not think he would fit into the realm of interesting jobs discussed by masculine men. T6 also acknowledged his friends and family could see he was doing a good job and had a rewarding work life, alluding to the fact he was trying to make a difference. For T2 there was an unexpected divergence, as his family had not accepted him undertaking the male HV role, and this had caused him to evaluate his position.

4.1.1.6 *Intimate Care*

Before asking a question about intimate care a short narrative was given to each participant expressing that intimate care could be related to both physical and psychological care. However, all eleven participants initially talked about the minimal physical intimate care that they gave within the HV role negating the intimate nature of some discussions, around issues such as historical abuse, birth trauma, sexual

health, breast feeding and MH issues, all constituting the need for psychological care (Cowley *et al*., 2015).

The initial surprise at how long his PT could spend talking to a client was superseded by the realisation that this one-to-one skilled intimate conversation was aimed at giving the clients permission to say how they were feeling and to assess need (T5). T3 acknowledged a need to be aware of intimate care issues at every contact and not to become complacent as this could be the first time a couple have had a baby or seen a HV, so maintaining self-awareness was required. Importantly T8 acknowledged that he associated personal care as a 'physical thing', and that he had not considered the MH aspects of wellbeing as being personal or intimate.

Possibly, a degree of naivety was shown by T4 who talked about no other mothers withholding information from him, when he reported missing suicidal ideation in a client. This notion is questionable, as clients will choose the information they share at that time, demonstrating the importance of building a therapeutic relationship (Cowley *et al*., 2015). Critically, the lack of disclosure here is multifaceted, the parent could want to be seen as a good mother or the practitioner may lack the insight into the complexities of MH and suicidology or may not have utilised advanced communication skills required to draw out such intimate information at that time.

When discussing intimate care, as a midwife and qualified male HV, T1 missed the physical hands-on care of feeling how the baby was lying in utero and assisting birthing as he delivered limited physical care toward the parents. However, there was lots of hands-on care to the baby which was fine (T1). Interestingly, T6 wanted insight into birthing as a student HV but was not allowed access possibly due to his gender or capacity yet T1 delivered babies demonstrating a divergence in contextualisation of men in caring roles across the health care setting.

As a MH champion, T1 delivered low intensity therapeutic interventions, that he found fulfilling. Four of the male HVs recounted personal insight into psychological issues with some having experienced depression, suggesting that this had given them insight that enabled discussion with clients (T2, T3, T4, T5). T5 advised he talked about intimate issues such as the parent's childhood, MH issues and sexually intimate details as follows.

> *I kind of normalised it or maybe that comes with the environment to talk about it...people talking to me about intimate stuff at the twelve-week visit, I would always talk to them about sex, have you started (having) sex, what's happening and are they comfortable?* ***T5 P24 L14-16****.*

Here T5 acknowledges the need for HVs to routinely enquire about arguably intimate subjects such as sexual health and MH as a part of the mandated HV service contact (DH, 2009). Critically, T5 advised parents that they did not have to answer questions if they did not want to, demonstrating the elements of consent, choice and sensitivity he considered when providing the HV service. Assessment of the mother's MH is a core aspect of HV service delivery with the National Institute of Health and Care Excellence (NICE) recommending the consideration of using the 'Whooley Questions' screening tool, with all mothers (Bosanquet *et al.,* 2015).

> *I've never had like an issue (delivering intimate care), when I first started asking the questions, you know, the Whooley questions? I found them like kind of quite awkward, but that was just because I'd never been used to asking, you know, they're quite, you know, quite long wordy things that you have to kind of say verbatim and I always, I found that awkward but I don't think I ever found anything else (any other aspect of service delivery awkward) just because you know, because of who I am (a male HV).* ***T9 P18 L2-6.***

Here T9 expresses here how awkward asking sensitive information can be when done in a contrived and prescribed way, yet he presents not having an issue with any other aspect of HV service delivery possibly due to finding his own flow of communication techniques at other times. Parenthood is at times overwhelming for mothers and fathers with T7, T8, T10 and T11 also noted the intimate support they gave to depressed parents due to traumatic births, work issues, feeling responsible for partners and while supporting mothers to breast feed, all of which required respect and good communication. T11 demonstrated his empathic approach noting some people could be embarrassed and want to see someone else and he supported that showing respect for their decision with personal confidence to allow them that decision.

A discrepancy was noted for T10 who mitigated the professional risk of intimacy suggesting intimate care was not a big part of health visiting as it was not a touchy-feely, hands-on examination and should not be. Here, T10 aligns to the notion that intimate care is physical in nature rather than physical and psychological in nature.

4.1.1.7 *Chaperones and Joint Visits*

During discussion around the issue of chaperones, none of the participants had required a chaperone within the home that was related to their male gender, this was different to their previous nursing/midwifery practice experiences where all eleven participants had used chaperones routinely.

> *So, I can't recall thinking I specifically need a chaperone for this particular examination. If I needed to do an examination like that, I was probably out of my depth anyway (as a male HV) and I would be getting the doctor to do it.* ***T10 P35 L8-12***

The notion here is that chaperones are used traditionally for physical examination when a health care professional and client of two opposing sexes are in a room together. However, this is historically and routinely when the man is in the more powerful position of care giver. Whereas female care givers would not routinely ask for a chaperone when undertaking an examination of a male patient.

T2 voiced that most parents were fine with male HV support and guidance for breast feeding and that this should be no different from having an Electrocardiograph (ECG) in the Emergency Department, by a male nurse. Critically, it could be easier to seek a chaperone within an Emergency Department or offer another professional of the preferred gender to undertake an ECG at that moment in time, rather than in someone's home. Interestingly, T11 and T3 had worked with families with specific cultural and religious practices, where a male and female would not be expected to be in a room alone and had still been accepted to provide a service. T3 added that rather than visiting with a chaperone it made more sense for one of his female colleagues to visit as required. These narratives acknowledged that being male does have an impact on HV service delivery but if male HVs remain professional, respectful and sensitive to the client's needs they would be able to deliver the HV service effectively. Cultural and religious stereotypical assumptions should be checked out with each client to ensure the service meets all clients' unique needs.

T8 acknowledged that, possibly due to his gender, he had been asked to do a joint visit where a female colleague had felt intimidated by the child's father. However, T8 was unsure if he had been chosen, for the joint visit, as he was a man, or because he was the HV who was available at the time. The notion of undertaking a joint visit due to perceived risk rather than acting as a chaperone was echoed by T3 who advised he and his colleagues would plan accordingly. Here, the notion of men being the stronger sex and being able to mitigate risks linked to the original literature review and will be discussed in section 6.1, 6.2.1 and 6.4.

Importantly, T10 noted that as a man he was always conscious that his gender would impact on both male or female gendered service users, questioning if this was about him or because he was more cautious as a man. Similarly, T11 talked about being respectful and mindful especially when mothers were breast feeding as they could be embarrassed and he gave clear communication, to normalise the situation, while being confident and professional.

4.1.2 Theme: Male as a difference causing rejection: A notable lack of equality, through oppression and discrimination.

This theme captures a variety of male HV shared experience regarding the notion of difference that resulted from being in the minority gender group. As can be seen below T5 expressed that he had shaken up the status quo regarding the female dominated HV service provision.

> *Erm, so I bought, I think I bought a different perspective. (In what way?) Erm, well simply a man's perspective and stuff. You know erm, I might come onto this later, but I certainly bought a bit more challenging kind of perspective, I think. Ready to kind of shake up the status quo really, and to put things from a man's perspective really. Which, it's hardly heard of in Health Visiting.* ***T5 P5 L7-11****.*

Here T5 is inferring that the traditional female application of the HV service delivery needed review and challenge. T5's terminology of challenging and shaking up aligns to the hegemonic masculinity that would be a divergence from the 99% traditionally female approach to service delivery yet HVs are expected to lead and manage multi-professional teams around the child, which could be considered a traditional male

orientated role. Being in the minority gender, delivering the HV service, resulted for some, in rejection, isolation, bullying and harassment as discussed below.

It was noted by clients that they had not come across a male HV before (T1), and the mother of T6 initially questioned why he would want to be a HV. This view was noting a difference between expectation and reality of HV service delivery. The perceived male HV difference was noted by T10 advising that guys either thought he was fine or would question what he knew about 'that sort of thing' as a man. Male HVs are notably the minority group within the female dominated service delivery. T7 and T5 point out that around 50% of the population are men so should not be shocked and are not being represented across HV workforce.

> *the people were aware of me… because I stuck out like a sore thumb. So, I always felt almost as if I needed to be at least as good as everybody else. …I knew that if I made a mistake or did something odd, or silly then people would remember me and if you went into a room, you knew virtually everyone knew my name straight away, whereas I would struggle to know everyone else's name, so that's kind of a bit intimidating.* ***T9 P8 L12-15 & P9 L1-3.***

Here T9 acknowledges the pain, in the use of the terms 'sore thumb', of being in the minority alluding to the isolation as the only man and the threat of not meeting the standard required of the female students. T10 supports T9 reporting, there was an element of him that needed to prove he was just as good as the other HVs. There is a difference acknowledged by T10 whereby he wanted to be a HV, not a male HV doing male health things. The narrative highlights that T10 thought he would be expected to undertake different job roles than those expected within the regular female HV service delivery. This narrative fits in with the genderless position related to feeling accepted and convergence toward section 4.1.1.4.

4.1.2.1 *Rejection from families*

There was discussion around the notion of rejection of male HVs from mothers and families, when being seen routinely in clinics and surgeries and specifically in the client's own homes for new birth contacts. However, T10 and T7 note there was a gender barrier evident from some fathers, that could be expected when a 'strange man' came into the home to see their new baby and wife or partner. Here T10 and T7

are possibly alluding to a father's role to protect their offspring as the male, parent (Lamb, 2010). T3 agrees, stating a mother phoned straight after a visit to ask that the male HV did not visit again as her husband was uncomfortable with him talking about her breasts. T5, T8 and T9 state a couple of mothers phoned and asked for a change to a female HV before they had even met them, without generally giving a reason or giving broad statements like '*it's not me it's my partner, he's not happy'* (T8 P29 L2-3). T5 added that some mothers look physically shocked when they opened the door to a man. T7 expressed that he was not giving any personal care to the mother, so being rejected due to his gender was interesting. The experience of being rejected made T3 question if it was the way he had said things during the contact. T4, T6 and T9 recount being rejected by a few mothers, tending to be from a Muslim or other orthodox religious background, which they reported having no problem with, as it was parental choice if they received the HV service or not. If a mother was not comfortable with a male HV supporting her with breast feeding the male HV proactively offers alternative female team member support toward breast feeding assessment and guidance (T8, T9). Other families had English as a second language and T9 was conscious not to have an overload of men visiting a mother alone with her baby, so would request a female interpreter. There was a discourse around it being easier for a client to refuse or 'ditch' a practitioner based on gender rather than ethnicity (T5, T6, T9). This refusal to accept the service of certain HVs was seen as an easy way for families to evade scrutiny particularly regarding child safeguarding concerns (T4, T9) ultimately being seen as leaving the child at risk.

T5 seemed to experience the most rejections noting about 20 from clients purely due to his gender and not on his skills, which as he stated annoyed him. T5 appears upset, hurt and frustrated by the injustice he has experienced and at times felt he was a burden on the team.

In the verbatim quotation below, T8 uses the term 'Ouch' here to denote pain, because of his rejection. This emotional labour takes its toll on T8 and if this happens regularly will affect his self-esteem, resilience and ability to continue in the HV role.

> *I guess where it hurts me or I take it personally is where I kind of met the family, where I've gone in antenatally. Baby is born and when I've rang up to say congratulations and I've done a consultation over the phone. I say is*

it possible that I arrange to come and see you? I've heard the babies 10 to 14 days and then when they refuse it, that's when you think ouch! ***T8 P28 L5-9.***

T3 also found rejection, after meeting the family, difficult noting how it made him question himself and his approach. T6 acknowledges he had never been rejected, before working as a HV, for just being a man, and suggests he 'cannot win'. Despite advising a family he was male before visiting, they did not know what to expect having never had a male HV before but, when he raised safeguarding issues, the family then refused to have him (T6). T6 sounds defeated here suggesting he cannot change his gender to carry out a job role, so he is beaten.

Maleness was put forward by T8 specifically, raising the issue of aging as a man, professionally visiting young families and babies. T8 articulated the wish to relate with the families and for them to open-up, noting a female HV would be seen as a warm Aunt. T8 appears to have this utopic view of female HV professional progression compared to the male HV yet goes on to highlight the male unique stance, communication style and warmth, which it could be argued all aging HVs could bring.

4.1.2.2 *Domestic Abuse*

T5 acknowledged that visiting a mother on her own, who was a victim of domestic abuse, could be an issue. However, the quote (T10 P40 L13-16, see section 4.1.1.1) negates the consideration of inflating a volatile situation, as a male HV, visiting a vulnerable female with a controlling or jealous partner. Of note, T9 had felt awkward visiting a female victim after she had sustained an horrific attack and wondered if he should visit. On arrival the mother had a friend with her, possibly as a man was visiting, but soon seemed at ease. T9 questions if he should think more about home visiting as a man, as he sees it as normal. Critically T9 also notes comments from clients, saying there are not many male HVs and it is a shame as having male HVs is a good thing. While delivering the routine HV service, T9 highlights his need to consider the impact for the client in detail, as they may be new to the service and unaware of their choices. Here T9 demonstrates ethical and inclusive practice by considering the client choice first rather than how he could have felt if his visit had been rejected.

A limitation to his service delivery was noted by T6, advising that, as a man, he could not attend the women's group due to the nature of conversation, but that he had

continued to publicise it to his families. In this section all the participants acknowledge that having a HV who was male could impact on the acceptance rates of the service but that at times this needed to be challenged especially in the realms of safeguarding as it was an easy way to deflect from services gaining access toward monitoring child safety.

T6 went on to highlight two fathers who had disclosed domestic abuse to him. This narrative demonstrates that domestic abuse affects men and women and is difficult for all victims to disclose their experiences. Critically, men are traditionally seen as stereotypically the stronger of the sexes and with this in mind the topic of male victims of DA will be discussed further in section 4.2.3.

4.1.2.3 *Rejection from the team*

T5 acknowledged while he was accepted into the immediate team there was a staff member who refused to shake his hand on religious grounds. Although this initially irritated and offended T5 he quickly moved on and they worked together effectively.

> *maybe because I was the only male health visitor at the time, I don't think there is any male (health) visitors there anymore now, since I left a couple of years ago. Erm, it was really new to them, and they were obviously worried about it.* ***T5 P7 L10-12****.*

Here T5 alludes to the difference he brings as a male HV, in the gender minority, to the majority female HV workforce. T5 uses the word worried in relation to male HVs being an unknown quantity and others not knowing what to expect from them. T5 took the time to reflect on how this behaviour could be interpreted when working with clients and a multi-professional team and concluded that as a female she was unsure of him and was 'sussing' him out.

The narrative below links to section 4.1.1.3 and gives insight into the male HV as a lesser-known professional giving rise to inspection from practitioners and other staff who did not know what to expect.

> *I literally knocked on this reception desk and said I want to see doctor X about the job… the receptionist looked at me as if to say, it's a man, ... I was sort of interrogated interviewed, … I met doctor X and actually thought I can really work with this guy. Yeah, he was challenging, but so were*

surgeons where I came from. So, I ended up in the practice where every one of my PT colleagues, peers, kept ringing me up going are you alright? Are you sure you're alright? 'I'm fine', are you? 'Yep fine'. I had a whale of a time, it was brilliant. ***T10 P9 L9-16****.*

Here T10 can see the conscious bias that being a man delivering a perceived female service evoked for the practice manager. Being interrogated sounds as if T10 was under suspicion of wrongdoing and had to endure an unforeseen ordeal. Despite T10 finding Doctor X challenging, he felt he could work with him, whereas his colleagues were highly concerned for T10's wellbeing, as the female HVs had challenging experiences with the same hegemonic GP.

Interestingly, although T1 was accepted into the HV team his PT would discuss a previous male HV negatively, making him conscious of his gender and making him question if his performance would be judged by his gender. Uncertainty from the team was also noted by T8 in his new team, where he perceived some team members questioning what he would be able to do and how the team would function. This rejection from the team was taken to an extreme in some cases with T4 having initially been accepted and when the team moved buildings the team's functionality went 'pear shaped', with 'fall outs' and it went 'scary and bizarre'. This change in the team's cohesions appears to result from overwhelming stress, leaving T4 to feel shocked and exposed to experience of attack, as terms such as '*back biting'*, and '*stabbed in the back*' are used (**T4 P11 L6,** see section 4.4.3.1).

Regarding career progression the wider HV service provision was implied as not accessible to T9, who was advised that 'travelling families' would not accept him as a male into their domain. As such T9 was advised that he would not secure a job in the travelling family team. Critically T9 recounted working with travelling families later in his career and had not had any issue raised by the family. This narrative demonstrates that service delivery assumptions are made that are linked to gender regardless of personal client choice.

4.1.2.4 *Hearing the marginalised voice*

When undertaking IPA and following the dynamic hermeneutic circle from the part to the whole and to the part (Moustakas, 1994; Smith, Flowers and Larkin, 2009) (see section 3.6.4), it is my belief that the polarised position should still be considered. While

the SOTs are derived from abstraction and subsumption, the facets of polarisation and function help to bring clarity that the lived experience within IPA will not be the same or even similar for all concerned. Nolan (2011) echoes the fear of moving from 'the particular' in the case of the individual, to the shared across the participants, as it can feel like losing the specific focus to find more common ground. However, Smith, Flowers and Larkin (2009, p.101) support the notion of retaining 'unique idiosyncratic instances' while also looking at higher order concepts across transcripts. As such it was important to highlight the function within the scripts and it was apparent that the notion of victim was not as prevalent as the survivor narrative yet was an important theme requiring discussion. This research approach, I would argue, should not negate the valuable narrative of any participants, particularly when they have found the strength to share, what for them, at the time, was life changing. In many ways the narrative of T5, was like that of other participants, as can be seen throughout the study, yet fundamentally from his perception he was leaving his client facing HV team role due to bullying and harassment within the workplace.

The following powerful verbatim quote puts into perspective the trauma expressed by T5, one of the participants in my study.

> *I always said before this happened that when I retired, I would write an article about it, not that anyone would listen. But, you know, but they need to be aware of, aware of the blatant discrimination that there is against men in the Health Service.* ***T5 P5 L4-6****.*

T5 disclosed that he almost left as he felt bullied and harassed by team members.

> *As I say the only unfortunate thing is if I hadn't got this job two years ago (a HV safeguarding role), I would have probably gone on long term sick because I've been bullied, harassed and it was because I dared to question things that were going on you know. Kind of slightly different but I think sometimes all this banter and stuff can actually turn into bullying.* ***T5 P39 L3-6.***

Here T5 refers to a fine line of humour versus scapegoating and later goes on to tell how he was called a woman and had his clothing ridiculed in front of the team. This humiliation had taken its emotional toll as T5 considered the only way out was to remove himself from work or apply for a different role within the HV service, as it was

the abuse instigated by colleagues that was unexpected within a caring profession and unacceptable to him more than any experience he had with clients. When advising a client, they could have a female HV but that he was not happy they had this choice and they would not be as good as him. T5 states his discourse was not very nice or professional. When analysing his terminology and actions, T5 appears to be frustrated that he is a good practitioner, but people would not give him a chance due to his gender and as he could not change his gender this was pushing him toward breaking point. T5 also recounts he advised a female HV colleague, "*they don't want you because you are rubbish, they don't want me because of my gender, it is nothing to do with my skills*" (T5 P11 L4-5). Here, T5 appears to be lashing out due to relentless frustration from ongoing discrimination. Essentially proposing, T5 was unable to change the fact he was a man, but the female practitioner could ultimately change her practice.

When T5 found himself speaking out against a decision made at a recruitment training day, he was asked to see the manager as he had been noted to '*upset a few people*' (T5 P14 L16). In his quest to challenge discriminatory practice it appears that T5 himself became oppressed. When raising further issues about discriminatory practice T5 reports being advised "*you chose the job, you should know what to expect"* (T5 P15 L7). As this was a manager interaction T5 expressed that he could not go anywhere with that. It appears that T5 was being subjected to oppressive rather than emancipatory management styles. This oppression becomes evident again later in the interview when T5 states he gets on with it, because he has tried to shout out about it, but is slapped down. Hence, T5 has resigned himself to become subordinate and not speak up in the face of adversity. T5 proclaims that he would not be able to write anything about it (his experience) as he would be worried about repercussions. This personal narrative from T5 resonated with my experiential insight as a HV, into the effects of sustained emotional abuse, negating his voice and wish to be heard and this will be discussed in section 6.2.1and 6.3.

Blatant discrimination was how T5 described a midwife telling a mother that she would receive a call from an HV who was male and that she did not have to accept him, she could have a female HV if she wanted. T5 challenged this practice asking if all the clients were offered a choice of a male HV, if they had a female HV, to which the answer was no. Here T5 is shocked at the discrimination from fellow professionals that he faced in the workplace. Here T5 is aggrieved by the MW's gender bias affecting his

potential interaction with clients before they have met him. However, all clients do have choice, but it is the context in which the information toward the choice is given and the way in which the options are portrayed that concerned T5. This research explores the lived experience of male HVs and here from the narrative of rejection.

T5 recounted facing discrimination wherever he went such as working in the office, attending meetings and undertaking training, including recruitment training and discrimination related to male applicants (T5). Some of the discrimination came from practitioners who were from minority groups themselves and this unsettled T5 who suggested they could have had experience of discrimination and the effects discrimination has and should therefore, have known better. Listening to the lived experience of T5 left me feeling drained on his behalf and concerned as he sounded traumatised and yet still maintained that becoming a HV was the best thing he had ever done. Here the overt post-traumatic stress left me reflecting on how this damaging behaviour could take place in a caring profession.

Unexpected support was found for T5 during some safeguarding training with the National Society for the Prevention of Cruelty to Children (NSPCC) whereby T5 states they recognised that there was a blatant discrimination against male staff in the health service that left T5 with a feeling vindication, as someone had listened.

Further narrative from T5 features throughout the study that sits more readily alongside the other participant experience, but this specific perception warranted further elucidation.

4.1.3 Theme: The potential vulnerability of the male Health Visitor and the need for constructive managerial input as a determinant of male HV role fulfilment

Some participants had emotional traumas resulting from the vulnerability they faced as a minority group within the workplace. The challenges they faced will be presented here.

4.1.3.1 *Vulnerability within caseload management (Intimate care)*

An allegation of inappropriate sexual conduct, toward a mother, was made against T3, after he raised a safeguarding issue about a child, while in the child's home. T3 was in shock and reported it immediately. T3 was suspended the same day, to return when cleared six weeks later. However, the events took a psychological toll on his MH and

T3 suffered the impact of a lengthy depression and highlighted the discriminatory connotations below.

> *it simply wouldn't have happened if I was a woman…highly unlikely that she would have made those allegations against a woman.* ***T3 P18 L12-14***

Here T3 emphasises the vulnerable position that male HVs find themselves when visiting women in the home as a male HV compared to female HVs, noting the difference for men.

The team were not told what had happened to T3 until he returned and recounted events, but this also took an emotional toll.

> *I mean everyone was shocked by what happened… I never felt that anyone questioned my practice at all. But once I started, I then went off, depression came back, and once I started back doing visits my persona, I suppose for several months did change. I was very, very, wary all the time.* ***T3 P19 L13-15****.*

T3 was obviously traumatised by the event, stating his nerves would have been on edge all the time in a heighted anxiety state, "*very, very, wary*." T3 is somewhat vindicated as his team are supportive trusting his word, but also shocked by the events, so he is not alone in his narrative of innocence. Despite the trauma T3 later notes that he was very well supported by his manager, on his return to the workplace, but that he was not at all supported by the process. The process alluded to by T3, in his transcript, was of being suspended immediately, regardless of personal judgment or opinion, pending investigation and this would feel like being judged with implied guilt before any questions had been asked. T3 reported this event had a profound effect on him as he was more wary, felt vulnerable and had the need to protect himself for a long time after but as communication is key, if he had not dealt with it, he could not have continued in the HV role.

T7 highlights negating potential allegations of sexual abuse in the narrative below.

> *I do feel the one restriction might be if I came to see you and you were upset, the one thing I'm very mindful of, is not actually touching you in any form, whereas some of my (female) colleagues would feel quite comfortable.* ***T7 P13 L11-13***

Here T7 alludes to the fact that if he did not touch a client then it could not be construed as anything else such as sexual misconduct and is therefore protecting himself from allegations against his professional male integrity.

As implied above, some events were not only psychologically damaging with their impact, but they had a professional connotation potentially leading to professional body intervention from the NMC. Professional body intervention in itself would undoubtedly add to any psychological pressure and trauma being experienced by the male HV participant(s) (T3, T4), potentially leading to financial pressures if away from work for a substantial amount of time and requiring legal intervention to support the case (T4).

4.1.3.2 *Isolation*

As the men were in a minority, as an individual or group, they became isolated at times with T2 reporting he felt like an add on during his training and in the workplace upon qualification (see section 5.4). This notion of isolation, as an emotional toll, also came through from T4, who when returning to work following prolonged sick leave, recounted being moved from a team, who he got on well with, to another team. The words, "*I really enjoyed it there, got on well with the team, a good experience"* (T4 P9 L10) portrayed contentment that was followed by sadness as T4 was hoping to return to a nurturing positive team and he found himself in a new place and a new team, without the support of familiarity. Due to a tendering process T4 and the team then got moved again and this time he recounts "*massive fallouts between members of the team…it's just been horrendous, absolutely horrendous*" (T4 P11 L1-3). T4 acknowledges he has two colleagues he can trust during the turbulent time. Here, the notion of being isolated due to difference or being in the minority can have an effect on overall wellbeing yet being attached to supportive familiar colleagues and surroundings helps toward building staff resilience and retention in the workplace.

4.1.3.3 *Managerial input*

Managerial input was a determinant of male HV role fulfilment with one of T5's managers stating it was the clients right to refuse to have a male HV. While T5 relates to continuous discriminatory practice he highlights that a new manager was a breath of fresh air, saying she had seen lots of discrimination and wanting to take it on and speak to them. There was also a concerted effort to tackle client refusal with the

manager asking T5 to complete an incident form for every client refusing his service, with their name as it was unacceptable. Another male HV had thrived because of their manager being very supportive (T6), setting up and running various initiatives within the locality. As noted in section 4.1.3.1, T3's manager was very supportive during his suspension and subsequent return to work. This positive management input bolstered the self-esteem and sense of worth felt by the male HV participants. Again, from the short examples given, positive managerial input here builds a sense of value and enables staff retention.

4.1.3.4 *Wider support networks*

Precious support networks enabled the male HVs who had experienced poor MH to return to work and strive toward full role functionality (T2, T3, T4, T5) such as the GP, Occupational Health, Therapeutic service intervention, family, friends, colleagues and managers. At times returning too early and needing to take further time away from work to make a full recovery (T4).

4.2 Superordinate Theme Two. The Cultural Marginalisation of Fathers in England: Health Visitor Service Impact.

SOT2 comprised of three themes: Service delivery a double lens perspective for fathers who are male HVs; Invisible fathers the hidden male voice within England's cultural norms and Gender bias HV service delivery, that will be presented here.

4.2.1 Theme: Service delivery a double lens perspective for fathers who are male Health Visitors.

The experience of fatherhood for men who were male HVs working in the HV service bought with it an additional layer of reflection, a triple hermeneutic interpretation, as they interpreted the father's narration as a father and HV and then, I interpreted their interpretation (Mavhandu-Mudzusi, 2018). When engaging with fathers T9 relates to the early days with his own son where he was not that interested in a new-born baby, that seemingly did not do much and advises fathers that so much is now known about what they can do every single day to help stimulate a child's development.

Showing convergence with unconscious bias or blatant bias in other themes T10 reflected on a trip to a local clinic alone with his baby as a bad experience.

I remember walking through the door with my baby son, taking him to clinic…there was a Health visitor and clinic receptionist. They both looked at me and verbally said nothing, but what they actually said was, 'oh my god it's a man, grab the baby'. I remember distinctly thinking, oh hell, oh my god, I'm not coming here again. ***T10 P16 L13-16****.*

T10 reported they took the baby off him, then undressed, weighed, measured, and redressed the baby before returning baby to him and then he left. T10 sounds shocked at the unconscious bias he experienced as a father. Despite being silent, the receptionist and HV would have had the same impact if they would have shouted at him, and that as a man he had no idea what to do with his own baby. Using terms such as 'hell' likening the experience to a worst-case scenario and 'god' as in praying for the situation to stop, demonstrated the wish of T10 to never repeat that experience again or inflict it on anyone else.

As a HV T10 was a proven asset as more men reportedly attended his clinic than any other clinic. T10 believes this heightened clinic attendance, especially with dads with their baby and no mother, resulted from his interest in them and not echoing the experience he had been exposed to as a father taking his baby to clinic.

When asking T2 if any specific HV roles had been adapted due to his gender I was not expecting him to answer it through the double lens as a parent (father) and HV, related to HV service provision. The verbatim script below puts forward the conflict being experienced by T2 but also the gender biased service delivery and the discrimination, presenting convergence with SOT1.

Yes, and it's ridiculous personally, since I qualified there was an introduction of registering dads on like SystemOne (the electronic record keeping system). A, it's completely arbitrary and B, it's like really short sighted and I don't think, not very safe practise anyway, because you are doing it without consent and opening care for somebody that you are potentially not having anything to do with. ***T2 P8 L8-11.***

When recounting his personal experiences T2 said it had been difficult as a male HV to marry parenting at home with what he knew from the workplace (evidence-based practice) as there was no respect for his opinion. This had caused problems and he sounded in pain as he recounted his experience (T2).

This issue of recording in records for the father (T2) was also raised by T10 stating if you are talking to dad, you should be able to record it in his record. T10 was not able to record in the fathers record due to the commissioning process, it was not actually possible. However, as an autonomous specialist practitioner, T10 states they have mums record but not dads, questioning why and advocates explaining to the commissioners that raising a record of the interaction in the father's record would add value for money, demonstrating the three contacts rather than one. T10 also raises the valid point that the baby is the key to the door but HVs rarely talk to babies, they listen to babies especially from a child protection point of view and recording all information is also an NMC perspective. Here T10 justifies how he can challenge the questionable omission of data collected during intimate contacts with the mothers, fathers and babies.

There is no national predetermined method for data collection or specific computerised health record linkage for the father in which to record the contact, or lack of contact, contemporaneously, with the entry section for fathers being an add on or missing (T3, T5, T10).

> *The computer is set up for registering the mother, on the record, and registering the child on the record, but there is no facility, as far as I can see for doing a separate record for the father… that's not because I am a bloke, that's because I can see the inequality. It seems unequal the inequality of that service.* ***T3 P21 L3-6****.*

The new knowledge provided regarding the inequitable gender biased HV service delivery, from T2, T3, T5 and T10 above, requires action through a revision of the HV service infrastructure to meet the cultural shift that more parents are sharing parenting and workload arrangements. Although this research did not look at the cultural shift toward the increase in same sex couple parenting, this is also a national consideration to take forward regarding record keeping and family history taking.

Supporting fathers was a priority for T2 who acknowledged, there was no support for them. T3 echoed this, as a father with a new baby, his experience of the new birth visit resulted in him receiving far less information than would be given to another parent not known to be a HV. T3 appeared to feel disadvantaged here, as if he had been pushed to the side and not been able to have the full experience of other new parents,

who were not HVs. T2 voiced the more time he spent having a negative experience as a dad himself the more he realised that the structures, laws and policies in the country were weighted toward the mothers' rights within the child and family arena. A lightbulb seems to go on for T2 when he proclaimed,

> *it is a funny thing being in such a gendered role and it is only now I have discovered the structures that really put together gender inequality, which is crackers.* ***T2 P11 L12-13***

This moment of 'hot cognition' for T2 allows him to understand such a significant experience and apply meaning to it (Smith, Flowers and Larkin, 2009, p.33). Here T2 is wrestling with the reality of the legal, justice, health and social care systems in England, and with his new insight the enormity of trying to change it. As such T2 decides to move on from his intended HV career as he cannot ethically or morally condone the oppressive nature of the inequality, or the lip service paid to engaging fathers. Additionally, going into work and doing developmental reviews, when not seeing his own child, got too much for T2, who says it was like a 'slap in the face'. T2 also set up a support network for dads which he now reflected on as ironic given his personal circumstance. The apparent lack of support T2 received as a father appears to weigh heavily on his mind and will take time to come to terms with. Here it is apparent that if fathers are not seen they will not be able to have a voice. The lack of voice for fathers will be explored further in the next theme and the discussion chapter (see section 6.4).

4.2.2 Theme: Invisible Fathers: The hidden male voices within England's cultural norms

Fathers were notably absent from much of the narrative from the participants other than when asked a specific question within the semi-structured interviews. T5 noted there were two types of HVs, those that focused on the mum and those that focused on the child but did not mention the HV that focuses on the father.

As women become pregnant, go through the pregnancy, and give birth, T6 supposed it was inevitable that fathers were side lined. T11 states nine times out of ten he would not see the father. Fathers were seen occasionally by T4, T6 and T9 antenatally, but the new birth visit (DH, 2009), usually completed at 10-14 days post-partum, was the main contact time with fathers, if at all. T9 and T11 expressed that some fathers would

disappear and busy themselves. Postnatally there was more opportunity to see the father if he was on paternity leave (T3). However, T4 highlighted that dad got two weeks paternity leave then returned to work and after that time it was not worth trying to contact them. It became apparent that not all fathers took paternity leave and if they had, as soon as they returned to work the HVs rarely saw them again.

Importantly there were benefits noted to engaging dads. Some fathers told T1 it was great to have a man to talk to. Taking the talking a step further, T9 also executed role modelling to engage the dads, making baby noises like, 'coouchy coo' to ease any embarrassment the fathers may have felt, and they then echoed his behaviour to their child. Engaging fathers was acknowledged to be difficult but having a HV of the same gender could help and T1 proposed there was some anecdotal and/or research evidence to support this. T9 reflected on how he talked to fathers about the first few weeks of caring for a baby as a series of jobs that are all a developmental stimulation opportunity. All of the 'engaging fathers' narrative above fits with the '1001 Critical Days' vision, of promoting healthy baby brain development (Department of Health and Social Care, 2021).

Equitable relationships with mothers and fathers were reported by T1, with his only negative experiences with parents being connected to safeguarding, which he referred to as 'strife anyway'. However, T3 noted that working with the young fathers was difficult at times, as some of them were immature, seeing child rearing as women's work and they were still trying to be a lad. In the young persons' group that T8 ran, some young fathers-to-be would sit quietly looking at their phones appearing disinterested within the class, but the picture changed when he visited post-partum and the situation was real, leaving the young dads with lots of questions. Some interaction had taken place for T5 with fathers where he had made referrals, but it 'died a death' as not much happened and this was acknowledged as 'a bit of a losing battle'. The use of words like 'strife', 'battle' 'difficult' and 'all the time' sounding as if engaging with fathers had been relentlessly hard work and at times traumatic within the narratives.

Tactics to try and engage fathers were raised by the participants including T1 and T8, who tried to arrange contacts when Dad would be home, but as service delivery was nine to five, this was not easy. T7 also highlighted letters were written intentionally to

mothers and fathers, and some fathers' groups were set up to try and engage fathers to acknowledge fathers were part of the family. Positively T6 liked to see the father as it gave him a better idea of the family dynamic, how it was all going to work and identify action required through his public health role. With T7 highlighting that a guy coming to visit a wife or partner is a bit strange, so fathers are there for the first male HV visit, but once the fathers know him, it no longer seems a problem and he may not see the father again. T1 likes engaging with fathers as if the father is involved, he is seen as taking on his responsibility and enjoying the baby which is better for the family and children. Interestingly some men asked for T7 to visit, rather than a female HV, for a chat about a worry they had about themselves and T7 sees this as a bonus. This unified narrative demonstrates how the male HVs were consciously trying to engage with the fathers to facilitate service delivery and attributes toward positive parenting for the long-term gain of the child.

An important divergent perspective was the lack of the fathers' voices. T5 made a resounding narrative around the marginalised father's voice asking if his colleagues watched TV (television), read the newspapers and noted the interviews with parents where they always interviewed the mother every single time, never giving the father's perspective, so men learnt very quickly they are not needed, not valued. Highlighting, it was nothing to do with the fathers not being bothered, it is the message they are being sent (T5).

> *Even the letter that we send out antenatally, saying we'd like to visit you, is directed at the mum. So erm, unless the father happens to be there, as he's either specifically got the day off or he is not working, erm, you tend to just see the mum.* ***T3 P26 L10-12****.*

Here, T3 proposed that the parental inequality, related to HV service delivery, started early. T3 added that fathers were uncomfortable and did not know what their role was when the baby is first born. Fathers need to be included from the outset to be given the important information required toward positive parenting and child development and this will be discussed in section 6.4.

The notion of lip-service surrounding the inclusivity of father affected T2 who chose to leave the HV service as he did not believe in what he was doing anymore, he was informing dads on all aspects of parenting but realised that as soon as the mum did

not want the dad involved anymore it would all be gone. Here T2 sounded sad and isolated having experienced, as a father and HV, how a father's role, the bonding and parenting, that is presented as so important, at any point can be taken away by somebody (alluding to the mother) and morally he could not, personally or professionally, continue to sell fathers the false message and hope.

4.2.3 Theme: Gender bias Health Visitor service delivery

There was a pervasive undercurrent of gender bias in favour of women throughout all eleven participant interviews. This did not emanate from the participants themselves but from a long-standing cultural norm within the professions approach to service delivery (see section 5.3) and the child and family arena. T10 highlighted clear gender bias when recounting two answers that he received while undertaking some research into how best to engage fathers. One experienced female HV answered, I actively discourage fathers and another female HV replied, fathers are not part of my caseload (T10). This unforeseen response obviously rocked T10s perspective of an inclusive public health role, as he referred to this example a few times during the seventy-six-minute interview. T10 notes he had never actively discouraged anyone, of either gender, against using the service, all service users were given information and subsequent engagement was then their choice. Despite enjoying seeing dads, T11 recounted a stereotypical traditional service engagement regardless of class, religion or social status as he rarely engaged with fathers.

The stereotypical traditional connotation drew resonance with a slightly dated example given by T5 where fathers appeared to be paid lip service, he shared the following during the semi-structured interview.

> *We are supposed to be public health specialists, but unfortunately the profession doesn't really care about men. I mean that is a fact, that is what I have experienced, they are not interested in men at all, really you know what I mean? I mean if you remember a few years ago, about five to six years ago there was a poster about breastfeeding, and it had a man and his baby and it says, I have time with my baby so that mum can relax, you know after breastfeeding. So, I think, is that the only reason that this man has the baby, so it gives this woman a rest, what about his active role within him? It has to be justified, so far, as I'm doing it to help my wife or my partner*

out, the woman. I didn't put that poster up, as I refused, it was patronising to men and insulting. ***T5 P29 L11-10***

This example from T5 reflected his position as an advocate, for male health, throughout his interview highlighting men, in the context of child and family services, received an inequitable service and fathers were undervalued as a resource toward bonding, attachment and baby brain development.

As a former MW, T1 wanted to champion women's health, but knew there was evidence about men feeling disempowered with their journey through maternity services. Acknowledging there was a lack of empathy reported by male clients during interaction with some female MWs and HVs, which was perceived in a gendered way (T1). Regarding maternity care, T5 raised an issue of nomenclature, for the dads who attended the delivery of their baby in 'the women's unit', at the local hospital and questioned how that made the father feel before the baby was even born.

Using the public health approach of proactive upstream thinking, T5 promoted male public health by discussing testicular cancer and providing supportive leaflets. T5 said this was about supporting dads to take responsibility for their own health, especially the young men, while being a role model to their own children, particularly their sons. Controversially, having put some prostate man badges (prostate cancer awareness) and leaflets on colleagues' desks for distribution, T5 noted a female HV asking what 'the hell' she needed that for as it was nothing to do with her. T5 highlighted the relevance to male public health, advising perhaps the information could be shared with her husband or son. T5 alluded to an unprofessional reticence in that the specific female HV possibly had an issue with him personally, however this discourse appeared to scapegoat and bully T5 while also negating the wider public health role expected from a specialist public health professional.

Offering flexible contact was the approach taken by T8, to engage fathers, with the success of supporting an older dad who was overwhelmed by the responsibility of fatherhood, leading to post-natal depression. Depression in men gave rise to a perception of wimps, with the potential for them to be ignored by HVs suggested T10, who said he saw fathers with significant depression who required extensive support. T10 added that the dads could not understand why they felt the way they did. This discourse provides evidence of the discrepancy in service provision for men

acknowledged by male HVs, within a female dominated workforce. This type of discriminatory behaviour presents convergence with SOT1 (see 4.1.3), requiring effective managerial intervention in line with the NMC Code (NMC, 2018a) and if that fails, potential use of the whistleblowing expectation as discussed in section 4.2.3.

Consistency in service delivery was a barrier toward engaging fathers as noted here.

> *Within the children centre I helped to set up a father's group on a Saturday morning, and that was really appreciated by the ones that attended. Now we are not in that situation, particularly where I am, we don't have a children centre for a start, but also your, the pressure of work is such that you just do not have the time to do additional things, you can't, you haven't got time to think outside of the box… search for health needs…* ***T3 P21 L11-15***

The narrative here highlights that when funding is scarce the proactive public health approach stops and services for vulnerable groups cease to exist.

T1, T4 and T5 also highlighted work that could be or had been done by male HVs to engage with fathers, noting that a stable service was required for delivery, as staff or funding shortages resulted in cessation of creative initiatives and the delivery of core services only, at the time of the interview. Consistent managerial vision was also an issue for T1, who had a manager who was keen for him to take forward work on engaging with fathers, but it never came to fruition as he had a change of manager with a different vision. One fathers' group was slow to get off the ground as some female HVs did not see it as their role to promote the group, despite having some single fathers in the area and stay at home dads who may have required a different type of support (T5). The fathers' group got stopped due to criticism that the fathers did not talk as much as the mothers. T5 recounts highlighting, at the time, that women have an historical culture around about feelings and these men had taken a little longer to open up and talk about how they were feeling and how they felt about their kids. T5 recalled highlighting that yet again they were trying to frame the fathers' and mothers' groups within the female experience, adding it was not their experience it was the experience of the men. T5 wondered why he had bothered. Here T5 sounds exasperated using the terms 'yet again' when wondering why he had put effort into an initiative that was working and amazing, in his mind, around childbirth, relationships and parenting but was marginalised and negated by the dominant female cultural

norm. T3 concurred noting the value fathers' groups can bring, reporting that during the fathers' group he gleaned useful information stating that the fathers all had different valid life stories that impacted on how they saw fatherhood, their role, the relationships with the mother and how she perceived her maternal role, with all of this being intertwined. This information sharing then allowed him scope to work with the fathers effectively.

Visiting the family and fathers at home bought different limitations as the men could go off into another room, assuming the MW and HV service was for the mother and baby (T1, T2, T5, T8). To initiate engagement, T1, T5 and T8 shouted through to the fathers to try and open dialogue by asking questions and advising about weighing the baby.

T2 found that more dads 'scurried upstairs' when they (male HV student and female HV) visited during his training, but now as a qualified male HV, more dads tended to stay in the room stating, possibly, as he had more things in common to discuss.

Having attended a child health clinic as a father, T9 had a contingency plan to engage fathers.

> *I'd like to think that me… a male going into the house, because sometimes talking about things that might seem a bit like airy fairy, like tummy time and skin to skin, and things like that. And I always, … brain development, I just try to make it sound like a really exciting science project.* ***T9 P20 L10-12***

T9 puts a stereotypical slant on the contact here, which he thinks will make it more appealing to the father by going straight to the 'exciting' scientific physiological facts around child development he uses the term 'airy fairy' when referring to emotions and feelings, implying that this type of information will not be of interest to men.

The importance of giving information to all fathers, including those who are health professionals, is highlighted by T3, as the reality of the fatherhood experience is different to the theory. This was bought into sharp focus when T5 reports a man disclosing domestic abuse in a clinic setting to his female HV colleague to which she said that she only had his word for it. In challenging this view T5 highlighted the guts it would have taken for the man to come in to disclose domestic abuse and compared the event to the inequity of a woman's disclosure of domestic abuse, raising the point

that these were examples of why supporting fathers never got off the ground. Here T5 has resigned himself to the fact that support for men from the HV service is inequitable and despite challenging service provision and advocating for men repeatedly, the HV service needs a complete overhaul, to give men the same priority as women. T6 also spoke of two male victims of domestic abuse with female perpetrators and one father who had a restraining order on the mother, acknowledging it took him a while to get his head around the fact that the woman was not on the receiving end (see section 4.1.2.2). T6 had therefore discovered he had to keep an open mind and use different skills to engage the men in therapeutic intervention. T8 agrees that gender stereotyping some male behaviour is not helpful, such as the dad being on the play station during the visit, suggesting the importance of repeatedly trying to engage with the dad, as what matters is the baby. The gender bias toward traditional women facing discussion within the health visiting service delivery is highlighted here and will be discussed further in chapter 5.

4.3 Superordinate Theme Three: Progressive Career Choice

SOT3 emerged from four themes noted across the eleven participants that will be presented here.

4.3.1 Theme: Pre Health-Visitor Career

In the following theme participants recounted why they had chosen nursing and/or midwifery at a particular point in their life and subsequently why they chose to move into health visiting.

4.3.1.1 *Why choose a career in nursing*

The narratives resonated with the pilot study (Le Blond, 2016) as there was an absence in careers advice highlighting nursing/midwifery as a career choice open to boys/men. For the majority, nursing/midwifery became a career move following other employment that they did not settle into or find rewarding.

There were a variety of reasons why the men chose to come into nursing or midwifery as a later career choice with equally varied prior job roles.

Most of the participants fell into nursing having not settled in former employment rolls (T1, T3, T4, T5, T6, T8, T9, T11). Two of the participants (T4, T7) had family members

in caring professions. Being unsure of which employment path to take, T7 decided to go with what he had been exposed to through his extended family and went into nursing as a natural progression. For T4, having never settled in other job roles, he decided to move into a career with a purpose as a mature student, first training as a Registered General Nurse – Adult (RGN), then completing his Registered Sick Children's Nursing qualifications (RSCN). Career advice was lacking for T4 who opportunistically saw an advertisement on television, rather than receiving information in the careers advice session within the core education system, also redundancy pushing him into nursing earlier than expected. Having done a variety of job roles and travelling, T11, realised that he had enjoyed work with a caring aspect to it. T11 also liked the flexibility of nursing, as once he had gained the skills, he could take them with him into different places and do a variety of nursing orientated roles.

> *I'd done a degree in race relations. Hadn't necessarily come out with particularly great job prospects…so I was looking for…a job at the end of it…a career almost guaranteed* ***T9 P1 L13-14 & P2 L1-2***

Here, T9 acknowledged the reality of holding a degree that gave no direct employment value and the realisation that vocational degrees offer the knowledge and skills required in the workplace by employers. Therefore, T9 undertook his original nurse training, offering the flexibility, as his plan to obtain a green card and get entry into Australia. It was also the flexibility of health care employment that first bought T6 into health services, having worked full time as a civil servant for years, but he also worked some weekends as a health care assistant with people with challenging behaviour. The family of T6 wondered why he would want to do this female orientated work, but he found caring focused work rewarding and eventually trained to be a MH nurse.

Redundancy was another catalyst for a career change for two participants (T3, T8) who did not want to do manual work or a desk job. Four participants had worked as Health Care Assistants (HCA) in care homes and were encouraged to apply for the nursing course having demonstrated the key attributes required (T1, T2, T6, T8). T8's family were surprised after 28 years of working in retail that he became an adult nurse working with the elderly and were even more surprised when he then moved into HV working with children and families in a stereotypical female role. While attending drama school and needing finance to sustain his study, T5 also worked as an HCA

during his holidays. After T5 kept returning to his HCA role he 'fell into nursing', deciding to do the registered adult nurse training and then the child route programme. Having been hospitalised as a young boy and being inspired by the care he received, T10 knew he wanted to be a nurse. However, T1, who was considering nursing, was influenced by the lecturer to choose direct entry midwifery as a way of focusing on good health rather ill health going forward.

What became apparent during the interviews was that none of the participants had been advised that nursing was a career option for them as boys during their school life. This omission in careers advice is a divergence from the present political agenda to get more females into science, technology, engineering and mathematics (STEM) the shortage being referred to as 'Stemism' (Teach First, 2020; Fisher, Thompson and Brookes, 2020). Teach First (2020) raise the more generic issue of the lack of female representation and role models affecting females seeing STEM as a viable route for them. This lack of representation can be mirrored for men in nursing, with young boys lacking the insight or aspiration toward a career in nursing. Acknowledging the need to unlock the potential of all children, regardless of their background and gender, Teach First (2020) recommend overcoming gender bias and allowing every child to develop their own skills and interests. This can only be done if a structured plan, with a corresponding message is consistently delivered to school children pre-GCSE choice and again to men who may be considering a career change at any stage in life. Fisher, Thompson and Brookes (2020) identified, within an Australian systematic literature review of thirty-six papers, gendered differences in the STEM undergraduate experience. While this Australian study cannot culturally mirror accepted social norms in England there were parallels identified that related to a minority gender studying in a gender dominated field. A theme of 'Masculine culture of STEM fields' (Fisher, Thompson and Brookes, 2020) was elucidated noting synergies with my initial literature review, such as a diminished sense of belonging for the female STEM students and a lack of gender role models, that bore resonance with the male nurses in some of the studies (Dyck *et al*., 2009; Jiunn-Horng *et al*., 20010; Herakova, 2012).

4.3.1.2 *Why Choose a Career in Health Visiting*

When asking the participants why they chose to move from nursing or midwifery into health visiting there were some common thoughts put forward around the notions of

career progression, work life balance including the flexibility (also noted for Nursing in section 6.5.2) and disillusionment in their current role.

There were multiple reasons given for choosing to leave roles in nursing and midwifery and undertake the SCPHN-HV programme of education. However, while seven participants had experienced health visiting during their pre-registration placement exposure (T3, T4, T7, T8, T9, T10, T11) three had little idea of what the HV role entailed (T2, T5, T6) and one (T1) was a direct entry MW so had frequent interaction with HVs. As can be seen below there were wider decision-making deliberations shared as the conversation developed during the semi-structured interviews relating to pay, autonomy, developing skills, working with children and job satisfaction.

T7 had no aspiration to be a HV as it was seen as a female role, for a certain type of female. However, as a paediatric nurse liaising with HVs, regarding safeguarding and hospital discharge planning, his interest grew. Although T7 enjoyed his HV placement during his Paediatric training it was not the right time for him, but he later saw it as a career development opportunity rather than going into management. As there were no community nursing opportunities when T6 qualified as a nurse and his lecturer highlighted the opportunity within HV. T6 did not know any HVs and researched health visiting, figuring out it was something he wanted to do. T6 had to have some reason to do health visiting, so being in MH, he saw a lot of people, their life chances and how they were progressing as adults that had been affected by childhood adversity. T6 saw a lot of unhappy adolescents and adults and when reading their reports, during his MH training, they had experienced awful childhoods, so he thought health visiting would possibly give him a chance to support people from the outset.

For T9 working in the four walls of theatres, it was a chance meeting with a student nurse who mentioned health visiting. Having become a father, with an interest in child and brain development, T9 thought he had to totally retrain to be a HV, as he did not know about the HV or specialist pathway. Having previously enjoyed his community HV placement, which was interesting and varied, T9 submitted his HV course application. T9 took himself to the local child health clinic where the HV supplied him with advice, leaflets and information in readiness for his interview. The HVs also advised that T9 should be aware that health visiting was about safeguarding and this HV became T9s PT when he started the programme.

As parents T1 and T4 had started their own families, highlighting the impact shift working had on their relationship, the inability to see their partners and spend quality time with their children. As T4's partner also worked shifts in the NHS they realised something had to change and T4 was inspired by a HV placement he had experienced eight years prior. The effects of shift work were also a catalyst for T3 and T11 to move into the community, where the working day for the child and family team was generally nine to five, Monday to Friday and upon qualification as an HV they would be working as a band six on the NHS Agenda for Change pay scale (NHS Employers, 2021). As a paediatric nurse T11 wanted to work in the community and liked health visiting and working with people, so he decided to stay. For T10 he was a charge nurse and noted he did not like management. Having been on an initial HV placement, that bored him, T10 impulsively applied to do his HV training, without knowing why, and got onto the course at the second attempt. However, T10 said health visiting was a logical next career step, to work independently allowing him to care and work, in his way, and not anybody else's, relating here to the notion of autonomy. T10 acknowledged from being a charge nurse, he had extra skills that he wanted to use and, while he was supported in practice as a HV student, he was also able to offer his managerial attributes to the team.

> *I went on two placements with two health visitors. One was horrible, I didn't enjoy it at all, very tedious…then I went on a placement with another health visitor, who… got you excited, got you interested in that job and made you realise that there were so many different aspects to the role.* ***T3 P2 L10-13***

T3 also perceived his first HV placement as boring, using the word 'tedious', but the second exposure ignited his interest and later passion, for the breadth of the HV role. The approach of the second HV showed T3 this was a role where he could work differently, it was interesting, exciting and inspired him to be a HV, as the role had longevity with different areas to work in if he chose to specialise. The community placement with the HV also showed T8 a different way of working, opening his eyes to working with children and families through a public health approach. During the placement, the HV shared her passion about working with families and sold the HV job to T8 through her supportive advice, warmth and caring she gave to the families.

Arguably, the placement experience during the pre-registration programmes is important for the education of the student nurse/midwife and future workforce recruitment. Critically if students are not inspired by their experiences and fail to see value in the role, there is little incentive to later apply to undertake such employment.

> *The health visitor placement stuck with me in my pre-registration training, as I could see that the health visitor was spending time with the family, because sadly that's one thing that we can't offer on a hospital ward, because, you know, they are short staffed certainly, and they have done long days and it doesn't work in a hospital, it should do, but that's where the NHS fails.* ***T8 P6 L10.***

Consistency of care giving was an asset noted, for T8 above, that left an impact while on his HV placement during his initial nurse training. T8 realised that the nature of acute hospital care and problematic staffing level resulted in reduced client contact, that for him was poor. For others it was their interest of working with children that influenced their decision to apply to be a HV (T2, T3). While studying a CPD safeguarding module, T5 engaged with the student HVs and gained insight into the extensive role of the HV. The main crux of T6 wanting to be a HV was thinking he could make a difference from day one (birth) so that adults would end up healthy and happy.

Some of the staff on T5's ward had also left to go into the HV role and as he did not want to go into higher management, he thought HV sounded interesting and seemed a more appropriate sideways move. However, T5 was unsure if anyone would want him as he could be seen as too experienced. Interestingly, T10, who was also experienced, proposed that all of his previous knowledge and skills were transferable and, despite being conscious he was a man, he had taken all of his professional assets with him. T10 also acknowledged the benefit of retaining his pay grade when training to become a HV. Critically, this situation changed and later HV applicants were paid at mid band five, while for some this meant a pay drop, for others this resulted in a pay rise to study a specialist course.

As T3 liked working with children he opted to do his HV training as a shorter way to achieve his goal rather than undertake a full paediatric course. Being constantly overlooked and stagnating in his role, T4 was disillusioned and made a new HV career

choice. While T1 was disillusioned with the midwifery role and reported low continuity, low empathy, low care and lack of direction within the local midwifery unit. The lack of professional leadership made T1 choose HV with the vision of care he wanted to deliver. T8 echoed the lack of continuity in holistic patient care left him disheartened with long shifts and lifting, with some nurses notably retired in post and ward politics being the motivator for change.

> *I got a little bit, what's the word, disheartened by the care that was given in the hospital and I kept thinking, well what am I going to do because, that's not the sort of nurse I want to be.* ***T8 P2 L8-9***

Here, T8 had reached a career crossroad as he was not happy with the care being delivered to patients in his workplace and aspired to deliver consistent care that met the clients' needs. The HVIP (DH, 2011) was launching and after speaking to a lecturer, careers advisor and reading the job description T8 decided health visiting was for him. The notion of promoting health early and up-stream thinking, inspired T8 regarding working toward preventative health care provision rather than providing reactive treatments.

During the HVIP (DH, 2011), there was a specific recruitment drive to build the HV workforce by 4,200 over a four-year period. Within the recruitment drive (DH, 2011; DH, 2012a), men were targeted and while all nurses on the NMC register received information, some men perceived there was positive discrimination toward their application (T1, T2, T7, T9). T7 stated there were two training places on the day of his HV course interview and they accepted three candidates. This increase in recruitment numbers, for T7, demonstrates the approach to positive discrimination within the recruitment cycle at the time.

4.3.2 Theme: Health Visitor Training. The minority issue (Specialist Community Public Health Nursing-Health Visiting (SCPHN-HV)

Within this theme the numbers of men and the intensity of the specialist programme are highlighted. As the participants were men, on their specific course, there was obviously at least one man in their cohort, which was them. Being the only man on the course was noted by T1, T3, T4, T5, T7, T9, T10. Critically there would have been many cohorts without any male candidates present. Importantly, the incidence of men in nursing is low, with few men then proceeding to train toward specialisms such as

health visiting (Department of Health and Social Care, 2011) (see section 1.4). Gender difference was therefore noted early within their SCPHN training toward their chosen career pathway of HV.

Here, T1 highlights his perspective that being a male HV is seen as different, due to the small numbers of men delivering the service.

> *I didn't realise that gender would be such an issue. I kind of imagined it would be a bit like nursing that there would be a much higher proportion of females and less males, but I thought it would be the same kind of gender split. It clearly wasn't.* ***T1 P10 L6-9****.*

Here T1 articulates his surprise that the numbers of male MWs and subsequently HVs could possibly be any lower than male nurses, who he knew were in the minority. T1's use of the word 'clearly' leaves him in no doubt that he is in the minority of the gender split.

Importantly, T6 raised the importance of enjoying working with women in such a female dominated service.

When asked about the training, in University and in the practice setting, gender did not appear to be an issue for T1.

> *In terms of gender. It was never a problem at all. The University were great, never made it an issue, I never felt like a male Health Visitor. I was just treated as a Health Visitor. You know, there was never any question about why I would want to become a Health Visitor. It was gender neutral really.* ***T1 P6 L12-15.***

The unique situation that T1 found himself in, above, through his idiosyncratic experience, during his HV training caused him to reflect on gender and in this case the neutrality which can be interpreted as genderless. T8 found that having two other men on the course helped as they studied together. Additionally, there were two other HV students within T8s placement that helped to negate the anxiety he felt from his initial lack of knowledge. T6 had another male student HV on the programme but they did not mix in the same supportive groups, demonstrating it cannot be assumed that minority groups will be supportive of each other in all cases.

Despite the minority of men undertaking the role of the HV, T3 did not get onto the course at his first attempt, due to the lack of management experience. From experience as a programme interviewer, this is not uncommon as the number of applications are usually more than the funded places available. The ring-fenced funding for the programme presently comes through Health Education England (HEE) and places are limited making it more difficult to acquire a training place on the HV programme than on some other programmes of study.

There was a view that the SCPHN academic programme was tough and never to be repeated by T6, T8 and T10. T10 studied at diploma level and the HV programme became a degree the following year, also seeing the cohort numbers drop from seventy to twenty-five due to funding cuts in the NHS. T6 and T8 continued studying straight after their nurse training and thought it would be similar but found the speed and intensity in one year harder.

> *You know that time, that experience, that year was tough. I speak to other colleagues who have done the course (SCPHN-HV) a good few years before I did, and they have said, they would never repeat it (laughs) my goodness.* ***T8 P10 L8-10***

T8 relates to the intense, stressful nature of the specialist HV programme of study, noting others found it the same. T8 said to that day he had not been able to pick up a novel and went on to suggest that the course could be spread over eighteen months as the intensity had been a roller coaster. T8 remembered thinking, he could not learn all the content in a year, so he would pick it all up as and when he was qualified. After a good three years in health visiting T8 stated there was still so much to learn. This narrative from T8 demonstrates the broad range of knowledge, skills and attributes required to move into a new area of specialist practice. In addition to the SCPHN course content, that was predominantly female student focused, T6 reflected that as a man, he was never going to be able to give birth or have periods etc, so he did additional extensive research on female orientated healthcare issues. Here, T6 notes an assumption that the female HVs know about childbirth, the menstrual cycle etc however, this may not be the case, but it did cause him to act by undertaking extra curricula study so that he had the knowledge base required to meet the needs of the clients.

T6 said how much he had enjoyed the course and that it was not just about the stereotypical notion of weighing babies, it was about being empathetically supportive and involved with the families from a broader perspective. The HV tutors were unanimously praised as being supportive by the participants.

Other course issues were raised with T4 finding the travel and intensity of the course hard and the impact on his family life difficult. While T10 said that practice was a good experience and the course gave good grounding but did not give a perfect insight into what was required for issues such as report writing and how to deal with safeguarding as he was quite protected, as a student, learning the most during consolidated practice at the end of the course. The financial drop from a G grade to a mid-band E (Agenda for change G grade equates to band pay 6-7 and E grade to mid band 5) was frustrating for T5, who also found that rather than valuing his transferable skills the PT and HV would discuss issues that he could have added value to, while not engaging with him. Despite this, T5 acknowledged that doing his HV training was the best thing he had ever done, noting his personal growth in knowledge and skills, especially related to psychological and emotional care giving.

A specific future focused point was raised by T9 who had completed the Post Graduate Diploma SCPHN-HV programme and had intended to return to complete his full masters award; however, locally there was no structured framework for this or for career progression. Of note this situation may reflect across the HV workforce in general and would not be particular to gender but is an aspect that requires further consideration within national HV workforce planning.

4.3.3 Theme: Practice Teachers and their influence on student progression

Student HVs have traditionally been supported, in the practice setting, by experienced HVs who have undertaken additional study related to learning, teaching and assessment (NMC, 2008) (see section 6.5.5 and appendix 16 table C). The name given to such practitioners varied but they were commonly referred to as a PT, community PT, or practice educator. PTs were accountable for assessing students' capability and proficiency to 'beyond initial registration' (NMC, 2008, p.53).

Within the narratives of the research participants there was an overarching appreciation of the PT support, enthusiasm and inspiration shared with the student HVs. This was articulated well by T9 in the quote below.

I had two very strong like practice teachers and both… were like similar in a way very, very kind of like enthusiastic. Did the job you know, dotted all the i's, like you know teachers, and they, I think both…recognised…, from early on, they understood my learning style…, if I'm just sat in the corner of the room watching two other people interact, I just don't, I don't pick it up. Or I tend to, you know switch off a little bit…, so …, they got me involved in visits very early on and they let me lead … contacts and they intervened when necessary and it fills you with a bit of confidence when you do that. ***T9 P6 L14 & P7 L1-10.***

T9 highlighted the word strong here, meaning they know their own mind and have an opinion on how the student should be supported to learn within the placement setting. By dotting the i's he alludes to a higher level of practice in that they wanted to do it right to maintain a quality standard of HV education. T9 reported a variety of experience between HVs and that his PTs realised the heavy academic workload, so they pushed him with practise in the daytime but didn't give him extra work to look at in the evenings. This again is linked to the NMC 2008 Standards to support Learning and Assessment in Practice (SLAIP).

Initiate the creation of optimum learning environments for students at registration level and for those in education at a level beyond initial registration (NMC, 2008, p.55).

T9s PT would have received further education in the facilitation and management of the learning environment and had taken this on board while managing the student experience to meet their learning styles and needs. Alternatively, T4 reflected on the relentless push he got from his PT, without which he may not have succeeded as he had a lot of personal issues going on at the time. T10 also acknowledges the importance of the PT support, noting the experience gained in the training generally depended on the PT. As T10 had an excellent PT and HV team who used him for his strengths while developing his weaknesses, he hoped to be half as good as his PT one day and then he would know he had made it. From the previous narrative the notion of PTs possessing higher level assessment skills comes through when considering how each student can be supported individually to achieve their best outcome. Of note the SLAIP (NMC, 2008) were superseded by the Standards for

Student Supervision and Assessment (SSSA) (NMC, 2018), and this will be discussed in Chapter 6.

Crucially, T10 acknowledged that once on the course the PT generally accepted him but there were colleagues who questioned, as a man, would he be able to talk about contraception and breast feeding like female HVs. Whereas T5's PT had never had a male HV before, so worried and did not know what to expect, whereas he was used to being in the minority from his nurse training (see section 1.4). Critically, a couple of male HVs did not feel their needs had been considered during their HV training. T11 remarked his PT was 'old school' and advised against him telling families that he was a nurse. T11 went on to highlight that now he himself was a PT he told his students to let the clients know they were nurses to illuminate all that the students had to offer. T3 was told by his PT that he did not need to know the basics as he would go quickly into management. T3 was also advised not to visit certain clients, as they would not listen. T3 had insight here and questioned this approach to client interaction. Having sought support from the academic university lead, T3 moved to a second PT who he reported as inspirational and fitting with him so well that he then learnt so much.

A notion of evolutionary role modelling became apparent as T3 recounted some PTs giving the same advice at each home contact, while other PTs tailored the information at the right level to bring each family on board and get positive engagement. Role modelling was seen as impactful for T11 and T10 who were able to learn from their role model PTs, while also being able to demonstrate positive parenting their selves, by sitting on the floor with the children and interacting, from a subordinate level, to build trust with families especially those who were hard to reach. The ability to be a positive role model was also raised by T7, who noted that where family breakdown and abusive relationships were apparent, it was good to demonstrate positive male attributes. The role modelling highlighted by four of the participants here demonstrates that by taking alternative approaches and adapting to the environment some service users previously noted to 'not listen' (see above in this section) could engage, given the right approach and circumstance.

4.3.4 Theme: Being a qualified Health Visitor and career progression

When talking above becoming a qualified HV, T9 reflected on his previous theatre nurse experience around working as "*a bit like a second-class citizen"* (T9 P23 L8-9)

and subsequently as a HV being treated like a ‘grown up’, organising his own workload autonomously. Having more responsibility than he had ever imagined and taking on the leadership role, that comes with being a HV, allowed T9 to organise his own system and as he disliked creating additional work unnecessarily, this enabled him to illicit change across the team. Noting a difference from other roles, T3 acknowledged as a nurse he had previously stayed in areas for a year, e.g. cardiology, then deciding to move on; however, he had been a HV sixteen years and time had flown by. Here, T3 alludes to the HV role as being broad and holding his interest over time.

Acknowledging his HV role as a career pinnacle T5 asserted it was the best job he had done.

> *I will always say that health visiting is the best job I've ever done, I've really enjoyed it and feel privileged. I thought when I did Ward management that I was kind of there, with my profession, but actually what I realise is, that as a health visitor, I was kind of up there and actually had a lot to learn and I could never go back to the wards, because I find that kind of restrictive and the ability (to) not use all of the skills frustrating.* ***T5 P35 L11-16****.*

The narrative from T5 above was important to highlight as in section 4.1.2.4 T5 was notably experiencing isolation in the workplace due to being seen as different. Yet, T5 was still able to see his experience in terms of the value it gave him as a HV specialist practitioner.

The term privileged was used in relationship to being a HV both through the developmental opportunities the role afforded, and the close intimate work undertaken with families and witnessing how they moved through their lives (T1, T5, T11). The CPD opportunities and the training investment was acknowledged by T1 as a privilege linked to the HV and community nurse role toward improving practice. T11 highlighted the best bits of health visiting as working with all sorts of different people, the diversity, being invited into their homes and it being a privilege. The male HVs illuminated the notion of a privileged role, where others were proud of the job they did, the families shared intimate information and their life stories, and the valued communication when working autonomously on the caseload.

The value of heightened communication skills and knowledge base is reflected in the following quote by T7 and section (4.4.4).

> *When I was training…and…qualified as a health visitor it did feel quite awkward to start with questions about periods, sex, family planning…questions you never ask as a paediatric nurse…it was me overcoming the fact that I did feel, at that point, I am a man and this is a lady I'm talking to, but now…it's almost second nature…people are more than happy to answer the questions if they don't feel uncomfortable with that process so there was a bit of me having to…deal with that* ***T7 P12 L4-10***

The notion of developing knowledge and advancing communication skills together with capability, competence and the confidence required to do a specialist professional role becomes apparent from T7's quote above. The postgraduate new field of practice gave extensive need and opportunity for learning. This learning would be unique to the individual, as for example an adult nurse with gynaecological or emergency nursing experience would have knowledge and skills in the aforementioned areas but equally would need to do similar extensive learning in child development. As such the roles of the academic and practice educators in identifying learning needs of individual postgraduate students is critical with regarding competence, capability and confidence and the subsequent affective retention of HVs.

Strong preceptorship, post HV qualification, was raised with the need for this to be formalised especially around support for safeguarding responsibilities. T8 noted his preceptorship was excellent but time limited and should be protected with a clear induction into the roles and responsibilities especially with non-engaging, non-complying families as that was daunting for a newly qualified HV practitioner, leaving them vulnerable. T8 expanded how through experience and time he had since developed professionally, as he would have expected, but had been naive enough to think he would know it all after his HV training noting he was continuously learning, as the boundaries and goals kept on changing.

The lifelong learning and CPD expectation synonymous with NMC registration and subsequent revalidation (NMC, 2019) was alluded to across all eleven transcripts. T10, noted he was as much of a nurse as he was in 1984 and as much of a HV as he was in 1995 and he had continuously developed, found his voice and used it to impact the service and safeguard others. As society does not standstill eliciting new learning

requirements, T3 found peer observation, and the questioning of his own practise and knowledge base, increased his self-awareness and CPD.

Over time T8 had various line managers and an encouraging team that supported his ongoing development.

> *As time moved on the learning opportunities have always been there and the opportunity to progress and develop your skills. There was a few things I volunteered to do… I did my mentorship and then had my own student HV last year and I did the young parents group, evening group, I volunteered to do that. I set up a young parent's group in the preceptorship period. We had a building community capacity project to do, and this was mine.* ***T8 P33 L11-15***

In the quote above T8 is proud of his ongoing development, he is noted to volunteer, giving a sense of agency to his learning, taking charge to forge his own destiny rather than waiting for others to orchestrate learning on his behalf. Controversially, when asked if he had progressed professionally as he would have expected T2 answered 'no' as he did not expect to be leaving, because he loved health visiting as a job. T2 elaborated he did not want to skew my results and he realised that personal reasons had stopped him being a HV, but that he would recommend that men go into health visiting, if they did not have other external pressures to contend with. T5 supported this idea, stating that despite almost leaving at one low point health visiting was the best job he had ever done. Having moved into the safeguarding arena, T5 acknowledged supervising HVs had replaced advising his clients, thus sharing his experience on a broader scale and having more impact, a notion shared by T10. Importantly, T10 initially had to prove he was as good as the other (female) HVs undertaking the role. T10 added he matured into his role and that the seniority was about more than money, it was about the challenge and the confidence to share personal knowledge and skills.

From the participants' narratives there seemed to be a virtual junction, after gaining a certain amount of generic qualified HV experience, that entailed either continuing to provide the progressive universal HCP (DH, 2009), moving into team leadership (management), becoming a PT (educator) or moving into a particular area of specialist practice such as safeguarding, working with travelling families or working with

vulnerable teenage families within the family nurse partnership type teams. Arguably the change in the NMC educational standards that removed the titles Practice Teacher and Teacher (NMC, 2008; NMC, 2018) will impact on the educational route for career progression in Health Visiting going forward.

Having no preconceived ideas for career progression post HV training, T1 found he was in the right place at the right time and was encouraged to undertake his PT training. Having had, what he called a 'gold' PT himself, T1 had an inspirational lecturer on his PT course. T1 did not see himself in management but liked education and as his allocated HV students had been passionate about the role, so far, this had enriched his PT role. The opportunity to undertake the PT programme had been paused locally for T6, who suggested there was no longer any real career progression. As such T6 did not know what his next career move would be, but he loved health visiting. T11 had been a PT for sixteen years and during this time a joint PT/TL role had become available, and he got it, but this was later revised as it was too broad practically to continue with. Despite T4 progressing well in the field of health visiting he now found he was at the top of his pay band and had hit a wall, with the staff joking about him coming to work on a walking frame in the future. This was echoed by T3 who thought there was potential for career progression as a HV, but not locally, adding he tried to access PT training, but it was like 'hen's teeth' due to being outsourced to a different area.

T5 was advised by female colleagues that men would not stay in the HV Team Leader role (TL) as they were ladder climbers. T3 wanted to avoid management and work with children and families where possible, at one stage taking advantage of the flexibility, noted in section 4.3.1.2 as a reason to go into nursing, within health visiting. T3 seized an opportunity to live overseas and travel back to work, as a HV, on a sessional basis over several years, before moving back permanently to England.

T5 did not envisage becoming a TL or safeguarding named nurse; however, due to his paediatric nursing background he had a passion for safeguarding and the progression in role was noted as organic. Despite being bullied and oppressed within his HV role, causing him to consider resigning (see section 4.1.2.4), T5 maintained becoming a HV was the best thing he had ever done. T5's latest role was supporting HVs by providing safeguarding supervision to them. Interestingly, no HVs refused T5's

supervision due to his gender. This newly acquired acceptance of T5 in his managerial safeguarding leadership role reflects an expected male orientated role within the patriarchal hierarchy and was much less controversial to accept for the female child and family teams.

When asked where the male HVs expected to be in five years, T3 and T4 said retired. T5 agreed suggesting he could not tolerate working in a diminishing service any longer, stating HV was dying a death, due to the political agenda, adding he loved the team but not the organisational approach. T3 concurred with T5 in that he loathed what was going on with the HV service, being target driven, when some families required more contacts. Personally, T4 resented having his base moved without being consulted by management. Polarising their views, from these, T8 and T3 noted that in five years they would still be in health visiting, as they loved it. T8 was also passionate about health visiting and was embarking on a secondment with the multi-agency safeguarding hub, trawling records to tease out the child health needs. This secondment for T8 reflected the breadth of diverse opportunity for career development within health visiting as noted earlier. T6 also hoped to broaden his HV skills and be lecturing in the future if the opportunity arose to study on a Practice Educator programme. T2 did not expect to be leaving HV service delivery due to personal circumstances, as he loved working with children and families, but he would take his transferable skills into school nursing and possibly the Child and Mental Health Service in the future. While T11 acknowledged he had done all he could in Health Visiting, having been a PT and TL, but needed to keep working, so was considering returning to a nurse practitioner role he had trained for prior to health visiting and possibly do some further study. T10 had also progressed, as a HV, through to designated safeguarding lead and had recently been working in a nurse consultancy post. T10 highlighted that HV was a great career for the ‘right guy’ and he had loved every job he had done. From the transcripts all participants had successfully negotiated the qualified HV practitioner role and were excelling in or toward wider specialist PH specialties to share their knowledge and skills further.

4.4 Superordinate Theme 4: Evolutionary Health Visitor practice and eclectic workloads

The following four themes present the cross-participant pattern of findings that together, form SOT4.

4.4.1 Theme: Health Visiting: A hidden service

It became apparent from all participants that health visiting, as a service, is not known about widely or at all for many practitioners or the general population. Every child under five years of age, regardless of class, race, heritage or culture has a HV as part of the HCP (DH, 2009). Yet unless directly working with HVs as a professional or involved with HVs as a child or family member, the HV service is hidden.

Upon qualification as a nurse T6 found there were no community nursing posts available, but his lecturer mentioned the HVIP (DH, 2011) to him. As T6 wanted to work in the community but had never heard of health visiting he looked online, contacted the local children's centre and met up with a HV manager to ensure men were able to apply for this seemingly female orientated role. T6 highlights here that by chance his lecturer 'mentioned' the HV service to him, he then demonstrates agency in the effort he puts in to finding all the information possible before making his next career decision. Other male nurses or MWs may also be valuable assets to the HV service but if it is hidden, they will be more difficult to attract. Below, T1 emphasises how proud his parents were, when he worked as a MW, which is another female dominated role with a greater degree of intimate hands-on care.

> *My mum and dad are gutted that I am not a midwife anymore, because they used to love telling people…they wondered why I wanted to be a Health Visitor and not carry on as a Midwife.* ***T1 P10 L10-13***

Interestingly T1's parents questioned why T1 wanted to become a HV, as if they did not know what being a HV entailed, again intimating health visiting as a hidden service. Similarly, T7's friends did not know what a HV was either, so could not comprehend what it was he was doing as the role was so different to anything he had done before.

> *My time with the Health Visitor, in my general training…was so different to anything else we were actually doing at the time and yes, I must admit I did*

really enjoy that and remember I enjoyed that and got pretty decent feedback. ***T7P5L5-7***

From the quote above, T7 became aware of health visiting during his nurse training while working in the community in the diverse HV role, that was so far-removed from his acute ward experience. T7 'must admit' he enjoyed the HV experience as this was not his expected reaction to working in a female dominated role, so admitting this came with the realisation and risk of being perceived as different. T7 also recalled the type of feedback he got from the placement demonstrating he was not expecting to get good feedback, possibly because he was a man working in a woman's domain.

T6's mother also questioned why he would want to be a HV which then made him question himself, adding.

I think it takes time to work out what being a health visitor is and I'm still working on that. ***T6 P5 L12-13***

Despite T6 acknowledging that from his first day as a HV he knew he had made the right decision, the quote above demonstrates the diverse range of roles within the HV service provision results in T6 still learning while on the job. The notion of still learning what a HV is when actually working in the role bears resonance with the evolutionary nature of the HV service that will be illuminated in the rest of this theme.

4.4.2. **Theme:** Caseloads: The challenges and continuity

The notion of the workstream undertaken by HVs was commonly referred to as the 'caseload', meaning the families and children the HV teams worked with directly and the resulting challenges and complexities dealt with on a day-to-day basis. Below, T8 recounts the changeable nature of the caseload and the challenges this brings.

The profession keeps changing, I've definitely grown and developed new skills and practice. One of the frustrations of the HV job is the pace and the caseload, it is always so fast and so heavy, that you don't get time to do that further study, the further research, investigation. You are just skimming and scratching the surface. I never used to be a skim reader. I could never do it, I mean certainly as a HV you have to develop that, well you kind of just skim what you need to know and then go on. ***T8P31L1-8****.*

Here, T8 talks about change, that I see as service evolution, to meet the needs of the population, the determinants of health, government priorities and the use of the latest research-based evidence. The challenge faced daily to meet the high demanding and complex workload, referred to as 'fast and heavy', caused T8 to do what he could to get the job done, rather than to engage with service users utilising the latest evidence base to the higher standard that he preferred.

The uniqueness of caseloads and workload, the variety and construction were portrayed further by T11 who had worked in a variety of roles and areas, both inner city and rurally from small towns, to visiting farms, across the locality, gaining the opportunity to simultaneously be a team leader and PT, with the latter being county-wide. However, T11 said he was unable to continue with the three roles, PT, HV and TL, as the manager made the wise decision that it was not practical to do all three roles at the same time due to excessive workload. A binary connotation of caseload variety was portrayed by T5, having trained in a deprived area, then moving to an area of increased affluence, for approximately six years before returning to the deprived area again. T5 also advocated working in different organisations and experiencing other caseloads to ensure professional growth. Critiquing a colleague's extensive input into one caseload over two generations of families, where the babies were having their own babies as parents, T5 suggested that was not healthy. This questioning about longevity with certain families from T5 suggests connotations of potentially diminishing thresholds of concern or collusive practise resulting from becoming too familiar with entrenched family functioning. Alternatively, when related to some safeguarding concerns it is that consistency of care that can prevent some children from slipping through the safety net. This highlights the need for effective intervention rather than debating the fine line between consistent intervention and/or collusion, where safeguarding children is concerned.

Despite not being asked as part of the semi structured interviews, safeguarding within caseloads was a subject noted by T1, T2, T3, T5, T6, T8 T9, T10, T11. T2 highlighted that his first qualified HV role was in a high safeguarding and high ethnic mix caseload that was a positive and interesting learning environment.

> *I had a high degree of child protection and complex cases…and you had to get on with the families, the mums and dads, and…speak about really*

contentious stuff, difficult stuff, so communication is your ultimate tool I suppose. ***T3 P20 L3-5***

Here, T3 talks about the importance of building therapeutic relationships with the families to work effectively and protect the child(ren), using advanced communication skills. T10 also shared the importance of clear communication related to safeguarding, being open and honest if taking someone to 'case conference' and not surprising the parents with information but explaining every concern and what to expect, appropriately. There was an important link made between intimate care and safeguarding for T11 below.

Maybe psychologically… you are opening up lots of sometimes very painful experiences and things. So that requires tact, good communication, while being mindful of all the safeguarding processes when things get disclosed. ***T11 P10 L9-12***

The empathetic sensitivity needed at times, even within a safeguarding arena, shines through from T11 above yet safeguarding can be anxiety provoking for practitioners and safeguarding conversations do not always go as planned. When reflecting on his initial professional encounter with child protection (safeguarding), T10 recounted 'cutting his teeth' in relation to his first child protection referral. T10 recalled he was so inadequately prepared to execute his safeguarding role effectively, that the mother did not speak to him for six months after the event. The notion of 'cutting teeth' aligned to having the experience, of safeguarding a child for the first time and the resulting outcome demonstrates the need for specialist practitioners to develop advanced communication skills when working with complex children, families and communities. Regarding complex caseload management and safeguarding requirements, from his experiential learning within the HV training programme, T8 insightfully planned ahead, and chose his first qualified HV position based on the team he thought would provide regular support and supervision to him regarding his professional development.

There was a different connotation regarding safeguarding that acknowledged the daily stresses experienced by some marginalised populations. The diversity within the caseload came in different forms as can be seen here. T3 came from the capital and had grown up around a rich ethnically mixed population, advising that he did not think about difference in that way, and it did not occur to him to think about how many white

faces were around him, as diversity was usual to him, stating, ‘that's life’. Whereas, his local working environment, at the time, was different and any ethnicity, stuck out like a ‘sore thumb’.

> *Any ethnicity will stick out like a sore thumb. Unfortunately, I've supported quite a few families from Syria… in the local city, where they were placed in blocks. They had daily abuse. That's the hardest thing for me to get my head round to be perfectly honest.* ***T3 P23 L5-8***

T3’s narration here sounds painful for him. T3 talks about a sore thumb in relation to racial abuse meaning acute in nature initially, with throbbing, that usually comes in waves, like the daily nature of the abuse he recounted. Using the word ‘unfortunately’ as if he already knows the ramifications for marginalised groups, being put in one identified place together, making targeted abuse easier for perpetrators. T3 went on to highlight that in the city there was some diversity due to the University, but rurally the people were very negative about difference and other ethnicities coming in as they did not have the insight toward understanding and tolerance. Another participant, T10, questioned his value as a professional having visited an isolated lady, living with her in-laws, from an ethnic minority background who rarely spoke during the contacts. However, on the last arranged visit, before he planned to request that another HV took over, the mother spoke to him and acknowledged she was glad he visited as he was the only one who listened to her. This gave T10 a feeling of value as psychologically he doubted his professional acumen and suddenly, he realised he was performing his role well by giving benefit to that lady. Importantly, T11 embraced the diversity of the people he got to meet and work with every day acknowledging that he could not think of another job like it, meeting different people in their own homes from all walks of life and that was a privilege.

4.4.3 Theme: Evolving Health Visitor service versus Health Visiting service demise

The evolution of HV service delivery was notable from all eleven participants who discussed their everyday working lives in relation to changing service delivery, caseload management and the changing characteristics of the child and family teams. As the participants worked across the length and breadth of England, which was a welcome but unplanned occurrence, the differences in provider and commissioner approaches to HV service provision also became apparent. Caseload organisation

and distribution notably changed and varied, ranging from a GP based or GP attached, to a geographical orientated and/or a lone HV managed caseload, to a corporate caseload management style by HVs or by HVs within a skill mixed team arrangement. Historically HVs emanated within the philanthropic voluntary sector as Sanitary Inspectors, before moving to the LA in 1862, then moving to the NHS in 1974 (Cowley *et al*., 2013). Latterly, in 2015, the commissioning of child and family services from pregnancy to five years of age moved again to the LA, as such HVs are sitting within the Department of Public Health (GOV.UK, 2022a). HVs are presently noted as NHS services providers but have a variety of employers ranging from the NHS, LA and Social Enterprise Organisations and private businesses. Cowley *et al*., (2013) effectively pointed out that health visiting has been and is a misunderstood profession, with ongoing debate over how the service should be run and by whom.

Technological advancement has impacted on service delivery, with the evolution of record keeping from handwritten hard-copy records, moving to electronic record keeping systems with various templates provided for mandated contacts. Using the GP electronic record keeping system was seen as inappropriate by some HV team members but as it benefited some clients T10 used them, advising that it was better to benefit some clients than none.

Times had changed with T10 noting he had done health visiting “bog standard” (generic HV service provision), but he initially also provided a broader vision of SCPHN practice including pre op vasectomy clinics and impotency clinics, jointly with the doctor while also doing the counselling, he taught the men how to inject ‘various bits of their anatomy’ with drugs, prescribed by the doctor. T10 also did electrocardiographs (ECGs) heart readings, on older people, because, as he recounted, he had negotiated this with the GP and had the necessary skills required. The fundamental PH activity of immunisation uptake was raised by T10, who illuminated his proactive approach to increase the local rates of immunisation uptake.

> *‘I went out, where the health visitors at the time, were going we don't do immunizations, I took over the entire immunisation setup at the practise and we went from 80 to 98% (immunisation uptake) so I was kind of pushing the boundaries.’* ***T10 P11 L1-2***

However, T11 makes the point below that the HV service delivery has changed from the medical model that T10 had previously articulated.

> *We have moved to a more social model of care, in my experience. Where we were doing a lot more…'nursey stuff', in inverted commas, a more medical model, we appear to have moved away from that…, so it's more advice and support, working with vulnerable families is more the social aspects of care…when weighing babies…you are right there but the …families are lifting them in and out of the scales…I am not handling them.* ***T11 P11 L1-12****.*

T11 refers to 'nursey stuff' denoting the hands-on physical care and intervention associated with being a traditional nurse, doing to and for patients, rather than enabling them to take control of their health through a more socially focused public health approach. Other factors impacted on the service as T3 added sometimes he worked as a lone HV and other times with a HV team that may or may not have administrative support.

Broader Community development work had traditionally been initiated by the HVs with T8 starting up a young parent's group with family support workers. T8 invited a variety of specialists to speak around dental health, baby massage, housing and budgeting. They ran a messy play area for the children and eventually, as is the nature of community development work, the parents took over and ran the group. Here T8 relates to social enterprise and community capacity building supported by another principle of health visiting, 'to facilitate health enhancing activities' (iHV, 2022c).

T3 talks about a change in service organisation and delivery, with community nursery nurses becoming community development workers, a reduction in qualified HVs and a family support worker being employed as part of the HV corporate team. T10 acknowledges the values of a skill mixed team, as people wondered if he could work out breast feeding, but he did not need to as there were breast feeding experts to support mothers as needed, highlighting he did not need to be a master of everything. Caseload variety was also raised by T3 who worked with caseloads both inner city and rurally, while working attached to a GP or in a children's centre, both autonomously or with a skill mixed team, plus working as a HV on the nursing bank, where he was called to fill shifts, as and when required, due to staffing shortages.

We're going through an unbelievable…big period of…change, the way they want us to work. We've just obviously been given like a new contract which is more kind of like 0 to 19 (age range) service as opposed to…0 to 5 years (age range). …our role is still going to be predominantly 0-5 years. But the way we work is going to change. We're going to agile working so we're going to lose all our bases, … but none of that kind of puts me off, it's definitely the best job I've done. ***T9 P25 L8-14****.*

Here T9 demonstrates his reflexive approach to service delivery, his resilience and perception of perpetual change and service restructure across the health landscape (see section 4.4.2). Importantly, T9 acknowledges the 'unbelievable' level of change, as if the change is on an unprecedented scale within his HV working experience. The 'obvious' nature of the new contract presents the feeling of a 'done deal', as if there is no discussion and the change will be happening and as such, they have been given this new contract. T9 sounds unfazed by the notion of working without a designated area to call an office or desk space. The reality of working in a physically isolated way from others compared to the constant supervision noted in Section 4.4.2 would be interesting to revisit in any future research.

A service restructure was also noted by T6 who worked within a 0-5 year child and family service, although the service was being reviewed with restructuring plans being drawn up as a cost saving measure, with the potential for the tendering to be attractive to private business. The local vision was to move toward a 0-19 year service with school nurses and HVs providing the service across the full age range. The regional variation of providers leaves the national HCP programme (DH, 2009) open to a variety of interpretations at local level for children and families, that is known colloquially as a post code lottery. This deviation in the application of practice was demonstrated below by T8.

There's talk that we will do telephone consultations at the twelve-week review, we only really ever go out now if there's concern or problem. Otherwise, we give the family a call to say is everything alright and talk about home safety and weaning and different things. ***T8 P9 L1-4***

Above T8 describes the situation but below T8 critiques the result of the service change suggesting that not accessing the house and seeing the situation through a trained critical eye, could heighten risks for vulnerable children.

> *A few minutes over the phone is not the same as a face-to-face contact because you can talk about home safety, then we have turned up and can see that there is no fire guard against a roaring gas fire and no stair gate. Then we would question it and ask a little bit more. Or you can pick up that mum is not happy, not so well, if she's not dressed, there's so much you can't see over the phone.* ***T8 P9 L7-11***

T8 questions the overall value of phone contacts as people can say what they choose to and if they are convincing in intimating that everything is alright, there is no reason to think otherwise, but being in the home and seeing for oneself allows the HV to 'seek out health needs', and address them accordingly, as one of the four principles of health visiting (iHV, 2022c).

4.4.3.1 *HV Service Demise*

While the notion of HV service evolution ran throughout all eleven scripts as the generally accepted norm, there was a narrative that the more recent changes presented a potential death knell regarding the demise of the HV service.

> *Health Visiting in general is changing, it feels like, from a commissioning cycle we are… back to 1976 where councils ran Health Visiting…I think the working together bit, erm is back maybe 30 years. I'm not sure Health Visiting has gone back to its Public Health roots, and I think actually, is probably a service at risk right now.* ***T10 P48 L7***

The importance of listening to the audio recordings and transcribing the participant interviews personally, added value here as where T10 suggested 'he was not sure', he said it in an ironic way, interpreted as, the HV service was no longer using a traditional public health approach and was not engaging effectively in the multi-agency arena, as expected within the Working Together policy toward safeguarding children (HM GOV, 2018a). T10 expanded by highlighting the inequitable HV service delivery locally, noting there were male HVs who started their HV career in a health commissioned HV service, that was managed and delivered in the health arena. Going forward, T10 portrayed his HV service was going to become a LA commissioned

service, but be managed by health, but other local male HVs were part of a pilot where social care both commissioned and managed the HV services, that resulted in a different dynamic. T10 was unsure if this would impact male HVs differently to female HVs but expressed having no unified HV service nationally, resulting in divergence between communities, the workforce and the services delivered.

The impact of the HV service delivery changes on the workforce was elucidated by T4 who stressed there was a good HV team cohesiveness and they all worked together supportively. However, when the HV team all moved into one base to cut costs due to the tendering process, this then impacted on the cohesiveness, with sickness and disciplinary issues rising.

> *Can't say for sure if this is due to service change, I honestly don't know it's as if somebody has flipped a switch and people have changed. They have gone from being really supportive of each other to backbiting, backstabbing. It's been dreadful absolutely dreadful. To the point now where the only people I trust are the two that are off sick, as far as being absolutely stabbed in the back and dumped on big style without reason. So, I don't know quite what happened. It's very bizarre.* ***T4 P11 L5-9***

Sounding shocked and traumatised by the violent attacking nature of the conflict within the office, T4 has lost faith in the wider team members. T4 is isolated as his only trustworthy colleagues are on sick leave. ‘Being dumped on’ resonates with being scapegoated or blamed for something that T4 believes is not his fault. The sudden nature of the change in team dynamics leaves T4 confused regarding the strange causation and the resulting serious implications for him.

4.4.4 Theme: Professional Health Visitor attributes and values toward service provision and caseload management

The government produced a guidance document (DH, 2012c) toward the successful recruitment of candidates with appropriate academic standing, behaviours, skills, attributes and values as students onto SCPHN programmes of study. Importantly, the resilience, flexibility and reflexivity noted in section 4.4.3 is convergent with the Government recruitment guidance required for the HV role (DH, 2012c) and the flexibility of the career development that attracted many of the men toward the HV profession (see section 4.3.1.1).

All 11 male HV participants talked about their transferable skills and qualities, that they bought with them into their role. A business acumen was raised by T8 who spoke of his good customer service skills in retail, relating to client care and his fundamental care skills, from his part time job in a nursing home, being directly related to nursing and subsequently health visiting. T8 was also a V300 Independent nurse prescriber, a transferable skill that could be utilised across the HV service delivery.

T2 expressed he had received positive praise from his HV team for him bringing a different dynamic and calmness to a team with some big personalities. Helping the team to gel when it got fractious was also mentioned by T11, as he brought his team leader experience, rationality and stability to provide balance and organisation. Organised and logical were attributes echoed by T9 from his theatre days. T9 also brought life experience and insight of parenting children with reflux, who cried uncontrollably for six months, reflecting on this as a difficult time. T9 said he could empathise with parents rather than mirror them, relating to no sleep for three weeks and further insight as his wife had post-natal depression that was only realised later.

The useful life experiences were echoed by T3, who had become a HV in his thirties, rather than his twenties, he had some children, supported friends and family with life pressures and developed empathy, causing him to be down to earth and appreciate what some families were experiencing, in a less judgemental way. He highlighted that some people had less life choices and did the best they could and HVs should consider how families got to that point, demonstrating empathy for the clients he worked with.

T3 talks about building relationships with clients and the time constraints that negatively affect the role and client interaction especially when dealing with some difficult issues that were reported to happen routinely, with the time restriction affecting the professional-client interaction. Consistency in a relationship toward building trust was also highlighted by T3, reporting that antenatal contacts enabled time for introductions of himself and the HV service, rather than ringing up last minute or arriving as a *'bald fat bloke, on the doorstep, wanting to talk about their baby and their breasts' (**T3 P17 L4**).* T3 is somewhat derogatory about himself here, describing what he thinks must be a surprising sight to service users yet negating to mention he is a highly qualified professional more than capable of doing his job well. Although we both

laughed at that comment the reality of the situation and the importance of relationship building was serious to T3.

> *It goes back to building up relationships, doing the antenatal and consistency of care, the same person doing it (the visits), because they are far more open. Someone may not want to discuss something antenatally, when you have just turned up on the doorstep for the first time, but If you are lucky enough to have seen them two or three times, then that relationship is built up and they feel confident enough to talk to you prebirth they feel confident to talk to you… I like to think that's not related to whether you are a man or a woman, it is more the nature of the relationship than anything else.* ***T3 P25 L1-6****.*

The quote above demonstrates the use of advanced communication skills toward negotiation of information sharing and trust building to illicit intimate information, while making the process seem organic to the service user, thus building confidence.

The notion of HVs holding advanced communication skills is not unique to male HVs (DH,2012c) and all eleven participants acknowledged developing their communication skills over time, regarding interprofessional collaboration, building trusting therapeutic relationships and challenging complex safeguarding issues. However, there were some notions of specific communication styles that were raised.

> *Some of my approach was I talked a lot about the anatomy and physiology of breastfeeding…to…appreciate I know what I'm talking…I'm not going to be able to tell you how it feels, but I can let you know what common problems people have told me about and break it down like that, so maybe the fact that it was medical helped.* ***T2 P7 L12-15***

Here, T2 regularly broke topics down to address clients' issues, looking at subjects technically, such as breast feeding, using anatomy and physiology rather than guessing how it felt for them to breast feed as he did not and would not personally know. T2 acknowledged that he talked frequently from a scientific and technical stance to strengthen communication with parents.

Professional negotiation and collaboration are expected when leading the HCP (DH, 2009) but T10 took this a step further and pushed the boundaries having conversations

with the GP across a breadth of topics (see section 4.4.3) utilising advanced communication to negotiate service delivery and challenge the HV service provision.

> *Had I not been me, there may have been times when I wouldn't have done things e.g. If my colleagues had said, you don't do that as a HV, maybe I wouldn't have done them. Me being me, I just thought why…are you wrong…so I…got on with it.* ***T10 P24 L12-15***

A hegemonic masculinity pervades the narrative of T10 here. T10 takes the lead from the front, making decisions and acting, rather than asking the question and waiting for an answer. Below T10 has a mutually trusting and respectful relationship with a 'notoriously difficult' male GP.

> *It worked really well and I had people coming to see me instead of taking up GP appointments and there's times I could go, doctor…I need you to see this kid now. There would be times, particularly with Dr X he would ring up and go (say) T10 can you come up because I've got a kid with me, and he's like, oh my God I've got a kid in here, I've got a mother and a kid, what do I do with them? and he go (say) T10 can you examine them?.* ***T10P20L6-10***

Here there is evidence of a proactive GP/HV relationship based on the prior negotiation noted in section 4.1.1.3 that ultimately benefits the GP, HV, child and parent. T6 also highlighted his proactive approach to setting up groups from scratch, recounting taking the lead and getting things done. T6 wondered if that was a male trait, he bought to the HV role. The male mitigation of approval seeking was the notable difference noted here and the assumption that, if they were expected to be leaders, men would lead, whereas within the hierarchical establishment of the NHS with restricted budgetary there is a certain amount of request and approval expected before taking actions that will incur any type of cost within the commissioned service delivery specification and standards operating procedures.

4.5 Summary.

Chapter four has presented the findings systematically, following the use of the six-step IPA analysis process in line with that suggested by Smith, Flowers and Larkin (2009). When working with a larger sample for IPA, validity was improved by noting the recurrence of themes across the corpus, recognising convergence and

divergence, while remaining mindful of the individual voice retaining an ideographic focus, to ensure all voices were heard. This approach enabled the elucidation of fourteen themes and four SOTs that will be discussed further in chapter 6.

Chapter Five. Updated Literature Review 2015-2022. The Male Nurses' Experiences

5.0 Introduction

This chapter will present an updated literature review covering the dates after the initial literature review (see chapter 2), from 1st January 2015 to 31st December 2022. Consideration will be given to how these papers add to or alter the original themes presented (see table 4, section 2.4) while providing synergy with the findings from my study and noting any new perspectives.

The details of the literature review process, the sifting of papers for relevancy on the subject of male nurses' experiences, with a description and list of the new papers found are provided. When undertaking the literature review, note was made of the theoretical context applied to some of the papers. The specific theory identified from the final papers resonating with my study was gender role conflict (GRC) (Blackley, Morda and Gill, 2019; O'Neil, 1981a&b) and this theory will be presented in the discussion chapter to elucidate the findings of this study. A further theory echoed in my mind while reading the papers, namely the theory of novice to expert (Benner, 1984). Benner's (1984) theory is firmly rooted in the nursing field, looking at developmental constructivism resulting from education, exposure and experience toward developing expertise. As all HVs have successfully completed their preregistration nurse education and have the word specialist in their academic award, the theoretical concept, novice to expert (Benner, 1984) was interesting to consider. However, in order to keep an open mind while the analysis of the papers took place, the application of these theories was undertaken later and can be seen in the discussion chapter 6.

This chapter will critically discuss the final 21 papers while reflecting on the original literature review, the overarching themes and relating the narrative to the research findings.

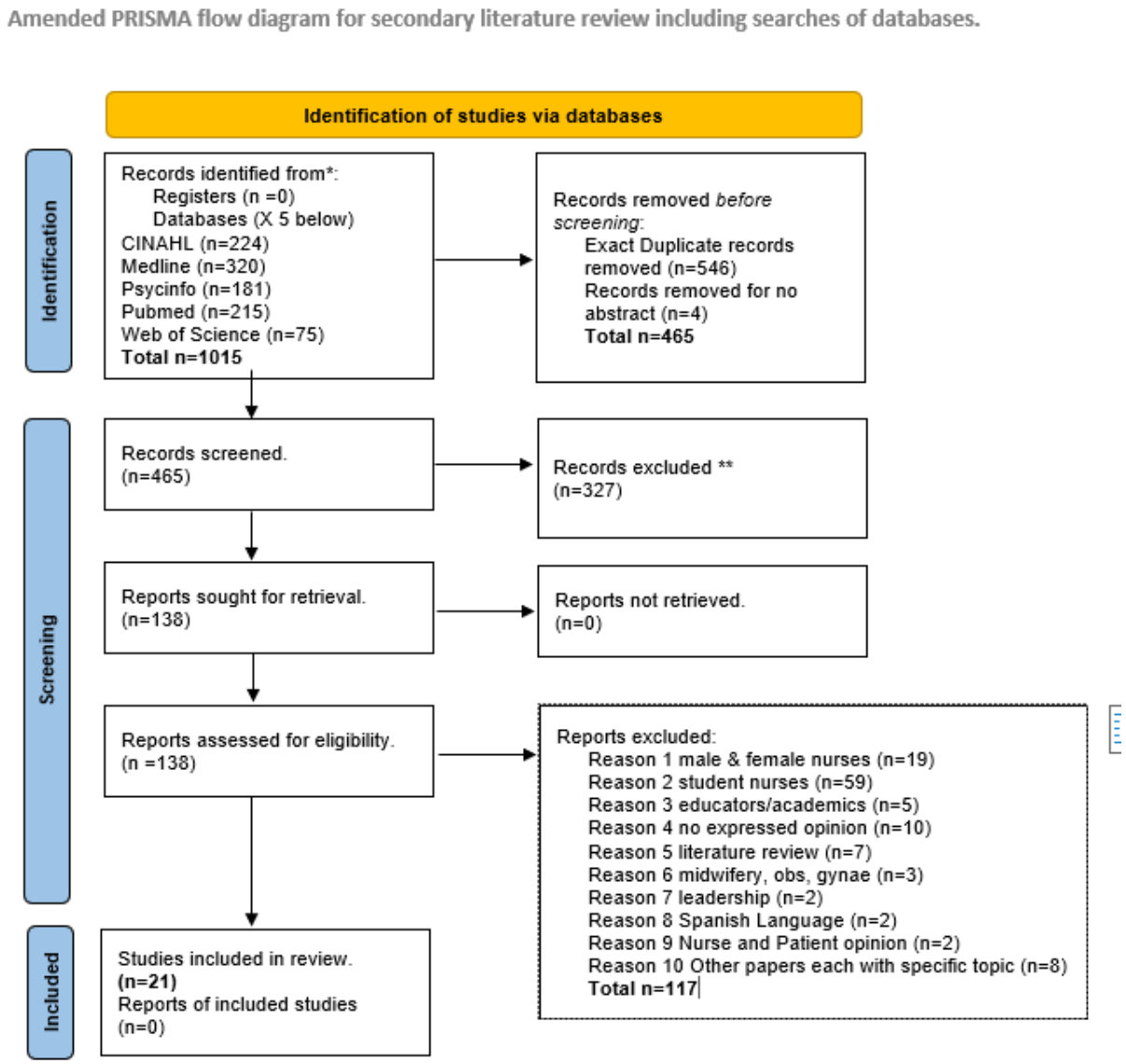
5.1 The updated literature search process

Despite the research question for this study being specifically related to qualified HVs who are male, throughout the length of my study there have to my knowledge, been no published research papers on this topic. As such, as all HVs are qualified nurses and/or midwives the updated literature search is based on male nurses, using the

same search terms as the initial literature review, ("male Nurs*") AND (experience* or perception or view or attitude* or feeling*) AND ("2015/01/01"[Date - Entry] : "2022/12/31"[Date - Entry]) AND ("english"[Language]). Using these search terms, five data bases were searched, namely CINAHL, Medline, Psycinfo, Pubmed and Web of Science.

The following Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow chart (PRISMA, 2020) (see Fig 4) presents the search strategy and numerical outcomes of papers found during the literature review.

Figure 4. PRISMA flow diagram for secondary literature review including searches of databases 2015-2022.



(*Reason 10: relationship with families (n=1), Veterans (n=1), personal narrative (n=1), school pupils (n=1), research protocol (n=1), COVID 19 (n=1), care of dying (n=1), concept analysis (n=1)

As detailed (Fig. 4) the 138 papers that initially appeared appropriate were reviewed for relevance, sifted, assessed for quality regarding ethical approvals and rigour and then read for detailed content. As there were numerous papers retrieved relating specifically to qualified male nurse experience a workable number of papers was required. To isolate qualified male nurse studies specifically the comparative male female nurse studies and studies looking at student experience were excluded. Papers that did not include any heard voice of the participants were also omitted, which resulted in excluding the final quantitative research, leaving 21 qualitative papers for consideration.

During the screening process a critical appraisal tool for qualitative studies (Critical Appraisal Skills Programme (CASP), 2022) was used to assess the strengths and weaknesses of the studies. All but one of the final studies had full ethical approval from a research committee. The paper written by Kluczyńska, (2017) noted that ethical approval was not required in Poland for their qualitative grounded theory study. Kluczyńska, (2017) highlighted that consent was given by the participants and that anonymity was ensured. For this reason, the Kluczyńska, (2017) paper was included. Arguably, the protection of the participants is called into question when a study is not subject to quality control mechanisms. Conforming to ethical standards and timelines that are required procedurally by a formalised research committee considering geographical variations is important to protect participants.

Following this process, the final 21 papers (see appendix 19) were then critically analysed and subjected to thematic analysis in line with Braun and Clarke's (2020) approach. Following thematic analysis 20 subthemes were extracted (see appendix 20), considered and rationalised into four themes (see appendix 21). The formation and nomenclature assigned to the subthemes and themes within qualitative research is subjective and under the control of the writer within their cultural and specialist area of practice at the time of extensive reading and writing. Terminology also evolves over time for example O'Neil (1981a) within the GRC theory refers to masculine mystique and 30 years later as masculine ideology (O'Neil, 2013). The same applies to my choice of terminology assigned to the themes and overarching themes here, yet it should be noted that there are threads within the narratives that can and do overlap as no one narrative can be seen in isolation when relating to human experiences. After

further extensive review and consideration the following two overarching themes and four subthemes emerged (see table 8).

Table 8. Identified themes and overarching themes from the updated literature review.

Themes	Overarching Themes
Isolation	Being the minority gender: the negotiated factors for male nurses.
Work related stress	
Career development through job security and flexibility	Opportunities and advantages for male nurses.
Valued as a professional	

As can be deduced when comparing Table 8 to Table 4, the review of the new 21 papers has added to and slightly altered some original themes. Firstly, the two previous overarching themes ‘isolation’ and ‘work related stress’ have now become themes to the overarching theme, ‘being the minority gender: the negotiated factors for male nurses’ (see Table 4). Secondly, the updated literature review (Table X) has resulted in the need to add two new themes; ‘career development through job security and flexibility’ and ‘valued as a professional’ to a new overarching theme, ‘opportunities and advantages for male nurses’. This resulted from the updated literature review shining a brighter light on the advantages afforded to men who take up nursing as a profession. Although some men did have positive experiences in the original literature review (see chapter 2) and the pilot study (Le Blond, 2016), the narrative of advantages for men as nurses was substantially elucidated within the findings of the main study (see chapter 4) and the updated literature review and as such will be discussed in sections 5.3 and 6.5.6.

5.2 Overarching theme one. Being the minority gender: the negotiated factors for male nurses.

When revisiting the original literature review, considering my research findings and undertaking this updated literature review, it became clear that many of the subthemes

pulling through in the recent papers related easily to the two original previous overarching themes, now themes, namely, ‘isolation’ and ‘work related stress’. As such the new subthemes were subsumed into the original themes (See table 9) and will be discussed below.

Table 9. The subsumption of the updated literature review subthemes into the original literature review themes and original overarching themes.

Original Literature Review		**Updated Literature Review- subthemes**
Overarching Themes	**Themes**	These subthemes are subsumed into the original themes on the left.
Isolation	Minority	← Female Gendered Nurse image. ← Exclusion/Isolation ← Genderless identity/Otherness
	Sexism	←Gender discrimination ←Lateral violence sexual harassment
	Communication	←Communication
Work related stress	Intimate Care	←Intimate care delivery. Touch
	Workload	←Stress inc. Masculine task assignment. ←Balancing
	Role model	←No knowledge of nursing. ←Lack of support / role model.

5.2.1 Theme: Isolation.

The theme isolation was constructed from the subthemes of minority, sexism and communication, that will be presented below.

5.2.1.1 Minority

Being the minority gender for men working in a female dominated nursing environment was evident from the outset. This section is constructed from narratives around the female gendered nurse image, exclusion/Isolation and genderless identity/otherness as follows.

5.2.1.1.1 *The female gendered nurse image.*

The sub theme that garnered the most narrative across the 21 papers was related to the female engendered profession of nursing with 19 of the 21 papers articulating this within their text.

Of the 21 papers (see appendix 19) all 21 discussed the feminisation of nursing within the rationale or introduction for the study echoing the original literature review. Guy,

Hughes and Ferris-Day (2022) present the voice of Ian (a participant), who asserts an issue that the connotation of the term ‘nurse’, socially still represents a woman feeding and attending to their baby rather than the scientific art of supporting and caring for others who are in ill health. When examining this claim, it appeared that Ian himself was outdated as the Cambridge Dictionary (2023) presently presents a variety of meanings for the word nurse related to caring for ill and injured people, animals, plants and to feed a baby from the breast. Arguably, nursing as a term related to suckling a child has been an enduring linguistic meaning historically and it is unclear when the amendment to the dictionary may have taken place. Guy, Hughes and Ferris-Day (2022) continue with Ian’s narrative adding that nursing remains a concept that sits beneath that of medicine and as a barrier to nursing recruitment per se and in particular recruiting men into nursing. Azadi et al. (2018) agree with this from an Iranian patriarchal societal perspective, suggesting that nursing is woman’s work and is there to support the medical team. Yet in times of war the University male nurse student ratios were noted to rise to facilitate the provision of emergency care (Azadi et al., 2018).

The societal inferences of nursing being a caring profession and as such women’s work posed difficulties for men being accepted as nurses within the workplace (Martinez-Morato et al., 2021; Cavayé, 2018; Chang and Jeong, 2021; Holyoake, 2020; Kalemba, 2020; Kim and Shim, 2018; Kluczyńska, 2017; Queshri, 2020; Saleh et al., 2020 and Smith et al., 2020). This narrative links to the first literature review where rather than fitting in, men sometimes stood out due to their masculine characteristics of leadership and competitiveness (Dyck et al., 2009). The difficulties for some participants related to a perceived discrepancy of being a compassionate and caring nurse thus aligning with a female gender norm, while remaining manly is more in line with the male gender norm (Blackley, Morda and Gill, 2019; Bouret, 2017 and Kalemba, 2020). Cottingham (2015) and Shin and Lim (2021) suggest that male nurses continuously reframe the realities of the nurse role in order to cope. This notion was particularly important for those men working as nurses within the Child and Adolescent Mental Health Services (CAMHS). Through an ethnographic lens across six CAMHS sites over six years, Holyoake (2020, p.397) witnessed male nurses ‘showing your feminine side’, as this unique service was a debateable place for

displays of hegemonic masculinity when dealing with vulnerable children and young people.

The need for professional socialization and identity is required for all nurses to negotiate the broad array of expected proficiencies, yet there is an added layer of complexity for male nurses who have to justify their choice of occupation regularly (Cavayé, 2018; Cheng et al., 2018 and Kluczyńska, 2017). The initial family and patient reflex reaction when expecting care from a nurse, is that the care will be provided by a woman (Martinez-Morato et al., 2021; Cavayé, 2018 and Frimpong, 2016). This societal reflexivity results in male nurses and HVs having to justify their role as was also noted in the first literature review (see section 2.4.2) and the main study (see section 4.1.2).

5.2.1.1.2 *Exclusion/Isolation*

Isolation, also termed exclusion or separateness in other studies, was identified by 8 of 10 participants in the study by Frimpong (2016), in the initial literature review (see section 2.4.1) and in my study (see section 4.1.3.2). Frimpong's study (2016) explored the lived experience of Ghanaian male nurses working in America, through an intersectionality lens of being an ethnic minority within a gender minority group (Frimpong, 2016). Despite the isolation or separateness for male nurses manifesting in other studies, being a minority within a minority provides an extra barrier to inclusion. Frimpong (2016) highlights that even when there were other male nurses on shift, if they were white, they would rather interact with white female colleagues than associate with the Ghanaian male nurses. Yet some male nurses within the same study expressed being welcomed and included, in contrast to the colleagues (Frimpong, 2016). This anomaly opens the consideration of the differences between the male nurses within the study that caused some to have a positive experience while others did not, and this difference will be considered further in the discussion chapter (see section 6.7.1). Qureshi, Ali and Randhawa (2020) also highlighted the intersection of British South Asian male nurses, who despite having enablers to their profession were excluded through the lack of getting their voice heard. For Jordanian male nurses the societal gender context resulted in them becoming socially isolated in the community, with some refusing marriage to their daughters due to the male nurse denigration of their masculinity (Saleh et al., 2020).

Kalemba (2020) highlights that for some being the only male working in an area presented opportunities to demonstrate the uniqueness of male nurses and be seen as special amongst the backdrop of the dominant female workforce. In contrast, Blackley, Morda and Gill (2019) put forward that being the only male nurse left a feeling of exclusion and at times the female dominated environment felt toxic. This narrative relates to Participant 5 in my study who reported being isolated and victimised by a toxic female working environment (see section 4.1.2.4). However, where there were a few male nurses, the atmosphere was said to alter for the better and the feeling of isolation reduced (Blackley, Morda and Gill, 2019; Cheng et al., 2018; Shin and Lim, 2021 and Smith et al., 2020). Smith et al. (2020) and Cheng et al. (2018) discuss the notion of female cliques, whereby groups of female nurses get together in a subculture that can exclude male nurses, leaving them isolated but if the men can join a clique, it can offer support toward learning and the reduction of stress. Smith et al. (2020) take the clique narrative further noting that male nurse cliques exist too and can equally alienate female nurses who are protective of their female dominated workspace in a patriarchal American society.

Isolation was listed as one of the factors associated with lateral violence for Bouret (2017). Due to their gender minority status the male nurses stood out as different (Chang and Jeong, 2021; Holyoake, 2020 and Kluczyńska, 2017) thus leaving participants isolated (Guy, Hughes and Ferris -Day, 2022; Kim and Shim, 2018 and Martinez-Morato et al., 2021). The participants noted that if there were other men in their cohort or workplace it provided great support toward their ongoing nursing practice (Juliff, Russell and Bulsara, 2017).

5.2.1.1.3 *Genderless identity/Otherness*

While culturally the male Jordanian nurses had an expected strong masculine identity, when faced with challenging behaviour from some male physicians one participant noted transcending his thoughts of thumping him, for the greater good of the patients (Saleh et al., 2020). This narrative offers a notion of otherness rather than succumbing to the male narrative of physical strength and being more assertive than female nurses with the physicians (Saleh, 2020). British South Asian men also transcended the sociocultural expectations of being in the higher paid expected role of a physician and

some recounted that the caring and compassion associated with their religion did relate to the nursing qualities required (Qureshi, Ali and Randhawa, 2020).

Martinez-Moreto et al. (2021) recounted participant narratives that some male nurses had heightened maternal attributes and as such were able to fit in and provide care more easily. This narrative was added to by Mao et al. (2020) positing that male nurses were noted to have empathetic attributes that have been likened to female gender traits. Empathetic and sensitive attributes were also recognised as a need in the profession by male nurses, but this was again linked towards a feminine trait (Kluczyńska, 2017). Further, emphasis on the trait of empathy was added by the participants who shared that they were gay although this was noted as potentially linked to gay stereotyping (Kluczyńska, 2017).

In South Africa despite much movement in law supporting the rights of expression and same sex relationships for lesbian, gay, bi, trans, queer, questioning and ace (LGBTQ+) people (Stonewall, 2018), sociocultural norms mean that any identity other than heterosexuality is seen as un-African and a societal threat (Kalemba, 2020). The association of nursing with femininity brings an added intersection for black male nurses in South Africa in post-colonial and apartheid times, as male nurses are assumed to be homosexual (Kalemba, 2020). This assumption that male nurses must be gay was also noted in the original literature review (see section 2.4.1). In order to refute the assumption of being gay, the male nurses raise the reality of being in paid work and thus performing the masculine role of being the breadwinner and providing for the family (Kalemba, 2020). Taking paid labour, a step further, one participant explicitly noted the lack of men in midwifery as an opportunity to progress through promotion to a higher level and increase his earnings (Kalemba, 2020). Yet the idea of working in midwifery increased the notion of masculine subordination for others, who voiced the ultimate feminised orientation of childbirth and being not inclined to be a midwife (Kalemba, 2020).

Holyoake, (2020) highlights the historical positioning of nursing as a feminised domain on which to measure any type of ‘otherness’ or difference. In the first literature review Herakova (2012) and Harding (2007) talked about the notion of otherness increasing isolation among male nurses. Within CAMHS, male nurses assume this ‘otherness’ being measured against a female nurse positioning regarding behaviours and

attributes (Holyoake, 2020 p.395). Participants referred to taking on a performative role closer to a balanced male persona by demonstrating feminine traits such as caring and empathy rather than hegemonic masculine norms (Holyoake, 2020).

Female nurse colleagues were highlighted as inspirational, supportive and integral to male nurse success (Smith et al., 2020). In the same study most of the male nurses suggested that their female nurse colleagues were not biased against them and mitigated the male nurse gender to view them as nurses rather than male nurses, thus negating exclusion (Smith et al., 2020). Promoting nursing as a gender-neutral profession could be a positive approach to negate the unconscious and overt bias toward men who are nurses and bring more men into the workforce (Juliff, Russell and Bulsara, 2017). This notion of genderless, thus being seen as a HV rather than a male HV was given as a perception of acceptance within my study (see section 4.1.1.4).

5.2.1.2 Sexism

Sexism within the theme of isolation is underpinned with narratives of gender discrimination, lateral violence sexual harassment and communication that will be discussed here.

5.2.1.2.1 *Gender discrimination.*

The issue of gender stereotyping and discrimination was magnified within the Jordanian culture where the norm for men would be a dominant patriarchal position, yet these same men, when working professionally as a nurse, endure social stigma impacting on their options for marriage and family persona (Saleh et al., 2020). In South Africa the position was similar with participants raising the issue of being perceived as gay due to their career choice subsequently demeaning their societal position (Kalemba, 2020). While not portrayed as an overt patriarchal culture, the American male nurses also expressed the societal stigma that negatively impacted on them, reflecting on the impact of films and media portrayals of nursing (Smith et al., 2020). An enduring but changing stereotypical view in Taiwan, places nursing as a role for women presenting newly qualified male nurses with frustration as they adjust into the workplace. As there was limited opportunity for career development due to their gender the consideration for redirected future career choices were evident (Cheng et al., 2018).

Frimpong's (2016) study discusses the dimension of being an ethnic minority male nurse in America causing discrimination and isolation. Qureshi, Ali and Randhawa (2020) also highlight that through intersectionality the participants were discriminated against due to their gender and ethnicity resulting in limited career and pay progression. This lack of developmental opportunity for male nurses was echoed in the study by Kim and Shim (2018). Some studies highlight overt prejudice when participants are advised as a man, they should not be a nurse (Guy, Huges and Ferris-Day, 2022) or they will not be able to do the job of a female colleague (Martinez-Morato et al., 2021). This prejudicial narrative was given clear context in an extensive ethnographic study by Holyoake (2020). Holyoake (2020) undertook 400 hours of direct participant observation within child and adolescent mental health services (CAMHS) units, while working and interacting with 50 specific male nurse participants, across six sites in four UK cities. There are ingrained societal perspectives that nursing is women's work (see section 2.4.1 and 5.2.1.1.1) and this narrative is perpetuated within CAMHS services (Holyoake, 2020). Here, Holyoake (2020) explains the gender negotiation that male nurses manage, to facilitate effective engagement with children and young people who may have been previously abused to offer safety and care, while negating risk.

Chang and Jeong (2021) specifically studied workplace gender discrimination and sexual harassment in their qualitative South Korean study with ten participants. The findings depicted that gender discrimination for male nurses manifested socio-culturally from inherent historical multifactorial causes (Chang and Jeong, 2021). The discrimination came from patients, their families and colleagues, expecting that men would work to cover maternity leave and carry out physical tasks while expecting that the work would not be completed to the standard of a female nurse (Chang and Jeong, 2021).

However, this was not the case for all male nurses with as Juliff, Russell and Bulsara (2017) can only mention one participant whose male nurse colleague had tried to dissuade him from nursing as a career for a short time. Nine papers did not highlight gender discrimination (see appendix 20).

5.2.1.2.2 *Lateral violence sexual harassment*

Lateral violence is a concept denoting a variety of harmful behaviours between working colleagues leading to negative health outcomes for the victim resulting in workdays lost or resignation (Bouret, 2017). Lateral violence through scapegoating, bullying and harassment was reported extensively by T5 in my study and highlighted the resulting and enduring negative psychological impact on him (see section 4.1.2.4). Working in oncology gave rise to increased aggression permeating from grieving families (Cavayé, 2020). Cavayé, (2020) acknowledged the lateral violence between colleagues possibly resulted from the emotionally demanding oncology workplace and potentially resulted in compassion fatigue.

The concept of sexual harassment can work both ways, being the victim of sexual harassment or the perpetrator of sexual harassment. The lack of support for men who were sexually harassed while working as a nurse further demonstrates the lack of understanding and support for some men working in a female dominated workplace (Bouret, 2017). Chang and Jeong (2021) found that as men were not expected to be victims of sexual harassment it was difficult to ascertain what action should be taken against it or if it was considered a problem. This level of ambiguity sat along-side the covert gender discrimination, that despite awareness being raised little action was taken (Chang and Jeong, 2021). Within the first literature review it was apparent that bullying and sexual harassment happened to some male nurses due to the homosexual stereotype irrespective of the male nurse's sexuality (Harding, 2007). When highlighting lateral violence within the workplace, one of the unacceptable lines is sexual harassment and this is highlighted as a social taboo (Bouret, 2017 and Chang and Jeong, 2021). Sexual harassment is defined in the Equality Act (2010) and is unlawful in the UK. Yet, poses a challenge for nurses as sexual harassment is not only a form of lateral violence between working colleagues, but can result from unwanted sexual advances from patients (Chang and Jeong, 2021). The need for clear boundaries when working with vulnerable young people in CAMHS was highlighted as some female patients would fall in love with the male nurses (Holyoake, 2020). Even the accusation of sexual harassment was something to be taken seriously within the CAMHS arena causing the observation of all staff and patients but especially male staff to be a priority (Holyoake, 2020). Critically, the subtlety of approach through which

the sexual harassment emanates is difficult to identify and control but can result in an unwanted hostile environment (Bouret, 2017 and Chang and Jeong, 2021).

5.2.1.3 Communication

The differences between men and women with regard to behaviour and communication resulted from sociocultural influence (Smith et al., 2020 and Azadi et al., 2018). However, in an effort to integrate both in and outside of work male nurses used various communication methods such as self-censorship and the highlighting of common ground with their female nurse colleagues (Bouret, 2017). These papers emulate the initial literature review where Dyke et al. (2009) highlight the high level of engagement and communication from male student nurses and despite being seen as outsiders the men continued to contribute. Communication was important to the male nurse participants in the study by Blair (2016), with three participants moving across from the medical field to garner heightened direct patient interactions within the nursing field.

This sociocultural perspective regarding communication was bought into stark positioning when related to the context of male nurses working in the Child and Adolescent Mental Health Services (CAMHS) (Holyoake, 2020). In this study the narration of embodying gendered spaces, moderating tone and power of speech and performing a role to negate retraumatising vulnerable service users was all part of the job (Juliff, Russell and Bulsara, 2017). The interpersonal skills developed over time were also acknowledged as fundamental to patient, family and their own emotional wellbeing when working in oncology (Cavayé, 2020).

Azadi et al. (2018) highlighted the male nurse notion that they could communicate more effectively within the internal health care organisation as the female nurses had other external pressures to contend with, such as family commitments. In a different study, participants suggested that miscommunication between the sexes could evoke negativity, with men seen as lacking emotional intelligence while meeting the culturally expected masculine role (Smith et al., 2020). Shin and Lim (2021) echo the need for clear communication to facilitate positive working relationships with colleagues and went as far as to say it was necessary for survival. Miscommunication was also raised as an issue by Mao et al. (2020) with male nurses in disagreement with the confrontational approach taken by the female nurses with the doctors. The male nurse

relationship with doctors was different in different settings and different physician genders, with more harmony noted with male physicians and within the emergency departments (Mao et al., 2020). This more positive relationship between male nurses and male physicians were based on mutual understanding (Azadi et al., 2018), interests and undertaking activities together outside of the workplace that helped to build a productive team and aid communication (Mao et al., 2020). This proposed positive communication style between male nurses and male physicians was also borne out in my study particularly focusing where one participant was able to work successfully with a GP where female HVs had been repeatedly unsuccessful (see section 4.1.1.3).

Communication with patients was also raised as a therapeutic and spiritual intervention to ease suffering (Salah et al., 2020). Critically, strict protocol was necessary for a male nurse communicating with a female patient within the Arabic culture, in order to negate any misconstrued compromise of the woman's honour or the male nurse's intentions (Saleh et al., 2020). Cultural difference was also considered in my study where male HVs would check first if it was permissible for them to visit any woman within the home, while paying particular attention to cultural or religious background (see section 4.1.2.1).

For participants in the study by Martinez-Morato et al. (2021) the development of alternative approaches to communication through the use of games, humour and distraction was not only helpful to the patients, especially children, but also to the psychological wellbeing of the participants themselves. This psychological wellbeing for the male nurses came via job fulfilment that was enabled by the development of higher levels of communication toward enhanced engagement and 'competent decision making' (Juliff, Russell and Bulsara, 2017). Male nurses also communicated through the sharing of information to calm their own and the patient's anxiety while educating them on conditions and care pathway management processes (Cottingham, 2015). This narrative mirrors participant T2, who developed his rapport with families through his modification of communication by breaking topics down to enable understanding (see section 4.4.4). Cheng et al. (2018) identified male nurses being complimented for their communication skills yet in the same study male nurses were noted to smile less and be harder to form a relationship with. This finding demonstrates the subjectivity arising from the unique experiences of participants.

As a manager, one participant had to exert advanced levels of communication to ensure care was carried out to the best standard across an interprofessional arena (Frimpong, 2016). This sort of collaborative working opposes the notion of exclusion or isolation in sections 2.4.1, 5.2.3 or table 4 and shows a different positive element of the male nurse lived experience. Participants raised the importance of collaborative practice to improve patient outcomes and the need for tolerance to ensure this happens (Salah et al., 2020).

5.2.2 Theme: Work related stress.

This theme was constructed from the following subthemes: Intimate care, workload and role model. The subthemes were underpinned with narratives including masculine task assignment, intimate care delivery, balancing the role and identity, limited initial knowledge of nursing and lack of support, all of which will be discussed here.

5.2.2.1 Intimate care

Intimate care and touch were clearly raised as issues that can be stress provoking for male nurses and HVs in the initial literature review (see section 2.4.2), my study (see section 4.1.3.1) and in this updated literature review. Demonstrating that there is limited change in this area. Providing care to female patients that required touch was raised as an issue and was a potential area for stress and accusations of inappropriate sexually predatory behaviour (Guy, Hughes and Ferris-Day, 2022; Smith et al., 2020 and Blackley, Morda and Gill, 2019) or traditionally unacceptable (Cheng et al. 2018). Martinez-Morato et al. (2021), highlight the use of touch as a therapeutic intervention can not only be construed as an issue in female care delivery but also in that of caring for children. Here Holyoake (2020) highlights the stance of CAMHS, where no male nurse is ever left alone with a patient and the door is always open. A supporting hand would not even be given unless consent was obtained (Holyoake, 2020). This approach to CAMHS provision tries to redistribute the obvious power relations between staff and clients and across genders (Holyoake, 2020).

Saleh et al. (2020) support this notion adding, in the Arabic society it is unacceptable for male nurses to care for women and children due to the culturally determined hierarchy of dominance that men hold. Kalemba (2020), Mao et al. (2020) and Azadi et al. (2017) add that some patients prefer their personal care being provided by the same sex nurse such as bathing. With male nurses giving a choice to female patients

where possible (Mao et al., 2020). Blackley, Morda and Gill (2019) add that all participants highlighted their apprehension in delivering personal hygiene care requirements to females and at times, that clients had refused such care. This refusal of care from male nurses was also frustrating for the participants in Chang and Jeong's study (2021). Subsequently, participants either set out to prove their worth in order to fit in or developed strategies for providing care in different ways as required (Martinez-Morato et al., 2021; Holyoake, 2020). Critically, a strength of the male nurses was being able to offset some unwanted behaviour from male patients toward female nurses through their communication skills and their provision of care (Guy, Hughes and Ferris-Day, 2022).

5.2.2.2 Workload

5.2.2.2.1 *Stress including masculine task assignment*.

Stress was experienced in a variety of ways connected to gender such as being expected to work with limited autonomy as a nurse within the patriarchal Iranian societal structure (Azadi et al., 2017). Following instruction from others including female nurses was difficult for Iranian male nurses in this situation, provoking psychological stress (Azadi et al., 2017). As the physicians carried higher levels of professional kudos, it was important to follow commands if wanting to continue working as a nurse (Azadi et al., 2017). Being assigned heavy lifting, typically associated with increased stereotypical physicality was also aligned to increased stress (Blackley, Morda and Gill, 2019; Chang and Jeong, 2021; Kalemba, 2020 and Saleh et al., 2020), as also presented in the initial literature review (see section 2.4.2). Kim and Shim (2018) also noted the physicality of the job and questioned the age at which participants would either quit or retire. Aging in the profession was also raised as a point in my study by T8, questioning the appropriateness of an older man visiting young mothers and their babies (see section 4.1.2.1). However, an important point raised by Blackley, Morda and Gill (2019) is that stress and role conflict expressed by their participants appears to have reduced when compared to earlier studies, suggesting that this is possibly due to the progressive cultural views in Australia.

A different perspective was elucidated by Bouret (2017) whose 15 participants highlighted a plethora of exposures to lateral violence evoking stress including abuse verbally, stereotyping, scapegoating and discrimination (see section 5.2.1.2.2).

Working in oncology was notably stressful at times for participants relating to patients and families through terminal illness (Cavayé, 2020). Martinez-Morato et al. (2021) recounted participants used physical force rather than emotionality and rejected or accepted gender stereotypes when it benefited them, thus balancing out stress provoking situations. To combat the different sources of stress, Cheng et al. (2018) found that negating extra optional shifts and gaining the support of a work-based clique helped to negate occupational burnout.

5.2.2.2.2 *Balancing*

As noted in section 1.4, the attrition rate for men in nurse training is higher than that of their female nursing colleagues. Those that achieve success and qualify are more likely to leave in the first four-years post qualification (Sochalski, 2002). As such, either those who remain have a positive time throughout their training and education, or they learn to be resilient and negotiate an acceptable work life balance. The narrative of constantly balancing the complexities of a female dominated career in nursing was highlighted by Azadi et al. (2018), Blackley, Morda and Gill (2019), Saleh et al. (2020) and Qureshi, Ali and Randhawa (2020) and Smith et al. (2020). It took time and effort, through extensive practice to be respected and recognised as a member of the organisational nursing team (Shin and Lim, 2021). Cottingham (2015) adds that the balancing included emotional distancing by the participants to maintain and subsequently increase self-control and lessen the risk of emotional burnout. Emotional burnout was a particular factor associated with working in oncology by Cavayé (2020), who notes the reliance on colleagues to balance workload and share challenging situations was critical.

Holyoake (2020, p.397) refers to the constant personal balancing of genders as a male nurse, ‘in an effort to dismiss risk, ensure equality and safety’, in the CAMHS arena. Here the male nurses want to portray the effective male role model that some vulnerable young clients may have lacked in their lives while facilitation therapeutic relationships, in which the clients can share their life stories (Holyoake, 2020). For male HVs the realisation that they may be the only positive male role model in a child’s life shone through in my study when interviewing T7 (see section 4.3.3). Striking the balance toward building a therapeutic relationship but not crossing the professional line, through the use of emotional management strategies and boundary setting was

also important within a Spanish paediatric setting (Martinez-Morato et al., 2021). The young male nurses used these strategies to mitigate potential emotional burnout and promote their patients and their own emotional wellbeing in order to continue their important work (Martinez-Morato et al., 2021).

This constant balancing of identity was also highlighted by Kalemba (2020) from the colonially imposed origin of nursing in South Africa. The male nurse participants noted that their relationship with male physicians was less tense than with female doctors who liked to demonstrate their power through their occupation, in contrast to the culturally driven social hegemonic masculine norms (Kalemba, 2020).

Kim and Shim (2018) produce a range of narratives that are influential in the potential decision to leave the nursing profession in South Korea. Here the balance of having a rewarding and valued job, against poor treatment, achieving a work life balance and negotiating occupational conflict was an ongoing consideration for participants (Kim and Shim, 2018).

5.2.2.3 Role Model

5.2.2.3.1 *No knowledge of nursing*

When reviewing the initial literature, Loughrey (2008) highlights that some boys probably avoid a career in nursing due to the gender role conflict (O'Neil, 1981a) of caring being stereotypically assigned to females as a gender norm. The notion of boys having no or little knowledge of nursing being a viable career prospect is an important point from the pilot study (Le Blond, 2016) and the primary research undertaken (see section, 4.3.1.1). For those men who enter nursing as an occupation without an understanding of what the profession entails, they potentially open themselves up to work related stress from the outset. This lack of knowledge or understanding is a fundamental flaw in the education and careers system in the UK and in some other areas of the world. Kalemba's study (2020) in South Africa, adds to the notion of lack of knowledge regarding men working as nurses, noting that despite men undertaking nursing duties historically in nursing orders, the omission of men's narrative in nursing enables the feminine construction of nursing as a female orientated occupation. This narrative aligns well to the initial literature review (see section 2.0) (Liminana-Gras et al., 2013 and Oxtoby, 2003) but takes in a broader geographical perspective here.

Of the 13 geographical areas of the world covered within these 21 papers (See Table 10), 20 papers situate male nurses as being in the minority, with Jordan being an outlier.

Table 10. **Geographical setting of the 21 research papers**.

Country	Number of papers
Australia	2
China	1
Iran	1
Jordan	1
Korea	1
New Zealand	1
Poland	1
South Africa	1
South Korea	2
Spain	1
Taiwan	1
United Kingdom	2
United States of America	6

Critically in Jordan, men appear to know about the opportunity of nursing as a career of choice. Saleh et al. (2020) highlighted a Jordanian increase in men working as nurses to 65% in 2012 that then declined to 38% over five years. This reduction in male nurse student numbers to a capped 30% reflected the wishes of Jordanian patients who expressed in a study that they would rather be nursed by female nurses (Saleh et al., 2020). Ensuring a capped number of male nurses was aimed toward raising the number of female nursing students (Saleh et al., 2020). This geographical and cultural anomaly regarding a training number cap of male nurse students (Saleh et al., 2020), presents an interesting juxtaposition compared to the other 20 papers positioning men as being in the minority and the wish to increase male nurse numbers.

Qureshi, Ali and Radhawa (2020) highlight that none of the participants in their study had sufficient knowledge of the nursing role requirement and that this could inhibit applying for nursing as a career. Azadi et al. (2018) support this narrative, noting one participant's father thought there were no men within the field of nursing. A perspective of chance and an accident rather than knowledge of nursing at the entry point for nursing was raised by Kluczyńska (2017). The chance of discovering nursing as a career option by receiving information from others rather than school, was also evident

in Blackley, Morda and Gill's (2019) study. Controversially when aiming to build nursing numbers and bring more men into nursing, one New Zealand study noted there remained a lack of knowledge about the nurse role, with two participants being actively discouraged to pursue a career in nursing (Guy, Hughes and Ferris-Day 2022).

5.2.2.3.2 *Lack of support / role model.*

Azadi et al. (2018) found that male nurses noted a lack of support within their initial training and career from three areas namely, relatives or friendship groups, the educational setting and from a lack of access to role models. One participant reported the time he advised his previous employer that he was going to become a nurse, noting an initial laugh and then asking him if a man could be a nurse (Azadi et al., 2018). These socially constructed beliefs highlight that for men entering the field of nursing, the endeavour to establish oneself as a nurse, for some can be thwarted from the outset.

Once in the nursing role, men were stereotyped in several ways and particularly lacked constructive support when they fell victim to sexual harassment (see section 5.2.1.2.2) as this was an act that was thought not to affect men (Chang and Jeong, 2021).

The negative impact resulting from a lack of role models was raised in the initial literature review (see section 2.4.2) and an element of discussion in seven papers for the updated literature review (see appendix 20). Guy, Hughes and Ferris-Day (2022) note the paucity of male nurse role models in both the education and clinical settings. Shin and Lim (2021) raised the scepticism of the male nurse participants, as they had not experienced male nurses in higher level positions and were therefore not confident of their future prospects. However, this was not the case for all participants as Blackley, Morda and Gill (2019) note one participants uncle set the scene as a nursing role model and together with further nurturing from his sisters, this enabled him to develop the caring attributes required in the nursing profession. Qureshi, Ali and Randhawa (2020), echo this perspective advising that nurses who were family or friends positively influenced the participants of their study. However, the enduring female engendered perspective of nursing provides a scarcity of male nurse role models affecting both recruitment and retention of men to the field (Bouret, 2017). Taking this point further Qureshi, Ali and Randhawa (2020) add the lack of male role

models together with an ethnic minority origin is also a barrier. The specific cultural norm of men being hierarchically ordered above women, leaves Arabic men somewhat lacking support and isolated with perceived diminished masculinity when entering the female dominated workspace of nursing (Saleh et al., 2020).

5.3 Overarching Theme Two: Opportunities and Advantages for Male Nurses.

The overarching theme of 'opportunities and advantages for male nurses' has been constructed from the two themes: career development through job security and flexibility and being valued as a professional. Despite some of the subthemes being discussed in the original literature research papers the same narratives were not recurring to the degree of forming themes at that stage. The updated literature review adds this new overarching theme, two themes and nine subthemes (see table 11) that will be discussed below. As discussed earlier the research questions for this study were based on the themes from the original literature. Interestingly due to the rich data collected from my research participants the findings do synergise with table 7 and will be linked to the narrative below and within the discussion chapter.

Table 11. Overarching theme two: Opportunities and advantages for male nurses, with subsumed subthemes and themes.

Updated Literature Review		
Overarching Theme	**Themes**	**Subthemes**
Opportunities and advantages for male nurses	Career development through job security and flexibility	• Career development / Flexibility. • Advantages inc. Job escalator • Evolution of self • Finance security / dichotomy. • More technical roles higher pay
	Valued as a professional	• Escape male work environments. • Proud or privileged providing job satisfaction. • Essence of care • Valued as a professional

5.3.1 Theme: Career development through job security and flexibility

5.3.1.1 *Career development and flexibility*

Despite Saleh et al., (2020) noting barriers to male nurses working in obstetrics and gynaecology due to this speciality being seen as a female orientated field of health care, Smith et al. (2020) highlight one male nurse participant who has worked there for ten years, with only one female patient refusing his care during that time.

Interestingly in my study T1 was a direct entry MW and as such had worked in obstetrics and raised no discriminatory issues during the interview. Smith et al. (2020) advised, the male partners of the female patients were more likely to question their receiving care from a male nurse and this echoes similar narrative within my study of male health visitors (see section 4.1.2.1).

Blair (2016) looked closely at career decisions within her phenomenological study of 17 male nurse participants and found three motivating factors including job opportunities, job flexibility and financial stability. Overall, Blair's (2016) participants were supported by their friends and family and entered nursing as a later career option in order to support their own families through the stability of their profession. This narrative was echoed by Qureshi, Ali and Randhawa (2020). Supporting extended family financially was also raised by Cheng et al. (2018) as despite none of the 14 participants being married, they still considered a career in nursing as a career with stability in order to ultimately be the main breadwinner. Supporting one's family including the parents if required, is a culturally driven male expectation within Taiwan (Cheng et al., 2018). This was also the case for male nurses in South Africa (Kalemba, 2020) and Jordan (Saleh et al., 2020). Entering and remaining in a female dominated profession was justified through being paid a wage, as this was not the case for other South African men (Kalemba, 2020). There was discrepancy found in the study by Kim and Shim (2018) as male participants entered nursing knowing it would be a hard, but a valued and rewarding career, yet on the contrary the participants were apparently not ready for the subsequent experiences awaiting them, resulting in high levels of turnover. The extra pressure in supporting families bought conflict to the Korean male nurses (Shin and Lim, 2021). These nurses voiced they had a stable job with relatively good wages, but questioned how long they could sustain a quality of life for themselves and their families unless they earned more in the future (Shin and Lim, 2021).

For Ghanaian immigrants in America nursing was a second career that offered continuing employment benefits such as pension and sick pay and ongoing educational opportunities (Frimpong, 2016). These positive factors enhanced job retention as when subjected to discrimination they were able to change roles rather than leaving their nursing career in its entirety (Frimpong, 2016). Juliff, Russell and Bulsara (2017) also noted that nursing was a second career for most of the participants in order to find some job satisfaction and help others. Eight of the 11 participants in

my study had experienced other employment before moving into nursing (see section 4.3.1). The certainty of employed work and gaining job satisfaction was a driver, demonstrating future themes for marketing toward increasing male nurse numbers. Guy, Hughes and Ferris- Day (2022) agree, highlighting that despite all participants mentioning the high attrition rate for male nurses, the plethora of diverse opportunities available within nursing, the flexibility and the propensity for travelling could be used effectively for marketing strategies. This narrative of flexibility and travelling adds to my study where T3 moved abroad and retained his HV role on a sessional basis, meeting both his personal and professional roles and requirements (see section 4.3.4).

Interesting perspectives for entering nursing as a career were put forward by Kluczyńska (2017) including the extremes of accidentally falling into the nursing profession or working abroad when qualified. The accidental narrative was also put forward for T5, who despite being an intermittent HCA says he fell into nursing (see section 4.3.1.1). Kluczyńska (2017), Kalemba (2020) and Qureshi, Ali and Randhawa (2020) frame the accident as a way of negating responsibility for not conforming to the traditional perceptions of masculinity. Despite not having sufficient information about nursing and lacking support from friends and family, once qualified the nursing career opportunities for male participants took shape (Azadi et al., 2018). The narrative above provides the breadth of reasons why men enter the nursing profession as a career option.

5.3.1.2 *Advantages inc. job escalator*

The perception of male nurses being afforded advantages and faster opportunity for promotion was referred to as ‘ladder climbing’ (Williams, 1995) in the initial literature review (see section 2.0) and will be discussed in section 6.4.6. Being in the minority gender group was sometimes advantageous for participants. Preferential treatment by default of being a male nurse was reported by participants in the study by Blair (2016). Despite not holding higher credentials or experience over their female colleagues they were afforded leadership role opportunities (Blair, 2016). Some men reported being given preferential treatment in situations where female nurses would be reprimanded, yet the male nurses would be shown tolerance and encouragement (Chang et al., 2018). Smith et al. (2020) add to this notion of special treatment through identifying the respect from physicians toward male nurses, potentially resulting from masculine

camaraderie. My study adds to this narrative particularly the recount from T10 (see section 4.1.1.3) who utilized his masculinity to garner advantage with a reportedly oppressive male GP.

Participants also noted that they were aware some patients especially females could feel uncomfortable, so they used comedy and male attributes as reassurance, resulting in some patients openly stating they preferred male nurse care (Smith et al. 2020). Preferring male care due to perceived increased competence was also noted by Salah et al. (2020) although this was offset by cultural norms, where men are not allowed to provide sensitive care to women or children. My study found that overall male HVs believed their gender to be an asset, they were generally accepted into family homes and able to provide objective support and advice (see section 4.1.1).

Increased opportunities for promotion were a reason for entering and remaining in the nursing profession (Kluczyńska, 2017). Conversely, Blair (2016) and Azadi et al. (2018) acknowledge that some promotional opportunities are not accepted by the participants, as once in a higher managerial salaried role the men cannot undertake the offers of overtime available within the general nursing role. Whereas for participants categorised as type 2 in a study regarding intention to leave, there was a notable lack of opportunities to develop for the male nurses (Kim and Shim, 2018).

There was an assumption that men entered the nursing profession as a means to an end toward climbing the professional ladder, also known as an ‘escalator’ or ‘elevator’, into management or specialist positions. An example of this assumption is clear in Cavayé’s study (2020) where one participant was offered a promotion that he had not applied for. In contrast another participant in the same study had to prove himself to be able to care for specific clients (Cavayé’s, 2020). Kalemba (2020) reports that in South Africa the assumption is that the male nurses once qualified, will move to more highly paid occupational therapy roles in the industrial mining sector. Yet despite being in the minority, men are able to benefit from gender orientated advantages such as promotion, with leadership or specialist opportunities presenting increased renumeration (Frimpong, 2016).

However, Frimpong (2016) also raised the point that six of the ten participants in the study, through the intersectional dual marginalisation of race and gender were not afforded a turn on the notional glass escalator. Instead, the six participants referred to

moving down rather than up the pay scale, a potential '(d)escalator' (Frimpong, 2016). One participant was requested to resign for alleged misconduct, with others recounting discriminatory acts against them affecting their professional and personal experience (Frimpong, 2016). Bouret's study (2017) also presents participant's experiences of being refused the observation of a birth and being victimised by a course leader as they did not like men in nursing as they were seen as ladder climbers. One participant referred to a glass ceiling, where he recounted being a 'misfit' and after being promoted for two years and leading a service he was the first to have his employment terminated, then returning directly to the same unit working under someone whom he had trained personally (Frimpong, 2016 p.93). Frimpong's (2016) study demonstrates that the glass escalator (elevator, ladder) is fluid dependant on intersectionality but also presents unique experiences against specific contexts. The specific experience of race plus gender from an intersectional minority perspective within nursing brings something new to my study. The HV participants who showed interest and agreed to take part in my study were outwardly noted to be white British and as such my study lacked any further intersectionality of race, disability or any other minority differences.

A reported indigenous term form men noted as 'shimani', was discussed by Kalemba (2020, p.567), suggesting that the male nurses were not disciplined for minor misdemeanours purely due to their gender, as that was the culturally expected way that men behaved. In this way the male nurses were privileged, despite female nurses being potentially superior professionally, and seen as special like 'eggs' in a culturally patriarchal society (Kalemba, 2020 p.657). This special treatment vocalised by other male nurses arose from them being the token male or only male in the work space and as such they got special treatment compared to their female nurse colleagues (Smith et al., 2020).

5.3.1.3 *Evolution of self*

Adapting to the female dominated workspace was deemed a necessity to prevent isolation and fit in (Smith et al., 2020; Shin and Lim, 2021 and Azadi et al., 2018). One participant (Smith et al., 2020 p.1216) voiced this adaptation as a matter of survival that could be interpreted as being in a battle or challenging terrain such as a jungle or desert, negotiating tactics on which way to go next. Shin and Lim (2021) stressed that the male nurses put in conscious continuous hard work and effort to adapt and gain

recognition as part of the organisation. Whereas Azadi et al. (2018) referred to this ongoing re-invention and negotiation of self as a balancing act within the engendered feminine profession of nursing.

However, for others they evolved as they took on new components of the role such as caring for children. Initially caring for children through therapeutic touch and emotional connection was not deemed a necessity of the male nurse role but the evolution of a performative act to fulfil these professional needs meant they could emotionally protect themselves (Martinez-Morato et al., 2021). Developing a performance to form a therapeutic relationship with traumatised children and young people within the CAMHS arena was a necessity (Juliff, Russell and Bulsara, 2017). Watching their backs while being constantly monitored in case of any impropriety was normal life for men within the CAMHS service but for the male nurses they had to develop and evolve to successfully embody this working existence (Holyoake, 2020). Facing frequent loss while working in oncology took its toll emotionally on the male nurses who developed over time knowledge, technical and interpersonal skills to be able to continue and mitigate compassion fatigue (Cavayé, 2020). Despite the participants in my study evolving over time to constantly meet the needs of a developing HV service, they had seemingly negotiated substantial development of their personal identity within their initial nurse training and newly qualified nurse status (NQN). This narrative adds to the original themes and will be discussed within the theoretical consideration of novice to expert (Benner, 1984) in section 6.2.2.

5.3.1.4 *Finance security / dichotomy*

While the income of the qualified nurse seems attractive for male nurse participants in some studies (Kalemba, 2020; Frimpong, 2016; Blair, 2016; Azadi et al., 2018; Saleh et al., 2020; Shin and Lim, 2021) in other studies it was the seemingly low wage that caused the male nurses to consider leaving or to leave the nursing profession (Kluczyńska, 2017; Kim and Shim, 2018; Cheng et al., 2018; Qureshi, Ali and Randhawa, 2020). Yet, if the men could secure a higher managerial role this would bring with it higher earnings (Kluczyńska, 2017; Shin and Lim, 2021). Particularly for Poland, where men stated they chose nursing as this would provide the option for working abroad and securing a higher income (Kluczyńska, 2017). Although there was no mention of income in the papers by Juliff, Russell and Bulsara (2017) and Guy,

Hughes and Ferris-Day (2022) the notion of job stability alludes to a regular income that was voiced by the younger research participants and this narrative should be explicit within future marketing materials. Despite originally entering nursing for reasons including a stable career, once established, the reality of insufficient income to support expected family responsibilities proved an economic challenge for some (Cheng et al., 2018). This narrative showed promise in that participants could earn more by completing night shifts, but this took an emotional and physical toll on family life, so was unsustainable over the longer-term (Cheng et al., 2018). Conversely for the participants in my study, by moving toward health visiting any shift work was negated, thus allowing for more family time (see section 4.3.1.2). Equally for T10, who had been a charge nurse, it was important that he retained his pay grade while undertaking his HV training, presumably to continue to meet his financial commitments (see section 4.3.1.2).

Supporting the family is a traditional enduring cultural expectation for men, with this salient factor related to male nurses and the salary being the means with which to provide the financial support. The attraction of higher salaries in nursing plus the financial benefits of a pension and health insurance made nursing the career of choice for the Ghanaian male nurse participants having a career change within America (Frimpong, 2016). Blair (2016) echoed this notion of the second career choice for nursing being influenced by the pull of having time with the family due to job stability and a secure income. Wanting to help others was also an altruistic reason but the notion of job security as the mitigating factor against the discrimination experienced was still of benefit to support themselves and their families (Frimpong, 2016; Saleh et al., 2020). The discrepancy of salary between mainland China and the Chinese comparatively affluent region of Macau, caused participants on the mainland to have a justified position of disadvantage on receiving a constantly low income (Mao et al., 2020). Similar to other studies discussed here the propensity to provide for their families in both areas was a noted advantage (Mao et al., 2020). This capacity to provide was also the objective within British South Asian male nurses (Qureshi, Ali and Randhawa, 2020) who related the low status of feminised work within the UK attracting low wages that underpinned the perception of nursing being a lower status job. While in Korea the salary of a male qualified nurse initially appeared attractive but as there were seemingly limited opportunities for promotion associated with higher

earnings and the participants wondered how this would work as their families grew (Shin and Lim, 2021).

5.3.1.5 *More technical roles higher pay*

Despite experiencing discriminatory practice at times, some participants positively shared requests by mothers and female patients to carry out technical tasks such as cannulation due to their assumed competence (Saleh et al., 2020). By taking on more technical roles some male nurses were able to achieve higher pay grades that enabled motivation and retention within the workforce (Blackley, 2019). For others the technical tasks determined their vision of providing good care by controlling emotional investment and output, negotiating challenging situations through emotional self-control and acting in a way that favoured them professionally (Martinez-Morato et al., 2021; Cottingham, 2015). This reframing of the male nurse role around technical reference points to manage personal emotions was also used to support patient emotions through the sharing of anatomy, physiology of disease processes and care pathways, in order to reduce anxiety and stress (Cottingham, 2015). One participant shared that due to a colleague being good at Intravenous cannulation rather than his social skills, he had been accepted by the team (Cheng et al., 2018). The updated literature review adds to my study where the ability to provide technical skills subsequently enabled acceptance (see sections 4.3.3 and 4.4.4).

In the study by Mao et al. (2020) higher earnings were attributed to the nurses in the specially administered area of Macau, who were deemed to be professional due to attaining a bachelor's degree. The nurses from mainland China were able to register as graduates but were not afforded the same income due to a lesser developed economy and overall earning much less (Mao et al., 2020). Higher pay was welcome in the highly technical oncology arena especially as one participant stated.

> *"I'm getting paid to do something that I would do for free"* (Cavayé, 2020).

Within Kalemba's (2020) study there was a strong narrative about specialities such as nursing within industrial mining, oncology, trauma and the epitome of female engendered health care, that is midwifery. Here the male nurses talked about moving into specialisms through additional training. This training brings with it more knowledge and technical skills within subjects such as non-medical prescribing and subsequently asserting a higher status than other nurses, by taking on roles that were traditionally

the domain of doctors (Kalemba, 2020). By taking on stereotypical traditionally masculine technical skills, the male nurse is able to move away from the feminised role delivery of personal care such as bathing, assisting to the toilet or feeding the patients (Kalemba, 2020). Technical expertise was intrinsic to the study by Juliff, Russell and Bulsara (2017). Technical advances across all areas of nursing practice are becoming common place, arguably dependant on a country's socioeconomic ability to provide such equipment. Nevertheless, the development of technological skills toward career promotion to enable positive patient outcomes was the aim for some participants (Juliff, Russell and Bulsara, 2017). Exposing men who come into nursing early or as part of a recruitment drive to areas that use high levels of technology was seen as a positive intervention to increase the numbers of male nurses in a study by Guy et al. (2022). It is important to note here that a core level of digital and technical skills is now expected for all health care workers in order to deliver a basic level of care and to keep contemporaneous electronic records within the UK. This was a technological change from handwritten to electronic record keeping for the male HVs (see section 4.3.4). T10 recounted embracing autonomy and using both the community and the GP electronic systems for the benefit of the clients, something that other HV chose not to do (see section 4.4.3).

5.3.2 Theme: Valued as a professional

5.3.2.1 *Escape male work environments*

The armed forces, a bastion of the male working environment, have somewhat diversified the gender mix in more recent years, yet in Poland a pragmatic decision for entering the nursing profession was at the time for the male nurses, to avoid compulsory military service (Kluczyńska, 2017). Avoiding working in the competitive male work environment was also given as a driver of employment choices for the male nurses in Australia (Blackley, Morda and Gill, 2019). Holyoake (2020) gives a different perspective here related to the CAMHS environmental context. Holyoake (2020) suggests that due to the complex sensitivities related to gender, the male nurses have a constant renegotiation of difference toward providing a therapeutic equilibrium on a daily basis. The narrative above adds to the initial literature review where men have chosen a female dominated working environment yet still find themselves fulfilling

hegemonic masculinity roles associated with strength through lifting and handling and attending to violent patients (see section 2.0).

5.3.2.2 *Proud or privileged, providing job satisfaction.*

The notion of being proud has synergy with the subtheme essence of care (see section 5.3.2.3) and shone through from the participants in my study (see section 4.3.4). Being proud and privileged to be a nurse was specifically highlighted by Blackley, Morda and Gill, (2019). Providing care for those who needed it resulted in giving the participants great job satisfaction and privilege (Blackley, Morda and Gill, 2019; Saleh et al., 2020; Juliff, Russell and Bulsara, 2017). High job satisfaction was a particular attraction for the choice of occupation in the type 1 subjective categories, mitigating against the intention to leave (Kim and Shim, 2018). Job satisfaction grew as the participants gained respect from their colleagues, service users and their families (Blair, 2016). For those that chose to leave the occupation in the study by Kluczyńska (2017), it was the need for job satisfaction that enabled them to revise their decision and to return back to their nursing role.

It was the development of knowledge and skills to successfully deliver the support to patients that made participants proud to have met the professional challenges (Cavayé, 2020). For those for whom nursing was a second career, they were seeking job satisfaction and were willing to negotiate known difficulties as a male nurse to achieve their goal (Juliff, Russell and Bulsara, 2017).

5.3.2.3 *Essence of care*

Studies highlighted that for some of the participants the essence of care was the passion and driving force toward and then within their male nursing lives (Kluczyńska, 2017; Smith et al., 2020; Saleh et al., 2020; Martinez-Morato et al., 2021; Juliff, Russell and Bulsara, 2017; Frimpong, 2016; Cottingham, 2015; Cavayé, 2020). Saleh et al. (2020) added that the male nurse participant aptitude for care provision was directly related for their wish to lessen the suffering of the patients. Qureshi, Ali and Randhawa (2020) presented a study whereby the British South Asian male nurses demonstrated caring attributes that potentially aligned to religious tenets within faiths such as Hinduism, Islamism and Sikhism. This reinforcement of caring was seen as a potential enabler to entering and remaining in the nursing profession for British South Asian men (Qureshi, Ali and Randhawa, 2020). For participants in the study by Juliff, Russell

and Bulsara (2017) caring equated to helping people. One participant related his caring to wanting to help the country through protection while he was in the army and now transferring that to caring for the people of the country as a nurse (Juliff, Russell and Bulsara, 2017). Similarly, for Martinez-Morato et al. (2021) their participants asserted the provision of care was a driving force, yet at times they talked about care being delivered differently by female and male nurses. This was particularly noted in the care of violent patients, where the care from male nurse participants was noted to be as good as or better than that of female nurses (Cheng et al., 2018).

Unfortunately for some, despite caring being a fundamental aspect of being a nurse, their ability to care was compromised through their isolation due to the intersecting discrimination they faced because of their gender and race (Frimpong, 2016). This narrative of wanting to care but at times being negated from doing so adds to the initial literature review (see section 2.4.1 and 2.4.2). For some, compassion fatigue affected their ability to care, being overwhelmed and lacking empathy resulted in having to take a break to revitalise their emotional wellbeing (Cavayé, 2020). For others, not all patients receiving care recovered and some participants recounted reframing their role to manage their emotional stress (Cottingham, 2015). This notion of reframing roles within the profession also links to the primary study, where the safeguarding of children is paramount, and the consistency of care enables effective intervention rather than collusion (see section 4.4.2).

5.3.2.4 *Valued as a professional*

The initial literature review provided subjectivity to the notion of physicality for male nurses regarding feeling valued (see section 2.0). Some men felt valued due to the physical contribution they could make (Milligan, 2001) and others suggested being devalued when being expected to undertake repetitive manual tasks (Evans, 2004). The notion of value will now be added to through the updated literature review. Providing care for others as a means for self-fulfilment allowed the male nurses to feel valued (Juliff, Russell and Bulsara, 2017; Cavayé, 2020). Receiving compliments from patients was also affirmation that male nurses were valued as professions (Cheng et al., 2018). Being valued as a professional by the management, doctors and the female nurses also garnered a feeling of acceptance (Smith et al., 2020). Saleh et al. (2020) explains how the male nurses became valued and recognised in their Jordanian

communities through hard work, maintaining health physically and building professional status. Some men did not raise the notion of being valued by other practitioners while working as a nurse but did highlight that they personally felt value through providing care to those who need it (Qureshi, Ali and Randhawa, 2020). Martinez-Morato et al. (2021) do not mention being valued as a professional, but value comes through in the study, portraying the perceived value to their approach to therapeutic care that the male nurses provide. A similar narrative shines through where a hierarchy is still evident, but the power base is somewhat flattened (Mao et al., 2020). This was achieved through the forging of interpersonal relationships between the male nurses and their physician colleagues outside of the emergency department working environment resulting in them feeling valued (Mao et al., 2020).

An alternative view was raised by a participant, who shared feeling undervalued as his reason for leaving the nursing profession (Kluczyńska, 2017). The male nurse added that for men taking orders from doctors and being considered feminine as a nurse, had a stark impact on his mental health resulting in his decision to leave (Kluczyńska, 2017). Working in a feminised role was an issue for others in the study who reframed the nursing role as without gender or in terms of providing protection as their coping strategy (Kluczyńska, 2017). Others in the study did feel valued as male nurses, through their self-fulfilment from their ability to help others (Kluczyńska, 2017). For those men who did feel valued in the nursing profession this resulted in higher self-esteem (Kluczyńska, 2017). The development of knowledge, technical and interpersonal skills over the years, provided a feeling of self-worth and motivation to continue as a male nurse (Cavayé, 2020). This feeling of being valued through employment and retaining the masculine norms of being the breadwinner was apparent within Kalemba's study (2020).

All of the HVs personally discussed the professional attributes they brought to their team or service provision elucidating their sense of pride (see section 4.4.4). Whittaker et al. (2013) note the importance of feeling valued and particularly being listened to by managers across the HV workforce. Within my study being valued by the manager determined the male HVs fulfilment within the role (see section 4.1.3.3). Having team cohesiveness also resulted in feeling valued yet this value between colleagues can be quickly eroded through constant change as can be noted in section 4.4.3.1.

5.4 Reflections on the initial literature review.

5.4.1 The synergy with the original themes.

When undertaking the updated literature review from January 2015 to December 2022 it became apparent that while the identified themes attracted alternative nomenclatures, on further inspection the content and meaning of the original literature review themes were generally unchanged. As such when considering the original subthemes and overarching themes (see table 4, section 2.4), the majority of the updated literature review subthemes could be subsumed into the original subthemes (See Appendix 21)

5.4.2 New perspectives and adding a new theme.

Interestingly, there is in more recent years an evident progressive social discourse, related to the positive aspects of taking up a career in nursing for men referred to as opportunities and advantages. Within the more recent literature there are additional nuances and elements that require heightened recognition. The positive outcomes expressed by the male nurses and the cultural variations, not previously captured in the initial literature review, are captured within the new overarching theme, ’opportunities and advantages for male nurses’. The opportunities and advantages for men working in a female dominated space may have been evident before and did not readily pull through the final chosen papers that provided the qualitative data for analysis. Critically, the broader scope of global facing papers and larger final number of papers collated could have been responsible for providing the higher recognition of the positives that men noted, when working as nurses in a female dominated environment. As the dimension of time has passed, there has been evolutionary social change across different countries and communities, that could have contributed to a somewhat enhanced positive narration of the experiences of male nurses generally. This cultural shift is noted by Blackley, Morda and Gill (2019) who highlight Australia’s socially developing views on gender equality and wider cultural issues that may have influenced their findings. This theme was echoed by Smith et al. (2022) however, the participants emphasised a continuing discourse of women being better suited to nursing through caring and men suited to medicine through the notion of curing.

5.5 Summary

The construction of this updated literature review is cognisant of the themes from the original review and the findings from my study. The original two overarching themes of isolation and work-related stress have become subsumed as themes into the overarching theme of ‘being the minority gender: the negotiated factors for male nurses’. This alteration emanated from a broader global discussion on the engendered notion of nursing being a female occupation. A second new overarching theme was formed, ‘opportunities and advantages for male nurses’ comprised of the themes: ‘career development through job security and flexibility’, and ‘valued as a professional’. All papers from both literature reviews and the findings from my study will be integrated within the following discussion chapter, while considering the theoretical frameworks of GRC (O’Neil, 1981a) and novice to expert (Benner, 1984).

Chapter Six. Discussion.

6.0 Introduction

Chapter six initially introduces two theoretical frameworks namely Gender Role Conflict theory (O'Neil, 1981a) and the theory of Novice to Expert (Benner, 1984). The findings will then be situated against the two theories throughout this discussion chapter, integrating the narratives together to build a clear picture that positions my study within a theoretical context. The four SOTs are discussed while referring to the initial and updated literature reviews (see tables 2, 3 and appendix 19) and will bring in other selected pertinent literature, to critically examine the key concepts within the SOTs. The initial literature review (see chapter 2) provided evidence and narrative to form the semi-structured questions (see appendix 9) for the one-to-one research interviews, for both the pilot study (Le Blond, 2016) of male nurses and the main study of male HVs. Due to the paucity in evidence related to male HVs, the initial literature review necessitated exploration into the experience of male nurses, as a wider yet still relevant audience. However, despite professional commonalities, in that all male HVs are qualified nurses and/or midwives, there are notable differences in the HV profession and service delivery that will be discussed such as the sociological rather than medical model of care delivery. The serendipitous finding around the marginalisation of fathers was not expected or anticipated before the analysis phase of the study and required exploration of wider literature to support, refute and broaden the discussion and to illuminate the points raised (Smith Flowers and Larkin, 2009). As such, relevant literature is introduced that resonates with the findings to draw in evidence, theory and research to provide conjecture or frame the points being made. Contemporary policy was also explored to take the discussion forward.

The literature reviews do not identify any other studies that look at the lived experience of male HVs, as such this is a unique study that makes an original contribution. The research question, aim and objectives below, are at the centre of the study and this discussion chapter:

> Do men encounter any gender specific issues when working as a registered Health Visitor?

Aim: To explore the lived experience of being a registered male Health Visitor.

Objectives:

1. To collect personal experiential narratives of being a registered male HV.

2. To investigate why the participants chose health visiting as a profession.

3. To consider the impact on service delivery by male HVs.

The following conceptual framework presents the evidence-based concepts of becoming and being a male HV. The framework was developed from the interpretation of the rich verbatim narratives provided by the male HVs, from which four SOTs were drawn together.

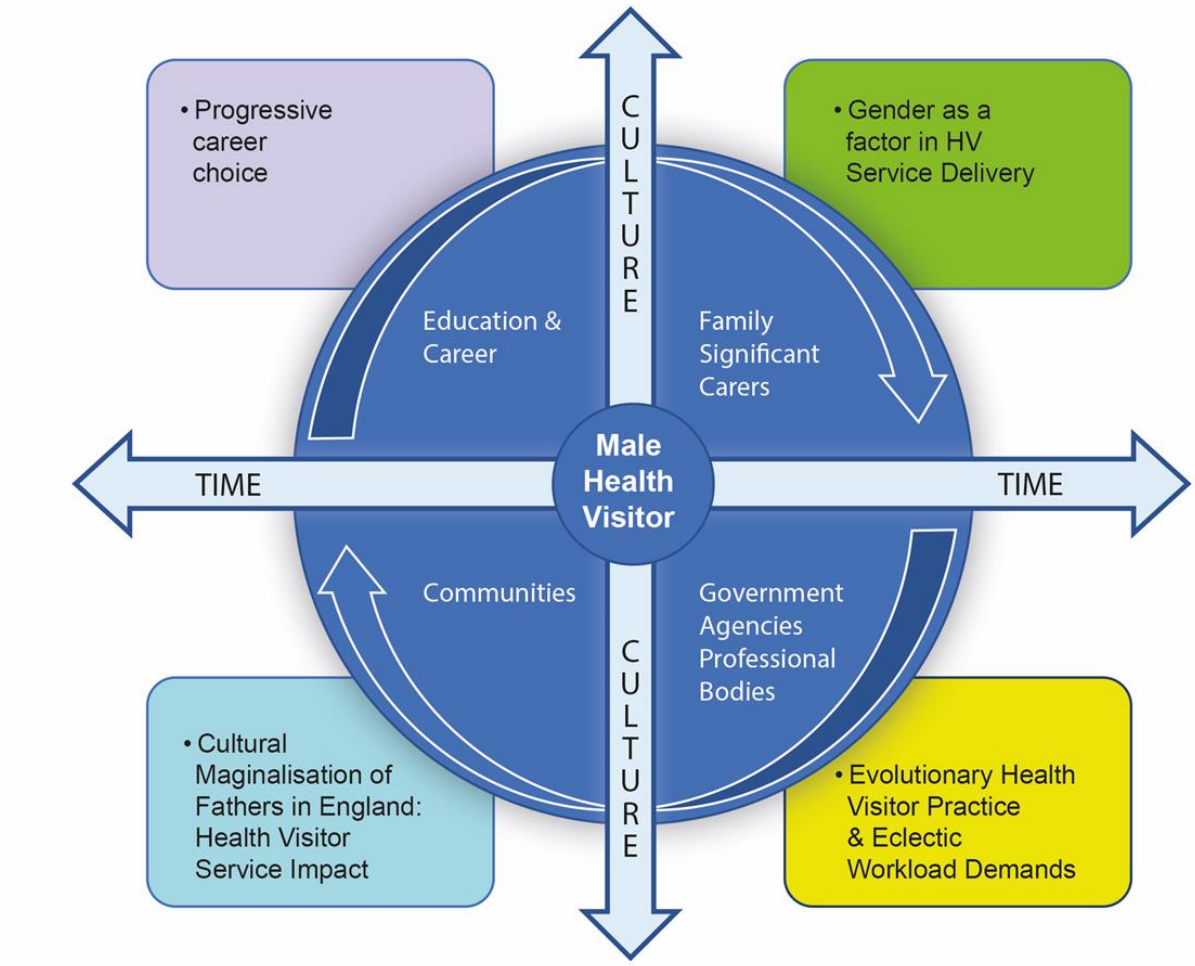
6.1 Conceptual Framework

The conceptual framework (Fig 5) provides a visual representation of the four SOTs; Gender as a factor in health visitor service delivery; the cultural marginalisation of fathers in England and the impact on male health visitor service delivery; progressive career choice and evolutionary health visitor practice and eclectic workload demands, all four SOTs reflecting the lived experience of male HVs, through cultural and social constructs across the dimension of time.

This conceptual framework (Fig 5) was adapted from my initial considerations and reflections (see appendix 15), where an adaptation of the ecological model of Urie Bronfenbrenner's (1977) Ecological Model seemed to encapsulate the key concepts derived from this research study. However, following further reflection (Schön, 1983) as the writing and contemplation moved along, the notion of cultural change across the dimension of time related to all social constructs shone through and my conceptual framework needed to reflect this. Interestingly, Bronfenbrenner's ecological framework was critiqued by Vélez-Agosto *et al*. (2017), highlighting the need to encompass culture at the individual micro level of development, rather than the macro level, as culture resonates throughout human activity and cannot be deemed as separate to it. Vélez-Agosto *et al*. (2017) suggest that gender is commonly attributed to the characterisation of strength, occupation, and/or the ability to care (Cameron, Moss and Owen, 1999) across a range of societies. This notion resonates with my study however, gender is a complex concept that can be developed over time rather than

driven by the biological binary sex assigned, from sexual characteristics, at birth (Frosh, Phoenix and Pattman, 2002; Suen *et al*., 2020). Gender will also be considered from the GRC theory perspective throughout this chapter (O'Neil, 1981a).

Title. A conceptual framework: Becoming and being a male Health Visitor.



KEY:

- The four coloured boxes represent the four superordinate themes.
- The straight arrows portray the notion of intersecting cultures across the dimension of time.
- The cyclical arrows portray connections and fluid interactions across socially and politically constructed systems leading to and from the superordinate themes that influence male entry into and experience of being a male Health Visitor.

Figure 5. A conceptual framework: Becoming and being a male HV.

The conceptual framework presented in Fig 5 highlights the notion of culture and time that are moving dynamically and impacting on the male HVs lived experience. The time and culture arrows together with the cyclical arrows give a notion of constant movement and interaction, with the four SOTs, demonstrating the variety of evolving influences impacting on the lived experience of the male HV over time.

The influences on the individual male HV are from a plethora of sources including family, peer groups, social, religious or work orientated communities. On a macro level governmental agencies and professional bodies are influenced by cultural and ideological positioning, including mass media that resonate across the dimension of time, all of which are influential on the working life of the male HV. This list is not exhaustive but the dynamic cyclical arrows together with the time and culture arrows within the conceptual framework (Fig 5) demonstrate that nothing is static. When referring to the four SOTs (see below). there will be reference to the conceptual framework to highlight the points being raised.

1. gender as a factor in health service delivery
2. cultural marginalisation of fathers in England and the HV service impact
3. progressive career choice
4. evolutionary HV practice and eclectic workload demands

During and following the analysis and the presentation of the findings, it was impossible to stop reflecting on my research; the process, the individuals, and concepts forming the SOTs that have been highlighted above. Many theorists have discussed reflection (Schön, 1983; Johns, 2000; Driscoll, 2007 and Kolb, 2015) as a means of making sense of interaction with events and the world around us. Bearing in mind my positionality (see section 1.1) and ongoing in-depth personal reflection, the following theoretical frameworks and areas of discussion are pertinent to the findings of this study.

6.2 The Theoretical Frameworks of Gender Role Conflict and Novice to Expert

The theoretical frameworks of Gender Role Conflict (GRC)(O'Neil, 1981a&b) and Novice to Expert (Benner, 1982&1984) place the findings of this study into a theoretical context. The two theories will be outlined here and later will be considered within the SOTs noting any synergy or discord.

6.2.1 Gender Role Conflict Theory

It is important initially to provide a definition of gender norms in order to later consider why and where gender role conflict may arise:

> *"Gender norms are social norms defining acceptable and appropriate actions for women and men in a given group or society. They are embedded in formal and informal institutions, nested in the mind, and produced and reproduced through social interaction. They play a role in shaping women and men's (often unequal) access to resources and freedoms, thus affecting their voice, power and sense of self"* (Cislaghi and Heise, 2020 p.415).

The definition above, provided by Cislaghi and Heise (2020), reflects on the two intersecting theories of social and gender norms. The perceived benefit of providing this cross-cutting definition is to facilitate amelioration of detrimental social and gender norms through increased understanding. For my study the definition above provides the underpinning perspective of the gender and social norms on which the findings and subsequent discussion were constructed.

Traditional gender norms often prescribe specific roles via behaviours, traits, and occupations to individuals based on their gender (Solbes-Canales, Valverde-Montesino and Herranz-Hernández, 2020). Men are typically expected to be strong, assertive, and unemotional, while women are expected to be nurturing, empathetic, and submissive (O'Neil, 1981a and Frimpong, 2016). However, these expectations do not encompass the breadth of diversity across human experiences and identities, or across the dimension of time. Consequently, individuals whose traits, interests, or orientations do not align with these norms can find themselves in a state of conflict. Mac an Ghaill and Haywood (2007) highlight a post modernity 'cultural flashpoint', as politics, lifestyles, technologies and working practices evolve, with gender providing a discursive lens through which to view societal changes.

The theory of GRC provides explanations, five definitions and ten assumptions to aide an understanding of the mental and physical impact that narratives around sex and gender can have on individuals and groups (appendix 22 & 23). These definitions and assumptions (O'Neil, 1981a) will help to support the narrative, critique and discussion presented within this chapter.

Gender role conflict refers to the psychological and behavioural tensions and difficulties that arise from the discrepancy between societal expectations of traditional gender roles and an individual's own beliefs and identities (Tabassum and Nayak, 2021). Despite Tabassum and Nayak's (2021) research being carried out with women in management and being the minority female gender within a traditionally opposing majority male gender workplace, this study raised similar conflicting gender issues to male nurses in a female dominated workspace. Gender role conflict often emerges in societies where strict gender norms dictate how men and women should behave, leading to a plethora of challenges, particularly for individuals who do not conform to these traditional roles. However, as will have been seen within chapter two, five and in this chapter GRC permeates in a variety of ways across diverse global settings.

At the heart of GRC is the clash between societal expectations and personal identity (O'Neil, 1981a). O'Neil (1981a) highlighted two negative outcomes of GRC. The first is personal investment in supporting restrictive gender roles for self and others, at times leading to discrimination and devaluation of those who chose to deviate from the imposed norms (O'Neil, 1981a). The second is rejecting restrictive gender norms and embracing self, expressing personal identity openly, regardless of other and society perspectives (O'Neil, 1981a). However, O'Neil, (1981a,) adds that the persistent devaluation or discrimination and belittlement from others, resulting from the rejection of gender norms, can result in psychological manifestations such as depression, low self-esteem and emotional instability, with strain being noted in both cases.

In the context of research, academics have studied GRC to understand its impact on individuals and society (O'Neil, 1981a; O'Neil, 1981b; Stilson, O'Neil and Owen, 1991; O'Lynn et al., 2020; Wolfram, Mohr and Borchert, 2009; Dodson and Borders, 2006). Gender role conflict explores the various forms of conflict that individuals experience due to societal gender expectations. One significant aspect of this conflict is the pressure on men to conform to traditional male roles (Harding, 2007). Men who do not fit the expected social norms of the stoic, unemotional provider may face ridicule, discrimination, or marginalization (Harding, 2007). This GRC can manifest in various ways, including internal struggles with self-acceptance, mental health challenges and strained interpersonal relationships. As novices (Benner, 1984) during their preregistration training, all male nurse learners developed new knowledge and skills that were previously unknown to them. They experienced a roller coaster of

negotiating a new career and identity and were presented with expected and unexpected barriers to overcome. Upon qualification some newly qualified nurses experienced ‘transition shock’ into their new professional role, which is well documented by Duchscher (2009). However, when entering the post registration CPD arena, the male nurses/midwives had already experienced being a minority member and as such they were able to generally negotiate working in a female dominated HV environment successfully.

Of importance, gender can intersect with other social constructs such as race, class and sexual orientation, further complicating the experiences of individuals regarding role conflict (see sections 4.1.2.3 & 4.1.2.4). Intersectionality highlights the interconnected nature of these identities, emphasizing that individuals experience oppression and privilege in complex and overlapping ways. For instance, a gay man of colour may face unique challenges that stem from both his sexual orientation and race, compounding the gender role conflict he experiences within his occupation.

Addressing GRC requires a multifaceted approach that involves challenging individual perspectives, societal norms, promoting inclusivity and diversity, and promoting open conversations about gender identity and expression (Government Equalities Office, 2019). Educational institutions, workplaces and communities play a pivotal role in dismantling harmful gender stereotypes and creating environments where individuals can express their identities authentically (Solbes-Canales, Valverde-Montesino and Herranz-Hernández, 2020).

To summarise, GRC is a pervasive issue that arises from the rigid expectations imposed by society regarding gender roles. This conflict can have profound effects on individuals' well-being, self-esteem, and interpersonal relationships. Academics, activists and members of society continue to advocate for a more inclusive cultural norm that recognizes and celebrates the diverse ways in which individuals express their gender identities. By challenging traditional norms and promoting acceptance, society can pave the way for a more equitable and understanding future where everyone is free to be their authentic selves, regardless of gender.

6.2.2 Novice to Expert Theory

Patricia Benner (1982) reviewed the work of two professors, both with the surname Dreyfus, who studied the skills and performance of chess players and pilots. Benner

(1982 p.402) found that the so-called Dreyfus model of skills acquisition could be applied readily to the complexities of nursing career development. Positing the rise in technological advances and the movement of nurses into specialisms, Benner (1982) identified how the beginner and expert attended to their nursing duties differently and noted the need for a clear pathway for continued professional development. When Benner's book was released in 1984, from recollection, it became the must have piece of literature for learners, nurses and educationalists.

The resulting novice to expert theoretical framework acknowledges the five stages of proficiency related to the skills and knowledge required to be developed over time (Benner,1984). The five stages of development are: novice, advanced beginner, competent, proficient and expert (Benner,1984).

In the novice stage, individuals have limited or no experience and perception of what to expect and rely on rules and guidelines to perform tasks. They struggle to prioritize tasks effectively. The second stage of advanced beginner is characterized by gaining some practical experience and starting to recognize recurring situations. However, they still rely on rules and guidelines and may find it challenging to grasp the overall requirements of patient care. When moving to a new clinical environment the student nurses may well move back to novice stage due to the new context. These first two stages require close contact with the mentor/supervisor/role model/facilitator/practice teacher, all of which are non-exhaustive terms that denote a more knowledgeable other who supports the learner within the clinical setting.

Moving on to the competent stage, nurses begin to organize their actions based on long-term goals and plans. They can prioritise tasks and efficiently manage patient care. Proficient nurses, in the fourth stage, have developed a deep understanding of the clinical situation. They perceive wholistic situations and make decisions intuitively. The last, expert stage is marked by an intuitive grasp of complex clinical situations, allowing nurses to make rapid decisions based on vast experience together with an expanded knowledge base.

Using Benner's theoretical framework (1984) as a guide, it would be expected that pre-registration nurse/midwives would exit their training upon qualification as being a competent practitioner. Following their subsequent qualified nursing experience of around a year and strong preceptorship (NHS England, 2022), it would be deemed

appropriate to expect a level of confidence and the development of some proficiency (Benner, 1984).

Benner's (1984) model has been critiqued for being a reinterpretation of the work by Dreyfus and Dreyfus that was created within the specific domain of chess players and pilots rather than the nursing context (Cash, 1995). The coders other than Benner were not nurses, raising the question of how they would be able to identify nursing expertise (Cash, 1995). Although, Benner (1996) replied to Cash reiterating the use of Heidegger's interpretative phenomenology methodology. Benner (1996) added that member checking by meeting to compare interpretations ensured that all research-team members took the same approach, valuing similar narratives.

English (1994) gives further critique of Benner's (1984) theory, suggesting it possibly oversimplifies skill acquisition that is complex in nature. Critically, Benner's (1984) theory emphasizes the significance of experiential learning in nursing. It recognises that expertise is not solely attained through theoretical knowledge but also through hands-on experience, reflective practice and effective support. The concept of intuition was paid particular critical attention (Cash, 1995; English, 1994). It is important to note that novices transform into experts by continuously engaging with real-world clinical situations, learning from successes and failures, and reflecting on their experiences and feedback over time (Benner, 1984). This process of experiential learning is fundamental in shaping highly skilled and knowledgeable nursing professionals (Benner, 1984). Benner (1984) also highlighted the importance of mentorship, supervision and role modelling aligned to practical exposure and lifelong learning in nursing education and practice toward the optimal outcome for the learners, be they pre-registration or post registration. Through this immersion into the female dominated nursing workspace, a cultural 'know-how' in the form of tacit knowledge is gradually developed (Cash, 1995). This tacit knowledge together with the accrued and developing explicit knowledge, stored within memory, subsequently creates professional intuition towards the recall of previously similar events (Gobet and Chassy, 2007; Cash, 1995; English,1993).

The theories of GRC and Novice to Expert have been outlined above and will now be considered within the SOTs emanating from my study noting any theoretical alignment, extension of theory or discord.

6.3 Gender as a Factor in Health Visitor Service Delivery

The SOT 'Gender as a factor in health visitor service delivery', resulted from the subsumption of three themes as seen in table 6 (section 4.0 and appendix 16 Table A). SOT1 retrieved the richest and largest volume of data regarding content reflecting the research aim and research question reassuring me that I had asked relevant questions. The aim of this study together with objectives one and three have been met within the findings in section 4.1, chapter four and the following higher-level discussion.

This SOT presents the unique insight into the lived experience of male HVs. The intersectionality of various cultural expectations and stereotypes influencing their ability to practice effectively within a traditional female dominated workforce. Intersectionality was taken further within the updated literature review with regard to race and gender intersecting, at times causing further discrimination (Frimpong, 2016; Qureshi, Ali and Randhawa, 2020; Kalemba, 20200. For the HV participants there was not racial intersection noted (see table 6). The voice of the male HV, when supported effectively within the workplace, was able to facilitate creative enterprise, yet oppressive practice at times left some men voiceless. Arguably, the lack of effective managerial input leaves male practitioners questioning the best course of action to take (Bouret, 2017; Chang and Jeong, 2021).

The 11 male HVs were accepted within their role by staff and clients on a day-to-day basis; however, a need to consider every contact due to their gender became apparent as the analysis moved on. For some (T1, T7, T8, T10) being accepted was noted as being known as a HV, proposed as "*gender neutral*" (T1 P6 L14-15), rather than a male HV. This narrative of being a HV recognised the professional connotation, whereas being a male HV could suggest the practitioner is lacking in some way. The notion of lacking here refers to being male thus lacking femininity and the ability to care within the altruistic nursing role. This gender role conflict in turn will affect the psychological wellbeing of men (O'Neil, 1981b). Interestingly, Liminana-Gras *et al.* (2013) studied 98 male and 98 female nurses of similar socioeconomic background in Spain and found that male nurses demonstrated diminished masculine gender norms and had better health than their female colleagues and male counterparts. Kluczyńska, (2017), Martinez-Moreto et al. (2021) and Mao et al. (2020) all report the

demonstration of heightened female traits, at times put forward as 'otherness' in order to fit in and negate the male gender role. There is a possibility that some men in nursing were not able to fit in with the gender role conflict that the role may have presented to them and as such they chose to leave. Luminana-Gras et al's (2013) study looks at men working as nurses in their role and does not look at those who have left. It would be interesting to explore if those who had left had diminished gender norms or not. O'Lynn *et al*. (2020, p.3) acknowledge O'Neil's (2018a&b) GRC theory, where control and constraints synonymous with oppressive practice operate adversely against those acting outside of the expected gender norms. The construct of GRC (O'Lynn *et al.,* 2020) sits well with my study as all 11 participants identified where gender impacted their practice to a greater or lesser extent. Despite T1 stating he was "*treated as a health visitor…never any question…gender neutral really*" (T1 P6 L12-15) he went on to add "*I felt that I would be judged…as the previous student (male)…is that to do with gender?"* (T1 P7 L11-12). Here it is interesting to note that T1 had not related his fear of being judged to his gender, even though the previous student who was negatively discussed in the office had been male.

Hsiu-Yueh *et al*. (2010) wrote that nursing had been considered women's work since Florence Nightingale's time. All 21 papers in the updated literature review (see appendix 19) discuss the feminisation of nursing within the rationale or introduction to the study supporting the initial literature review. Reporting that male nurses, as professionals, have double the attrition of female nurses and that job stress resulted in the significant impact of professional burnout for men due to role conflict and isolation with job loading being an issue for both sexes (Hsiu-Yueh *et al*., 2010). My study supported the findings of Hsiu-Yueh *et al.* (2010), as four of the 11 participants reported taking a significant time away from the role due to stress associated health issues. The narrative of constantly balancing the complexities of a female dominated career in nursing has been highlighted (Azadi et al., 2018; Blackley, Morda and Gill, 2019; Saleh et al., 2020; Qureshi, Ali and Randhawa, 2020 and Smith et al., 2020), together with the time and effort to be respected and recognised as a member of the nursing team (Shin and Lim, 2021). The stress for T2 resulted from his HV role impacting on his position as a father within the family home and the realisation that fathers were marginalised, demonstrating the complexities of gender role conflict (O'Neil, 1981a; O'Lynn et al., 2020; Azadi et al., 2018). T2 noted finding it unethical

as a professional to sell fathers false hope (see section 4.2.1). T3 struggled with his mental health and confidence following an allegation of sexual misconduct towards a client (see section 4.1.3.1), T4 had two breakdowns initially impacted by workload and moving bases (see section 4.4.3.1) and T5 reports being bullied and harassed by colleagues within the workplace (see section 4.1.2.4), all of which took an untenable emotional toll on the professional male HV.

During his training T1 was evidently concerned that he would be judged differently to other HV students due to his gender, particularly as a male HV student had been at the same placement before him and did not appear to fare well. Featherstone, Rivett and Scourfield (2007, p.183) highlight 'oppressive gender-based systems', that need challenging to allow men, women and children to engage in caring responsibilities rather than to conform to stereotypically engendered norms. This notion of a gender-based system is echoed in SOT2 regarding marginalised fathers (see sections 4.2 and 5.3). Oppressive gender-based systems are also highlighted in later studies (Saleh et al., 2020; Kalemba, 2020; Cheng et al., 2018), demonstrating that there is still a need to challenge these reductionist perspectives.

The traditional lack of opportunity for male nurses to work in some female orientated workspaces such as gynaecology and obstetrics or undertaking the assessment of women, can be viewed as in the interest of the female patients. For other male nurses this was seen as discriminatory as male physicians work in all areas (Saleh et al., (2020). Despite male nurses now accessing those areas and assessing women in some more progressive areas of the world (Smith et al., 2020), in other strong patriarchal societies there is a lack of progression per se or possibly a move backwards (Frimpong, 2016). Within my study, some male HVs (T3, T5, T9, T10), as part of the minority gender group, were subjected to discriminatory behaviour within the workplace (see sections 4.1.2, 4.1.2.3 and 4.1.3). In one team T9 was prevented from working with traveller families, advised that they would not want a male HV, yet he went on to successfully work with travellers at a subsequent location without any problem being raised (see section 4.1.2.3). Here developmental opportunity for T9 was stymied due to his gender. While in section 3.3.1.1, T3 was accused of sexual misconduct, that he raised would not have been likely if he had been a woman. Importantly there is a potential risk for service uses, such as a woman home-alone or with a young child, when being visited by either gender of professional. To enhance

the safety of vulnerable service uses the Disclosure and Barring Service (DBS, 2022) provides enhanced criminal record checks for employers at the recruitment stage. However, the inverse risk of accusation of misconduct for all professionals, has an implication for training (see section 7.1) including those who work alone within clients' homes. The impact of this emotionally traumatic experience caused T3 to take prolonged sick leave and on return change his style of communication as a means of self-preservation. Before the accusation T3 recounted forming a therapeutic relationship through terms such as

> "*chat to them normally…pick one issue to deal with…build that relationship…so then you can deal with the more contentious difficult issues*" (**T3 P6 L16, P7 L1-2**), but on return from sick leave his approach changed as he stated, "*my persona for several months did change…that way of talking to people…I dropped that…to the almost robotic way of speaking…to protect myself* (**T3 P19 L16-16, P20 L1**).

Inoue, Chapman and Wynaden (2006, p.563) echo this coping strategy noting their participants managed their feelings as a method of self-protection and icebreaking. Self-censorship was also highlighted as a method of positive integration toward self-protection for other male nurses (Bouret, 2017). The notion of self-protection resonated with T3, T7 and T5 to mitigate any misunderstanding, especially if using touch in a therapeutic caring way.

In the 2009 study of 308 male nurse participants by Jiunn-Horng, Hsing-Yi and Sheng-Hwang, they found emotional labour significantly impacted on career development which supports the findings in my study and emerged as the concept of vulnerability (see section 4.1.3.1). Delgado *et al.* (2017) explain emotional labour as every facet of nurse interaction, including where nurses are expected to act in certain ways at particular times when there is discrepancy between the situation and emotional investment, or prolonged emotional labour then burn out can occur. Constantly balancing the complexities of a female dominated career in nursing was highlighted as a way to lessen the risk of emotional burnout (Azadi et al., 2018; Blackley, Morda and Gill, 2019; Saleh et al., 2020; Qureshi, Ali and Randhawa, 2020; Smith et al., 2020). This time and effort through professional development and the evolution of self, extensive and constant balancing for some would be too arduous to endure, hence

the excessive attrition rates. Crucially, resilience can lessen the burnout from emotional labour but the emotional labour itself requires reduction (Delgado, 2017).

Vulnerability within the narratives of male HVs related to, in some cases, being in the minority starting with being the only man on the SCPHN (HV) course (T1,T3,T4,T5,T7,T9,T10)(see section 4.3.2), having to plan ahead, as all HVs would do, with the additional consideration of potential impact of their gender on the client contact when visiting females in the home (all participants), or potentially being judged because of their gender (T2,T3,T4,T5,T6,T7,T8,T9,T10) (see section 4.1.2.4). These findings are original contributions to the narrative around men who work as qualified HVs. Studies considering GRC (O'Neil, 1981a; O'Neil, 1981b; Stilson, O'Neil and Owen, 1991) note the psychological impact arising from nonconformance with the expected gender norms. Health Visiting as a career choice for men is considered nonconformist yet, as male HV participants are still in employment they appear to have negotiated a successful career path. Benner (1984) notes that proficient and expert nurses are able to negotiate a whole situation rather than separate events, thus improving service delivery through heightened decision-making practices.

Visiting anyone alone in their own home could be seen as an intimate act depending on the context. Inoue, Chapman and Wynaden (2006, p.560) write that intimate care comprises of 'care provided by nurses in all care settings and is defined as nursing care that involves psychological, emotional and/or physical closeness'. They go on to highlight that pre-registration nursing programmes lack education and support toward negotiating gender barriers when delivering intimate care (Inoue, Chapman and Wynaden, 2006). Despite the majority of the male HVs reporting they do not deliver intimate care, they are all expected to discuss relationships, domestic abuse, sexual health and personal physical and emotional wellbeing with end service users (NMC, 2008), that is private, personal, confidential and as such intimate detail. Providing female care requiring touch was concerning with potential stress with the opportunities for accusations of inappropriate sexual predatory behaviour (Guy, Hughes and Ferris-Day, 2022; Smith et al., 2020 and Blackley, Morda and Gill, 2019). Harding (2007) found non-sexual touch was fundamental to care. Globally, some male nurses are not allowed to deliver any care to women and definitely not able to provide therapeutic touch (Saleh et al., 2020). Herakova (2014) raises the point that touch as a comforting action between nurses and patients is construed differently for female and male nurses

adding that men planned ahead, making contingency plans where possible. This strategy was also highlighted by Inoue, Chapman and Wynaden (2006), sharing a participant's view of feeling uncomfortable if delivering care alone to a female and seeking a female nurse for a chaperone. Holyoake (2020), in his ethnographic study within CAMHS services reports the need to keep the door open and constant observation when working with vulnerable children and young people. If a contingency plan is required for all community contacts by male HVs, workforce planning will need to take this into account, which will not be easy with the present reduction in HV staffing numbers (Conti and Dow, 2021). This finding has an implication for practice.

The participants highlighted the toll of emotional labour, noting patterns of prolonged sick leave required to recover (T2, T3, T4, T5). Juliff, Russell and Bulsara, (2017) noted that if there were other men in their cohort or workplace it provided great support toward their ongoing nursing practice. The male HV participants valued support from the HV teams, and the support of positive leaders or managers appeared to offset some negative impact for T1, T5, T6 adding to the findings of Sheng-Hwang *et al*. (2013). Sheng-Hwang *et al*. (2013) highlight the increased citizen behaviour of male nurses resulting from good working conditions and supervisor support. Conversely Hsiu-Yueh *et al*. (2010) recount significant professional burnout for male nurses related to role conflict and the stress of the job, echoed by Bouret, (2017) and Chang and Jeong (2021) who raise the lack of support as an ongoing problem. Conti and Dow (2021) highlight that before the covid 19 pandemic, HV teams were managing extremely high caseloads, with some negotiating over 1000 per full-time member of staff rather than the 250 children recommended by the iHV (2021). HVs gave accounts of emotional labour including stress, exhaustion, panic and anxiety through their overwhelming workloads and a third highlighting they would quit if they could (Conti and Dow, 2020).

Importantly, where there was positive emotional labour and the potential for effective managerial support, then job satisfaction and career progression were increased, with higher professional empowerment (Jiunn-Horng, Hsing-Yi and Sheng-Hwang, 2009). These outcomes were echoed in work by Whittaker *et al*. (2013) who found managers who listened and made their employees feel valued were likely to benefit from increased staff retention. Notably, it will take the HV workforce some time to recover a staffing compliment that is effective enough to reduce pressure on the HV staff. In

my study it was apparent that one participant voiced a negative connotation regarding management causing him to reconsider his workplace. Asking for support goes against the male masculine norm of stoicism and subsequently not receiving support would add to emotional burden causing further GRC (O'Neil, 1981a&b; Tabassum and Nayak, 2021). Whittaker et al. (2013) and Jiunn-Horng, Hsing-Yi and Sheng-Hwang (2009), present a narrative promoting effective management, communication and a positive work environment toward feeling valued and the improvement of staff retention. It is important to note here that HVs are specialist practitioners working with a high level of autonomy and as such they manage their own immediate caseload and any skill mixed team (NMC, 2022c). Clarity of direction and support from managers is imperative to alleviate any unnecessary pressure.

6.4 The cultural marginalisation of fathers in England and the impact on male HV service delivery.

The cultural marginalisation of fathers in England and the impact on male HV service delivery (SOT2) was a serendipitous or unexpected finding within my study (see section 4.2 and appendix 16 Table B).

The reason for including this important SOT is twofold. Firstly, the HVIP (DH, 2011) and subsequent marketing materials gave an impetus to bring nurses with increased ethnic and gender diversity into the HV profession as part of the recruitment drive (Nursing Times, 2012). Critically, the issues that could arise through the further intersectionality of race, combined with gender were not highlighted (Frimpong, 2016; Qureshi, Ali and Randhawa; 2020) and planning ahead to help to mitigate barriers to workforce integration is prudent. The HCP highlighted the need for increased contact with families including fathers (DH 2009). A perception that health visiting was delivered by women for women, was noted as a barrier to the engagement of fathers (Page, Whitting and Mclean, 2008; Lee *et al*, 2011). This socialised perspective of gender roles therefore has a negative impact on the support for fathers through GRC (O'Neil, 2013). As such it seemed sensible that by increasing the number of male HVs, there was a potential to enhance engagement with fathers. Secondly, there was a notable elucidation for the male HV participants, as knowledge grew around their specialist role, and they noted the fundamental inequality for fathers regarding contact, information sharing and/or subsequent support from the HV service.

The stereotype of fathers, in line with HTM, as provider and leader has moved culturally within the UK toward a partnership approach of raising children including the advent of statutory shared parental leave (GOV.UK, 2022b). Inequity was found around the notion of inclusivity for fathers in that there is no national HV electronic record keeping system that includes the father from first contact with the family for the HV service. Male HVs who were also fathers experienced the vicarious lens of service users and noted the exclusive practice delivered by some female colleagues. Fathers experiencing domestic abuse was also raised a point of conjecture. The perceived marginalisation of fathers in England needs further research, discussion and action to improve engagement, their health and wellbeing and consequently that of their children (see recommendations/actions in section 8.1). There are further implications for fathers from black and minority ethnic (BAME) communities; however, this study does not have the scope to review all intersectionalities but acknowledges BAME fathers can face additional challenges (Thompson, 2018).

Within the participant narratives there was a pervasive undercurrent of men being sidelined within the field of mother and baby services both as staff and as fathers (see section 4.2). This research was not able to determine if the marginalisation of fathers is a wider children's services issue and will require further research to explore this notion. However, my research adds to the body of knowledge regarding marginalised fathers such as Paige, Whitting and Mclean, 2008: Lee *et al*, 2011; Donetto *et al*., 2013; National Childbirth Trust, 2015; Khan, 2017; Burgess and Goldman, 2018; HM Gov, 2021. Of note, families are growing in complexity with same sex couples, the potential for invitro fertilisation (IVF), surrogacy, adoption, multiple extended families and either of the parents actively choosing to lone parent. As such the notion of father used here could include other types of partners, in the context of being a principal care giver to the child. This research does not cover all scenarios, but the researcher is mindful, from experience, that the construct of family has evolved (HM Gov, 2021). However, fathers remain a prominent feature antenatally and perinatally, as noted here. Burgess and Goldman (2018) stress that 95% of UK births are registered by the mother and father together. Despite no formal invitation, the father attends the ultrasound scans and some antenatal appointments (Burgess and Goldman, 2018), with 90% of fathers in the UK attending their baby's birth (Redshaw and Henderson, 2013). This demonstrates paternal involvement from the outset. Stargel *et al*. (2020)

found in their study of 894 young mothers that the mothers were more likely to continue with an American home visiting service if the fathers were also signed up to the intervention. Despite this being an American study there is paucity of such studies in the UK and this study helps to illuminate the value that fathers bring to maternal engagement with services while enabling their child to meet their outcomes (Stargel *et al*., 2020). Fathers who are positively engaged have an important role in supporting the holistic development of their children that is unique to that of the mothers, especially regarding the child's psychological stability over time, communication and their ability to manage adversity (Khan, 2017; Grossmann *et al*., 2002).

Yet overall, Donetto (2013) found that fathers' engagement with the HV service was scarce due to their insufficient knowledge of the service, the scheduling of service provision and maternal dominated arenas and materials. T11 referred to contact with fathers being traditional and stereotypical in that the mothers were home, and the fathers were back at work and rarely seen. Yet it is known that the fundamental wiring of the baby brain, determining development of the prefrontal cortex, the nervous system to enable stress and emotional regulation and the ability to have socially accepted behaviour traits and form lasting relationships, relies on an emotionally attuned, available, committed, and consistent caregiver of any gender (Gerhardt, 2004; Shonkoff and Garner, 2012; HM Gov, 2021). Importantly Khan (2017) highlights the need to advise fathers early of the crucial legacy they can provide from their child's secure paternal attachment toward their long-term outcomes even if the parents may not cohabit. This knowledge has new implications for HV service delivery in that all fathers should be provided with this vital information and knowledge around child development during the antenatal period, and according to the male HV narratives fathers are rarely seen, negating the sharing of information with them.

Traditional male stereotypes are discussed by Lisa Arai (2009) in her book about teenage pregnancy. Within her work, Arai (2009) notes that the father's voice is seen as silent or overlooked, being positioned as irrelevant, while importantly the young father can be a protective factor to the mother and their children. Arai (2007) adds the young father's bond with the mother can determine their attachment to their children. Again, this demonstrates the importance of engaging with and including the fathers within delivery of the HV services as, if the parental relationship breaks down, the HV service can still engage with the father to ensure he is informed of developmental

expectations, safety issues, the immunisations schedule and positive parenting techniques as per the HCP (DH, 2009).

A significant original finding is the barrier to communication channels and sustainable interventions with fathers resulting from an inadequate national approach to record keeping. In section 4.2.1, T2, T3 and T10 highlighted the lack of acknowledgment of the father from the outset regarding their local HV service delivery. T3 raised concerns that some fathers were the carer at home with the baby, while the mother returned to work and that the record keeping system did not provide a facility for that scenario.

The narratives highlighted that there was no predetermined method for data collection or any specific computerised health record for the father, in which to record any contact, or lack of contact, contemporaneously (T2, T3, T5, T10). As such the health needs of the father were either not discussed or not recorded, as there was no universally accepted place in which to keep a record of such a discussion and/or subsequent intervention. From experience there is the potential to 'pull through' a father or partner health record in the computerised record keeping system but this requires time, commitment, and consent from the individual. Rectifying this anomaly at source, by an adjustment of the electronic record keeping software, is a recommendation going forward as this could bring a significant impact regarding the inclusivity of fathers. This lack of clarity within the health record regarding fathers could have been why T10 received feedback in his local research that "*the fathers were not part of my caseload"* (T10 P16 L11) from one of the local senior HVs. If fathers are to contribute positively to the wellbeing of their partner and child, they need to be included in commissioned health services as a routine metric for capturing impact of the HV service delivery. This new knowledge builds on the voice of a service user study that is outlined below (Donetto *et al.,* 2013). The missed opportunity to capture the fathers' information on the electronic record keeping software would not have been illuminated in Donetto ***et al's*** (2013) study as the service user would not have known of this service provision and record keeping anomaly. Therefore, my study has provided this original contribution and new knowledge.

Donetto *et al.* (2013) highlighted that fathers did not know much about the HV service and that the service on offer was aligned with the mother, with inaccessible clinics and groups for fathers due to poor timing. The engagement with the fathers was complex

during HV contacts as the fathers would choose to engage or not, dependant on the mother, HV and/or father's preference. A notable creative approach to engaging with fathers was taken by the male HVs in my study by arranging contacts when fathers were available, setting up fathers' groups and altering the organisational letter template, that traditionally introduced the service to the mother in isolation, all to increase the inclusivity of the father.

However, this narrative of men requiring support goes against the HTM notion of strength and power, leading toward not only depression, but the added risk of suicide (Coleman, Feigelman and Rosen, 2020). The notion of 'wimp' is discussed in work on young masculinities by Frosh, Phoenix and Pattman (2002, p.59) noting that at a young age the girls disliked the 'emotionally leaky boys'. This terminology could be deemed outdated and critically does not help men to have a voice and be in tune with their emotions but has some commonality with the narrative experienced by T5 in section 4.1.2.4. With the evolution of the stereotypical or traditional fatherhood role moving from the notion of 'bread winner', providing financial stability for the family, toward that of being a partner in the upbringing of the children, more awareness has been raised regarding paternal MH issues (National Childbirth Trust (NCT), 2015). Baldwin *et al*. (2021) propose a proactive approach to engaging fathers through the use of a Promotional Guide tool and give a logical rationale moving from policy and training through face-to-face contact with fathers offering identification, support, intervention and resources toward improved paternal mental health and to reduced negative cost for society. Their study gave insight into the discrepancy of fathers' experiences across midwifery and HV service provision and their transition to fatherhood (Baldwin et al., 2021). Most fathers had not been asked about their own mental health as the mother was deemed priority (Baldwin et al., 2021). The fathers would welcome the ability to build a relationship with a consistent professional and be given information related to groups where they could meet likeminded others (Baldwin *et al*., 2021). Importantly from the perception of male HVs in my study and the fathers in the Baldwin *et al*. (2021) study, services are lacking for fathers. Therefore, the Government and local commissioners will need to be the catalyst for such change to happen, especially following reports of unprecedented service provision cuts that are still impacting HV service delivery following the Covid-19 pandemic (Best Beginnings, Homestart and Parent Infant Foundation, 2021).

Further gender stereotyping of masculinity was highlighted in the narrative of T5 and T6 regarding fathers sustaining domestic abuse (see section 4.2.3), especially for T5 where his female colleague negated a disclosure of domestic abuse from his partner. The evidence that twice as many women reported partner abuse than men 2017-2018 and many victims still do not report domestic abuse at all (Office for National Statistics (ONS), 2018) should mean that all disclosures from men and women are taken seriously, supported at source and assisted to take the matter further. For T6, a father had a restraining order against a female perpetrator demonstrating that action can be and will be taken against perpetrators of this crime and as such all disclosures should be taken seriously. A recommendation here would be to review training materials on gender-based violence to ensure that fathers as partners are also highlighted as potential victims within the context of child and family services.

Khan (2017) highlighted social, cultural, and ideological systems intersect, causing the lack of engagement of fathers and recommended early support, toward building fathers' capabilities, through policy and practitioner intervention.

The intersectionality of being a father and a male HV (FaHV) revealed critical introspection from four participants on their personal experience as a recipient of the HV service (See section 4.2.1). The experience of HV intervention had a notable effect on the HVs, those who were fathers, to a greater or lesser extent. One FaHV felt pushed aside during the HV new birth contact in his own home, the second FaHV recounted having his baby grabbed from him by a female HV in the clinic, the third FaHV described discriminatory practice against fathers and the fourth not receiving as much information as he would have liked as a father. One of the FaHV even chose to leave the profession due to personal elucidation that the intersectionality of the social, legal and cultural processes in the UK supported an inequality for fathers, in favour of mothers. This insight provided a significant discrepancy against his own moral and ethical positionality. He expressed the irony as he had been providing support groups for fathers and yet he would not be able to influence the policy or change practice to enable other fathers, or himself, to parent if the mother decided against that. Khan (2017) reflects the FaHVs' realisation here, highlighting barriers to effective fatherhood such as social constructs, legal and public policies, workplace orientation, cultural and institutional ideologies. A juxtaposition here is the need to revise policy, that has traditionally focused on fathers continuing to provide financial support to their children,

to include the promotion of time toward positive father child emotional interactions (Khan, 2017). In contrast, if there is heightened parental conflict and the father is unsupportive then the children could be impacted negatively (Khan, 2017). Therefore, there is need for scrutiny to ensure the balance of any parental/carer interaction, regardless of gender, is always in favour of the child's best interest (Khan, 2017; HM Gov, 2018a).

Raising the issue of parental leave, T3 expressed men can share paid parental leave to care for the baby in the UK (GOV.UK, 2022b), which was much needed in his locality due to higher level of unemployment and more mothers returning to work than fathers. Scott and Brito (2022 p.129) concur advocating for 'accessible, flexible and equitable' paid parental leave that will enable cognitive, physical and social development within the home environment through consistent constructive parental input. The issue of paternal parental leave is important here as the implication of restricted leave was that the fathers were seldom seen by HVs per se. During the HVIP (DH 2011), male HV students were proactively recruited (Ford, 2012) against a narrative of engaging fathers, yet specific HV services such as groups for fathers had stopped locally for T3 and T5 due to low attendance numbers, lack of engagement and/or the children centre closure. T7 acknowledged his organisation were trying to engage with fathers but no other participants mentioned any type of specific service for fathers. T3 highlights that for those fathers who did use the shared parental leave, rather than the mother, there was little to no service that was father and child focused or they could attend. The notion of group work delivery demise whenever financial cuts are made was borne out across all eleven participant transcripts, leaving a question on the value placed by the commissioners of proactive public health intervention to support the wellbeing and outcomes of children. It was noted by the participants that connecting with fathers also allowed the chance to discuss male health issues such as prostate cancer. When T5 provided pin badges to highlight and support raising awareness of prostate cancer it was met with controversy by one of his female colleagues who reported this was not within her role. It is clear that as a public health specialist there is a remit to support a stable home environment through health promotion activity (PHE, 2020a, 2020b & 2021). Within a systematic literature review looking at men seeking help for health, it was found that traditional masculine beliefs caused delay for men with ill health seeking information and service support (Galdas, Cheater and Marshall, 2004). In my

study, some fathers reportedly found it useful having a man to talk to, as an advocate and role model (see section 4.2.2). This finding is important and would benefit from further investigation.

While writing up this study the 'build back better' government commitment introduced the notion of family hubs to support the 'Best Start for Life' offer, while the narrative is supportive of children, families and particularly mothers there is acknowledgement that fathers need a voice to influence service provision, access to support and inclusive information (HM Gov, 2021). It is too early in the development of the start for life offer to comment on future impact, but it will affect the HV workforce going forward and link to SOT3 progressive career choice (see section 6.4).

6.5 Progressive career choice

When referring to progressive career choice there was a need to consider the associated career transition points. The transition points under consideration here are preparation for moving from education to the workplace, choosing nursing or midwifery as a career choice, transitioning from a qualified nurse/MW professional to the SCPHN (HV) specialist student, moving into a SCPHN (HV) area of work and ongoing career trajectories (see section 4. 3 and appendix 16 table c).

When referring to working in a female dominated workforce such as nursing or midwifery and subsequently health visiting, consideration of traditional masculinity and GRC (see sections 2.0 & 6.2) is required to identify how more men can be attracted into the female orientated profession of nursing and/or midwifery and subsequently health visiting.

6.5.1 Moving from general education into Nursing or Midwifery

Attracting men into nursing/midwifery and subsequently health visiting has fundamental issues including firstly the lack of careers advice within the UK and other international education systems (Azadi et al., 2018; Blackley, Morda and Gill's, 2019; Guy, Hughes and Ferris-Day, 2022; Kalemba, 2020; Kluczyńska, 2017; Qureshi, Ali and Radhawa, 2020) and secondly masculine stereotypes perpetuating GRC (O'Neil, 2018a). Whittock (2003) professed a lack of careers information toward nursing as a profession for young men. Importantly, none of my research participants were advised of nursing as a career choice within their compulsory education, which would have

been mandated from age five to sixteen for their specific school years. However, more recently, in 2015, compulsory education in the UK was extended to age five to eighteen years, meaning all children had to remain in some form of education or training from sixteen to eighteen years of age (Education and Skills Act, 2008). While many children remain in sixth form style education, be it a school or in college settings, others embark on advanced apprenticeships, comparable to two 'A' levels with twenty percent off the job learning, resulting in being paid to learn (UCAS, 2022a). Amongst the plethora of sectors, on the UCAS (2022b) website sits Health, Public Services, and Care within which there are a broad range of job roles. However, the industry guides are then broken down into subsections including medicine, dentistry and nursing or public health, social care and childcare services. HVs are qualified nurses and/or midwives who are registered with the Nursing and Midwifery Council (NMC) regulatory body and have undertaken additional, Specialist Community Public Health Nursing, training at degree or masters' level (NHS Careers, 2022). As such, the HV career pathway crosses the two industries respectively and would be unclear to pupils choosing their subject options for subsequent examination (UCAS 2022a & b).

The NHS Careers (2022) website is somewhat clearer discussing educational requirements, how and where to apply, general job roles and the variety of employers now in the marketplace that was traditionally occupied by the NHS. The nomenclature is also problematic as the term HV, that was traditionally used denoting the public health aspects of the role, was changed in line with revised education and professional body registration requirements, to SCPHN (HV) (Adams, 2012; Baldwin, 2012). However, SCPHN (HV) as a working title never gained traction within the community setting, with the public or other professional colleagues. This ongoing confusion for prospective applicants is apparent in the NHS Careers (2022) website, where the title HV is used in the first instance and subsequently the terminology SCPHN (HV) is explained, as the course to be studied toward qualifying as a HV. While sifting through the complex websites can compromise both genders from discovering that nursing, midwifery or heath visiting could be a career for them, it is important to note the missed opportunity to attract men into health visiting, within the NHS careers (2022) and the UCAS (2022a&b) website information, as none of the sites highlight the case for a diverse HV workforce that includes men to meet the needs of the diverse population.

6.5.2 The choice of Nursing or Midwifery as a career option

Within my study, nine of the eleven participants, chose nursing or midwifery as a later career choice. There was a discourse of a flexible workplace, giving something back and doing something worthwhile, these important strap lines could be used toward attracting men into the nursing and HV workforce. The second career choice was also a strong narrative in the updated literature review for a variety of reasons including an altruistic perspective (Frimpong, 2016; Juliff, Russell and Bulsara, 2017; Blair, 2016. A more pragmatic decision of acquiring a 'green card' for entry into Australia was given by T9, although he never went and as such the workforce gained one more male nurse and subsequent HV. Interestingly, Kluczyńska's (2017) Polish study highlighted a similar perspective, with participants voicing opportunities to move abroad to work as a nurse upon qualification.

None of the HV participants chose nursing or midwifery as a route to ultimately become a HV as a long-term goal. Through my positionality as a HV, PT and latterly a HV pathway lead within the HEI, some female HV applicants have expressed starting their original nurse/midwife training with the goal of becoming a HV in the long term, usually from their experience of motherhood. Critically this raises recruitment potential related to negating the marginalisation of and striving toward engaging fathers as a way of highlighting nursing, midwifery and ultimately health visiting as a potential career choice (see section 4.2). Further recruitment potential could be realised by targeting men already established in the workplace who are looking for a change in career direction. This notion was also reflected in my pilot study (Le Blond, 2016) where participants recounted how they came into nursing as mature students, having worked in a broad range of occupations.

6.5.3 From qualified Nurse and/or Midwife to Health Visitor and beyond

Interestingly, all participants shared openly their reasons for choosing to move from being a nurse/MW to become a HV and were frank about their disillusionment with the absence of consistent care giving, constant pressure and the lack of role or career progression opportunities. The openness of the participants was stark as having been involved in the recruitment of student HVs for around ten years at the time, no students ever openly reported their reasons for leaving their previous post. The potential students proactively chose to highlight that they wanted to enter the profession of HV

for altruistic reasons. With reflection, being negative about a previous workplace in an interview would be deemed unprofessional but importantly, when trying to improve retention, it would be prudent to interview leavers six to twelve months later, to allow for the clarity of hindsight rather than immediate emotionally reactive responses. This could help to reframe experiences and to build effective recruitment and retention plans. Herakova (2012) stresses the need for a sustained effort to recruit men into nursing as nursing shortages have a national and global implication. A recommendation to increase community SCPHN-HV placement exposure to preregistration nurses would increase knowledge of the hidden HV workforce (see section 4.4.1). Positive inspiring HV placement experiences influenced T3, T4, T7 and T8s' career progression into the HV profession. Although, T10 had a HV placement that he found boring, and he applied for the role on impulse, as he recognised the opportunity for increased autonomy, again this notion as a key selling point could be used for recruitment purposes. Here the importance of providing a positive spotlight on the working and learning environment, that inspires learners, is crucial to influence recruitment and retention of the future workforce. Jerome (2013) supports this notion highlighting the ongoing relevance of Maslow's hierarchy of needs in valuing people within organisational culture to improve performance. This same organisational culture was also noted as a barrier to sustainable developments across the NHS due to the need for sustained and substantial leadership and increased staff engagement (Ling *et al*., 2012). Internationally an intersectional perspective of race and gender provided additional barriers in some countries toward career progression and for male nurses and this type of discriminatory practice should be routed out in all areas (Frimpong, 2016; Kim and Shim, 2018). However, the consideration of the ability of those who did not progress is important, as different individuals will have various levels of knowledge, skills and attributes (Benner, 1984).

Conversely, other men working as nurses had opportunities and advantages afforded to them, sometimes in the same study (Frimpong, 2016) (see section 5.3.1.2). The notion of a glass escalator passing seamlessly through the different levels is attributed to male nurses entering higher level job roles more readily than female nurses (Williams, 1995; Blair, 2016; Chang et al., 2018). While others received different advantages such as increased respect due to their gender (Smith et al., 2020; Salah et al., 2020; Kluczyńska, 2017). Within my pilot study the six male nurse participants

were all employed within the HEI setting teaching others (Le Blond, 2016). Being a lecturer is deemed as a higher-level role attracting increased finance and further career development and progression. However, it can be argued that higher level qualifications are expected to progress within an HEI, incurring extensive commitment to study, which could be aligned with personal attributes rather than gender.

6.5.4 The male Health Visitor student and the Specialist Community Public Health Nursing programme (Health Visitor): Training to be a Health Visitor

From having undertaken and subsequently led the HV programme personally it was no surprise to hear all eleven participants voice their recall of the commitment and tenacity required to undertake the intense SCPHN-HV programme of learning (NMC, 2004a). Over the years the professional regulation, preparation, and standards of proficiency for health visiting has moved the recommended length of the programme from a year to at least 32 weeks and back to a year (NMC, 2004a; iHV, 2022). The latest standards for education and training for post-registration programmes (NMC, 2023b p.13) state the programme should be at least 45 programmed weeks, equating to a year when annual leave is factored in, mirroring the time scale experienced by most HV participants in this study. All participants in this study expressed that the SCPHN programme length was enough or could have been longer, to account for the complexity of content and knowledge acquisition required. Some (T4, T6, T8, T10) implied that the high course content almost broke them and T4 added he would not repeat the course again. Yet all participants acknowledged the SCPHN-HV programme provided the fundamental knowledge and experience, but the real learning happened as a newly qualified practitioner, a notion echoed in research undertaken by Henshaw (2021) looking at the transition of qualified practitioners to the HV role. Wesson (2012) adds, the frustration felt by qualified practitioners having to move back to the novice stage (Benner, 1984) when entering a new role was tantamount to reversed transition shock (Duchscher, 2009). Despite the pervading narrative of rising to the challenge of completing the ‘tough’ HV programme (T8), all participants acknowledged the array of skills and knowledge they had exited the course with.

Most of the male HV students did not raise the issue of being in the minority while on the SCPHN-HV course. However, being a lone voice during the HV training and later when qualified (see sections 4.1.3.2 & 4.2.2) caused isolation for T2. Theorists (Inoue,

Chapman and Wynaden,2006; Smith et al., 2020; Shin and Lim, 2021; Azadi et al., 2018) acknowledge this sense of male participant isolation from female clients and nurses, both in the education and placement setting, suggesting that gender diversity should be taught in the classroom and clinically based support services should be developed for male nurses. This inclusive approach would help to combat the GRC (O'Neil, 2018a&b) pervading the male nurse experience. The context of the gender related education could be a barrier, as while gender issues relating to service users are high on the equality and diversity agenda, the gender implication for the professional in this case male, delivering care may not be in the spotlight. A future recommendation would be to include scenario-based work on mindfulness '*of* and *for self*', while delivering compassionate care to others. Petit and Stephen (2015, p.7) highlight the value of promoting resilience for HVs and the HV workforce and in their literature-review identified 14 models that could support compassionate self-care including, 'supervision, mentoring, coaching, courageous conversations, relationship-based models, action learning, performance feedback, interagency/disciplinary groups, peer support and compassionate resilience.' While these models may be in place in some areas it is unlikely that the time can be prioritised to engage regularly with what would be in the long-term, a beneficial health enhancing activity, while the HV workforce sustains unprecedented workforce shortages (Conti and Dow 2020, 2021). However, by exposing the student via a two-pronged HEI and practice approach, to the compassionate resilience model suggested by Petit and Stephen (2015), a cultural shift can gather momentum and evoke change. Building communities of practice will be important to foster support networks, develop knowledge exchange practices and influence policy, this is especially important when considering the isolation noted by some male HVs (see section, 4.3.1.2) who from the outset may be the only male HV student on the SCPHN programme.

A further issue raised by the participants was female orientated course content. Despite the SCPHN-HV education programme covering a broad range of subject matter both in the HEI and practice setting (NMC, 2004a), some participants (T6, T7) resorted to looking up what they referred to as basic female orientated knowledge that they lacked due to being a man. Information related to the menstrual cycle, family planning and childbirth were mentioned as lacking within the course content. This narrative has future implications for further training on women's health issues and also

on paternal MH issues in line with section 6.4. This finding concurs with other studies that have identified female gender bias related to the programme delivery style and study materials (O'Lynn, 2004; Whitfield *et al*., 2019). O'Lynn (2004) developed an Inventory of Male Friendliness for Nursing Programmes (IMFNP) that would be good to use within highly female orientated programmes such as health visiting and midwifery to see the orientation toward being male nurse friendly. Relating back to general education and the missed opportunity to inform boys about a potential career in nursing (see section 5.4.1) there is also an argument to ensure boys are educated about menstruation and childbirth. In their study on the school nurse management of questions within primary school sex education, Piercy and Hayter (2004) found that the teaching around the menstrual cycle took place in a girls' only session. As highlighted above this single sex approach later became a barrier for male nurse students in the classroom.

6.5.5 Supporting Education in the Practice Area

The participants generally found the support they received within the practice area helpful, with good role models who were empathetic to their learning needs (T1, T3, T4, T7, T8, T9, T10, T11, and see section 4.3.3). Within the NMC SCPHN programme standards (NMC, 2004a; 2022c) there is a requirement that 50 percent of the programme will be spent in the specialist field that the student is working toward, be it health visiting, school nursing or occupational health nursing. Traditionally within the community setting there were community PTs (CPTs), later known as PTs or Practice Educators (PEs) in line with the NMC (2008) Standards to support learning and assessment in practice (SLAIP). As such, qualified experienced HVs could do a post graduate programme of study and record this qualification locally as a PT or complete a Post Graduate Certificate (PG Cert) of Education to register formally with the NMC and locally as a Stage 4 NMC Teacher. This qualification provided HV practitioners with the opportunity to develop knowledge, skills and attributes around education of the specialist practitioner, with leverage toward career progression and a potential pay increase. This narrative sits alongside the theory of novice to expert where initially students have close access to a mentor/supervisor/knowledgeable other (Benner, 1984), to support their learning within the practice setting. In the case of SCPHN HV students this knowledgeable other need to be a specialist within the same field of HV

practice, particularly when it comes to assessment and the signing off of competency (NMC, 2018b) and proficiency (Benner, 1984).

A crucial aspect of the PT role was assessing the student SCPHN at a higher or advanced level, beyond that of pre-registration nursing. The expertise of the PT was multifaceted including role modelling, leading the placement experience and facilitating learning (Wesson, 2012). This would be the case for all HV students being supported by a PT, however, in the case of the male HV student there would be a need to offset the potential for 'otherness' and mitigate barriers to learning, the skills that would have been expected from an NMC (2008) stage 3 PT and stage 4 Teacher.

As stated, traditionally student HVs were supported by PTs on a one-to-one basis over the length of the SCPHN-HV programme (NMC, 2004a, 2006, 2008). However, with the HVIP (DH, 2011) and the sudden growth of HV students in the practice areas, there was a move to facilitate a 'long-arm' model of practice support such as an overarching PT role, with the direct support to students given by mentors. There were a variety of adaptations to this 'long arm' model with some PTs retaining traditional teacher student support in practice, some relinquishing caseload work, some having the student in the same placement and others giving 'long arm' support to the student(s) and mentor(s) over wide geographical areas. The NMC (2011b) circular 08/2011 stated that 'all PTs must be in clinical placement and carry a clinical caseload' but did not propose student numbers, rather supplying an eight-point list for consideration by the NMC approved HEI, in line with their accountability and responsibility. Whittaker *et al.* (2013) concurred stressing the importance of HV-PTs retaining currency within the practice area when supporting students to ensure the best evidence base is shared. However, Wesson (2012) highlighted that despite the PTs acknowledging their critical role in teaching the specialist students, competing demands left little time for crucial elements of learning such as guided reflection, that is critical when learning a new role and working across complex caseloads. The NMC (2008) SLAIP educational standards provided a four-stage developmental approach for nurses and midwives to support the learning and assessment across the practice settings for the variety of nursing students. An important aspect, in my view, of these standards (NMC, 2008) was the need to be qualified and registered with the NMC and on the same part of the register, for two years before taking on the educationalist role of a PT to support a SCPHN student. This approach ensured some level of experience

for the PTs working across an interprofessional arena to be able to construct an appropriate learning environment and adapt effectively to change, while making judgements related to the HV students' specialist competence and proficiency (NMC, 2008). This narrative sits well with Benner's (1984) theory, as becoming proficient within the higher-level specialist HV role before becoming a PT would allow for effective sharing of knowledge and facilitation of learning with the specialist students.

Critically the NMC (2008) educational standards, have been superseded by the NMC (2018b) Standards for Student Supervision and Assessment (SSSA), and have met the goal of opening up more placement opportunity. However, they appear to be focused on preregistration nursing and midwifery, through a more generic approach, rather than supporting and assessing the higher level of practice associated with the SCPHN practitioner. Section 6.5 (NMC, 2018, p.9) includes the only specific reference to the SCPHN qualified assessor having appropriate equivalent experience for the student's field of practice, as such there is no mention of the amount of experience or underpinning knowledge related to learning, teaching or assessment approaches for specialist practice. Wesson (2012) highlighted the concern around the dissonance between university and employer approaches that provided conflicting lenses of either nurturing a future capable workforce or training to meet specialist areas of competence both of which were compounded by limited budgets and resources. This point of conjecture is now further compounded by the lack of regulatory body expectation for supporting specialist students within the present educational standards (NMC, 2018). Henshaw's (2021) study highlighted the significance to positive support from the PT's and mentors in relation to their student HV journey. Unfortunately, there were no male student HV's in the study by Henshaw (2021). The PTs in my study were generally praised for their nurturing approach, through positive role modelling, relationship building and reflexive approaches to teaching, learning and assessment, that met the needs of the learner (see section 4.3.3). One participant (T3) reported having to move placements as his first PT could not see the value in teaching him, as she believed that as a male HV he would move quickly into management. This perspective echoes the findings of the literature (Williams, 1995; Blair, 2016; Chang et al., 2018; Frimpong, 2016), where the perspective pervaded of male nurses being afforded advantage of higher level or managerial roles due to their gender. This discriminatory approach is underpinned by GRC (O'Neil, 1981a) and is unhelpful toward supporting student

learning. The latest NMC standards for education (NMC, 2018b) split the supervisor and assessor roles to provide further subjective opinion before determining objective assessment of competencies. The devolved roles of supervisor and assessor (NMC, 2018b) may well have been supportive of T3, as if the supervisor was not offering an inspiring placement environment T3 would still have the opportunity to access his assessor and visa-versa.

The notion that men automatically climb the notional career ladder and become managers by right of gender, will be discussed in the following section.

6.5.6 Ongoing Health Visitor Career Trajectories

It could be argued that becoming an academic (all six pilot study participants, (Le Blond, 2016)) or HV denotes a higher-level of practitioner who has undertaken further study beyond that of initial nurse/midwife registration and as such the participants had moved up the career ladder. The predominant narrative from the male HVs was despite being encouraged or expected to take on a managerial role they strived not to do so. Not wanting to go into management could be explained by many of the male HV participants voicing their wish to care (see section 5.3.2.3), implying the retention of direct client contact. Within the literature review some male nurses negated the opportunity for promotion as this would affect their potential to earn additional income through overtime payments and fulfil their role as ‘breadwinner’ (Blair, 2016; Azadi et al., 2018). This picture would not be the same globally as some countries operate agency and bank nurse systems where nurses can opt to undertake further shifts.

Being a HV requires complex management of the caseload, skill mix team and relationships across the child and family multiagency teams with regard to leading the HCP (DH, 2009; PHE, 2021a). The progressive universalism of the HCP (DH, 2009) requires the HV to assess, diagnose and provide therapeutic intervention or advocate for children aged 0-5 years, who are vulnerable by nature, to greater or lesser degrees, to identify and as required escalate children in need of services or safeguarding to fulfil the requirements of the HCP (DH, 2009; PHE, 2021a) and ‘Working Together’ guidance (HM Gov, 2018). Importantly, the participants did not seem to align their SCPHN work with their notion of management. Benner (1984) would term this level of HV practice as proficient to expert due to the insightful adjustment to planning as complexities of caseload management arise. The expert (Benner, 1984 p.32) HV

would use intuition based on an extensive range of experiences over time, demonstrating ‘perceptual certainty’.

Researchers (Liminana-Gras, Sanchez-Lopez and Javier Corbalan-Berna,2013; Juinn-Horng, Hsing-Yi and Sheng-Hwang, 2009; Frimpong, 2016; Bouret, 2017; Cavayé, 2020; Kalemba, 2020) highlight paternalistic traditions of role division influencing men moving into higher level job roles, ‘ladder climbing’ or riding the ‘glass escalator’, away from the more feminised caring aspects of the nursing role, despite being in the minority and at times holding less qualifications and/or experience. However, discrimination related to the intersectionality of race and gender caused an inertia or even (d)escalation in career progression for some male nurses (Frimpong, 2016; Cavayé, 2020). Despite none of my participants acknowledging ladder climbing as something they had experienced per se, some talked about the positive discrimination they experienced when being accepted onto the HV programme of study that was related to the HVIP (DH, 2011; Ford, 2012). Two male HVs had moved into higher level specialist management roles and three of the eleven participants were qualified PTs.

There was a notion of once being established as a HV there were two progression routes available, either going into management or becoming a PT. One HV said he would want my job and to work in education, but this was out of his reach demonstrating a lack of knowledge regarding working within the HEI setting. Some HVs talked about the lack of career progression they had found as a HV and that they had hit the ceiling of the HV career pathway.

The role of HV-PT is traditionally seen as a career progression point, that would have required further training (NMC, 2008) to work at a higher level to that of the general HV workforce with a prerequisite of a minimum of two years of experience. Historically upon successful completion of the PT qualification, PTs would apply for a named substantive role, that attracted a higher pay band, although in more recent times this has been challenged with financial cuts and the change to the educational standards (NMC, 2018b). However, the demise of the PT role across community nursing including all SCPHN and specialist practitioner qualifications (SPQ), district nursing for example (DN), met with national opposition. The Queens Nursing Institute (QNI, 2021) have taken forward the need to ensure quality of education and to assure an

advanced level of assessment of specialist post registration students, to ultimately protect end service users. To meet this goal the QNI undertook a national survey and focus groups, subsequently publishing the PT standards January 2023. I was a member of the QNI Standards Advisory Group working toward the production of the PT Standards (see appendix 18 & QNI, 2023) and my research has been fed into these national discussions. The demise of the PT role notably raised concern for the quality of SCPHN and SPQ education in the community practice setting and also put an end to the career development route that the PT role gave for experienced HV, DN and other advanced practitioners that could affect the retention of these experienced specialist professionals. The negative experience of T3 related to his PT discriminatory input should be negated through the QNI (2023 p.4) Standards for Community Practice Teaching Education and Practice that expect a cultivation of anti-racist and anti-discriminatory behaviour. Although this narrative sits within the clinical care domain it is important to note anti-racist and anti-discriminatory practice in all areas of professional health care practice.

The importance of providing appropriate support to students with robust assessment, that is equivalent to the specialist students' level of learning, cannot be understated and should help to ascertain the student's competence and capability (Wesson, 2012). There is also a need to assess professional suitability and fitness to practice, toward potentially mitigating the disproportionately higher professional misconduct sanctions against men on the NMC register. Loughrey (2008) highlights that 60% of those struck-off the register were male, with the majority being attributed to physical abuse. It was difficult to ascertain the gender division within the latest NMC report of hearings; however, when randomly selecting NMC regulatory body hearings for January 2022, seven of nineteen 'striking off orders', with an interim suspension order covering the appeal period, were men (NMC 2022b). There was no presented suggestion as to why there were more men than women who were nurses ultimately struck off. It would be useful for the government to support funding to investigate why the numbers of men facing disciplinary regulatory body proceedings continues to be high year on year in order to mitigate as this could be another factor that effects recruitment and retention of male nursing staff.

All 11 participants talked of demanding workloads, with four taking prolonged episodes of sick leave due to depression (see sections 4.1.3.2; 4.1.2.4; 6.3). Emotional burn out

and stress, due to role strain, taking a psychological toll on male HVs was mirrored in male nurses (Cottingham, 2015; Cheng et al., 2018; Cavayé, 2020; Bouret, 2017). Parton (2020) acknowledges that stress is causing HVs to leave the profession; a notion supported by the iHV (2018), stating 72% of the work force reported rising stress levels. Male HVs must consider their gender throughout their HV working lives as a point of otherness which if unsupported can lead to isolation and or burnout akin to male nurses (Dyck *et al*., 2009; Hsiu-Yueh *et al*., 2010; Herakova, 2012; Qureshi, Ali and Randhawa, 2020; Martinez-Moreto et al., 2021; Mao et al., 2020) and subsequent attrition (Salamonson *et al*., 2014; Parton, 2020). Of note some male nurses reframed their experiences as a coping strategy to mitigate their stress (Kluczyńska, 2017; Cottingham, 2015; Shin and Lim, 2021).

Whittaker et al. (2013 p.36) highlight that the 'perceived availability of developmental opportunities' will help to retain an experienced HV workforce. Importantly, within health visiting there were two notional paths for career progression, either moving into management (T5, T10) or education as a PT (T1, T7, T11) (see section 4.3.4). As the PT career pathway to progression ceases and the realisation of hitting the career ceiling (Frimpong, 2016) pervades there could be further attrition within the HV workforce as experienced professionals seek out a new challenge with a higher pay scale (Brook, Thurtle and Murray, 2019).

6.6 Evolutionary Health Visitor practice and eclectic workload demands

The SOT 'Evolutionary health visitor practice and eclectic workload demands', resulted from the subsumption of four themes (see section 4.0 table 6 and appendix 16 table D). Acknowledging the notion of time in relation to the evolution of HV practice gives a perspective of cultural and political changes and the impact on HV numbers, services and delivery (see conceptual framework section 5.1 Fig. 4).

This study provides a historical account of the role of the HV, identifying the engendered context (see section 1.2). This section would benefit from the highlights, as a precursor to the following discussion. Emanating from the Manchester and Salford Ladies Sanitary Reform Association (Baldwin, 2012), the HV, public health focused and community facing service, has seen shifts in the orientation of provision and delivery since inception. Originally noted as respectable women working predominantly with mothers with a focus on improving public health (Peckover, 2013).

This engendered narrative would have precluded men, from choosing health visiting as a profession of choice. Initially sitting within the LA, HVs were moved over to the NHS in 1970 and remained listed within statute, as a standalone profession before the HV register officially closed in 1997, as HVs had been amalgamated with seven other PH nursing professionals, listed as Specialist Community Public Health Nurses (NMC, 2020) (see appendix 17). More recently, in October 2015, the HV service has been relocated, and is presently commissioned by the LA (Public Health England, 2018). While the majority of HVs have remained with their original employers, there are a variety of employers in the marketplace including LA, social enterprise and private companies. The complexities of commissioning and provider organisations are not within the scope of this research but the impact and perceived extensive ripple effect on HV service provision were apparent throughout the participants' narratives and the recent reports of Conti and Dow (2020, 2021).

The demography of the nurse, MW and HV workforce numbers were presented in section 1.4 and here the changing focus of service delivery, commissioning and regulation will be discussed.

The length of time worked as a HV and the geographical area covered presented a range of experience and skills within the male HV narratives. This fits with the findings of Brook, Thurtle and Murray (2019) who note that the longer HVs had been in the role the more likely they were to stay. This is possibly because of time and experience they were deemed as proficient or expert in their HV field of practice (Benner, 1984).

The contrasting approaches to caseload management over time and across England were stark. Service delivery transformations included moving from a 'birth to grave' PH approach to an under-fives service framework; individual HVs covering GP attached and/or geographical orientated populations, when clients were not registered with a GP, and the introduction of corporate teams with or without a skills mixed team working within a health or interagency children centre setting.

As the participants had a range of experience over various time frames, they recounted their vast insight of the reshaping of the HV service provision and the subsequent impact on HV service delivery and their working practices, from this rich data the narrative of evolutionary service delivery developed. Adams (2012) highlights that the changing political landscape has, over the years, influenced and precipitated

ongoing change across the HV service and delivery. The commissioning of the HV service was moved from the NHS back to the LA in 2015, putting more pressure on HV numbers as staffing lacked investment due to continual LA cuts leaving the HV service with less HVs than before the HVIP (iHV, 2020).

The theme of Health Visiting: a hidden service emanated from the participant interviews noting that the general population were unaware of the HV service unless they had children and that the service was notably missing from outward facing general NHS, LA or NMC narrative (Conti and Dow, 2020, 2021; NMC, 2021). Information on health visiting numbers and the gender split within the profession was difficult to find. NHS England (2011) set up the Indicative Health Visitor Collection (IHVC) as part of the Government's commitment to increase the number of HVs by 4,200 full time equivalents (FTE) from 8,092 to 12,292 between 2010 and March 2015. From 2011-2015 HV numbers would be collated on a quarterly basis, as part of the HVIP when trying to reach the government set target for HV numbers (DH, 2011). Critically since the HVIP (DH, 2011) ended, finding the statistical data to inform HV workforce conversations are no longer readily available. There was a notable absence of specific HV data on the regulatory body website, with recent reports noting statistics regarding 'nurses including SCPHN', rather than SCPHN as a defined group (NMC, 2021). SCPHN practitioners are registered on part three of the NMC register and broken down into the fields of health visiting, school nursing and occupational health nursing and family nurse (NMC, 2017). The omission of specific information and data, in each specialist field of practice, could be perceived as a marginalisation of the SCPHN and HV specialist workforce (NMC, 2021). First 1001 Days (2022) took to twitter to voice their disappointment regarding the invisible narrative around HV and MW numbers, negating the Government's need to act toward rebuilding the workforce.

The notion of health visiting as a hidden service is supported by Donetto *et al.* (2013) and Cowley *et al.* (2015) who suggest the need to heighten public awareness and clarify the purpose, role and responsibilities of the HV and HV service. Bryar *et al.* (2017) also noted that in a survey of 1179 HVs, over 33% of HVs had little to no regular contact with GPs, to whom HVs had traditionally been aligned. This notion, rather than presenting HVs as being part of the child and family interprofessional workforce, suggests HV as being marginalised, remote and a potentially hidden service. Community practitioners per se are noted as invisible with Royal College of Nursing

for Wales (RCN, 2019) reporting that despite two thirds of their membership being employed in the community there is a danger that HVs, school nurses, occupational health nurses, DNs are not in the line of site for policy makers. In a study of the recruitment and retention of HVs (Whittaker *et al*., 2013), it was highlighted that most people are unaware of the HV service until they become parents their selves. My study adds to the perception of health visiting being a hidden service and takes it further in that even when the HV service is seen, many fathers are marginalised from the service offer (see section 4.2).

Yet, the male HVs demonstrated their attributes (iHV, 2012c) showing reflexivity in their practice, through their ability to change and adapt to the environment. Even the four participants that had taken sick leave due to stress related depression had returned and taken up their former roles. T2 moved out of his HV role due to personal circumstances beyond his control but still recommended that men are well placed to be HVs.

6.7 Placing the findings within a theoretical context

The theoretical frameworks used for guidance within the findings from this research were Gender Role Conflict (O'Neil, 1981a) and Novice to Expert (Benner, 1984).

6.7.1 Gender Role Conflict.

This study looks at GRC within the context of a man working within the female dominated role of health visiting. When comparing the findings of my study with the definitions and assumptions of GRC (see appendix 22&23) it was evident, within the transcripts of the male HV participants, that there was GRC at times and more so for some participants than others. The GRC, sexism and gender role strain emanated through narratives related to isolation, discrimination, sexual harassment and lateral violence within the workplace. When seen in the whole the male HV narratives presented the socialised norm that health visiting was constructed as women's work. The socially constructed feminisation of the nursing and health visiting profession resulted in little if any careers advice being given to the participants that promoted nursing as a suitable occupational choice for men.

Four of the 11 male HVs experienced excessive role strain, culminating in substantial sick leave being required for recovery. Fundamental ways of negating GRC emanated

through narratives of socialisation with strong professional connections within a community of practice and effective managerial support.

Interestingly, most men in my study fared well, although the interviews were carried out with HVs who were still at work rather than those who had left health visiting. For Male HVs who had chosen to leave there will be a further narrative to explore in future research. T2 had planned his exit due to personal reasons but loved health visiting and would still recommend it as a good job for male nurses and midwives to move into. T5 enjoyed his role but the oppressive nature of his experience from HVs, the skill mix team and ineffective management had taken a long-term effect on his psychological wellbeing.

Mirroring the research by Brook, Thurtle and Murray (2019) the longer professionals were employed as HVs the more likely they were to remain. Duchscher and Windey (2018) also note that the transition shock will be felt most acutely in the first few months when moving into a new profession. All 11 male HVs were established in their roles and spoke positively overall of their professional HV role noting the privilege of working so closely with families. The male HVs spoke of the added value they brought to the HV team, building cohesion and the positive influence they had when delivering the service to young families (see sections 4.1.1, 4.1.1.1, 4.1.1.2). They noted the wider positive public health influence they made embracing project work (see section 4.3.4) or increasing immunisation rates (see section 4.4.3).

The male HVs also highlighted the need to value and engage more with fathers, who were overlooked most of the time, as T10 articulates here.

> *'I got mums ringing me going, can you come and see my husband…and it made me think, we kind of maybe we ignore guys and think they're just wimps if they get a bit depressed, but I was seeing guys who were significantly depressed, and they just couldn't understand why'* **T10 P15 L 15-16 & P16 L1-2.**

The need to record the father/partner contact as a default requirement within the record keeping software was raised, as this was not available or happening routinely across England at the time. This narrative of father engagement being stymied by software systems and causing the marginalisation of fathers is new knowledge. A national approach is needed to amend the family record-keeping templates making it

easier to communicate with fathers and maintain a contemporaneous record in line with that of the mother.

Both sexes are culturally socialised with regard to stereotyping job roles. Inflexible stereotypes maintain GRC and inhibit professional growth and diversity in gender dominated professions such as health visiting. Globally, societal norms are experiencing a cultural flashpoint (Mac an Ghaill and Haywood, 2007) where blurred traditional gender norms allow self-expression yet cause confusion and some conflict especially for countries with entrenched gender norms. My research adds to gender role conflict theory in that the study brings further understanding of how the male HV lived experience is affected through interaction with HVs, the HV management team, interprofessional colleagues and clients. The study also aligns to the theory of gender role conflict in that there are examples where male HVs were disadvantaged by their gender in the female dominated workplace. Yet, GRC theory is challenged as the narratives of advantage and opportunity in entering the HV profession, the positive impacts made within teams and through service user interaction together with the further developmental opportunities prove to extend the GRC.

6.7.2 Novice to Expert

Despite Benner (1984) noting the need to diversify the nursing workforce by increasing the number of male nurses 40 years ago, the numbers have not really changed (see section 1.4). As such the numbers of qualified male nurses that can apply for HV training remain small.

Benner's (1981a) theory of Novice to Expert proved helpful to consider the journey of male HVs who as qualified and experienced nurses or midwives made the choice to retrain toward the new profession of health visiting. The HVs spoke of the value of good support during their HV programme of study from the PT. This earlier quote clearly presenting the importance of providing a positive learning environment to meet the unique needs of each learner.

> *I had two very strong like practice teachers and both… were like similar in a way very, very kind of like enthusiastic…I think both…recognised…, from early on, they understood my learning style…, they got me involved in visits very early on and they let me lead … contacts and they intervened when*

necessary and it fills you with a bit of confidence when you do that. ***T9 P6 L14 & P7 L1-10.***

Again, the importance of this support in the early transition, identifying and acknowledging transferable skills, can make the different between retention and attrition in the longer term (Duchscher and Windey, 2018). When moving from a previously skilled knowledgeable proficient or expert position to feeling deskilled as a novice or advanced beginner this can be anxiety provoking (Duchscher and Windey, 2018). Cash (1995) critiqued Benner's study, raising the lack of reference to trait and talent being the basis for effective acquisition of skills and knowledge. The male HVs acknowledged a male engendered trait regarding communication style, resulting in the clients voicing their preference for a male HV rather than a female HV in service delivery. The male HVs particularly spoke about their approach to communication, within what can be a challenging occupation (see sections 4.3.4, 4.4.2, 4.4.4). Added to this T10 embraced his patriarchal advantage through his collegiate approach to working with a challenging male GP. T10 utilized his traits and talent together with prior skills and knowledge towards addressing the wider public health agenda, including male health issues such as counselling for impotency. My study extends Benner's theory (1984) in highlighting that trait and talent do play a part in the theory of novice to expert particularly when extending and advancing practice into the postgraduate specialist arena.

6.8 Summary

This discussion chapter has brought together the salient points from the analysis, findings, literature reviews, theoretical frameworks and the positionality of the researcher. The four SOTs have been discussed considering more recent changes to the HV service demonstrating the evolutionary nature of the profession, constantly changing to meet health, social, technological advancement and political requirements. The reflexive nature of the HV workforce shines through and for the men who are HVs. The added dimension of the participants' gender brings both benefits and barriers to them. The theoretical frameworks of GRC and Novice to Expert have been considered in relation to my findings and important points regarding theory alignment or extension are noted. Chapter seven will draw together the conclusions of the study including this discussion chapter.

Chapter Seven. Conclusions, Original Contributions and Study Limitations

7.0 Introduction.

This original study has examined the lived experience of male HVs. This study is unique as it brings new knowledge to fill the gap in research specific to male HVs. Here I will share my contributions to the subject matter, both the new academic knowledge and the implications for professional HV practice through the key findings. This chapter will illuminate how the study question, aim and objectives have been met.

There is no other study that explores men who work as qualified HVs and as such this study can reveal the lived experience of male HVs for the first time. Further research is needed to explore the service users, including the voice of fathers', perspectives of receiving the traditionally female HV service from a man rather than a woman.

7.1 Meeting the Study Aim, Objectives and Answering the Research Question.

7.1.1 Meeting the study aim.

From the outset the study aim: to explore the lived experience of being a registered male HV, leant itself to an IPA methodological approach and a constructivist paradigm where the participants were able to reflect on their lived experience and make meanings for themselves. Aligning with double hermeneutics allowed me, as the researcher, to analyse their elucidations through my 'fore-structure' and positionality. The study aim has been met through the collection of rich verbatim data and extensive in-depth analysis initially for each individual case and then across all cases, looking for patterns, as expected within an IPA study (Smith, Flowers and Larking, 2009; Willig, 2008). The conceptual framework (see section 6.1), created following completion of the analysis, draws together and presents, through imagery, the four superordinate themes across the dimensions of time and culture.

7.1.2 Meeting the research objectives

> **1**. To collect personal experiential narratives of being a registered male HV.

This objective was met by undertaking eleven, individual face to face, semi-structured interviews with the participants, recording the interview and transcribing the narratives verbatim.

2. To investigate why the participants chose Health Visiting as a profession.

This objective was met by asking question 1 with the subset questions 1.2,1.3 and 1.4 within the semi-structured interviews (see appendix 9). Once the participants had shared their motivation toward health visiting as a career, how they found out about health visiting as a career option, if any HVs had influenced their HV career choice, I was able to analyse their narratives and formulate my findings.

3. To consider the impact on service delivery by male HVs.

This objective has been met through the lengthy analysis, the consideration of the meaning, discussions with my supervisor and vast hours of reflection while using the hermeneutic circle (Pietkiewicz and Smith, 2014; Smith, Flowers and Larkin, 2009; Denzin and Lincoln, 2003) (see table 5). This objective is integral to the whole study as male HVs do have an impact on service delivery from the moment they decide to apply for the educational programme. What I was not expecting to find was the impact that delivering the service would have on them both personally and professionally (see sections 4.1 and 6.3).

7.1.3 Answering the research question

The research question: Do men encounter any gender specific issues when working as a registered Health Visitor? was answered and has resonance with all four superordinate themes**.** Male HVs do encounter gender specific issues working within the female dominated HV service. However, many of the issues aligned to their former roles as nurses or MWs within the female dominated workforce. They were a minority group, at times feeling a sense of 'otherness' (Herakova, 2012) and being isolated or, in contrast, they were embraced as someone with a different, more objective, opinion to offer. Male HVs were also afforded advantages due to their gender for example positive discrimination at the recruitment stage for TX and patriarchal advantage for T10 when working with a challenging male GP. Five of the 11 male HV participants (46%) were also in higher level HV roles such as safeguarding leads or practice teachers, highlighting role progression opportunities for these participants.

7.2 Key contributions of this study

1. This original study in its entirety makes a key contribution, as no other research could be located that has considered the lived experience of male HVs.

2. Male HVs must plan ahead when delivering the HV service due to their gender, especially when visiting females in the home (all participants).

3. Male HVs are more likely to be judged due to their gender.

4. The conceptual framework provides a visual ecological perspective of becoming and being a male HV across the dimensions of cultural change and time.

5. Fathers are marginalised from the HV default record keeping templates. This was an unexpected finding, not directly related to the research question, but recognised as clearly significant. To recognise the valuable contribution that fathers make toward child development and improve father engagement, all HVs should make a mandated contact with the father and contemporaneously record the contact within a bespoke section for the father within the child's records.

7.3 Limitations

One of the advantages of this study can also be a limitation. While the participant's experiential narrative is presented verbatim, the objective of this is not to question what the participant says but is for the researcher to interpret understanding of the meaning beyond the narrative (Willig, 2008). As such my role as the researcher, interpreting the participant narrative, impacted on the analysis due to my positionality expressed in section 1.1. My approach was reflexive toward the participant's experience rather than premeditated, to shine a light on their lived experiences and avoid imposing any personal researcher preconceptions. Through the consideration of my findings against the theoretical frameworks of GRC and novice to expert a broader perspective was attained.

Another limitation of the study was reflected in the corpus. The study sample would have benefitted from further diversity to identify experience of multiple intersectionality, when working within such an engendered role. The updated literature review suggested that any other type of intersectionality could have a further negative impact. However, there were also advantages for men working as HVs that were highlighted.

As the numbers of male HVs are nationally low the sample was reliant on meeting the purposive criteria and volunteers putting themselves forward to take part within the study.

The results of this study cannot be generalised but through the theoretical application to the health visiting service can be taken forward. The findings and discussion have identified implications for practice and suggested future research.

7.4 Summary

This chapter has presented the conclusions to the study, together with how the research aim, objectives and question have been addressed. The key contributions have been presented where they add to the body of knowledge of the subject matter. There were serendipitous findings around careers advice within the statutory education system and the marginalised voice of the father in England. The recommendations that can be seen in chapter seven.

Chapter Eight. Recommendations and Dissemination

8.0 Introduction

This chapter will present the recommendations and dissemination plans made from this study, the implications for a variety of organisations involved in the management of child and family mandated services that include the profession of Health Visiting.

8.1 Recommendations for the UK Government, Schools, Practice and HEI Curriculum.

Recommendations for the United Kingdom Government:

- Government to fund national research into the disproportionate numbers of men facing Nursing and Midwifery Council regulatory body disciplinary action.

Recommendations for Schools:

- Need to broaden discussions nationally regarding men in caring professions.
- Parenting to feature on national curriculum advising of importance of maternal and paternal involvement regarding new findings in child development.

Recommendations for Practice:

Fathers:

- Need mandated contact and identified record for father/other principal carer toward greater opportunity for information sharing and parental involvement.
- All fathers to be informed, at same time as antenatal contact, of the crucial legacy they can provide from their child's secure paternal attachment toward their child's long-term outcomes, even if the parents may not cohabit.
- Fathers to be consulted when revising national HV professional standards of proficiency.
- Fathers to be included in consultation toward local authority commissioning and NHS provider proposals toward a co construction of planned HV service delivery.

Workforce:

- Need to address workplace stress including effective management support, promote seeking help and facilitate self-referral for mental health intervention(s).

Recommendations for HEI curriculum:

- Education- managing challenging workplace situation e.g. gender based- when teaching personal safety and lone working discuss inverse risk of being accused of e.g. sexual misconduct when in someone's home.
- Simulated learning- Work through coping with rejection scenario e.g. from clients, team. Both as the staff member and as a leader/manager supporting staff.
- Training on rejection for all students especially men due to gender rejection, ethnicity rejection.

8.2 Recommendations for future research:

- Research is needed to investigate the inclusivity/marginalisation of fathers in other child and family orientated services e.g. Child and Adolescent Mental Health Services, Midwifery, Education, Social Work. As fathers have been shown to have much to offer, regarding the promotion of positive child development (Gerhardt, 2004; Shonkoff and Garner, 2012; Khan, 2017; HM Gov, 2021), it is imperative that fathers receive all appropriate child and family driven service information in a timely manner. In this way fathers will have an equal opportunity to contribute toward their child's outcomes.
- A study of fathers' experiences of receiving the HV service from male HVs would help to elucidate if such an approach would impact on father engagement, resulting from having a male HV to talk to.
- A follow up study of the mothers' experiences of being seen by a male HV would enable further considerations from different viewpoints to be taken forward.
- The delivery of intimate care as a concept was initially considered by all eleven participants to mean physical care delivery. The notion of physical and psychological intimate care needs further investigation.
- The concept of chaperones and consent was prevalent in the pilot study (Le Blond, 2016) of male nurses yet barely featured within my research for male HVs. As such further research around the female patient/service user experience, of receiving intimate care from a male nurse/HV, would provide a sociological and cultural lens into their considered decision-making process.

- There is a need to consider some intervention and a longitudinal study toward garnering heightened male entry into the fields of nursing/ midwifery and subsequently health visiting. Something along the lines of STEM toward enticing females into the sciences and engineering and/or a mass media approach such as the recurrent advertising campaigns toward armed services recruitment drives. My research has shown that many do not know about the HV service before the birth of their child or as a nurse/midwife during a placement contact. By marketing and advertising the nurse/midwife and HV services as appropriate for men, on a national scale, this could help to raising the awareness and recruitment overall. Ideas for marketing toward men can be seen in section 4.3.

8.3 Dissemination of the study.

Dissemination of the research for impact has taken place throughout the development of the study as can be seen in Table 7 below.

Table 12. **Record of research dissemination to date.**

Date	Mode of Dissemination	Audience	Location
12th March 2016	Poster Presentation- Pilot Study (Le Blond, 2016)	United Kingdom Standing Conference for SCPHN Educators annual Conference.	Unite Building, London
April 2016	Speaker 10-minute presentation.	Post Graduate Student Research Conference.	University of Derby
November 2016	Speaker 10-minute presentation.	Research Café.	University of Derby
25th Jan 2017	Research Away Day. Oral presentation: Dr of Practice work to date.	Department of Health Care Practice Staff.	University of Derby
20th July 2017	Presentation Title: A research journey towards doctoral study.	Department of Health Care Practice Research Showcase Event.	University of Derby
18th 19th Aug 2020	Abstract-Accepted. 45min oral presentation: Considerations of Data Analysis	Live International online conference.	Choithram College of Nursing. India (online)
May 2021	Blog About my research Men in Nursing and Health Visiting.	Online Careers event: Health & Social Care needs men. Secondary schools and mature learners.	Derbyshire Voluntary Action. Online Media.

Sept 2021	Poster Presentation: Lived Experience of male HVs. Initial Findings.	Professorial Council	. University of Derby
July 2022	Presentation Lived Experience of male HVs. Findings.	66 HV students and 2 academic staff.	University West of England
Dec 2022	Taught IPA methodology based on my study	81 interdisciplinary post grad health students	University of Derby

Table 13. **Future dissemination plans toward impact.**

Date	Mode of Dissemination	Audience	Location
May 2022	Accepted Invitation to contribute to iHV toward building HV workforce capacity	iHV	Online or London
May 2022	Accepted invitation to Create a 'Voices Blog' with iHV	New Recruits HVs	Online
Feb 2024	Journal Article: Marginalised Fathers: what the research says	Most appropriate journal	International Impact
March 2024	Journal Article: Don't sit on your laurels or you will get a pressure sore. 40 years from EN to DrP	Nurses	Nursing Times National Impact
May 2024	Journal Article The issues in male HV recruitment	Service Leaders	Health Service Journal & LA equivalent National Impact
June 2024	Journal Article IPA: Double Hermeneutics. Not just for psychology	Nurses/SCPHNs	Journal Nurse Education Today International Impact
2024-2025	Engage with UK Parliament. First 1001 critical days- Select Committee	Public Engagement	Houses of Parliament London

8.4 Summary.

This chapter presented the recommendations made from this study, the implications for a variety of organisations involved in the management of child and family mandated services, that include the profession of health visiting. The dissemination plans presented show the dissemination that has been planned to date and that which is planned for the future.

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Appendices: Appendices 1-5 Proof of Ethics approvals

Appendix 1. College of Health and Social Care Research Ethics Committee Approval

Dr Paula J Crick
Dean

Kedleston Road, Derby
DE22 1GB, UK

Approval

Date 16/05/16

Name: Suzanne Le Blond

Dear Suzanne

Topic: An exploration of the lived experience of male Health Visitors: An Interpretive phenomenological analysis

Thank you for submitting your amended application to the Health and Social Care Research Ethics Committee.

Your study has now been approved and you are able to proceed once any NHS permissions are obtained as deemed necessary – we note your present discussion with your local R & D office- please keep us informed of the outcome. Approval letters or correspondence confirming these are not required should be forwarded to the committee once obtained.

Once the study commences if any changes to the study described in the application or to the supporting documentation are necessary, you are required to make a resubmission to the College of Health and Social Care Research Ethics Committee.

We will also require an annual review of the progress of the study and notification of completion of the study for our records.

Yours sincerely,

[redacted]

Lorraine Henshaw
Chair, College of Health and Social Care Research Ethics Committee

Appendix 2. Approval of Application for Research Degree Registration

Kedleston Road, Derby
DE22 1GB, UK

T: +44 (0)1332 591060
E: researchoffice@derby.ac.uk
Sponsor Licence No: QGN14R294

Ref: LETT03/jd/049378123

23 May 2016

Suzanne Le Blond
[redacted]

Dear Suzanne

Application for registration

On behalf of the College Research Committee I am pleased to say that your application for registration has now been approved.

Please note that your date of registration has been recorded as 27/01/14 (this being back-dated to the day of your initial enrolment).

I would like to take this opportunity to wish you every success with your research degree. If you have any queries, please do not hesitate to contact the Research Student Office.

Yours sincerely

[redacted]
Jennifer Dean
Secretary CRC

cc Dr Helen Stoneley, Dr Wendy Wesson, Professor Susan Hogan. Dr Michael Townend

Appendix 3. NHS Research Ethics approval Via Health Research Authority (HRA)

From: KESHVARA, Rekha (HEALTH RESEARCH AUTHORITY) [mailto:rekha.keshvara@nhs.net]
Sent: 20 October 2016 15:42
To: Suzanne Le Blond <S.LeBlond@derby.ac.uk>
Cc: approval hra (HEALTH RESEARCH AUTHORITY) <hra.approval@nhs.net>
Subject: RE: HRA approval permissions outstanding

Dear Suzanne,

Further to my earlier, I can confirm that since the study does not involve NHS sites, this does not require HRA approval.

Once again, I apologise for the delay in getting back to you.

Best wishes,

Rekha

Rekha Keshvara | Assessor

Health Research Authority
Nottingham HRA Centre, The Old Chapel,

Royal Standard Court, Nottingham NG1 6FS

E: Rekha.Keshvara@nhs.net | T: 0207 104 8191

IMPORTANT – Click here for the latest details of the roll-out of HRA Approval in England

The HRA is keen to know your views on the service you received – our short feedback form is available here

Appendix 4. NHS Research Ethics Committee: IRAS approval discussion

Re: 16/NW/0596, IRAS Project ID: 204760

SB

Suzanne Le Blond

Reply all

Thu 21/07/2016, 14:59

Preston NRESCommittee.NorthWest- (HEALTH RESEARCH AUTHORITY) <nrescommittee.northwest-preston@nhs.net>;
Helen Stoneley;
approval hra (HEALTH RESEARCH AUTHORITY) <hra.approval@nhs.net>;
Wendy Wood
Sent Items
Label: Staff 7 Years Delete (7 years) Expires: 20/07/2023 14:59

Dear Carol.

Thank you very much for your phone call and advice. I would like to withdraw my study from the Rec approval Process and be put forward for the HRA approval process instead.

Thank you for your time

Kind Regards

Suzanne Le Blond

Get Outlook for iOS

On Thu, Jul 21, 2016 at 1:04 PM +0100, "Preston NRESCommittee.NorthWest- (HEALTH RESEARCH AUTHORITY)" <nrescommittee.northwest-preston@nhs.net> wrote:

Thanks for your application

I note from your form that you are aware that REC review is not required for studies involving staff only. However, you requested REC review when you contacted the booking team. Please can you confirm that you do not require REC review and I will transfer your study to HRA review

Please note the application is not currently valid as you have not completed the checklist or uploaded any documents other than the REC form and you should do this as soon as possible.

Please could you repond by close of play today

thanks

BW

Carol

Carol Ebenezer | REC Manager
Health Research Authority
3rd Floor
Barlow House
4 Minshull St
Manchester
M1 3HY
E: nrescommittee.northwest-preston@nhs.net | T: 02071048008 | www.hra.nhs.uk

The HRA is keen to know your views on the service you received – our short feedback form is available **here**

Appendix 5. NHS Research Ethics: Research and Development Unit (R&D) approval

From: Suzanne Le Blond [mailto:S.LeBlond@derby.ac.uk] Sent: 10 May 2016 08:40 To: Reza Rubina (RXM) Derbyshire Healthcare Foundation Trust Cc: Lorraine Henshaw Subject: Doctoral study research ethics advice

Dear Rubina,

I am writing to seek your advice regarding NHS ethical approval following the advice of Lorraine Henshaw, Chair of the Research Ethics Committee for the College of Health and Social Care.

I am a member of staff at the University of Derby and a student in the 3rd year of a Doctoral study (Doctor of Health and Social Care Practice-Nursing).

My main study is qualitative, and I am proposing to explore the lived experience of male Health Visitors via face to face semi structured interviews. I aim to get the participants nationally in two ways 1, via University Contacts as I am a member of the United Kingdom Standing Conference (UKSC) of SCPHN educators who will forward an email to all members 2, via the Institute of Health Visitors, of which I am also a member.

I plan to interview the participants away from NHS Trust premises.

As health visitors now come under the local authority, as an NHS service provider, I would welcome your advice regarding NHS ethical approval requirements for this study.

I have tried to phone you and was advised that an email could be the best approach.

I look forward to hearing from you.

Kind Regards

Suzanne

Suzanne Le Blond. Senior Lecturer. Dept of Health Care Practice. College of Health & Social Care. University of Derby, Kedleston Road, Derby. DE22 1GB. Tel 01332 592309. s.leblond@derby.ac.uk

From: Reza Rubina (RXM) Derbyshire Healthcare Foundation Trust [mailto:Rubina.Reza@derbyshcft.nhs.uk] Sent: 26 May 2016 09:40 To: Suzanne Le Blond <S.LeBlond@derby.ac.uk> Cc: Lorraine Henshaw <L.Henshaw@derby.ac.uk> Subject: RE: Doctoral study research ethics advice

Hi Suzanne

Apologies that I've not got back to you sooner.

You may not need NHS Research Ethics approval if you are doing research involving NHS or social care staff recruited as research participants by virtue of their professional role. However, all NHS and Social care research must be approved by the Health Research Authority (HRA) which came into effect from the 1st of April. HRA approval is obtained through IRAS also. If you are not aware of this new HRA approval process, I would suggest looking at their website http://www.hra.nhs.uk/research-community/hra-approval-the-new-process-for-the-nhs-in-england/

I believe that as some health visitors are employed by the NHS or Local Authorities and you want to interview them because of their professional role then I believe you will need to obtain HRA approval, but you can clarify this through the HRA.

Although you have opted to do interviews outside of NHS sites please do remember that if you do need to do any of the interviews on nhs premises e.g participant preference, then you will need to complete a research passport in order to be issued with a letter of access through us before you can do the interviews on site (but of course if all interviews are done outside of NHS premises then you don't need to do this).

Hope this helps and apologies again.

Rubina

Dear Rubina,

Thank you for your time and reply.

I have answered the four questions on the HRA decision making tool and attached the outcome sheet stating that my 'exploration of the lived experience of male Health Visitors: An interpretive Phenomenological analysis' is not considered research by the NHS. Taking your advice into account I will ensure that no interviews take place on NHS property.

Thank you again.

Best wishes
Suzanne

Suzanne Le Blond. Senior Lecturer. Dept of Health Care Practice, College of Health and Social Care, University of Derby, Kedleston Road, Derby. DE22 1GB. Tel. 01332 592309 s.leblond@derby.ac.uk

5/24/2016 Result - NOT Research

Go straight to content. SUZANNE LE BLOND

NHS
Health Research Authority

MRC Medical Research Council

Is my study research?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

An exploration of the lived experience of male Health Visitors: An Interpretive phenomenological analysis.

IRAS Project ID (if available):

You selected:

- **'No'** - Are the participants in your study randomised to different groups?
- **'No'** - Does your study protocol demand changing treatment/ patient care from accepted standards for any of the patients involved?
- **'No'** - Are your findings going to be generalisable?

Your study would NOT be considered Research by the NHS.

You may still need other approvals.

Researchers requiring further advice (e.g. those not confident with the outcome of this tool) should contact their R&D office or sponsor in the first instance, or the HRA to discuss your study. If contacting the HRA for advice, do this by sending an outline of the project (maximum one page), summarising its purpose, methodology, type of participant and planned location as well as a copy of this results page and a summary of the aspects of the decision(s) that you need further advice on to the HRA Queries Line at HRA.Queries@nhs.net.

For more information please visit the Defining Research leaflet

Follow this link to start again.

Print This Page

NOTE: If using Internet Explorer please use browser print function.

http://www.hra-decisiontools.org.uk/research/result7.html 1/2

Appendix 6. Participant Information Sheet

UNIVERSITY of DERBY

PARTICIPANT INFORMATION SHEET

Study title
The lived experience of the Male Health Visitor: An Interpretive Phenomenological Analysis.

You are being invited to take part in a research study. Before you make a decision, it is important for you to understand why the research is being done and what it will involve for you. Please take time to read the following information carefully and make contact if you require any further information.

What is the purpose of the study?
Background: The Health Visitor Implementation Plan: A Call To Action (Department of Health (DH), 2011) strived to increase the number of Health Visitors, working directly with children and their families, by four thousand two hundred, by March 2015. Subsequently Health Visiting has seen a growth in male Specialist Community Public Health Nurse (SCPHN) numbers (Nursing and Midwifery Council (NMC) 2016). As Health Visiting is traditionally a female area of practice (Unite the Union, 2012) male Health Visitors make up the minority of the profession and this caused them to be singled out as a priority group for recruitment (Nursing Times 2012). There is a notable gap in research evidence regarding the male Health Visitor and the perception of being a male Health Visitor. It is this research proposal that aims to fill the gap in research and knowledge and provide conclusions for national and potentially international discussion.

Aim: The aim of the study is to explore the lived experience of being a registered male Health Visitor.

The study will run until December 2017 with the participants being recruited May 2016 and the semi-structured interviews taking place June, July, and August 2016. The interviews will then be transcribed and sent for checking with the appropriate individual participant. The analysis will be carried out and if more questions arise a second interview may be conducted. The final thesis will be written up by December 2017.

Why have I been invited to participate?
You have been invited to take part as you are a male Health visitor and will have direct insight into the issues that have or have not impacted on your career. It is intended that eight to ten participants will be recruited to take part in this research in order to analyse the findings and draw some conclusions for local and national consideration.

Do I have to take part?
Taking part in the research is entirely voluntary and any decision not to take part will not impact on you from an employment or professional perspective.

If you do decide to take part you will be given this information sheet to keep and will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. Once the analysis has commenced you may still withdraw from the study but your data will still be included.
What will happen to me if I take part?
If you agree to take part, you will be asked to commit to approximately one hour of your time for a face to face interview. During this time this information sheet will be

reviewed, and informed consent gained. A semi-structured interview will then take place. The questions will be based around the themes that were generated from a critical literature review and pilot study around the subject matter. The interview will be recorded digitally and subsequently transcribed verbatim by the researcher. The transcript will then be returned to you for checking prior to analysis taking place. Your details will remain anonymous and a code will be applied to your contribution. It will be your decision if you disclose to anyone the detail of your involvement in this study. Due to the purposive sampling technique it may be assumed that you have taken part in the research by other Health Visitors, but this will not be affirmed by me. All data collected and transcribed will be kept in a locked cabinet. The information will be used towards completion of a Doctoral thesis. Any subsequent publications or dissemination will not have any identifiable detail included.

What are the possible disadvantages and risks of taking part?
A potential disadvantage of taking part in the study is that due to small numbers of male Health Visitors, the purposive sample and snowball technique, the participants may be known to each other. Upon recruitment to the study all information will be anonymised and confidentiality between the participant and the researcher will be maintained throughout.

What are the possible benefits of taking part?
This study will directly increase the understanding of the male Health Visitor experience regarding career development within the United Kingdom. It is envisaged that this knowledge will benefit local and national recruitment and retention initiatives to potentially improve the numbers of male Health Visitors and increase the Health Visiting workforce diversity and number overall.

Will what I say in this study be kept confidential?
All information collected about the individual will be kept strictly confidential in line with the Data Protection (1998) and Freedom of Information (2000) Acts. As the sample will be purposive, due to the limited availability of participants, it may be possible for participants to identify each other. You may choose to discuss the research individually but at no point will any information, data or details of participants be released from the researcher. Transcripts will be returned to the participant for checking prior to analysis.

All information will be stored in a locked cabinet, on a password protected device and encrypted USB stick, when not in use by the researcher.
Confidentiality, privacy and anonymity will be ensured in the collection, storage and publication of research material. Names will be changed to codes that will not be disclosed to anyone by the researcher although verbatim quotes may still be identifiable by the participant.

What should I do if I want to take part?
Please confirm by email s.leblond@derby.ac.uk that you would like to take part in the study. I will then contact you to arrange a date and time for the interview to take place. The information in this sheet will then be reinforced, with an explanation of any further detail required. Only after you have received all of the information that you require will you be offered a consent form to sign agreeing to participate in the study. If you choose not to take part that is your prerogative and this decision will be respected.

What will happen to the results of the research study?
The results of the research will be utilised within the academic work required for submission as part of the Doctor of Health and Social Care Practice (Nursing) (PB9AG) programme within the 'Independent Scholarship for Professional Practice and Service development' (8DP001) module requirements. The results may also be published in pertinent academic journals, utilised at conferences and within national discussion related to the subject matter. At no point will participants be identified, other than if previously agreed.

Who is organising and funding the research?
I am a Doctoral student studying toward the Doctor of Health and Social Care Practice (Nursing) (PB9AG) at University of Derby. I am independently conducting the research with no external funding attached. I am also a member of staff in the College of Health and Social Care.

Who has reviewed the study?
The research application has been approved by the University of Derby, College of Health and Social Care Research Ethics Committee and the NHS Research Ethics Committee.

Contact for Further Information
Researcher Name Suzanne Le Blond
Position Doctoral Student
Contact Address of Researcher: N306b North Tower, University of Derby. Kedleston Road, Derby. DE221GB. Tel 01332 592309 s.leblond@derby.ac.uk

If you have any concerns about the way in which the study has been conducted, you should contact my Research Supervisor in the first instance.
Name Dr Helen Stoneley
Position Research Supervisor
Contact Address University of Derby. Room 101Britannia Mill, Mackworth Road, Derby. DE223BL. Tel 01332 594022. H.E.Stoneley@derby.ac.uk

Thank you for taking time to read the information sheet. Date 10.02.2016 v2

References
Department of Health. (2011) The Health Visitor Implementation Plan: A Call To Action. London. DH
Nursing and Midwifery Council. (2016) FOI request ran 05/01/2016 Ref:COM003. Breakdown by Country of initial registration(from PIN), parts of the register and gender of effective practitioners on 5 Jan 2016. London. NMC.
Nursing Times (2012) More male and mixed-race Health Visitors wanted**.** Available at http://www.nursingtimes.net/nursing-practice/clinical-zones/district-and-community-nursing/more-male-and-mixed-race-health-visitors-wanted/5048260.article accessed on 7th July 2014.
Unite the Union. (2012) available at http://www.unitetheunion.org/uploaded/documents/Health150Timeline11-6513.pdf accessed on 8th January 2016.

Appendix 7. **Consent Form**

RESEARCH ETHICS: CONSENT FORM

Full title of Project:
The lived experience of the Male Health Visitor: An Interpretive Phenomenological Analysis.

Name, Suzanne Le Blond
Position Doctoral Student: Doctor of Health and Social Care Practice. PB9AG
Contact Address of Researcher: N306b North Tower, University of Derby. Kedleston Road, Derby. DE221GB. Tel 01332 592309 s.leblond@derby.ac.uk

		Please Initial Box
1.	I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. Once the analysis has commenced the participant may still withdraw from the study but their data will still be included.	☐
3.	I agree to take part in the above study.	☐
4.	I agree to the interview consultation being audio recorded and transcribed.	☐
5.	I agree to the use of anonymised quotes within the 8DP001 Independent Scholarship for Professional Practice and Service Development module, the final doctoral thesis, possible subsequent publications and conference presentations.	☐
6.	I agree to be contacted to take part in a second interview if further questions arise as a result of the research process.	☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

A copy for both, the researcher and participant, to be retained respectively.

Appendix 8. Introductory Email.

Dear XXXX.

Study title: The lived experience of the Male Health Visitor: An Interpretive Phenomenological Analysis.

I am a post graduate student undertaking The Professional Doctorate in Health and Social Care Practice (Nursing) programme at the University of Derby. I am conducting a study to fulfil the requirements of the programme. My study will involve interviewing experienced Male Health Visitors.

If you wish to be involved in the study as a research participant, please note the inclusion criteria detailed below to help you decide. **Please forward** this information on, if you know someone who may wish to be involved or please provide me with their contact email.

Study inclusion criteria

As a participant you would require to:

- Be a Nursing and Midwifery Council (NMC) Registered Health Visitor.
- Be male.

These parameters are important to ensure the participants have sufficient current experience to draw on. I have enclosed a participant information sheet to help you gather more information about the study. If you meet the inclusion criteria and you would be willing to take part in my study, please contact me by email at the address below. If you do so, you will have the chance to find out more about the study before coming to any decision. You would be under no obligation to take part.

The use of email to communicate this information to professional contacts for this study has been approved by the Ethics Committee within the School of Health and Social Care at the University of Derby.

Thank you for taking the time to read this email.

Best wishes

Suzanne

Name Suzanne Le Blond MPH RNT BSc SCPHN (HV) RGN SFHEA CNP
Programme Leader PG Cert Interprofessional Practice Education
Pathway Leader Health Visiting

T: +44 (0)1332 592309 | E: s.leblond@derby.ac.uk
University of Derby, Kedleston Road, Derby, DE22 1GB,

Appendix 9. Semi-Structured Interview Questions

Doctor of Health and Social Care Practice - PB9AG

'Independent Scholarship for Professional Practice and Service development' - 8DP001

Questions

Themes

1. Career choice

1.1 What motivated you to become a Nurse? Identify how long in nursing & which specialism prior to Health Visiting

1.2 What motivated you to become a Health Visitor?

1.3 How did you find out about Health Visiting as a career option?

1.4 Did any Health Visitors influence your decision to become a Health Visitor? Prompt. Can you tell me about him/her/ them?

1.5 What qualities do you feel that you brought into the Health Visitor profession?

1.6 Tell me about your Health Visitor training

1.7 Please recount your Health Visiting career to date.

1.8 What responses have you had to your career choice/occupation?

(Potentially prompt, from former colleagues, family, friends, clients and strangers/public?)

2. Roles and Responsibilities

2.1 Have you experienced any restriction within practice?

Prompt- why do you think this was? Prompt. Do you think your gender was influential?

2.2 Are you aware of any specific Health Visiting roles or tasks been adapted due to your gender?

If answer yes-Tell me about them. Prompt. Why was this? Was it discussed with you? How did this affect you?

2.3 Are there any other roles that you feel should be adapted? Can you tell me about them?

2.4 Did/Do you require a chaperone to carry out any parts of your role?

Prompt: could you tell me about this?

3. Intimate Care

Qualifying statement: Intimate care could be seen as personal care delivered to meet the physical and psychological needs of the patient. With this in mind…

3.1 Can you tell me what your experience has been with regarding the delivery of personal or intimate care?

3.2 What have been your perceptions of delivering intimate care to mothers?

Prompt: Did/Do you avoid intimate care? If so what strategies were used?

3.3 Tell me about your relationship with fathers.

3.4 Did anyone ever refuse to receive care from you?

Prompt. Why do you think this was? Do you think your gender had an impact?

END Q's

4.1 Have you progressed professionally as you had expected?

4.2 Where do you see yourself in 5yrs?

In addition to the prompts identified the following prompts may be used to help facilitate discussion as required;

-Why was this?

-Was that your choice?

-Was this due to not being allowed or not having the training required?

-Was this policy driven?

Appendix 10. United Kingdom Standing Conference on Specialist Community Public Health Nurse Education (UKSC) agreement to contact their members.

Chair:
Dr Karen Whittaker
Reader in Child and Family Health, School of Nursing, School of Nursing, College of Health and Wellbeing, University of Central Lancashire, Preston
PR1 2HE

Tel: +44 (0)1772 893786
E-mail:
kwhittaker1@uclan.ac.uk

Vice-Chair:
Dr Jane March-MacDonald
Lecturer in Public Health Programme Lead for Specialist Community Public Health Nursing (SCPHN)
Faculty of Health Sciences Building 67 University of Southampton Highfield, Southampton SO171BJ

Tel: +44 (0)2380 597944
Email: J.D.March-Mcdonald@soton.ac.uk

Hon. Secretary:
Senior Lecturer in Community Nursing
Seconded Non Medical Programme Director for GP Training
School of Public Health, Social Work and Midwifery
Canterbury Christ Church University
North Holmes Road.
Canterbury
Kent CT11QU
Tel: +44 (0)1227 767700
E-mail
jane.arnott@canterbury.ac.uk

Hon. Treasurer:
Lecturer, Health Visiting
HSRM Division
School of Health Sciences
City University London
Northampton Square
London
EC1V 0HB

Tel: +44 (0)20 7040 0361
E-mail: Judy.Brook@city.ac.uk

United Kingdom Standing Conference on Specialist Community Public Health Nurse Education

May 23rd 2016

Dear Suzanne,

In response to the request from the research ethics committee at University of Derby, I am writing to confirm that at the United Kingdom Standing Conference on Specialist Community Public Health Nurse Education (UKSC) AGM which was held on 11th March 2016, the UKSC membership agreed to be contacted by you as part of your research.

On behalf of the UKSC, can I wish you every success for your research proposal.

With very best wishes,

Jane Arnott

Appendix 11. **Example Revised Gantt Chart for timeline to completion**.

8DP002 Revised Research Project Plan -

April 2018 St No. 049378123

Action	Resource	Who	A	M	J 19	J	A	S	O	N	D	Ref	J	F	M	A	M	J	J	A	S	O	N	D	J
Read related research throughout	Articles, literature, research, e-resources	SLB										Review													
Write RD07 Form & Report	Time	SLB										Reconside													
Write draft Methodology & Submit RD07a		SLB				**RD7**						Reorganise													
Transcribing interviews P1,2,3&5 complete	Digi recorder voice activated softwear	SLB		P4 P6 P7 P8	P9 P10 P11																				
Secondary Literature review & Write up	Time, literature, Computer																								
Step 1 analysis reading & re-reading	Time	SLB																							
Step 2 initial noting	Time	SLB																							
Step 3 developing themes	Time, Flip Chart, Space	SLB																							
Step 4 Search for	Time, Flip Chart, Space	SLB																							

connections																											
Step 5 Repeat with each case	Time	SLB																									
Step 6. Find connections across cases. Create visual graphics of findings	Time, flip chart, space, IT graphics	SLB																									
Write up Introduction	Computer	SLB																									
Write up Lit Review	LiteratureComputer	SLB																									
Write up methodology	Computer	SLB																									
Write up findings	Computer	SLB																									
Write up conclusion	Computer	SLB																								Sub	
Prepare for Viva throughout	Supervisor support throughout	SLB																									
Action	Resource	Who	A18	M18	J18	J18	A18	S18	O18	N18	D18		J19	F19	M19	A19	M19	J19	J19	A19	S19	O19	N19	D19	J20		

*All time and resources to be discussed with line manager and supervisors throughout

Appendix 12. Timescales-recording, transcript, verification, and analysis process.

Transcript **T**	Info sent	Interview	Tape Code	Interview length	Transcribe	Sent them	Any Change	Agreed/ no reply	Initial Noting: Step 2	Superordinate themes Step 3&4	Patterns/Higher Order Concepts Step 6
T1	15.05.17	26.05.17	0048	36.51	04.3.19	10.03.19	N/A	30.03.19	05.05.19	21.01.20	12th, 19th & 20th Sept 2020
T2	28.10.16	29.11.16	0035	30.32	Jan 17	06.02.17	N/A	26.02.17	15.04.19	22.01.20	
T3	12.05.17	17.05.17	0041	49.17	July 17	22.08.17	N/A	22.08.17	16.04.19	23.01.20-24.01.20	
T4	15.05.17	24.05.17	0046	30.56	03.03.19	03.03.19	N/A	30.03.19	27.08.19	25.01.20	
T5	28.10.16	07.12.16	0037	1.09.48	24.08.17	25.08.17	N/A	13.09.17	26.06.19-29.06.20	30.01.20	
T6	28.10.16	05.12.16	0036	34.08	Feb 17	22.02.17	22.02.17	13.03.17	17.04.19	02.02.20	
T7	03.04.17	17.05.17	0043	32.08	25.08.18	29.10.18	N/A	13.11.18	19.01.20	20.01.20	
T8	28.10.16	12.12.16	0038 0039	46.57 22.21	30.10.18	02.03.19	N/A	07.03.19	23.06.19	18.04.20	
T9	28.10.16	25.05.17	0047	36.37	17.10.18	23.10.18	N/A	13.11.18	14.01.20	31.05.20	
T10	20.04.17	24.05.17	0044 0045	40.24 35.33	05.03.19	18.03.19	N/A	30.03.19	17.07.19	29.05.20	
T11	03.04.17	17.05.17	0042	24.52	02.03.19	03.03.19	N/A	30.03.20	19.07.19	22.01.20	

Figure 4.2 Presents the timescales for data collection and analysis to findings.
Data Collection = 7 months. Recorded interviews total time = 8hr,10min,22secs. Data transcription = 22mths. Data analysis: Step 2=14th Months. Step 3&4=5months. Step 6=3days

Appendix 13. Anonymised Transcript example 2 pages of T6

affected by childhood and I was seeing a lot of unhappy adolescents and adults and when I'd read their reports during my training. I've been reading it through and they'd had really awful childhoods. So, I thought health visiting you know the main crux for doing health visiting is it will possibly give me a chance to help people. This sort of sounds like my interview, when I went for it, but is that was the main impetus for me to want to be a health visitor thinking I could make a difference from day one, so that adults wouldn't end up unhappy.

SLB Yes, that is what health visitors try to do be proactive rather than reactive.

P6 Which I like and I think that's, that's important.

QU SLB Thank you very much. So what qualities do you feel that you've bought into the health visiting profession?

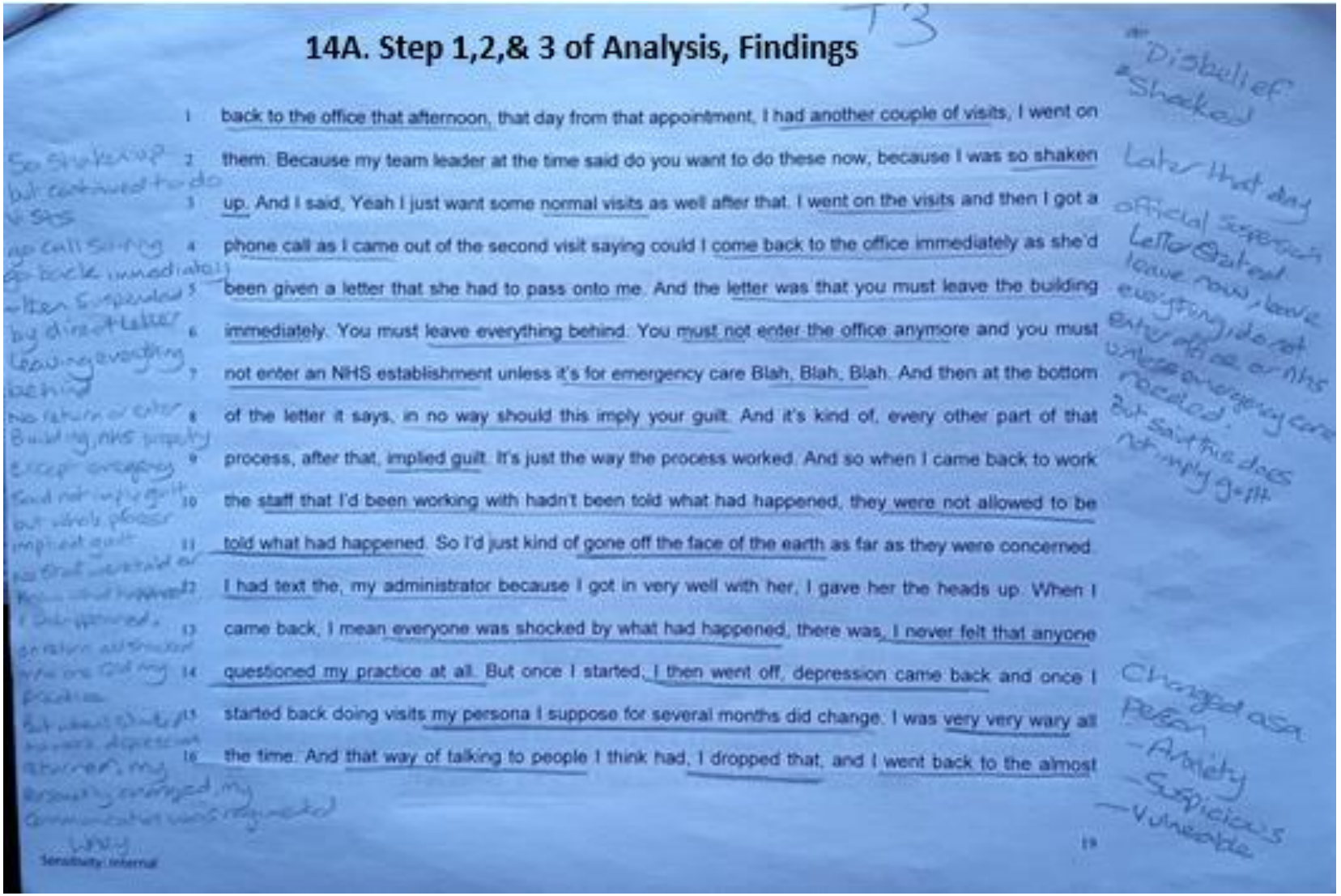
P6 I think as a nurse empathy, but I've also bought a male, or a gay male idea of it as well and I do enjoy working with women. I think you have to enjoy working with women to be in such a female dominated area but I think I bring a maleness to it and may be a different and sometimes a different viewpoint. I think I'm also, I've also been involved in a lot of the groups and starting them up, I really enjoyed that role. It's being more dynamic and getting on and doing things. From the course I, my

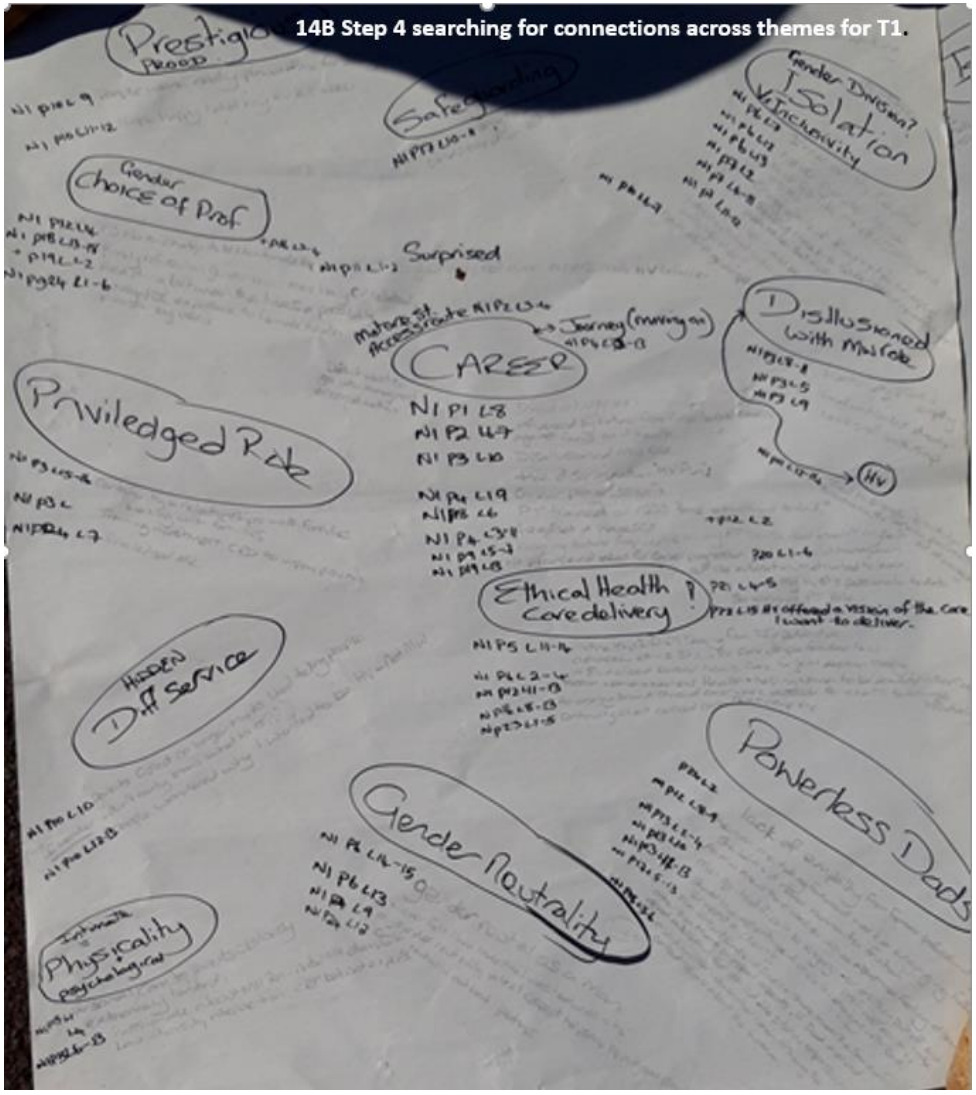
dissertation was on reading to children from day one, so I started up and ran a course here called Books for Babies. So I did that from scratch and I've recently just taken over a group called Bumps to Baby for pre-mobile babies and we cover the six key stages, key areas of health visiting. Like health, well-being promotion, the progression to being a parent. So I've been involved, I am the lead on that. So I quite enjoy the aspect of errm, kind of getting on doing things maybe that's a male trait I don't know. I have enjoyed doing that and being more errm, what's the word, arranging things and organising yeah. Not that women don't do that, but here I find I've had that role. I've got on and done it my manager has been very supportive. I enjoyed setting things up from scratch and doing all the work related to it. Yeah.

QU SLB Brilliant thank you. So can you tell me about your health visiting training, was it straight after the?

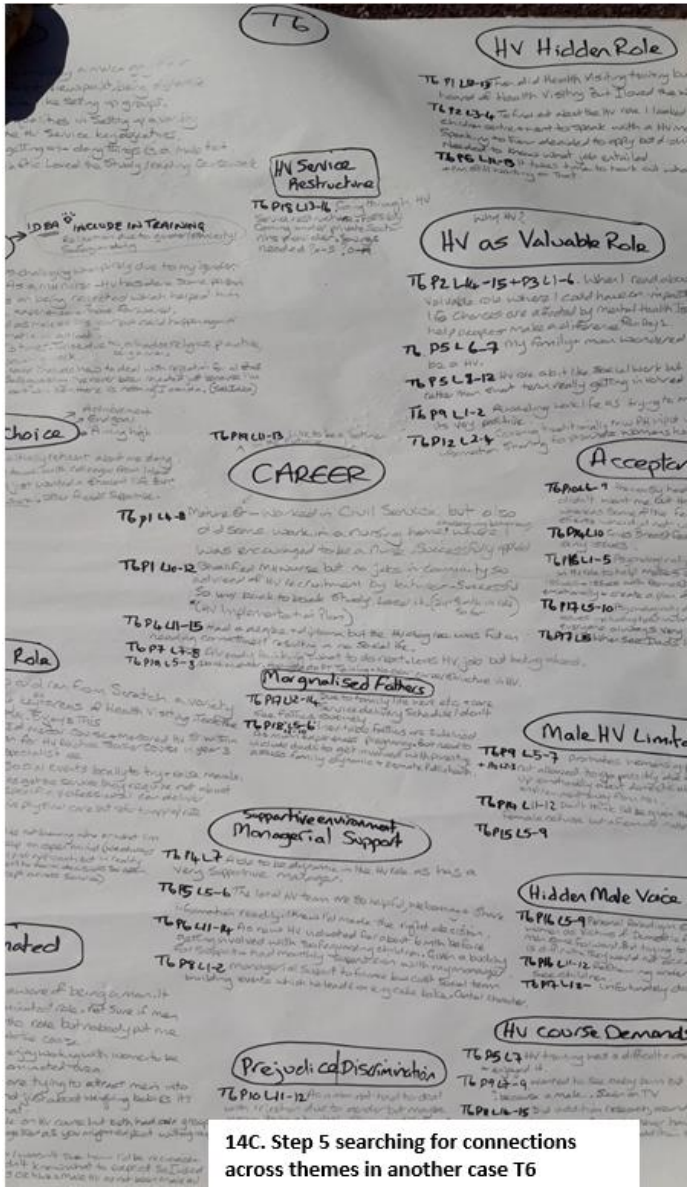
P6 It was straight after the, my nursing diploma so I didn't really have time to think about anything, it started in February so I had a month or so. So I commenced the one-year diploma, sorry the one-year degree. The mental health three-year diploma didn't feel like, sorry, I did a one-year art degree when I was 18-19, so, those three years seemed quite simple but the mental health diploma that was pretty full on but the one-year Health Visiting degree that was really full on. So there was no social life of me, I had

Appendix 14. Images of analysis process.

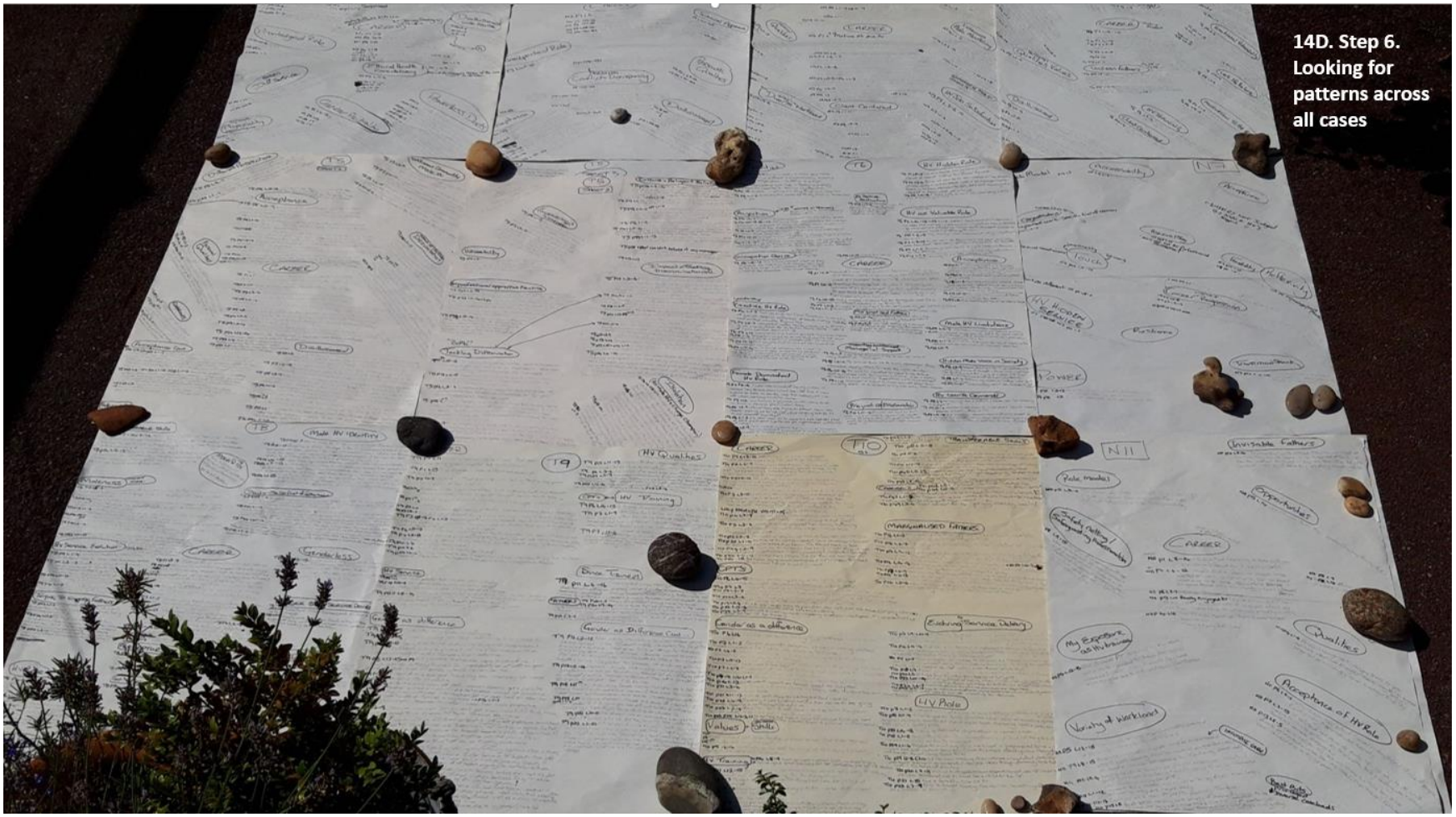




14B Step 4 searching for connections across themes for T1.

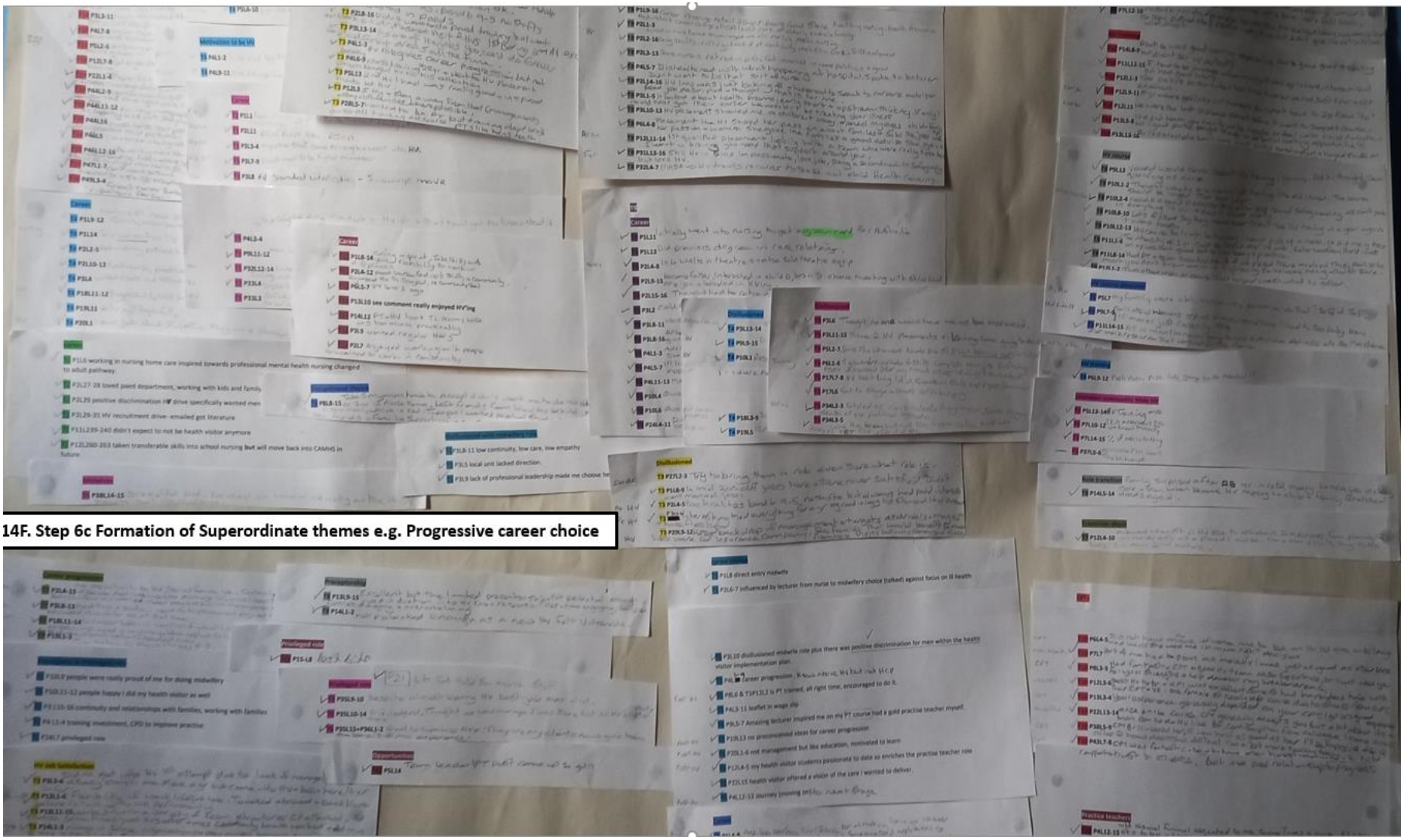


14C. Step 5 searching for connections across themes in another case T6



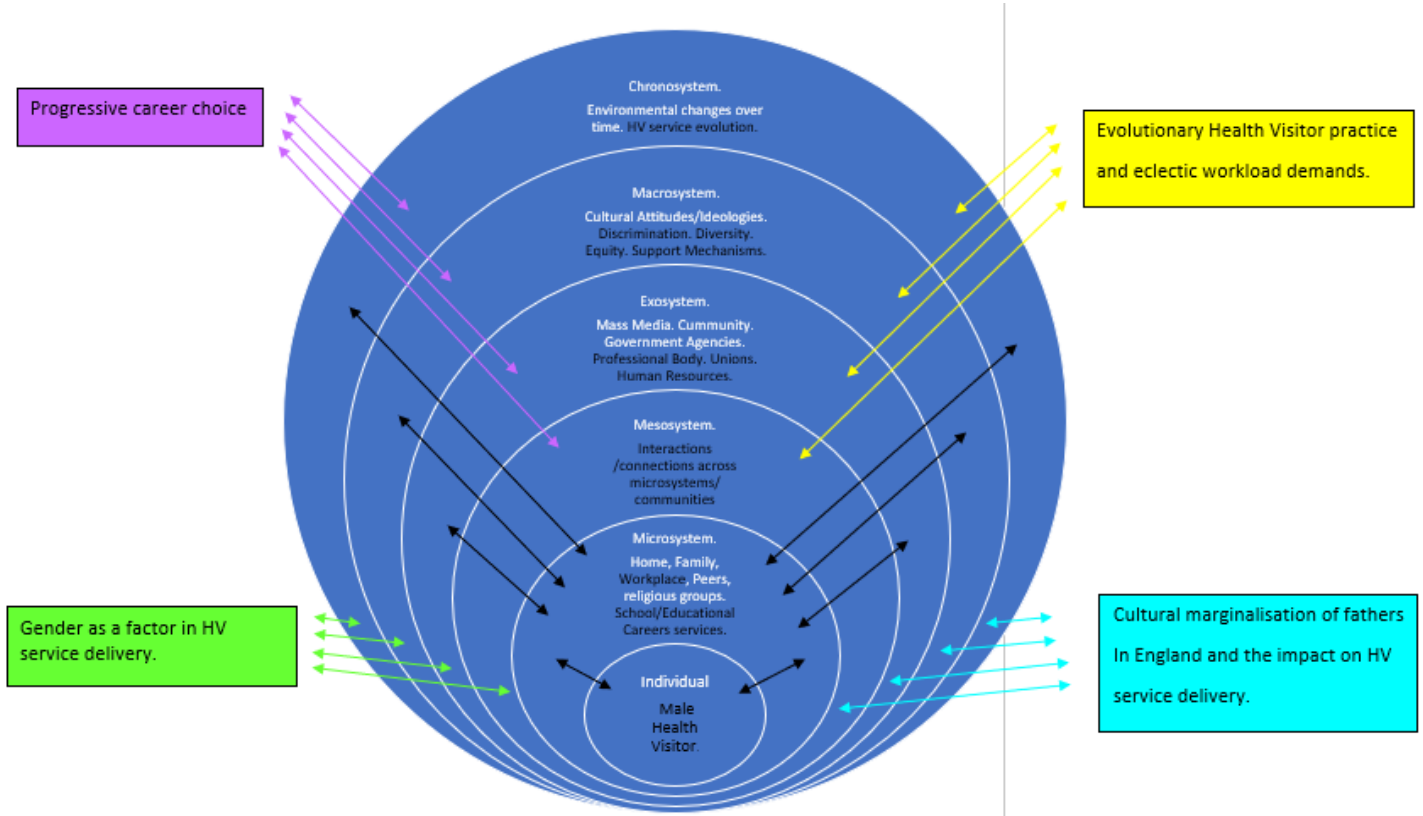
14D. Step 6. Looking for patterns across all cases


14E Step 6b. Looking for patterns across all cases
Female Dominated Role.
Oppressive HV Practice on clients
Preference for Male HV
Hidden Societal Male Voice
Invisible Fathers
Evolving HV Service Delivery
Job Satisfaction
Midwives Discriminatory
CAREER
Career Pre-HV
Career Post-HV
Privileged
Practice Teacher -ve +ve
Workload
Mothers NOT Judged by Male HV
Power
Diversity
Gender Bias Service Delivery
Oppressive Prejudical Discrimination Due to being Male
Men Bring Different Perspective
Transferable Skills
Dissillusionment
Attributes
HV Training + Course
Male HV Identity
Stigmatisation
Genderless
Male HV Limitations
Rejectia



14F. Step 6c Formation of Superordinate themes e.g. Progressive career choice

Appendix 15. Initial Proposal of a conceptual framework prior to writing the discussion chapter.



Key:
Four coloured boxes present the superordinate themes.
Coloured arrows demonstrate the fluid interaction of the superordinate themes across the 5 systems
Black arrows demonstrate the fluid interaction across the 5 systems.

Figure X. A proposed conceptual framework reflecting the lived experience of male health visitors.

REF: Created by Author 2021.

Appendix 16. Summary Tables A-D: Identifying recurrent themes.

The summary tables below show the participant transcripts that correspond to each theme and subsequently the superordinate theme, with a corresponding tick under each transcript number e.g.T1, demonstrating their contribution to a particular theme within their unique narrative. Key: ✓=Yes, x=No

Table A. Identifying recurrent themes for Superordinate Theme: Gender as a Factor in Health Visitor Service Delivery.

Superordinate Theme: Gender as a Factor in Health Visitor Service Delivery		**Transcript Numbers**										
		T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11
Themes	Being male as an asset influencing acceptance, toward Health Visitor Service delivery.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Male as a difference causing rejection: A notable lack of equality, through oppression and discrimination.	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
	The potential vulnerability of the male HV and the need for constructive managerial input as a determinant of male health visitor role fulfilment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Table B. Identifying recurrent themes for Superordinate Theme: Marginalised Fathers

Superordinate Theme: Marginalised Fathers		**Transcript Numbers**										
		T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11
Themes	Invisible Fathers: The hidden male voices within England's cultural norms.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Service delivery a double lens perspective for fathers who are male Health Visitors.	x	✓	✓	x	x	x	x	x	✓	✓	x
	Gender bias Health Visitor service delivery.	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓

Table C. Identifying recurrent themes for Superordinate Theme: Career Choice and progression.

Superordinate Theme: Career Choice and progression		**Transcript Numbers**										
		T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11
Themes	Pre Health Visitor Career	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Health Visitor training the minority issue	✓	✓	✓	✓	✓	x	x	✓	✓	✓	✓
	Practice Teachers and their influence on student progression	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Being a Qualified Health Visitor and Career progression.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Table D. Identifying recurrent themes for Superordinate Theme: Evolutionary Health **Visitor Practice and eclectic workloads.**

Superordinate Theme: Evolutionary Health Visitor Practice and eclectic workloads.		**Transcript Numbers**									
		T1	**T2**	**T3**	**T4**	**T5**	**T6**	**T7**	**T8**	**T9**	**T10**	**T11**
Themes	**Health Visiting: A Hidden Service**	✓	✓	**x**	**x**	**x**	✓	✓	**x**	✓	✓	**x**
	Caseloads: Challenges and Continuity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Evolving Health Visitor Service versus Demise of Health Visiting service	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Professional Health Visitor attributes and values toward service provision and caseload management.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Appendix 17. NMC (2020). Registration and qualification codes.

Statement of entry: Specialist community public health nursing part of the register

RHV: Health visitor

HV: Health visitor

RSN: School nurse

SN: School nurse

ROH: Occupational health nurse

OH: Occupational health nurse

RFHN: Family health nurse

FHN: Family health nurse

RPHN: Specialist community public health nurse

Appendix 18. QNI Letter asking to participate in Special Interest group, working toward the production of voluntary practice teacher standards.

11th August 2021

The Queen's Nursing Institute
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London W1G 0LZ
020 7549 1400
mail@qni.org.uk
www.qni.org.uk

Suzanne Le Blond
Senior Lecturer
Port Registraton Healthcare
University of Derby

Dear Suzanne

Practice Teacher Standards

I am writing to invite you to be a member of the advisory group for the development of Practice Teacher standards.

The QNI is leading a project to develop standards to support educational programmes for Practice Teachers across England, Wales and Northern Ireland.

We are undertaking this work in direct response to the feedback we have received from community service providers and programme leaders who have been clear that there is a significant and ongoing need for this level of teaching expertise in practice.

As many of you will know, the QNI and QNIS have a very successful track record of developing voluntary standards for community specialist practitioners and other practitioners and these can be found on our website: https://www.qni.org.uk/nursing-in-the-community/practice-standards-models/.

The work will be led by Angie Hack, QNI Assistant Director of Nursing Programmes, who has expertise in community nursing practice, practice teaching and in the development, validation and delivery of NMC approved programmes in Higher Education.

The work will start with an initial meeting on Tuesday 28th September 2021, where we will scope the work to be undertaken and discuss the draft project plan.

We would very much welcome your expertise as a member of the advisory group, which will be chaired by Professor John Unsworth, Chair of the QNI, and look forward to hearing whether you are able to participate in this work.

Best wishes.

Yours sincerely

[redacted]

Dr Crystal Oldman CBE
Chief Executive

Appendix 19. Summary of the collated final 21 papers

Paper No	Author(s) / Year of Publication / Geographic location	Title	Method	Participant Numbers	Ethical Approval	Informed Consent	Findings
1	Azadi, A. Valizadeh, L. Zamanzadeh, V. O'Connor, T. Negarandeh, R. and Taghinejad, H (2018) **Iran**	Maintaining Equilibrium: Socialisation sand Gendered Identities of Iranian Male nurses	Qualitative descriptive approach. Grounded Theory Semi-structured interviews x25. Data saturation	n=22	Y	Y	The core category of maintaining equilibrium comprised of socialisation strategies including informing, conforming and self-establishing. Four factors impact on the developing strategies. -Gendered image of nursing -Lack of support. -Gender and power realities of practice -Self-motivation
2	Blackley, L. S. Morda, R. and Gill, P. R. (2019) **Australia**	Stressors and rewards experienced by men in nursing: A qualitative study	Qualitative Semi-structured interviews. Phenomenology. 6 stage thematic analysis Interpretivist	n=6	Y	Y	Sense of satisfaction & rewarding career despite negotiating being a minority group in female dominated profession. Male nurse stressors and coping strategies inc. gender role conflict, workplace exclusion, female personal care delivery and apprehension, masculine task assignment, why men remain in nursing.
3	Blair, D. (2016) **America-Florida**	Thesis: Exploring the Lived Experience of Male Registered Nurses in the Workforce: A	Qualitative. Hermeneutic Phenomenology	n=17	Y	Y	Themes: Motivating factors- (job opportunity, job flexibility, finance stability) Breaking gender barriers-(moving beyond gender barriers, making a difference, caring for female patients)inc. social cognitive career theory Gendering- (preferential privilege, maintaining masculinity)

		Phenomenological Inquiry					
4	Bouret, J. (2017) America	Thesis: Male nurses' lived experiences with lateral violence in the workplace	Qualitative. Hermeneutic Phenomenology	n=15	Y	Y	4 Themes: (a) Experiencing lateral violence in a variety of ways, (b) Lacking organizational support, (c) Reacting to lateral violence, and (d) Effects of lateral violence. Inc social role theory. The study is anticipated to add to the nursing knowledge base and contribute to nursing leadership, practice, and education.
5	Cavayé, M. (2021)	Thesis: Male Nurses' Experience of Compassion Fatigue	Qualitative Phenomenological	n=3	Y	Y	Factors mediating the experience of compassion fatigue include; Positives-the rewards of nursing, the sense of agency, working in a specialism, salary, a supportive team and cumulative years of experience. Negatives- Shift patterns, workplace aggression inc; lateral violence, the business model and patient turnover rates. Strategies developed by male nurses to prevent compassion fatigue include; venting emotions, self-care, find meaning at work, work-life balance and for one engagement in less adaptive strategies.
6	Chang, H. E. and Jeong, S. (2021) South Korea	Male Nurses' Experiences of Workplace Gender Discrimination and Sexual Harassment in South Korea: A Qualitative Study	Qualitative Phenomenological	n=10	Y	Y	(1) experiences of workplace gender discrimination (2) sexual harassment
7	Cheng, M. L. Tseng, Y. H. Hodges, E. and Chou, F. H. (2018) Taiwan	Lived Experiences of Novice Male Nurses in Taiwan	Qualitative Descriptive study, content analysis	n=14	Y	Y	(1) choosing appropriate work departments based on personality and needs. (2) facing the pressure and frustration of independent work (3) getting help (4) obtaining acceptance among female cliques (5) reflecting on the relationship between gender and profession concerns about dependents and financial needs

8	Cottingham, M. D. (2015) America	Learning to 'deal' and 'de-escalate': How men in nursing manage self and patient emotions	Qualitative Metanarrative Audio diaries n=11 Interviews n=35 of which n=6 did both.	n=40	Y	Y	Categorized in terms of strategies for managing self-emotions and patient emotions including: (1) reframing the nursing role, (2) distancing, (3) relinquishing situational control (4) managing self as a means to managing patient emotion (5) Education/Knowledge as a means for managing patient emotion
9	Frimpong, D. K. (2016)	Men in a female-dominated profession: The lived experiences of Ghanaian male nurses in the United States	Doctor of Philosophy Thesis. Qualitative. Phenomenology. X6 semi structured 1-1 interviews + x4 focus groups	n=10	Y	Y	7 themes- 1. Separateness 2. Discrimination 3. job security and benefits 4. career opportunities 5. gender-based stereotypes 6. caring through spirituality 7. glass (d)escalator.
10	Guy, M. Hughes K. A. and Ferris-Day, P. (2022) New Zealand	Lack of awareness of nursing as a career choice for men: A qualitative descriptive study	Qualitative Thematic analysis Semi-structured online interviews	n=9	Y	Y	(1) men in nursing experienced isolation due to the societal gendering of nursing influencing the participant's knowledge and understanding of what nursing was, as a career. (2) for participants, nursing was not prominent in their awareness when leaving school and making career choices Limited geographical area to New Zealand. Male researcher-potential bias. Only 1 Māori participant
11	Holyoake, D. (2020) England	Similarly Different: Exploring How Male Nurses in CAMHS Experience Difference in Their Gender Performance	Qualitative Ethnographic of self, observation of others and spontaneous interviews across X6 CAMHS sites.	n=50 + 1 (self)	Y	Y	Emerging themes: related to the experience of identity, gender expectations and other related issues to do with the sensitivities and stresses of working with a patient population group emerging their senses of sexuality.
12	Juliff, D. Russell, K. and Bulsara, C.	The essence of helping:	Qualitative	n=9	Y	Y	**Key theme**: Motivators for entering nursing. Inc 2nd career.

	(2017) Australia	significant others and nurses in action draw men into nursing.	Semi-structured interviews 7 stage IPA				Subordinate themes: significant others' influence and support, career choice triggers **Key theme**: Essence of helping. Subordinate themes: External influence-significant others, Altruism
13	Kalemba. J. (2020) South Africa	'Being called sisters': Masculinities and black male nurses in South Africa	Qualitative Semi-structured interviews Thematic analysis	n=15	Y	N	(1) marginalised and subordinated masculinities (2) masculine performative practices. These two concepts work side by side in the daily lived experience of the male nurses
14	Kim, I. J. and Shim, H. W. (2018) South Korea	Subjectivity About Turnover Intention Among Male Nurses in South Korea: A Q-Methodological Study	Qualitative Q methodology	n=41	Y	Y	Four distinct types of subjectivity about turnover intention among male nurses were identified: (1) "Pursuing occupational values," (2) "Dissatisfaction with treatment," (3) "Seeking a relaxed and stable life," and (4) "Conflict related to organizational culture."
15	Kluczyńska, U. (2017) Poland	Motives for choosing and resigning from nursing by men and the definition of masculinity: A qualitative study	Qualitative Grounded Theory *Polish law no requirements for ethical approval in this type of study	n=17	N	Y	(1) vocation, interest in medicine (2) nursing as a method of pursuing an interest in medicine (3) accident (4) pragmatic motivation
16	Mao, A. M. Wang, J. L. Zhang, Y. Cheong, P. L. Van, L. K. and Tam, H. L. (2020) China	Male Nurses' Dealing with Tensions and Conflicts with Patients and Physicians: A Theoretically Framed Analysis	Qualitative. Thematic analysis	n=24	Y	Y	6 themes inc, **Four** themes identified are related to nurse/patient relationships: respecting patients' decisions, neglecting minor offenses, defending dignity, taking a dominant position; **Two** themes are related to nurse/physician relationships: rationalizing physicians' superiority over nurses, establishing relationships with physicians by interpersonal interactions. Inc. social identity theory

17	Martinez-Morato, S. Feijoo-Cid, M. Galbany-Estragues, P. Fernandez-Cano, M. I. and Maranon, A. A. (2021) Spanish	Emotion management and stereotypes about emotions among male nurses: a qualitative study	Qualitative. Semi structured interviews. Content analysis	n=12	Y	Y	(1) Stereotypes related to the emotional aspects of care: participants took for granted some gender stereotypes while questioning others and defended alternative ways of managing emotions related to care. (2) Emotional management strategies: Participants described keeping an emotional distance, setting boundaries, relativising problems and using distraction and humour.
18	Qureshi, I. Ali, N. and Randhawa, G. (2020) British South Asian	British South Asian male nurses' views on the barriers and enablers to entering and progressing in nursing careers	Qualitative interpretative intersectional approach	n=5	Y	Y	**Main themes**- **Barriers**: poor pay and conditions; negative immediate, extended family, community views; and a lack of knowledge and awareness of the nursing profession. **Enablers**: personal circumstances (including role models) and ethnicity (including the role of religion and masculinity)
19	Saleh, M. Y. N. Al-Amer, R. Al Ashram, S. R. Dawani, H. and Randall, S. (2020) Jordan	Exploring the lived experience of Jordanian male nurses: A phenomenological study	Qualitative Hermeneutic phenomenological approach.	n=22	Y	Y	(1) Personal gains (2) Masculinity (3) Cultural influences While male nurses saw themselves as more independent in decision making and more productive than their female counterparts Significantly the participants saw nursing as a means of spiritual fulfilment and personal gain.
20	Shin, S.-Y. and Lim, E.-J. (2021) Korea	Clinical Work and Life of Mid-Career Male Nurses: A Qualitative Study	Qualitative Phenomenological study.	n=9	Y	Y	(1) Limitations and adaptations to work performance. (2) Interpersonal Difficulties and coping. Facing reality and preparing for the future
21	Smith, C. M. Lane, S. H. Brackney, D.	Role expectations and workplace	Qualitative	n=11	Y	Y	(1) Role expectations (2) Work place relations

	E. and Horne, C. E. (2020)	relations experienced by men in nursing: A qualitative study through an interpretive description lens	Interpretative descriptive approach.				Role expectations influenced by sociocultural views, professional acceptance and patient/family perceptions. Workplace relations associated with being male, social cliques and peer support.

Appendix 20. The extracted and collated 20 subthemes, following the thematical analysis of the final 21 papers.

Paper	Authors	Subthemes																		
		Lateral violence sexual harassment	Balancing	Female Gendered Nurse image	Lack of support / role model	Security /finance dichotomy	No knowledge of nursing	Career development / Flexibility	Evolution of self	Advantages inc. Job escalator	Stress. Masculine task assignment	Intimate care	Proud or privileged providing job satisfaction	Exclusion / Isolation	Escape male work environments	More technical roles higher pay	Essence of care	Valued as a professional	Gender discrimination	Genderless identity/Otherness	Communication
1	Azadi et al. (2018)		x	x	x	x	x	x	x		x										x
2	Blackley, Morda & Gill (2019)		x	x			x				x	x	x	x	x	x	x				
3	Blair (2016)			x		x		x		X		x	x								x
4	Bouret (2017)	x		x	x						x			x							x
5	Cavayé (2021)	x	x	x					x	x	x		x			x	x	x			x
6	Chang & Jeong (2021)	x		x	x						X	x		x					x		

7	Cheng et al. (2018)			x		x		x		x	x	x		x		x	x	x	x		x
8	Cottingham (2015)		x	x												x	x				x
9	Frimpong (2016)			x		x		x		x				x			x		x		x
10	Guy, Hughes & Ferris-Day (2022)			x	x	x	x	x				x		x		x			x		
11	Holyoake (2020)	x	x	x					x			x		x	x				x	x	x
12	Juliff, Russell & Bulsara (2016)					x		x					x	x		x	x	x	x	x	x
13	Kalemba (2020)		x	x		x		x		x	x	x	x	x		x		x	x	x	
14	Kim & Shim (2018)		x	x		x		x		x	x		x	x				x	x		
15	Kluczyńska (2017)			x		x	x	x		x			x	x	x		x	x		x	
16	Mao et al. (2022)					x						x				x		x		x	x
17	Martinez-Morato et al. (2020)		x	x					x		x	x		x		x	x	x	x	x	x
18	Qureshi, Ali & Randhawa (2020)		x	x	x	x	x	x						x			x	x	x	x	
19	Saleh et al. (2020)		x	x	x	x		x		x	x	x	x	x		x	x	x	x	x	x
20	Shin and Lim (2021)		x	x	x	x		x	x					x							x
21	Smith et al. (2020)		x	x				x	x	x		x	x	x			x	x	x	x	x
Total		4	12	19	7	13	5	13	6	9	10	11	9	16	3	10	11	11	12	9	14

Appendix 21. The four themes and 20 subthemes from the updated literature review.

Isolation	**Work related stress**	**Career development through job security and flexibility.**	**Valued as a Professional.**
• Female Gendered Nurse image. • Communication • Gender discrimination. • Exclusion/Isolation • Genderless identity/Otherness • Lateral violence sexual harassment	• Intimate care delivery. Touch • Stress inc. Masculine task assignment. • Balancing • Lack of support / role model. • No knowledge of nursing.	• Career development / Flexibility. • Escape male work environments. • Proud or privileged providing job satisfaction. • Finance security / dichotomy. • Advantages inc. Job escalator.	• Evolution of self • More technical roles higher pay • Essence of care • Valued as a professional

Appendix 22 Definition of Terms: Gender Roles. (O'Neil, 1981a p.203)

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Appendix 23 Assumptions About Gender Role Conflict and Sexism (O'Neill, 1981a, p.204)

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