Socio-cultural perceptions of nursing and its influence on the recruitment and retention of males student nurses in Nursing Education Institutions (NEIs) – KwaZulu Natal Province

by

Simangele Shakwane

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SUPERVISOR:

Prof JH Roos

NOVEMBER 2014
I declare that Socio-cultural perceptions of nursing and its influence on the recruitment and retention of men in Nursing Education Institutions – KwaZulu Natal is my work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Simangele Shakwane

Date
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Abstract

Nursing is a female dominated profession; making it difficult for men in the profession to excel in their caring capacities as nurses. This study aimed at identifying and describing male and female nurses’ insights into and perceptions of socio-cultural influences on the recruitment and retention of men in the nursing profession and also explores their experiences in providing intimate care to patients of opposite gender. The study adopted a qualitative research methodology: 16 male and 11 female nursing students were purposively sampled and were interviewed using semi-structured questions. Themes of nursing seen as women’s work; low status; stigma; caring and helping others were developed. Feelings of embarrassment and discomfort; fear and refusal of care were experienced when providing intimate care to patients of opposite gender; this has led male participants to develop strategies to protect themselves from sexual accusations. The Nursing Education Institutions (NEIs) have insufficient toilets for male nursing students; there is a lack of male role models and feminine pronouns are used when relating to professional nurses.

Evidently socio-cultural perceptions of nursing enforce a negative image. The difficulties experienced by male and female nurses when providing intimate care and lack of male-friendliness in NEIs were discussed. These factors will lead to a further decline in the recruitment and retention of men in nursing; skilled and intelligent nurses are leaving the profession.

Keywords: socio-cultural, perceptions, nursing, gender, intimate care, recruitment, retention, social constructivism
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<td>DoH</td>
<td>DEPARTMENT OF HEALTH</td>
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<td>KZN</td>
<td>KWAZULU-NATAL</td>
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<tr>
<td>KZNMCN</td>
<td>KWAZULU-NATAL COLLEGE OF NURSING</td>
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<td>MRC</td>
<td>MEDICAL RESEARCH COUNCIL</td>
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<tr>
<td>NEI</td>
<td>NURSING EDUCATION INSTITUTION</td>
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<td>NIHR</td>
<td>NATIONAL INSTITUTE FOR HEALTH RESEARCH</td>
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<td>RSA</td>
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<td>SA</td>
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<td>SABC</td>
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<td>WCA</td>
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CHAPTER ONE

INTRODUCTION AND ORIENTATION OF THE STUDY

1.1 INTRODUCTION

This research study described the journey of the researcher in an endeavour to explore and describe the socio-cultural perceptions of nurses in the nursing profession and their influence on the recruitment and retention of men in the nursing profession as perceived by male and female student nurses. A qualitative research inquiry was employed to sample participants, collect and analyse data. Global societies perceive nursing as a female-oriented profession making it difficult for men to excel in their caring capacities as nurses. In the 21st century, men select nursing as a career of choice but they often do not complete the nursing course. There is a high attrition rate of men students compared with that of their female colleagues (Sienkiewicz 2012:49).

The Republic of South Africa claimed its democracy in 1994 and it was instituted on the values of human dignity, equality, non-racialism and non-sexism. The country embraced the constitution as the supreme law (SA 1996:3). Chapter two (2) of the constitution focuses on the “Bill of Rights of all citizens, which is the responsibility of the government to ensure that the rights of the people are respected, protected and promoted at all times regardless of race, gender and sexual orientation (SA 1996:6). The democratic constitution and other gender equality policies have assisted women previously discriminated against to enter male-dominated professions as a way to redress the past unfair treatment of women in education and the workplace. The same gender policies have indirectly discriminated against men regarding entering female-dominated professions, especially nursing and social work. In the past, medical officer occupations were dominated by men, but in the 21st century female doctors have shown a large increase in numbers compared with the number of men in the nursing profession. Are men pursuing the nursing profession less caring by nature, less responsible intrinsically or less empathetic biologically?
1.2 THE BACKGROUND TO THE RESEARCH PROBLEM

Society’s perception of nursing as a female-orientated profession makes it difficult for men to excel in their caring capacities as nurses. During the 17th and 18th centuries men dominated the nursing profession (O’Lynn & Tranbarger 2007:9). The nursing image was transformed by Florence Nightingale in the 19th century from male to female dominance; she advocated for improved nursing education, an increase in the status of female nurses and this was considered an early advocacy designed to broaden career options for women. In 1860 Florence Nightingale established schools of nursing that did not mix male and female students as men were barred from her schools. She considered nursing as appropriate for women because it was an extension of their domestic role. Her image of the nurse was someone who was nurturing, domestically oriented, humble and self-sacrificing. In the span of her lifetime nursing was identified as a profession deeply embedded in the female gender and males were excluded (McWilliams, Schmidt & Bleich 2013:42). Many hospitals and nursing schools followed in Nightingale’s footsteps of excluding men from nursing training. This was the beginning of the exclusion of men and the stereotyping of nursing as a feminine occupation.

Nightingale influenced the perception of society on the nursing profession resulting in few men being attracted to the profession. Culture contributes to the stereotypes surrounding men entering the nursing profession, for example, in an African culture men are socialised to be strong and they are frequently told “men don’t cry”, because men who show emotion are classified as weak (Ntibanyane 2008). As a result of this connotation, people tend to believe that men cannot provide the nursing traits of care, love and gentleness. Therefore, men who select nursing as a career of choice risk challenging traditional gender-defined roles and stereotypes.

The media are responsible for stereotyping and portraying the nursing profession as exclusively feminine. On Friday evenings at 20:00 a hospital drama called “Jozi H” portrays nurses as females only, while doctors consist of both males and females (SABC3 2013. Jozi H. Fridays, 20:00). On the annual celebration of Nurse’s Day on 12 May 2013, Naidoo (2013) wrote an article that supports the assumption that nursing is a woman’s job: “Being a nurse, you are always a mother: At work you are
a mother to the patients and you take care of the younger nurses who look to you for help and guidance”.

Globally men are in the minority in the nursing profession regardless of the economic status of the country. Statistics for the gender analysis of health workers for selected developed countries show that health occupations are subjected to both horizontal and vertical gender imbalance. Over 90% of nurses are represented by female personnel and less than 10% by male personnel (WHO 2008a:2). In South Africa nursing is dominated by women of all races and cultures. Statistics of the South African Nursing Council (SANC) show that female professional nurses number 92% and male nurses 8% while student nurse enrolment consists of 77% females and 23% males (SANC 2012a). These figures indicate that females will continue to dominate the profession for a long time if the recruitment and the retention of men are not prioritised and a “male” friendly environment not created for men entering the profession.

This study focused on KwaZulu-Natal province where females constitute 92% of professional nurses (SANC2012a). This study was motivated by the researcher’s experience in the teaching of nursing history to first year students in one of the campuses in KwaZulu-Natal College of Nursing (KZNCN). In the process of lecture preparation, the researcher observed that in the curriculum, objectives and prescribed books there was no mention of men’s contribution to nursing. The KZNCN consists of 11 campuses and 14 sub-campuses. The principals of these campuses are 92% female. The nurse educators consist of 91% females. These statistics indicate that male student nurses do not have male role models in the training schools.

The democratic constitution of the Republic of South Africa (SA 1996) states clearly that all citizens have a right not to be discriminated against regardless of race, gender and language or creed. Therefore, men should not be discriminated against with regard to the nursing profession on the grounds of their gender. Affirmative action policies, gender equality and employment equity have assisted South African women to move from female-dominated occupations to male-dominated occupations, particularly medicine, law and pharmacy. The movement of men into
the nursing domain, however, has been very slow. This serves to show that women have been given support to enter male-dominated professions, but little attention and support have been given to men to break into professions dominated by women.

The Department of Labour (2004) states clearly that all recruitment and selection processes should be conducted fairly and without discrimination of colour, gender and race. The purpose of the recruitment and selection policy is to achieve numerical targets and to increase the representativeness of designated groups in the workplace. Are men equally represented in the nursing profession and if not why is this ignored?

1.3 STATEMENT OF THE RESEARCH PROBLEM

Nursing is a female-dominated profession; therefore, men who enter the nursing profession are generally stereotyped as sexually deviant, homosexual and feminine, as if it were not possible to consider that a “normal” man would engage in “women’s work”. The ability of men to fulfil their jobs is often questioned. There are few role models and mentors in NEIs and men are not actively recruited and often people react to their gender rather than their qualifications and abilities as nurses (Clow & Ricciardelli 2011:194).

Rules and regulations seem to work towards excluding men rather than valuing them as an important part of the nursing profession. These sanctions do not simply occur because of gender; for example, male doctors are exempt from this concern. These sanctions arise as a reaction to men in an occupation that is not congruent with their traditional masculine gender roles (Clow & Ricciardelli 2011:191).

The Department of Labour (2008) in the national policy framework for women empowerment identifies three types of comparative [gender] discrimination law: “... the lack of role models from designated groups in senior positions in a corporation, workplace structured according to the assumptions of homogenous female/male workforce and sexist language in work place”. This comparative discriminatory law exists in the nursing profession because there is an assumption that nursing is a homogenously female profession. Male student nurses do not have
male role models in the NEIs and sexist language is used frequently; for example, a professional nurse is called “sister” or all nurses are classified as “she”, thus excluding men as active participants in the profession.

Bias and gender stereotyping of men entering the nursing profession are the major factors leading to the low number of male recruits and failure to retain them in the nursing profession. SANC gender distribution statistics for professional nurses and student nurses indicates that during the 5 year period of 2009 to 2013; male nurses on training were 22-25% and male professional nurses 6-8%. During this period there was 1% increase in the male professional nurses’ statistics. One may wonder what happened to the 14-18% male nursing students during their training. This statistics is an indication of the difficulties in the retention of men in the profession.

Intimate procedures put male nurses at risk of being falsely accused of rape. In a recent court case a female patient reported that she had been raped by a male nurse. According to New Age (2013:10), the reason for the woman to consider rape was that the male nurse was “fiddling” with her private parts. It is not clear how he was fiddling, but the male nurse was cleared of the allegations. If male nurses are not taught how to deal with intimate procedures and if society is not socialised to the fact that men can be dedicated caring nurses, more cases in this regard will be reported. The negative impact of cases like this on the profession is irredeemable.

In the gender equality and equity policies there is no provision for the recruitment and retention of men in the health workforce (nursing) and in South Africa there are no studies that have focused on the recruitment and retention of men in the nursing profession. Men have not benefited from gender equality, equity and affirmative action privileges; one may conclude that these policies were entrenched as a tool to penalise men for the past oppression of women. The minority status of men in the profession is a gender issue that needs to be addressed in order to attain gender equality and equity in the profession. If men are continually discriminated against in the profession, this will lead to an increased attrition rate and litigation based on the execution of intimate procedures by male nurses.
1.4 THEORETICAL GROUNDING OF THE RESEARCH

This study was grounded on the real-life experiences of people with personal knowledge of the topic under study. Interviews with human beings were used directly as the instrument through which information was gathered (Polit & Beck 2012:15). The social constructivism theory was used to guide the study. Social constructivists believe that people’s perceptions and descriptions of the world, including language, are social artefacts. The theory posits that what is known and understood by individuals is derived from communities of understanding rather than individuals operating as an isolated entity. It emphasises the importance of culture and context in understanding what occurs in society and constructing knowledge based on this understanding.

Assumptions of social constructivism are based on reality, knowledge and learning of people. Reality is constructed through human activity. Members of a society together invent the properties of the world. Reality is not a fixed entity but rather a construction of the individuals participating in the research; reality exists within a context and many constructions are possible. Knowledge is a human product and is socially and culturally constructed. It is derived from interactions among people and their environment; it resides within cultures. Individuals create meaning through their interactions with one another and with the environment they live in. Knowledge is maximised when the distance between the researcher and the participants is minimised. Learning on the other hand is a social process of creating meaning; and meaningful learning occurs when individuals are engaged in social activities (Polit & Beck 2012:12). This theory was incorporated into the study by investigating the male and female student nurses in their real-life situations at the NEIs. The reality of the phenomena was subjected to the participants’ knowledge, reality and experience of the subject under study. The researcher engaged with the participants and participant-researcher’s relationship was maintained.

1.5 DEFINITIONS OF KEY CONCEPTS

The researcher formulated the following definitions of key concepts in order to ensure that the reader and the researcher attach the same meaning to the concepts under discussion.
1.5.1 Experience

Experience is the knowledge and skills that one have gained through doing something for a period of time; and includes the things that has happened to an individual that influence the way an individual thinks and behaves. This knowledge and skills is shared by all members of a particular group in a society (Oxford Advanced Learner’s dictionary 2010:514).

In this study, experience is defined as an event, knowledge and skills that male and female student nurses have gained during their time of nursing training programme which has influenced their way of thinking and behaviour.

1.5.2 Gender

Gender refers to the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for male and female (WHO 2013). Gender attributes are defined in this study as the characteristics of socially constructed roles, behaviour and activities that a given society denotes as suitable for men and women.

1.5.3 Gender issues

Gender issues arise when inequalities and inequities are shown to exist between people purely on the basis of their classification as being female or male (Department of Labour 2008: xviii). In this study, gender issues are described as any inequality and inequity that exists in the NEIs regarding the classification of students based on their gender either as male or female.

1.5.4 Indirect unfair discrimination

Is a barrier that exists when a rule, procedure, policy, practice or guideline or an aspect of it limits the opportunities of employees because they belong to a designated group (Department of Labour 2004).

In this study, indirect unfair discrimination is regarded as any procedure, policy and guideline that limit the opportunity of any individual to enter nursing training on the grounds of their gender.
1.5.5 Intimate procedures

Intimate procedures involving inspection and possible contact with those parts of the body whose exposure can cause embarrassment to either the patient or the nurse (O’Lynn & Krautscheid 2011:24).

An intimate procedure is any procedure that invades the physical privacy of a patient. In this study the researcher defined these procedures as any task of an intimate nature which a male or female patient is unable to undertake on their own and is associated with bodily functions and personal hygiene which require direct contact with intimate bodily parts by male or female student nurses during the implementation of their nursing care.

1.5.6 KwaZulu- Natal College of Nursing (KZNCN)

Is the provincial institution dedicated to providing nursing training to all student nurses enrolled for training at public training schools in the province of KwaZulu-Natal; it encompasses 11 campuses and 13 sub-campuses.

1.5.7 Nursing Education Institution (NEI)

Is any nursing college/institution that is dedicated to providing nursing science education and training accredited by SANC in terms of Nursing Act No. 33 of 2005. The function of SANC is to accredit nursing education institutions and training programmes presented by those institutions (SA 2005:6). In this study it is regarded as the nursing education institution accredited by SANC to provide nursing sciences education.

1.5.8 Perception

Perception is defined as the act or process of becoming aware of internal or external sensory stimuli or events involving meaningful organisation and interpretation of those stimuli. It also applies to evaluation of one’s own and others’ internal states and beliefs; person’s perceptions are not necessarily identical to the stimulus object or event being perceived (Medical Dictionary 2015).
1.5.9 Recruitment

Recruitment is a process in which somebody does something to find new people to join a company or an organisation (Oxford Advanced Learner’s Dictionary 2010:1230).

Recruitment is a process of finding and hiring the best qualified candidates for a job opening, in a timely and cost effective manner. The recruitment process includes analysing the requirements of a job, attracting employees for that job, screening and selecting participants, hiring, and integrating the new employee into the organisation (Business Dictionary 2013a). The Department of Labour (2004) defines recruitment as a process that employers use to attract applicants to a job to determine their suitability while retention is the action of the employers to keep employees in their institutions.

In this study, recruitment is used as a process of searching and encouraging male candidates to enter nursing training in the NEIs.

1.5.10 Retention

Retention is an ability and effort of a company to keep employees from leaving and maintenance of a working environment which supports current staff in remaining with the company (Business Dictionary 2013b).

In this study, retention refers to the ability of the NEIs to take measures to encourage male nursing students to remain in the nursing training programme (SANC R.425 or R.683) until completion of the programme.

1.5.11 South African Nursing Council regulation R.683

Is the regulation relating to the minimum requirements for the bridging course for enrolled nurses leading to registration as a general nurse (professional nurse), the duration is two (2) academic years (SANC 1997:1).
1.5.12 South African Nursing Council regulation R.425

Is the regulation relating to the approval of and minimum requirements for the education and training of a nurse (general, psychiatric and community) and midwife leading to the registration as a professional nurse. The duration of the course is four (4) academic years (SANC 1988:1).

1.6 PURPOSE OF THE STUDY

There were two purposes for undertaking this study:

- To identify and describe male and female student nurses' insights into and perceptions of the socio-cultural influences on the recruitment and retention of men in the nursing profession
- To explore intimate procedures and the students’ experiences in providing these procedures to opposite gender patients.

1.7 OBJECTIVES OF THE STUDY

The specific objectives of this research study were to

- explore and describe the socio-cultural influences on the recruitment and retention of men in the nursing profession as perceived by male and female student nurses in KZNCRN
- identify intimate procedures provided by male and female student nurses and describe their experiences in implementing these procedures to opposite gender patients
- explore NEI's infrastructure for a male friendly environment and provision of basic needs

1.8 THE RESEARCH QUESTIONS

The researcher wanted to answer the following research questions:

- What are the socio-cultural perceptions of the nursing profession and their influences on the recruitment and retention of men in the profession?
- What are the experiences of male and female student nurses in providing intimate procedures to patients of the opposite sex?
1. Are the NEIs providing a friendly environment for male nurses to adapt and excel as professional nurses?

1.9 RESEARCH DESIGN AND METHODOLOGY

Generic qualitative research design was employed to conduct and direct the study. This research design offered the researcher an opportunity to collect data in the natural environment of the participants. Purposive sampling was used to enrol male and female nursing students as participants in this study. This sampling approach offered the researcher an opportunity to choose the participants to be sampled, participants that were thought to be knowledgeable about the subject understudy and was willing to provide valuable information.

The study was conducted in KZN province in public NEIs. Two campuses were purposively selected and the participants for this study were the students enrolled for R.425 and R.683 programmes. The researcher obtained ethical clearance from the UNISA Ethical Committee; research approval letters were received from KZN DoH, KZNCN, and Campus A and B principals. Data was collected till saturation was reached, semi-structured interviews and observations was used. This section of the study is discussed fully in chapter 3.

1.10 SIGNIFICANCE OF THE STUDY

Discrimination against men in the nursing profession is a global problem which needs to be addressed in order to combat nursing shortage and provide gender equality and equity in the profession. The knowledge generated from this study will assist nurse educators to better understand gender-related issues in nursing education, especially from the male student’s perspective. Nurse educators initiate the entire socialisation process for student nurses by teaching the traditions and knowledge of the field and then guiding students as they develop their abilities to think critically and behave as nurses. Non-accepting and non-supportive behaviours and attitudes place male student nurses at high risk of leaving the nursing training programmes prior to graduation (Kirk 2012:21). This study could assist in decreasing the attrition rate of male student nurses during their nursing training. It will also aid in the development of strategies which could assist in the improvement of male nurse’s growth and orientation in the nursing profession. The study could also empower
nurse educators in their methods of teaching and demonstrating intimate procedures to male and female nurses.

1.11 SCOPE AND LIMITATIONS OF THE STUDY
The researcher used a qualitative research design with purposive sampling; the findings of the study will not be generalised to other provinces. The sampling of the study includes only male and female student nurses enrolled for R.425 and R.683; other nursing programmes that might provide valuable knowledge were excluded. The researcher collected data from 2 of the 11 campuses and 14 sub-campuses. Participants from one campus were known to the researcher, their responses might have been influenced by their previous encounter with the researcher. The study focused on only the government NEIs; all private NEIs were excluded.

1.12 OUTLINE OF THE STUDY
This dissertation consists of the following five chapters:
- Chapter 1 gives the orientation and background of the research study.
- Chapter 2 contains the theoretical framework and the review of literature relevant to the research study.
- Chapter 3 describes the research design employed and includes the description of how participants were selected, the procedures that were followed, the instruments utilised and the analysis of the data.
- Chapter 4 depicts the results of the study.
- Chapter 5 provides an analysis, summary, concluding comments and recommendation for further study.

1.13 CONCLUSION
In South Africa, as in all other countries, nursing is perceived as a feminine profession. This study challenges this perception as a foundation for a review of policies that indirectly discriminate against men in the nursing profession. The qualitative approach guided by social constructivism theory provided rich and significant facets on the socio-cultural influences on the recruitment of men in the nursing profession perceived by male and female student nurses. Lack of role
models for male nursing students makes it difficult for males to be socialised in a female-dominated workplace. As the study focused on learners enrolled for R.425 and R.683 programmes, the researcher also aimed at assisting in the recruitment of men to the nursing profession, in turn increasing the number of male professional nurses in the country. For the country to claim democracy, gender equity and equality, men and women need to be accepted in their career choices regardless of their gender.
CHAPTER 2
THEORETICAL FOUNDATION AND LITERATURE REVIEW

“We are all influenced by our cultural context and history which in turn shape our view of the world, the forces of creation and meaning of truth” (Mills, Bonner & Francis 2006:2).

2.1 INTRODUCTION

In this chapter the researcher discusses the theory underpinning the study and the review of available literature. Social constructivism is a theory that befits social and cultural perceptions of the nursing profession which is based on individual socialisation and gender roles. Therefore, it provides a platform that enables us to understand the origins of all perception and knowledge related to the nursing profession.

This study’s purpose was to identify and describe male and female student nurses’ insights into and perceptions of the socio-cultural influences on the recruitment and retention of men in the nursing profession and also explore the students’ experiences in providing intimate care to opposite gender patients. The available literature will assist in identifying already known socio-cultural perceptions of the nursing profession, challenge known perceptions and identify gaps in the existing knowledge.

2.2 THEORETICAL FRAMEWORK

Theory is an abstract generalisation that presents a systematic explanation of the relationships among phenomena (Brink, Van der Walt & Van Rensburg 2012:218; Polit & Beck 2012:744) and it strives to make sense of a certain phenomenon understudy (Tracy 2013:49). A theoretical framework, on the other hand, is the overall conceptual foundation of a study (Polit & Beck 2012:128) which provides a context in which the researcher can examine a problem, gather and analyse data (Brink et al 2012:26). This framework embraces or supports the theory of a research study; it introduces and describes the theory explaining why the research problem exists (Polit & Beck 2012:131; University of Southern California Libraries 2014). It
allows the researcher to integrate observations and facts into an orderly scheme. It connects the researcher to an existing body of knowledge, guided by relevant theory and the choice of a relevant research method (USC Libraries 2014).

2.2.1 Constructivism

Constructivism is a term given to a range of theories about knowledge and learning rooted in both psychology and philosophy, seeking to explain what “knowing” is and how people come to “know”. It is characterised by people constructing knowledge, this creation of knowledge is based on their previous experience; therefore personal experience is used to create knowledge (Amarin & Ghishan2013:52). This constructivist worldview denies the existence of an objective reality, asserting instead that reality is a social construction of the mind and there are multiple realities (Polit & Beck 2012:11). Realities are constructed and reproduced through communication, interaction and practice. They are connected and known through society’s cultural and ideological categories (Tracy 2013:40). Therefore, this denotes that one cannot acquire constructed knowledge and a sense of reality in isolation. Once knowledge is constructed, meaning is developed which is a shared understanding among individuals whose interaction is based on common interests and assumptions that form the grounds for their communication.

2.2.2 Social constructivism

Social constructivism is an epistemology that leads to defining principles that maintain the social nature of knowledge, and the belief that knowledge is the result of social interaction and language usage, and thus is shared, rather than an individual experience. This social interaction occurs within a socio-cultural context, resulting in knowledge that is bound to a specific time and space (Barker 2012:9). This theory is orientated to teaching and learning, affirming that knowledge is socially constructed and mediated by a cultural, historical and institutional context (Zozakiewicz & Rodriguez2007:401). Social constructivists emphasise that our constructions of discourse are shaped by the manner in which we exchange our perceptions and portrayals of reality. What is known and real is, therefore, constructed through the social interpretation and inter-subjectivity influence of language, family and culture that organise society (Barker 2012:26). Community or
society is placed prior to an individual because an individual is seen as a by-product of the social sphere in which one interacts with the society to construct knowledge (Bossot 2012:33).

2.2.2.1. Social knowledge

Knowledge is the body of facts, beliefs and practical skills that people accumulate over time (Du Toit & Van Staden 2009:30). This knowledge is developed, transmitted and maintained in the social situation (Berger & Luckmann1966:15); therefore, all-knowing is mediated through social interactions and interchange (Barker 2012:26). This knowledge is created through language, meaning that knowledge does not exist in the minds of the individuals; rather it is situated and created by continuing relationships within a particular society. Hence, it is a human product and is socially and culturally constructed. Individuals create meaning through their interaction with one another and with the environment in which they live. Social constructivism assumes that all knowledge is socially constructed, that knowing is mediated through social interactions, where knowledge is viewed not as something that occurs within an individual’s mind but as a result of social interactions (Barker 2012:9).

Construction of this knowledge is influenced by subjectivity formed by cultural and historical factors of the community or society. Without the social interaction with more knowledgeable others it is impossible to acquire social meaning of important symbol systems and learn how to use them (Amarin & Ghishan 2013:55). Social knowledge is concerned with the relationship between human thoughts and the social context within which it arises, concerning itself with everything that permits construction of societal knowledge and reality (Berger & Luckmann 1966:26).

2.2.2.2 Reality

Social constructivist epistemology links closely to the post-modern worldview in which the idea that different realities are created by means of a social process of shared meanings (Van Zyl 2009:24). Reality must be perceived as a socially constructed aspect of human life and the process of reality construction must be analysed for its specificity to the social context in which it is created (Berger & Luckmann 1966:15). Realities are captured in the form of multiple, intangible mental
constructions, socially and experientially based, local and specific in nature and dependent for their form and content on the individual persons or groups holding the constructions (Guba & Lincoln 1994:110). These realities are not fixed but are the constructions of individuals (Polit & Beck 2012:11) and members of society invent the properties of the world within a certain context (Julian 2011). Therefore, reality cannot exist prior to social interaction. Social constructivism postulates that reality is constructed through a social process characterised by mutual agreement among people on the nature of reality, whereby shared meanings, beliefs and values are attained (Van Zyl 2009:24).

2.2.2.3 Learning

Learning is viewed as a social process which does not take place only within an individual, nor as a passive development of behaviour that is shaped by external forces. Meaningful learning occurs when individuals are engaged in social activities. These realities can either inform or challenge existing conceptions of meaning and in the process provide an opportunity for accepting new meanings or confirm currently held views on the phenomenon. Amarin and Ghishan (2013:55) identify basic assumptions and principles of learning:

Learning is an active process, adaptive activity. It is situated in the context in which it occurs. It is an essential process of making sense of the world and social interaction plays a [vital] role in learning.

These assumptions assume that an individual cannot learn in isolation; an interaction with members of the society provides an opportunity for one to acquire new information or to embrace what is known.

2.2.2.4 Language

Language is a system of vocal signs, which is historically and culturally established for human speech systems (Berger & Luckmann 1966:51). It is the foundation of every culture and is a major means of cultural transmission; the process whereby one generation passes culture to the next. Du Toit and Van Staden (2009:30) on the other hand define language as a system of symbols that allows members of a society to communicate with one another. Even though the authors differ in their
ideology, it brings to light that in order for the members of a society to bond and create meaning, they need both verbal and non-verbal communication which is characterised by vocal and symbol signs. These signs originate primarily from everyday life, a reality in experience of wide-awake consciousness which is dominated by a pragmatic nature. It provides one with a ready-made possibility for an on-going objectification of an unfolding experience of life. It typifies experiences, allowing one to consider them under broad categories in terms of which they are meaningful not only to an individual but also to others (Berger & Luckmann 1966:53).

2.2.2.5 Culture and society

In a sociological point of view, culture is defined as a multifaceted collective of knowledge, belief, art, morals, laws, customs and other skills and habits which one acquires as a member of a society (Du Toit & Van Staden 2009:19). Within a culture a society exists which is a system of interrelationships that connects individuals together. Each culture determines how members of the society think or feel; it directs their actions and defines their attitudes on life. It also defines accepted ways of behaviour for the members of a society; this behaviour is acquired during a process of socialisation (Du Toit & Van Staden 2009:24).

2.3 SOCIALISATION

Socialisation is processes of learning in which an individual learns the culture, beliefs, norms and values that are socially expected of members of a particular society, a way in which an individual becomes a member of a society or a group (Du Toit & Van Staden 2009:48). An individual needs to make adjustments in order to embrace and internalise the expected behaviour for the maintenance of order and discipline in the society (Du Toit & Van Staden 2009:49; O'Lynn 2009:179). Socialisation also establishes individual and societal discipline, gives an individual identity and sense of belonging, and teaches a person social roles and life skills (Du Toit & Van Staden 2009:49).
2.3.1 Primary socialisation

Primary socialisation is defined as the first induction an individual undergoes in childhood; through which he or she becomes a member of a society (Berger & Luckmann 1966:150). It means that a child has acquired or internalised the basic information and skills which are necessary to become a fully-fledged member of a society (Du Toit & Van Staden 2009:59). Each individual born into the world is helpless, physically dependent on older members and also lacks patterns necessary for living in society. An infant has to learn skills, knowledge and an accepted way of behaving in society. Within this lack of knowledge of self and culture the child encounters the significant others who are in charge of socialising and these people are imposed upon him or her. Socialisation agencies (family, schools, churches etc.) in the society are responsible for primary socialisation in order to ensure that the different roles of later adult life will be adhered to. The child should have mastered a language to a certain extent to able him or her to communicate with others; take over the basic norms and moral value systems of the cultural group; develop the ability to enter into a social relationship; acquire approved patterns of behaviour and acquire a culturally proper social identity (Du Toit & Van Staden 2009:59).

2.3.2 Gender socialisation

Gender is a social structural phenomenon which is produced, negotiated and sustained by everyday interaction. It comprises the social and cultural distinction between males and females (Barker 2012:9; WHO 2007). Scholars such as O’Lynn and Tranbarger (2007:104) and Mullenwise (2009:1) agree that gender is a socially constructed difference in the behaviours of males and females and is learned rather than being the inevitable result of biology. Gender socialisation is a process through which children of different sexes are socialised into their gender roles and taught what it means to be a male or female. Girls wear pink and play with dolls; on the other hand, boys wear blue and play with cars or guns. The distinctions between women and men are based on the idea that men are strong, rational beings that are generally expected to be aggressive, uncompromising, factual, and intelligent and providers of goods, whereas women are socialised to be submissive, obedient, innocent, intuitive and nurturing (Clow & Ricciardelli 2011:198). Therefore, men that
express their emotions run the risk of being called “soft”, of exposing their vulnerability, and having their manhood questioned. This discourages men from sharing their feelings (Wallace 2007:14).

2.3.3 Gender roles

Are the specific behaviours that men and women display congruent with the socially constructed ideals of masculinity and femininity (Barker 2012:20; Choi, Herdman, Fuqua & Newman 2011:507). Sociologists describe gender roles as “instrumental and expressive”. Instrumental gender roles are associated with men characterised with the ability to compete and to lead; with aggressiveness, accomplishment of task and power. Expressive gender roles, characterised with nurturing, affiliating, and sensitivity to the needs of others, are associated with women (Ozdemir, Akansel & Tunk2008:154). The differentiation of gender roles is manifested in gender-specific tasks, play and dress code (Andrews & Boyle 2008:121); these roles are learned during infancy, childhood and adult life.

Hamieh and Usta (2011:6) describe the ideal characteristics of a man as “a good provider … decision maker, an authoritarian, a protector…”. Men lacking these traits are treated as incapable and cowards and are marginalised (Hamieh & Usta 2011:13). On the other hand, women are encouraged to be good mothers; they are expected by culture and society to be giving, emotional, share their problems with others, are valued for their looks or charm, but not their strength or brains. They are considered “unfeminine” if they are ambitious, demanding and tough or rough.

Different gender roles and behaviours often create inequalities, where one gender becomes empowered or disadvantages the other. Gender inequalities have a great impact on the life of individuals and society as a whole. These roles contribute to gender inequalities in employment opportunities and promotion, level of income, representation and education (WHO 2008a:81).

2.3.4 Gender roles and career path

Labour divisions are postulated along gender roles; this means that occupations are socially and culturally defined through construction of gender. Gender segregation
roles lead men and women to participate in different active ways (Clow & Ricciardelli 2011:198). Career choices for men and women gravitate to those occupations that society defines as masculine or feminine. Expression of interest and career choice may be seen as congruent with or deviating from traditional gender choices and are subject to responses of others in society as whether or not those choices are socially condoned or rejected. Any individual entering a gendered dominant occupation is at risk of encountering prejudice and discrimination (Julian 2011).

2.4 CONCLUDING REMARKS ON THE THEORETICAL FRAMEWORK

In this section the social construction of knowledge, reality, self-identity and gender were discussed in considerable depth in order to provide a foundation for understanding why culture and society perceive nursing as they do at the present time. The section attests to the fact that it is not an intrinsic trait for men to be decision-makers and bread winners or for women to be nurturers and mothers, raising children. Rather such traits are as a result of learned experience in which one internalises these gender roles. Even in the 21st century our cultures continue to pressure men and women to conform to the prescribed gender roles. The family, society and friends’ expectations become internalised as one’s own self-expectations; feelings of guilt and failure may result if one doesn’t follow the prescribed roles. Gender roles limit what men and women can achieve in their best abilities. They enslave individuals forcing them to become what others want them to be.

2.5 LITERATURE REVIEW

A literature review is a critical summary of research on a topic of interest, which is often prepared to put a research problem into context (Polit & Beck 2012:732). This summary provides the in-depth knowledge of the topic in order to determine what is already known and to place the study in the context of the general body of knowledge (Brink et al 2012:71). This section of the study presents a review of the literature pertaining to the concept of the socio-cultural perception of the nursing profession; the history of nursing education; men in nursing education; and the legal framework for employment.
2.5.1 History of nursing

History offers one an opportunity to reflect on the past in order to understand the present and attempt to change the future. In this part of the literature the researcher focuses on the three important epochs in the history of nursing which has shaped what has been, what is and what will be as the profession grows. These periods are classified as pre-Christian, Christian and 20th century. As the research takes place in South Africa, the developments of nursing in SA were also a focus area.

Pre-Christian

This is the period in history when care for the sick was provided within the family boundaries. This means that people did not seek outside help; family members were involved in the care of their loved ones. The first trained individuals to provide nursing care outside family boundaries were men and were supervised by male physicians during the Hippocratic period of ancient Greece. At this time women were not allowed to work outside their homes as nurses and this was due to society’s perception of women’s role as homebound. The first formal school was established in India where only men were admitted to the school, as women were not considered pure enough to serve in this role. The following was included in the curriculum: cooking, bathing and caring for patients, massage and obedience to the physicians (Liminana-Gras, Sanchez-Lopez, Saavedra San Roman & Corbalan-Berna 2013:135; O’Lynn & Tranbarger 2007:9).

Early Christian era

As indicated earlier, care of the sick was performed by laymen, but during the time of the early Christian movement, nursing care was provided within the monastic systems of the early Catholic Church. This care was provided to the poor, sick and was consistent with the teachings of Christ: “Do unto others as you would like them do unto you”. Christian hospitals were born, monks (men) and nuns (women) served as nurses and provided bedside care for the sick, injured and dying (Mullenwise 2009:3; O’Lynn & Tranbarger 2007:10).

Between the period of 1500 and 1800, nursing experience declined in its knowledge base foundations, values and status while medicine benefited from scientific
advancement. This period was classified as the “dark ages” for nursing; this was caused by the massive closure of monasteries and convents owing to the upheavals of the Protestant Reformation. Even though the number of male nurses declined, they continued to work as nurses and whenever intimate care for men was needed or when physical strength was required male nurses were called upon (O’Lynn & Tranbarger 2007:22).

O’Lynn and Tranbarger (2007:24) describe three noticeable social changes during this period:

- Decline in the numbers of monasteries and male orders combined with a relative increase in the number of convents and female nursing orders. This led to women replacing male clerics and laymen as nurses.
- Nursing became undisciplined and poor quality in many secular hospitals resulted, because nursing care was provided by male and female prisoners. The status of and respect for nurses and consequently the pay plummeted.
- The onset of the industrial revolution in Europe and North America marked the opening of many factories leading the way to the growth of industries and requirement of physical labour and long days away from home. Men were ideal for these working conditions, so a large number of men had to work in this type of environment in order to fulfil their social roles as family providers.

19th century

The First World War in Europe was the driving force behind the appearance of nursing as a respectable profession for women; this was through the influence of Florence Nightingale. At this period nursing ceased to be a low status profession because nursing activities were no longer performed by male and female prisoners (Liminana-Gras et al 2013:136). The emergence of Florence Nightingale in the 1860s coupled with Victorian class structure and division of labour based on gender marked the marginalisation of men who were in the care-giving role. During this period male nurses ceased to exist as nursing was established as “woman’s work” and they were excluded from most hospital-based nursing schools until the late 1960s (Kirk 2012). This led to the assumption that it was natural for nursing to be
provided by women and further excluded men from the profession (McWilliams et al 2013:42; O’Lynn & Tranbarger 2007:22).

*Nursing education*

Nursing education is the process whereby students are guided, assisted and provided with an environment which enables them to learn the art and sciences of nursing so that they can apply it to the nursing care of people who are in need of such care. Thus education aims at producing skilled nursing practitioners (Mellish, Brink & Paton 2008:7). Nursing education began towards the end of the 19th century under the leadership of Florence Nightingale who is considered a pioneer of modern nursing education because of the establishment of the Nightingale School of Nursing in 1860. The school aimed at training hospital and district nurses for the purpose of caring for the sick in the community. The admission requirement to the school was a good background of general education, impeccable moral standards, good character and payment for their own training (Bruce, Klopper & Mellish 2011:21; Mellish, Oosthuizen & Paton 2010:40).

In the 20th century men in nursing received hostility from their female colleagues who perpetuated negative stereotypes of men in nursing and creating obstacles for their employment. In 1919 Great Britain established the Nurses Registration Act in which only female nurses were allowed full membership on the registry and trained male nurses were placed on a separate registry. This further deterred men from entering the nursing profession (O’Lynn & Tranbarger 2007: 26).

2.5.2 History of nursing in South Africa

The history of nursing in South Africa is interconnected with the history of the country as a whole and with mining commencements (Bruce et al 2011:23). Prior to formal nursing education, community care was provided by women in various families, neighbours and farmers’ wives. There were few sworn midwives from the Netherlands to look after mothers and new-born children. After the establishment of the Nightingale School and Home for Nurses in London 1860, nursing education was revolutionised and spread to many parts of the world (Bruce et al 2011:23; Mellish et al 2008:46; Mellish et al 2010:39). When the discovery of diamonds and gold in
Kimberley caused unhygienic circumstances and accidents, health authorities realised that nursing training was necessary to combat encountered health problems. The arrival of the Anglican nuns in 1874 influenced the history of nursing in South Africa (Bruce et al 2011:24; Mellish et al 2010:44).

In South Africa, formal education started in 1877 at Carnarvon Hospital in Kimberley under the leadership of Sister Henrietta Stockdale (Armstrong, Bhengu, Kotze, Nkonzo-Mthembu, Ricks, Stellenberg, Van Rooyen & Vasuthevan 2013:106; Mellish et al 2010:44). Sister Stockdale was not only the first to establish modern professional standards, but she also provided the nursing profession with its founding charter (Dolamo & Olubiyi 2013:15). The educational requirements had no prescribed standard of education as an admission requirement. She expected potential candidates to be cultured young women, who were able to read widely, knew Latin and played some musical instrument. The characteristics of her students were those of real ladies, God-fearing and honest (Bruce et al 2011:25; Mellish et al 2010:45).

The promulgation of the Medical and Pharmaceutical Act 34 of 1891 heralded a century of growth and development for nursing as a profession in South Africa. The intention was to make provision for the licensing and registration of medical practitioners, midwives and nurses. The Act included the basic principles of education, certification, registration and ethical control of nurses and midwives (Armstrong et al 2013:63; Mellish et al 2008:48). In 1891 South Africa became the first country in the world to implement state registration for trained nurses (Bruce 2011:25; Mellish et al 2010:45).

Sister Henrietta had envisioned nursing education as part of general education in which nursing students would receive theory first and move to the practical field to practise the skills they had acquired in the nursing schools. This ideology of nursing education was not implemented; an apprenticeship system of training was adopted instead. This training system opened a door for the exploitation of nursing students, for example, lectures were given only when the examination period was close and during the off-duty days. These students did not get time to rest; when they were not working; they were having lectures and writing exams. This led to a high attrition
rate. Interestingly, nurses were taught to do something but never encouraged to ask why. And through this, nurses adopted a submissive stance in society and in the workplace. A full block system was established by Ms Pike at Groote Schuur Hospital in 1932; which provided full lectures that alternated with periods of clinical experience (Mellish et al 2010:49). This method created a more educational basis for nurses and provided an opportunity for students to correlate theory and practical work.

In 1928 the South African Medical Council came into existence and the promulgation of the Medical, Dental and Pharmacy Act, 1928 (Act 13 of 1928) provided recognition by the Medical Council of the certificates issued and the registration granted to nurses by previous medical councils. This council became the registered body for midwives and nurses, with disciplinary powers and approval of nursing schools, conducting of exams and granting of certificates. It also provided for recognition of additional qualifications. For the first time in the life of the nursing profession, nurses represented themselves on the Medical Council and had input in their own affairs (Mellish et al 2010:48).

The changes in profession in the 1940s included gender, colour, class and racial discrimination. Hospitals were profoundly gendered social institutions and there was subordination of almost the entire nursing profession to medical practitioners who were males (Dolamo & Olubiyi 2013:15).

The South African Nursing Council (SANC) was promulgated in November 1944; all records from the SA Medical Council were transferred to SANC (Searle, Human&Mogotlane2009:344). SANC is the body entrusted to set and maintain standards of nursing education and practice. It is an autonomous, financially independent, statutory body, initially established by the Nursing Act, 1944 (Act No. 45 of 1944), and currently operating under the Nursing Act, 2005 (Act No. 33 of 2005). The purpose of Section 3 of the Nursing Act, 2005, is to establish, improve and control the conditions, standards and quality of nursing education and training. Section 4 of the Act makes provision for the accreditation and inspection of nursing education institutions; the monitoring of assessment conducted by accredited institutions; the conduction of examinations and the granting of diplomas and
certificates to nurses who have met the theoretical and clinical requirements (SA 2005).

The Nightingale era created a gender stereotype that linked nursing and femininity. South Africa followed on this idea of nursing as woman’s work which led to a decrease in the number of male nurses at the initial commencement of formal nursing education until today (Bruce et al 2011:25). The first male nurses were registered in 1911; however, few male nurses qualified before 1950 and were mostly employed in mines and psychiatric hospitals (Searle et al 2009:346).

2.5.3 Nursing programmes in South Africa

Nursing education has gone through dramatic changes from colonial training of white nurses, on-the job training for African males and later women, to hospital-based training and presently training at higher education institutions (Dolamo & Olubiyi 2013:16). This has led to changes in nursing education programmes. Presently the training of professional nurses in South Africa takes place through two programmes of SANC:

The first programme in accordance with Regulation 425 of 22 February 1985 is a four year academic comprehensive programme that prepares a student for registration as a nurse (general, psychiatric and community) and as a midwife. Examinations are conducted by NEIs in association with universities.

The second programme is according to Regulation 683 of 14 April 1985 and is a two year academic bridging programme for enrolled nurses with the appropriate school-leaving (grade 12) leading to single registration as a professional nurse. Examinations are conducted by SANC during first and second years of training. Once the student has met the theory and practical requirements as stipulated by each training programme regulation, SANC issues a certificate and practising licence to each qualifying nursing student.

2.5.4 Socio-cultural perceptions of men in the nursing profession

Gender roles imbedded in many cultures lead to health care being segregated between the genders (O’Lynn & Tranbarger 2007:8). Labour divisions are assumed
along gender roles; this means that occupations are socially and culturally defined through construction of gender (Julian 2011:15; Rajapaksa & Rothstein 2009:196). These gender labour divisions are thought to be regulated by “natural” laws, leading to women and men undertaking jobs that are more appropriate for their bodies and social roles. Sex division of labour has traditionally located men within the world of production while women are assigned to caring and nurturance (Simpson 2009:65). The ideology of motherhood emerged in the Victorian era when motherhood was considered a sufficiently fulfilling role for a woman. It became a constructed identity as opposed to a biological function of a woman and was associated with the idealised image of a nurse.

Public perception of nursing as a gendered role occupation exclusive to females is a well-entrenched societal belief based upon the tradition of a nurse being a female in white uniform and cap (Twomey & Meadus 2008:30). What becomes of a male in a white safari? The media supports this perception and is reinforced through images of nursing solely based upon female attributes (Kada 2010:1; Twomey & Meadus 2008:30). This creates a cycle of bias that limits the role of men in the nursing profession. Wallace (2007:19) describes the following four public images of nursing:

- Religious image entrenched in Christian values
- Servant image which is associated with period of “Dark Ages of Nursing” when nursing was considered a domestic service and nurses were treated as manual servants
- Angel of Mercy: this is the period between 18th and early 19th centuries when men and women were socialised to their gender roles; girls were prepared to be wives and mothers; education did not play a role in this preparation. This image reflected characteristics of nobleness, morality, religion, self-sacrificing and dedication
- Nurses as a “sex object”, an image which was portrayed in the media mid-1960 to 1990s. This image is characterised by sensuality, irresponsibility and promiscuity

The public assumed that all women had a natural affinity; that is, providing nursing work and providing care for the sick was second nature for them. The nursing
profession was deeply influenced by Victorian ideas about women and their proper place in society (Clow & Ricciardelli 2011:210; Harding, North & Perkins 2008:89).

Florence Nightingale considered nursing as a suitable job for women because it was an extension of their domestic roles and the social construction of what it means to be a nurse typically meant a caring, hardworking woman (Kirk 2012; McWilliams et al 2013:42; Ozdemir et al 2008:154). The study of Bartfay, Bartfay, Clow and Wu (2010:5) suggests that Canadian society is congruent with the global society’s general perception of nursing as a more suitable career choice for women than for men; and men who choose this profession are stereotyped as gay, less compassionate and caring (Julian 2011:17). This labelling of men in the nursing profession follows the assumption that women are better suited for nursing roles that require physical and emotional labour (George 2007:7; Julian 2011:19). This led to the view that perceived nursing and mothering roles as interconnected and nursing became one of the few options for women seeking employment and personal financial stability (Sienkiewicz 2012:11).

The nursing profession is strongly associated with women’s roles in society. Institutional factors that influence the status of nursing also reinforce the construction of societal perceptions and values about gender roles and career paths (Julian 2011:15). Even though nursing is viewed as a trustworthy and honourable calling, it is also generally considered less important and less valued (Julian 2011:16) and less independent, less educated and less powerful (Wallace 2007:17) than other health disciplines dominated by men. This comes to show that the value and the status of the profession are centred on gender dominance. The status of the profession is rated by the remuneration, which to date is regarded as a low-paying profession.

Moore and Dianemann (2014:87) identify two types of motivational factors for men and women selecting nursing as a career of choice: intrinsic and extrinsic motivational factors. Primary (intrinsic) motivation suggests that the basic reason for individuals to choose nursing as a career of choice is based on helping others and providing caring services to them; this motivation is similar for both female and male nurses. The difference is eminent in the secondary (extrinsic) motivation which is characterised by career opportunity, job stability and remuneration. In this motivation
male nurses are more pronounced than female nurses. Zamanzaden, Valezadeh, Negaranden, Monadij and Azadi (2013:53) acknowledge that even though male and female nurses may have the desire to help and care for others, they also have different aspirations for entering the nursing profession. Men enter the nursing profession on the grounds of practical motivation, whereas women are attracted to nursing mostly for altruistic desires and feelings of self-empowerment. Therefore, this difference proposes that as nursing is a female-dominated profession, there is a possibility that in the future, as in the present, nurses will not be inclined to fight for better remuneration and working conditions. This is supported by the findings of Rajapaksa and Rothstein’s (2009) study, which indicate clearly that more men leave the nursing profession for better salaries than women. This means that when the extrinsic motivational factor is not fulfilled, male nurses seek greener pastures for better remuneration.

2.5.5 Career choice in the nursing profession

Career interests and decisions are attributed to the internalisation of gender roles by individuals of effective realities about gender-appropriate occupations. Societal norms and values play a vital role in men’s and women’s career choices, as they stipulate careers appropriate for each gender. Consequently, individuals choose occupations that society defines as masculine and feminine. These assumptions encourage the development of gender stereotypes which in turn suggest that men and women are born with personalities that would be counterproductive in fulfilling the traditional social roles. This denotes that men and women in roles that are numerically dominated by the other gender are deviants, less qualified and lack the natural gifts possessed the normative gender (Clow & Ricciardelli 2011:198). Men’s sexuality and their ability to fulfil their jobs in feminine professions are often questioned (Clow & Ricciardelli 2011:193). The developed gender stereotyping of men entering the nursing profession shows low conformity to social gender norms and men are reprimanded by non-acceptance by female colleagues and female patients.

Nursing perpetuates cultural understanding and societal attitudes about occupations appropriate for men and women. Societal gender roles provide models to which boys
and girls are exposed for the purpose of learning and receiving appropriate messages regarding each gender. Women and men who attempt to enter fields typically dominated by the other gender frequently encounter stereotypes, prejudice or discrimination because the occupation is not congruent with their gender roles (Clow & Ricciardelli 2011:191).

Because of global society’s view of nursing as “women’s work” of low status, men are more likely to choose careers which are more gender appropriate (Julian2011:17); these careers offer them greater value, respect and pay in order to support their role in the social strata (Sienkiewicz 2012:12). In the 21st century there is an increased number of men opting for nursing as a career of choice (Moore & Dianemann 2014:91), but there is evidence of a high attrition rate. The increased attrition rate may be attributed to male educational difficulties caused by role strain, minority status and stereotypical social attitudes and lack of support from the NEIs (Kirk 2012:29; McWilliams et al 2013:41).

2.5.6 Feminisation of nursing

Nursing became a gendered profession in the 19th century under the influence of Florence Nightingale, the founder of modern nursing (Kirk 2012:13). In the 19th century Florence Nightingale changed the perception of health care to a “family based institution”. This placed doctors who were predominantly men in charge and women as nurses in a subservient role of natural caregivers, an extension of domestic service roles (Wolfenden 2011:2). In 1867 Ms Nightingale wrote “to take all power over the nursing out of the hands of men and put it in the hands of one female trained head and make her responsible for everything” (cited in Clow & Ricciardelli 2011:216; O’Lynn & Tranbarger 2007:24); this further excluded men from the nursing profession. The Turkish government in 1954 passed a law that described the nursing profession as a profession which can only be performed by Turkish women. Male nurses received education in nursing under a different name because traditional structure had to find a name for male nurses and they were given a title of “health officer” (Ozdemir et al 2008:135).

The study of Da Silva (2013:176) brings forth a diverse picture of nursing in Portugal between the years of 1940 and 1970. The Portuguese nursing schools were mixed-
gendered institutions in which numbers of male students held higher positions than female nursing students. After qualification, male nurses were sent to hospitals where they were responsible for all necessary care in the male wards, while female staff worked in female wards. Interesting enough, besides being mixed-gendered nursing schools, students had their lessons separated by gender. The Portuguese Salazar government adopted homogeneous nursing schools following the model of America and Britain which portrayed nursing as women’s work because they would be dedicated to their patients as to their families. On the 10th of April 1947, a law was passed that clearly dictated a preference for female nursing students; this law contributed to a decrease in the number of men in nursing.

In the 21st century, nursing schools are slowly becoming diverse, but the faculty remains unchanged; it is primarily staffed by middle aged female nursing educators (Kirk 2012:17). The statistics of the South African Nursing Council for Additional Qualification Register for 2012 shows that in South Africa there are 11 917(96%) female and 483(4%) male professional nurses registered as nursing educators (SANC 2012b). This statistic indicates that male student nurses will continue in the NEIs without having role models to socialise them into the nursing profession.

In many societies gender neutral or inclusive language has become the norm, for example, “chairman” changed to “chairperson”. The use of the pronoun “she” is commonly used for the generic nurse both in text and conversation (Le-Hinds 2010:1; Kirk 2012:87; O’Lynn & Tranbarger 2007:176). The language used within the profession betrays covert gender biases and preconceptions, for example, the expression of “male nurse” is used but seldom does one hear about a “female nurse” because it is considered outmoded and unnecessary (Andrews& Boyle 2008:315). The term “male nurse” could be viewed as offensive because it brings to mind a stereotype of someone who is less than masculine; assuming that nurses must be female (Wolfenden 2011:2; Moore & Dianemann 2014:88) and “male nurse” also implies that men in the nursing profession are not in keeping with the gender norms of society. But as long as the division between male and female is evident in the nursing profession the use of the term is deemed necessary.
Ozdemir et al (2008:135) describe “hemsire”, a Turkish word for a nurse, as having two meanings, namely, sister and woman who gives care to the sick. These words advocate for both the female gender and the nursing profession. The Turkish name for a nurse is similar to the Zulu word for a nurse “Umhlengikazi”. “Umhlengi” is someone who saves or cares for others and “kazi” suggests that the person who provides care is a woman.

2.5.7 Caring and intimacy

Caring is a human trait. This implies that caring is innate and essential to human existence; therefore, men also have the capacity to care. Caring has been historically and traditionally associated with women and femininity. The domestic work of women has been identified as caring (O’Lynn & Tranbarger 2007:128). Nursing is considered as emotional labour as it calls for special abilities that are deemed to be possessed by women. Emotional labour concerns the effort an individual invests to ensure personal feelings are controlled or manipulated so they can be congruent with socially prescribed norms (Simpson 2009:63). In the Western and African culture men are socialised to limit the expression of emotions (Ntibanyane 2008) and emotions have been side-lined as irrational and devalued as a weak appendage to reason (Simpson 2009:65); while women are socialised to display caring behaviour through touch and open expression of emotion.

Intimate care within the health care environment has a therapeutic effectiveness on the patient and it involves psychological, emotional and physical closeness (O’Lynn & Tranbarger 2007:8; Stauropoulou, Kuba, Obamwonyi, Adeosun, Rovithis&Zidianakis2012:480; Zamanzaden et al 2013:54). Touch is a vital aspect of nurse-patient relationships (Harding et al 2008:88). Nursing care requiring intimate care outside the family was provided by nurses of the same sex up until the 19th century (O’Lynn & Tranbarger 2007:8).

Intimate physical touch is employed to provide necessary care for the patient. Such touch involves inspection of and possible physical contact with those parts of the body whose exposure can cause embarrassment to either the patient or the nurse (Harding et al 2008:88). Touch is a primary component of care and sometimes is perceived as an invasion of an individual’s privacy and may be interpreted differently
The study of Harding et al (2008:88) of 18 male nurses revealed that touch is a pillar of nursing care, but is problematic for men because of the normalisation of women’s use of touch and the sexualisation of men’s touch; and also nursing educators neglect to prepare men for providing intimate care. Lack of content and instruction on touch in the NEIs is a serious problem for all students but especially for men. Owing to male gender roles that limit the use of touch; violation of these roles puts men in a suspect position and increasing litigation by society (O’Lynn & Tranbarger 2007:136; Zamanzaden et al 2013:54).

The male students in the phenomenological study of Meadus and Twomey (2011:279) view men’s caring behaviour in association with fear, inappropriateness and sexualisation of touch. This impacts how they are perceived by society in their roles as men and nurses. In the case of Blair vs Colonial Plaza in 2009 cited in Clow and Ricciardelli (2011:192), a nursing home instituted a new policy which banned male caregivers from working night shift. This policy was established because the nursing home felt that patients would be most susceptible to sexual assault during night shift. This action supports the assumption that male nurses are potential sexual predators on the basis of their gender not their offence.

Harding et al (2008:93) reveal the lack of support for men in the preparation of appropriate touch in their nursing work. Harding et al (2008:89) and O’Lynn (2013) are in congruence that male nurses’ touch of female patients during execution of nursing care is potentially dangerous behaviour because it has been sexualised and patients may misinterpret it as sexual advancement. As young female nurses are seen as objects of sexual desire; male nurses on the other hand, are constituted as objects of sexual threat.

O’Lynn and Krautscheid (2011:29) in their study focus on non-nursing participants on the issue of intimate touch. The study indicates that participants do not have a problem with touch itself, but need to be informed prior to the intimate touch, the reasons for the touch and what it involves; they expect nurses to seek permission before initiating intimate touch in order to be involved in deciding when and how it is
given and nurses must project a professional image in their actions and communication.

McWilliams et al (2013) argue that the failure of nursing programmes to prepare men to primarily work with women is a potential barrier to gender diversity in the nursing profession. The NEIs in their curricula must provide content for intimate care which will provide guidance and support to male and female student nurses in providing intimate care to a patient of the opposite sex. Even-though female touch is accepted as natural in the nursing profession, the question could also be asked: “Are female nurses well prepared to provide intimate care to male patients?” There is no available literature that focuses on the experience of female nurses in the provision of intimate care to male patients, as in nursing literature where male nurses express fear of misinterpretation and discomfort in providing intimate care to female patients.

As a nurse one does not automatically acquire the professional roles when registered with SANC as a student or professional nurse. Nursing roles are learned by locating oneself in the social structure that defines nursing roles. Nurses are socialised into the role by other nurses. Therefore, it is of high importance to professionally socialise both male and female student nurses to intimate touch in order to prepare them for their future encounters with sexually diverse patients. If neophytes are not socialised and prepared for their nursing roles in a positive manner, they will not develop positive values or will fail to internalise professional norms and practices.

2.6 LEGAL FRAMEWORKS FOR EMPLOYMENT

In the 21st century women are more likely to enter male-dominated occupations than men enter female-dominated occupations because women can elevate their status in societies that value masculine attributes of power, independence and competition; more than men can regarding feminine attributes of nurturing, passivity and cooperation (Julian 2011:17). Masculine and feminine inequalities created dissatisfaction about the subordinate role of women in society and the rise of feminism has increased freedom and opportunities for women in all walks of life.
Gender equality has always been the core value of the struggle for a democratic South Africa. In South Africa prior to 1994 gender stereotypes resulted in occupational gender inequalities in relation to resource allocation and status that favoured male employees (Julian2011:17). The value of gender equality was adopted into governance process with the establishment of the new dispensation in the birth of democracy on the 27th April 1994 and enshrined in the 1996 constitution of South Africa; this brought women closer to their liberation. Under the influence and leadership of the late former president Nelson Mandela many policies were formulated to redress past discriminatory laws and practices. The ANC chairperson of Gauteng, Patricia Choewu addressing the public at the Orlando stadium during the interfaith women’s day of prayer in memory of the life of the former state president acknowledged with deep gratitude the role Tata Mandela played in the liberation of women: “Women [today] can access rights they were previously denied; women are now taking up careers that were dominated by males; we now have female engineers, doctors and scientists because of Madiba – thank you Tata” (Mailoane 2013).


The South African struggle against an oppressive government system characterised by institutional racism, patriarchal leadership and oppression, led to a new democracy on the 27th of April 1994 with the obligation of advancing the country towards a democratic, non-racist and non-sexist society. Through the 1996 constitution, the citizens of the Republic of South Africa devoted themselves to the tenets of human dignity, the achievement of equality and advancement of human rights and freedom. “The Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in [the] country and affirms the democratic values of human dignity, equality and freedom” (SA 1996:6). Chapter 2 of the constitution is dedicated to the Bill of Rights for all citizens of the Republic of South Africa. Section 9(3) states clearly that no person should be directly or indirectly discriminated against on the grounds of race, gender, sex, pregnancy, marital status, sexual orientation, belief, culture and so on (SA 1996:7). Section 22 further emphasises that every citizen has the right to choose their trade, occupation or profession freely (SA
Therefore people can choose their career paths regardless of their gender constructed roles and society values.

2.6.2 Affirmative action and representativity

Affirmative action was designed to redress the past imbalances, to improve the condition of individuals and groups who had been disadvantaged on the grounds of race, gender, religion and which promoted practices that had as their objective the achievement of a workforce representative of the population of the country (KZN DoH 2009a). The objectives of the Affirmative Action policy were to ensure that all forms of discrimination in the employment situation based on race, creed, gender or any other forms of stereotyping of persons or groups be eliminated. And it also aimed at providing measures for the eradication of past discrimination and to develop equal opportunity programmes aimed at promoting equality in the employment environment (KZN DoH 2009a). The Affirmative Action policy classified three categories as the designated groups: Blacks (Africans, Coloureds and Indians); women, and people with disabilities. Other categories like men and non-Blacks did not benefit through this policy. This led to an influx of women into male-dominated professions compared with men entering female-dominated professions. In 2004 the Department of Labour revised the national Affirmative Action Target as follows: 75% Black people in senior management positions; 30% women in senior level management and 2% people with disabilities (Department of Labour 2004:13).

Men in South Africa are a minority and are underrepresented in the nursing profession. After 20 years of democracy, the professional nurse statistics by gender in KZN districts support the idea that men in nursing are underrepresented. The results (see Table 2.1) indicate that in SA between 2009 and 2013 there was 1% growth in the number of professional nurses – interesting to note that for 3 years there was no growth at all (2011-2013); male professional nurses remained at 8% until today. The statistics of the numbers of male student nurses are similar nationally to those of KZN province. What is of concern in these statistics is that in 2009 there were 22% male nursing students. One presumes that these students qualified and became professional nurses. Five years down the line the percentage has not changed (see Table 2.1). Therefore, these questions are asked: Why is the
policy of representativeness by gender in the nursing profession ignored and what happened to about 14-18% of the 22-25% of men during their training in NEIs?

Table 2.1: Gender distribution of professional nurses and student nurses in South Africa and Kwazulu-Natal

<table>
<thead>
<tr>
<th>YEAR</th>
<th>SA P/N</th>
<th>KZN P/N</th>
<th>SOUTH AFRICA S/T</th>
<th>KZN PROVINCE S/T</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M %</td>
<td>F %</td>
<td>M %</td>
<td>F %</td>
</tr>
<tr>
<td>2009</td>
<td>6</td>
<td>94</td>
<td>6</td>
<td>94</td>
</tr>
<tr>
<td>2010</td>
<td>7</td>
<td>93</td>
<td>7</td>
<td>93</td>
</tr>
<tr>
<td>2011</td>
<td>8</td>
<td>92</td>
<td>7</td>
<td>93</td>
</tr>
<tr>
<td>2012</td>
<td>8</td>
<td>92</td>
<td>8</td>
<td>92</td>
</tr>
<tr>
<td>2013</td>
<td>8</td>
<td>92</td>
<td>8</td>
<td>92</td>
</tr>
</tbody>
</table>

key notes: P/N = Professional nurses S/T = Student nurses

Adopted in SANC 2009 – 2013 Geographic Distribution

2.6.3 Employment Equity (Act no. 55 of 1998)

The employment equity Act was established to address past imbalances in terms of race and gender; to achieve equality in the workplace by promoting equal opportunity and fair treatment in employment through elimination of unfair discrimination and to redress the disadvantages in employment experienced by designated groups in order to ensure equitable representation in all occupation categories and levels in the workforce. In all government advertisements for vacant posts the following wording is contained “This department is an equal opportunity, affirmative action employer whose aim is to promote representativity in all levels of occupation classes of the department” (Department of Labour 2004:5). However, it must be borne in mind that people who are actively recruited are from designated groups as reflected in the affirmative action policy. This phraseology predisposes men to indirect discrimination; the wording appears consistent with the principles of equality but reduces the chances of men of gaining mobility in the nursing profession.

Equal opportunity is the fundamental right of every person destined to be recruited for employment on the basis of intrinsic personal merit, ability and potential to do a
job without favour or discrimination. In 2008 the South African National Policy Framework for Women’s Empowerment and Gender Equality was formulated. This policy framework takes into account women’s existing subordinate positions within social relations and aims at the restructuring of society so as to eradicate male dominance (Department of Labour 2008:xviii). In the same year the Department of Public Service and Administration published a Strategic Policy for Gender Equality within the Public Service which aimed at ensuring that women were empowered through gender mainstreaming and by fast tracking strategies that would address historical challenges experienced by women within the workplace. These strategies emphasised that the advancement of women and gender equality could not be achieved until and unless women were empowered (SA 2008:1).

In circular 138 of 2009 the Department of Health acknowledged gender inequality in the workplace. This is shown by the department’s wish to devise methods to attract males to traditional/historical female-dominated occupations, for example, nursing and dietary occupations. What is interesting to note is that on the same page the department commits itself “to ensure that women are provided with opportunities for empowerment, development, promotion and mentoring through the removal of physical, social, economic and psychological barriers” (KZN DoH 2009c:15).

2.6.4 Recruitment and retention policy

Recruitment is the process that employees use to attract applicants to a job to determine their suitability. The process should be conducted fairly and without direct or indirect discrimination (Department of Labour 2004). Retention is the retaining of employees who possess the required skills, expertise and competencies that are pertinent to realise a department’s goals and objectives through appropriate attraction, recruitment, training and development methods (KZNDoH 2009b:3). The recruitment and selection policies aim at achieving numerical targets and increasing the representativity of the designated groups in the workplace. It is believed that achievement of numeric targets will contribute to the transformation of workplace culture and be more affirming of diversity (Department of Labour 2004). Therefore, if men who are underrepresented in the nursing profession are actively recruited and
retained within the profession, their representativeness will lead to cultural and gender diversity in the profession.

The Department of Health has experienced an increase in the attrition rate of health care workers. This is perceived to be due to poor working conditions, poor remuneration and inappropriate placement leading to lack of job satisfaction (KZN DoH 2009b:6). This has led to the formulation of strategies for the retention of personnel which are “[the] recognition of good performance, career management, training and development, bursary allocation, incentives/rewards, good working environment and an effective grievance procedure” (KZN DoH2009b:8). The designated group are the people that employers need to actively recruit to the profession and retain.

The study of Twomey and Meadus (2008:33) highlights that men are overlooked during recruitment efforts for the nursing profession. The male participants in the study reported that inadequate recruitment and lack of role models in the media were the barriers that inhibited men from opting for nursing as a career of choice. The number of female physicians has increased in number, so female patients are offered the opportunity of choosing female physicians for themselves. Perhaps it would be an advantage for male patients to be cared for by a nurse of their own gender, someone who by birth would understand their anatomy and was experiencing life from a man’s perspective (Brandon 2007:284).

The statistics for gender analysis of health workers for selected developed countries show that health occupations are subject to both horizontal and vertical gender imbalance. Over 90% of nurses are represented by female personnel and less than 10% represent men personnel (WHO 2008a:2). In South Africa, nursing is dominated by women of all races and cultures. Statistics of the SANC show that female professional nurses are at 92% while student nurse enrolment consists of 77% female (SANC 2012a). These figures indicate that females will continue to dominate the profession for a long time if recruitment and the retention of men are not prioritised. As employment equity and representativity state, the prerequisite for the recruitment and retention of employees is that the employer must formulate the demographic profile of the institution and employment equity targets for each post
that is advertised in order to offer equal opportunity (Department of Labour 2004). The presented statistics clearly indicate that male professional nurses and student nurses are the disadvantaged groups in the nursing profession.

2.7 CONCLUSION

This chapter presented literature that shows that globally nursing is perceived as women’s work, based on socially constructed gender roles. In the 21st century, legal frameworks support women’s rights and empowerment, at the same time indirectly discriminating against men. Some women resist involving men in gender and development work, as they are motivated by anxiety over the diversion of limited resources away from women’s empowerment initiatives into the hands of men who previously were in power. However, not engaging with men may limit the effectiveness of development interventions and may intensify gender inequalities. As society learns that nursing is a valued and rewarding profession for both men and women, the increase in the number of male nurses in the profession will direct society towards change in social roles, and gender equity will have been achieved. Acceptance of men in the nursing profession will allow men to freely opt for nursing as a career of choice and excel in their profession; this will increase the number of role models for future male nurses.
CHAPTER 3
RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION
The purpose of this study was to identify and describe male and female student nurses’ insights and perceptions of the socio-cultural influences on the recruitment and retention of men in the nursing profession. And also to identify intimate procedures and the students’ experiences in providing these procedures. In an attempt to answer the research questions, a qualitative research approach was deemed relevant for this study as qualitative research inquiry study participants in their natural settings attempt to make sense of the phenomena in terms of meanings people attach to them. This chapter presents the research design, method and specific procedures used in conducting the study.

3.2 QUALITATIVE RESEARCH PARADIGM
Polit and Beck (2012:11) define a paradigm as a worldview, a general perspective on the complexities of the world. Brink et al (2012:24) further describe it as a set of assumptions about the basic kinds of entities in the world, about how these entities interact, and about proper methods to use for constructing and testing theories of these entities. A paradigm helps the researcher to be organised in thinking, observing and interpreting a process. It is a way of looking at natural phenomena that encompasses a set of philosophical assumptions and guides one’s approach to enquiry (Brink et al 2012:25). This study used the qualitative research paradigm for human inquiry which answers the basic philosophical question of the nature of reality (ontology), the relationship between the researcher and the participants (epistemology) and the methods used to obtain the information or knowledge. This paradigm involves sustained interaction with the people being studied in their own environment, and inquiry takes place in the field over an extended period of time.

3.2.1 Philosophical assumptions
Philosophy denotes assumptions, values and beliefs about the nature of reality, knowledge and methods of obtaining this knowledge (Brink et al 2012:26). In qualitative research, philosophy shapes how the research problem and questions are
formulated for the study and how the information is collected to answer the question (Creswell 2013:18). The researcher embraced the four philosophical assumptions of qualitative research paradigms which are ontology, epistemology, methodology and axiology.

Ontological assumption
Ontological assumption is related to the nature of reality and its characteristics. Qualitative research embraces the idea of multiple realities (Burns & Grove 2011:13; Creswell 2013:20). Multiple realities are evident in the use of multiple themes, using the actual words of different individuals and presenting different perspectives (Creswell 2013:20). It is postulated by Burns and Grove (2011:73) that the constructed reality is inseparable from the knower and the known. Participants share their knowledge of the phenomena in their natural environment, because what is known by the participants is the product of their lived experiences.

Epistemological assumption
Epistemological assumption is based on knowledge and how people come to know what they know. This assumption takes the stance that a relationship between the researcher and participants is important in order to understand the reality. The researcher must spend time in the natural environment of the participants in order to acquire knowledge of the phenomena understudy (Polit & Beck 2012:11). Conducting qualitative research on the natural environment of the participants gives a clear understanding of what the participants are saying and also gives an opportunity to gain first-hand information. Through the interaction of the researcher and participants knowledge is created. This is supported by Creswell (2013:20) on the grounds that epistemology is transactional and subjective, meaning that the researcher and participants are assumed to be interactively linked in order to create knowledge as the study proceeds.

Methodological assumption
Methodological assumption entails how the researcher should obtain knowledge. Qualitative research is characterised as inductive; it focuses on subjectivity, emerging insights grounded in participants’ experiences and seeks in-depth
understanding of the phenomena; and methods are flexible. It aims at reconstruction of previously held constructions. The phenomena and personal nature of social constructions suggest that individual constructions can be elicited and refined only through interaction between the researcher and participants (Creswell 2013:22; Polit & Beck 2012:10).

Axiological assumption
Axiological assumption in qualitative research focuses on the acknowledgement of the values a researcher brings to the study. The researchers admit the value-laden nature of the study and actively report their values and biases as well as the value-laden nature of the information gathered from the field (Creswell 2013:20; Polit & Beck 2012:12). The researcher openly discusses values that shape the narrative and includes own interpretations in conjunction with the interpretations of participants.

Interpretivism is an approach to social science that emphasises the importance of insiders’ viewpoints to understand social reality (Brink et al 2012:25). This study adopted the constructivist views and traditions that emphasise the inherent complexity of humans, their ability to shape and create their own experiences, and the idea that the truth is a composite of multiple realities (Polit & Beck 2012:14). Realities and meanings are multiple and varied. The goal of the research was to rely as much as possible on the participants’ views of the situation. These subjective meanings are socially and historically negotiated (Creswell 2013:25). This means that the constructed meanings are not imprinted on individuals but are formed through interactions with others. Chapter two of this study provided an intense description of social constructivism theory which elaborates how people construct knowledge, reality and meanings for their lives. The study focused on the NEIs in which male and female student nurses were enrolled for R.425 and R.683 programmes for better understanding of the historical and cultural settings of the participants. In the process of conducting the inquiry, multiple realities were constructed through lived experiences and researcher-participant relationships maintained by mutual trust and respect of participants’ values and beliefs. The quest to understand male and female student nurses’ experiences in the nursing profession, their perceptions of socio-cultural perceptions of nursing based on their
individual backgrounds and how these perceptions influenced recruitment and retention of men in the nursing profession was fulfilled when they shared their perceptions and subjective meanings were developed.

3.2.2 Generic qualitative design

A generic qualitative design is a method that simply seeks to discover and understand the worldview of the people involved. Qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meaning people bring to them (Flick 2007:12; Polit & Beck 2012:14; Creswell 2013:43). A qualitative research design is characterised by six principles which are:

- Belief in multiple realities
- Being committed to identifying an approach and understanding that support the phenomenon studied
- Being committed to the participants’ viewpoints
- Conducting the enquiry in a way that limits disruptions of the natural context of the phenomenon of interest
- Acknowledging the participants in the research process
- Reporting the data in a literary style rich with participant commentaries (Speziale & Carpenter 2003 cited in Brink et al 2012:10).

Brink et al (2012:121) and Creswell (2013:45) support these principles by identifying the key features of qualitative research as a research that is conducted in a real life situation or natural setting; the purpose is in-depth description and understanding of people’s beliefs, actions and events in all their complexity in order to portray meaning held by the participants. The researcher is seen as the main instrument in data collection through observation of behaviour and interviewing of participants and is subjectively involved in the research process.

This design investigates subjective phenomena in the belief that critical truths about reality are grounded in people’s lived experiences and the goal is to understand lived experience and perceptions to which it gives rise. In-depth conversations are the main data sources. The researcher helps participants to describe lived experiences
without leading the discussion. Through in-depth conversation, one strives to gain entrance into the participants’ world, to have full access to their experiences as lived. The inquiry not only gathers information from participants, but is also an effort to experience the phenomenon through participation, observation and introspective reflection (Polit & Beck 2012:295). Qualitative research also has limitations which are based on the use of human beings as instruments to gather data (Polit & Beck 2012:14), which may lead to bias.

3.3 RESEARCH METHOD

Research methodology refers to a technique and process utilised by the researcher to structure a study in a logistical, relational and ethical manner (Bloomberg & Volpe 2012:108); and to gather and analyse information in a systematic manner (Polit & Beck 2012:741).

3.3.1 Sampling

Sampling is the process of selecting participants who are representatives of the population being studied (Burns & Grove 2011:4; Polit & Beck 2012:742). In qualitative research, sampling is conducted to gain insight into and discover the meaning of a particular phenomenon, situation, cultural element or historical event. It aims at understanding the selected sample and not the generalisation of the findings. The researcher attempts to select participants who are considered experts in the area of study and who are willing to share rich, in-depth information about the phenomena (Burns & Grove 2011:312; Brink et al 2012:139). In this study the individuals whom the researcher considered experts were male and female student nurses enrolled for R.425 and R.683 programmes.

3.3.1.1 Population

A population is the entire group of persons that is of interest to the researcher and that meets the criteria that the researcher is interested in studying or set of individuals having some common characteristics (Babbie & Mouton 2012:173; Brink et al 2012:131; Polit & Beck 2012:738). As from March 2013, the total nurse learners’ population of the KZNCD is 5363: Campus A consists of 514 students (male 17% and female 83%) and Campus B of 257 students (male 19% and female 81%). The
site and target population for this study were all NEIs in KwaZulu-Natal offering the R.425 and R.683 programmes.

The following categories of nursing students were included in the study:

- Male and female student nurses enrolled for R.425 in KZNCN: 1\textsuperscript{st} year students who have completed their first semester (6months in training); 2\textsuperscript{nd} and 3\textsuperscript{rd} year students.
- Male and female student nurses enrolled for R.683 in KZNCN (1\textsuperscript{st} and 2\textsuperscript{nd} year).
- Male and female student nurses training at Campus A and Campus B.

The following categories were excluded from the study because the focus of the research study was on male and female student nurses whose programmes would lead them to be registered as professional nurses in the general field of nursing.

- Male and female student nurses enrolled for R.425 who are in their 4\textsuperscript{th} academic year (midwifery & psychiatric modules)
- Male and female student nurses enrolled for R.2175 and R.254

Participants for this study were male and female student nurses registered for R.425 and R.683 training programmes in the KZNCN at Campus A and Campus B. The students voluntarily signed an informed consent form to be part of the study. These campuses were the natural environment where data collection was conducted.

3.3.1.2 Non-probability sampling approach

Qualitative sampling is characterised by participants not selected randomly; the sample size is small and studied intensively with each participant providing a wealth of data. Sample selection is driven by conceptual requirements rather than by a desire for representativeness (Polit & Beck 2012:516). A non-probability sampling approach is a sampling process in which a sample is selected from elements or members of a population through non-random methods. Members of the population do not have an equal chance to be in the study. The researcher may use convenience, quota or purposive sampling. The prime criterion for participant selection is whether a person has experienced the phenomena under study and is
able to provide good information about the phenomena and is willing to participate in the study (Babbie & Mouton 2012:166; Brink et al 2012:139; Polit & Beck 2012:276).

3.3.1.3 Purposive sampling technique

Purposive sampling is a non-probability sampling method in which the researcher selects participants based on personal judgement about which ones will be most informative (Polit & Beck 2012:139). This method is further described by Brink et al (2012:141) as judgement regarding participants that are typically representative of the study phenomenon or who are especially knowledgeable about the question at hand. The logic in purposive sampling is selecting participants who will provide rich information, with the objective of understanding the phenomena understudy (Bloomberg & Volpe 2012:104; Tracy 2013:134). In purposive sampling the researcher consciously chooses the people who he or she deems to be knowledgeable about the phenomena under study and who are willing to contribute to the study. This sample is smaller and studied intensively with each participant providing in-depth wealthy information. Sample selection is driven by conceptual requirements rather than by a desire for representativeness (Polit & Beck 2012:516). Purposive research is characterised by onus given to the researcher to choose participants in accordance with knowledge of the subject being studied; the researcher does not know in advance the number of participants needed in the study; data is collected until saturation occurs (Brink et al 2012:114).

The reason for the researcher to choose this sampling technique was based on the purpose of the research study that wants to understand the insights and perceptions of male and female student nurses in the NEIs regarding the socio-cultural influences on the recruitment and retention of men in the nursing study programme. Therefore, the people deemed to have rich information were male and female student nurses.

The strength of a purposive sampling approach is that the researcher samples people who are knowledgeable on the subject; therefore, the data collected is rich and meaningful to the study. The limitation of this sampling approach is that it places a much greater responsibility on the researcher to judge prudently and it does not
contribute to generalisation as transferability is emphasised and the extent of sample error cannot be estimated and bias may be present (Brink et al 2012:139).

3.3.2 Data collection

Data refers to the pieces of information or facts collected during a research study (Brink et al 2012:211) to address a research problem (Polit & Beck 2012:725). Qualitative research data collection is more flexible and decisions about what to collect evolve in the field. It is collected in the natural setting or environment of the participants. The primary data collection method in qualitative research is interview and observation (Polit & Beck 2012:533)

3.3.2.1 Interviews

The interview is a method of data collection in which an interviewer obtains responses from a participant on a face-to-face encounter, through a telephonic or electronic means (Brink et al 2012:157; Polit & Beck 2012:731). Interviews are frequently used in exploratory and descriptive studies. It is a direct method of obtaining facts from the respondents and is useful for ascertaining values, preferences, tasks, attitudes, beliefs and experiences (Brink et al 2012:157). Interviews provide opportunities for mutual discovery, understanding, reflection and explanation via a path that is organic, adaptive and emerging. They elucidate subjectively lived experience and viewpoints from the respondents’ perspectives. They are valuable for providing information and background on issues that cannot be observed of efficiently accessed (Tracy 2013:132).

*Semi-structured interview*

A semi-structured interview is an interview in which the researcher has a list of topics to cover rather than a specific series of questions to ask but cannot predict what the answers will be (Polit & Beck 2012:537). It involves a number of open-ended questions based on the topic area that the researcher wants to cover. The interviewer also has the freedom to probe the participant to elaborate on an original response or to follow a line of inquiry introduced by the participant (National Institute for Health Research 2009:16).
The researcher prepares a written topic guide, which is a list of questions to be covered with each participant; it must be in a logical sequence, that is, from general to specific. The job of the interviewer is to encourage participants to talk freely about all the topics on the guide. This technique ensures that the research will obtain all the information required, and it gives the people freedom to provide as many illustrations and explanations as they want (Polit & Beck 2012:537).

The following specific topics/questions were asked during the interviews:

Q1. Please describe your perceptions of the nursing profession.

Q2. Please describe your experience as a male/female student nurse.

Q3. Which factors do you think may contribute to or influence the recruitment and retention of men in the NEIs?

Q4. What intimate procedures have you provided for female/male patients in the clinical area?

Q5. Can you tell me about your experience when you were required to provide intimate procedures to female/male patients?

Prior to the interview, participants were put at ease by sharing the important information about the study such as voluntary participation and the issue of confidentiality. Participants were given a copy of the summary of the study prior to the signing of the consent form and the demographic questionnaire. Participants were informed that the interview would be audio recorded and written consent was obtained.

The pitfall of face-to-face interviews is environmental distractions (Polit & Beck 2012:542; Tracy 2013:160). On Campus A the interviews were conducted in a quiet office without distractions; telephones were unplugged and participants were requested to switch off their cell phones for the duration of the interview. Outside the door a sign “DO NOT DISTURB” was pinned with the time (12:00 to 13:00) written on it. This environment was conducive to good interviews because the temperature was regulated according to the needs of the day and comfortable chairs, water and
tissues were provided for the participants. This environment provided adequate privacy.

There were some challenges regarding environmental distractions at Campus B owing to the nature of this environment. The campus is small in size and the boardroom was offered for the interviews. Noise was a major challenge because the boardroom was close to the tea/lunch area and interviews were conducted during lunch breaks.

Polit and Beck (2012:542) and Tracy (2013:161) encourage a researcher to take notes during interviews because non-verbal communication enhances the transcription and they are of value if the audio tape recording is lost or corrupted. During the interview the researcher took some notes on the non-verbal communication and emotions presented by the participants.

After each interview the researcher expressed appreciation for the participant’s time and rich information. The tape recorded interview was listened to and checked for audibility and completeness. Each interview was assigned a code which is found on the demographic questionnaire, for example, first interview of the day RSPN (Research study participant number) 2-10-6- 2014; this code indicates the day of the interview and number of interview. Each interview was recorded on a different file on digital audio tape; and were also saved on the computer and saved with an assigned interview code. Thereafter the interviews were transcribed. This was done because the researcher used a digital audio tape recorder; she had to delete each interview once it was transferred to the computer in order to protect the identity of the participants and to preserve the information in case of loss or damage to the recorder. The field notes, demographic questionnaire and informed consent forms were safely kept in a lockable cupboard; and digital audio taped files were saved as zipped documents with a password known by the researcher.

3.3.2.2 Observations

Observation is a technique for collecting descriptive data on behaviour, events and situations and it allows the researcher to observe behaviour as it occurs (Brink et al 2012:150). It is the act of noting a phenomenon in the field setting through the five
senses of the observer and recording it for scientific purposes (Creswell 2013:166). The main aim of observation is to understand the behaviours and experiences of people as they actually occur in the natural setting (Polit & Beck 2012:544). Observation forces the observer to familiarise him- or herself with the subject and allows previously unnoticed or ignored aspects to be seen. People’s actions are probably more telling than their verbal accounts and observing these is valuable (Babbie & Mouton 2012:295).

An observation technique has some disadvantages. During observation there may be a change of reactions by the observed when they become aware that they are being observed. Ethical problems arise if the researcher does not obtain consent. Emotions, prejudices and values can influence the way that behaviours and events are observed. It is also time consuming (Brink et al 2012:152).

**Unstructured observations**

Unstructured observations are a collection of descriptive information that is analysed qualitatively. The researcher attempts to describe events or behaviours as they occur, with no preconceived ideas of what she or he will see. The degree of researcher-participant involvement is low because the researcher studies the activities as an observer with little interaction or involvement with the group (Brink et al 2012:150; Polit & Beck 2012:293).

The researcher observed the infrastructure of the institution for male friendliness. She walked about the institution assessing the male student nurses’ toilets (number and hygiene), notice boards and wall posters for relevance to male student nurses. During the male friendliness assessment of the infrastructure, field notes were written. During the researcher’s stay at each campus, field notes were made on a daily basis. Each campus was assigned a code, for example, Campus A/Campus B and date of observation.

**Data storage**

Creswell (2013:175) suggests some principles to be adhered to when storing data such as developing backup copies of computer files; using high-quality tapes for audio-recording information during interviews; developing a master list of types of
information gathered; protecting the anonymity of participants; and developing a data collection matrix as a visual means of locating and identifying information for a study. In this study, a file with divisions was created and the following hard copy documents were filed: signed informed consent forms; completed demographic questionnaires; notes made during the interviews; field notes and draft transcriptions and analysis.

Electronic storage: after interview transcriptions and field notes were typed, they were stored in multiple hard drives, for example, CD-ROM and USB flash drive. These hard drives were to be used for research purposes only. Data was saved by using given codes.

3.4 DATA ANALYSIS

Data analysis reports were prepared on how the data was managed, organised and analysed in preparation for writing up and presenting the data. In qualitative research, data analysis is in the non-numerical examination and interpretation of interviews and observations for the purpose of discovering underlying meanings and patterns of relationships. It takes the form of narrative material as verbatim dialogue between an interviewer and a participant, field notes or diaries kept during the study. The purpose of data analysis is to organise, provide structure to and elicit meaning from data (Brink et al 2012:193; Polit & Beck 2012:556).

The following steps were followed during data analysis:

Step 1: Verbatim transcription and data management

Transcription is a procedure for producing a written version of an interview or conversation. It is a full script of the interview or conversation. After the transcription of the interviews, they are proofread for their accuracy. This step allows the researcher to become immersed in the data (Brink et al 2012:193). During this process, reflective remarks, marginal remarks and memoing is done as meaning comes to the fore.

Data management in qualitative research is reductionist in nature involving converting masses of data into smaller, manageable segments. Data analysis is constructional because it involves putting segments together into meaningful
conceptual patterns. It involves discovering pervasive ideas and searching for general concepts through inductive processes (Polit & Beck 2012:562).

Step 2: Developing category scheme

This is a process of aggregating the text into small categories of information, seeking evidence from the codes of different data used in the study (Creswell 2012:184). It is also described as finding patterns and producing explanations using both inductive and deductive reasoning to categorise data into segments (Brink et al 2012:193). This is done by careful reading of the data with an eye to identifying underlying concepts and clusters of concepts. Important concepts that emerge from close examination of the data are given a label that forms the basis for a category (Polit & Beck 2012:556). These concepts are put into symbols or abbreviations which classify words or phrases (Brink et al 2012:193).

Step 3: Formulation of themes

A theme is an abstract entity that brings meaning and identity to a current experience and its variant manifestations. A theme captures and unifies the nature or basis of the experience into a meaningful whole (Polit & Beck 2012:562). An area theme is also a broad unit of information that consists of several codes aggregated to form a common idea (Creswell 2013:186). The researcher continually compares data collected from one participant with that of another participant in the determination of the final theme (Brink et al 2012:194). These themes are organised into larger units of abstraction that make sense of the data and provide meaning from the participants’ perspectives. These themes are then interpreted in reference to personal ideas and literature (Creswell 2013:187).

Themes in this study were derived from narrative materials; similarity principles and contrast principles that were identified. These themes were validated and refined by using quasi-statistics which is a tabulation of the frequency with which certain themes are supported by data (Polit & Beck 2012:563).
3.5 DATA AND DESIGN QUALITY: TRUSTWORTHINESS

In quantitative research the standards frequently used are validity and reliability. If the research is valid it clearly reflects the world being described and if reliable the researchers studying the same phenomenon will come up with compatible observation. The criterion for evaluating qualitative research differs because it focuses on how well the researcher has provided evidence that the descriptions and analysis represents the reality of the situation and persons studied (Bloomberg & Volpe 2013:112). Trustworthiness is the degree of confidence qualitative researchers have in their data. It is used as a way of ensuring data quality or rigour in qualitative research, based on the model of Lincoln and Guba. This model proposes four criteria for developing trustworthiness of the qualitative study: credibility, dependability, confirmability and transferability (Brink et al 2012:172; Polit & Beck 2012:724).

Credibility and dependability

Credibility refers to the truth of the data and interpretation (Brink et al 2012:172; Polit & Beck 2012:724). It also refers to whether the participants’ perceptions match up with the researcher’s portrayal of the theme (Bloomberg & Volpe 2013:112). Dependability refers to the stability of the data over time and over conditions, meaning that the researcher must provide the audience with evidence that if the research were to be repeated with the same or similar respondents in the same context, its findings would be similar (Babbie & Mouton 2012:278; Bloomberg & Volpe 2013:113; Polit & Beck 2012:725).

An audio tape was used during interviews and field notes were written during observation in order to keep referential to raw data. During data collection, prolonged engagement with participants in their NEIs was carried out to collect data until saturation was reached. This technique assisted in gaining an in-depth understanding of the phenomenon understudy. Quasi-statistical procedures were followed in which a tabulation of frequency of certain themes or insights was supported by data. This procedure assisted the researcher to statistically support the socio-cultural perceptions of the nursing profession as a perceived experience by male and female nursing students in KZN province in South Africa. Member
checking was done to check accuracy of data and interpretation. The researcher requested a colleague, a qualified professional nurse in the R.425 programme who holds a BCur degree with specialisation in Nursing Education and Administration, presently employed as a nursing lecturer in KZN DoH to do the checking. She had to listen to the audio taped interviews, read the transcriptions and check whether the themes were supported by the data.

Transferability

Qualitative researchers do not expect their findings to be generalisable to all other settings. It is, however, likely that the lessons learned in one setting may be useful in others. Transferability is about how well the study has made it possible for readers to decide whether similar processes will work in their own settings and communities by understanding in-depth how they occur at the research site (Bloomberg & Volpe 2013:113). It refers to the extent to which the findings can be applied in other contexts or with other participants (Babbie & Mouton 2012:277). The researcher collected sufficiently detailed descriptions of data in context and reported them; this was achieved by conducting in-depth descriptive interviews. Purposive sampling was used to select participants for the study. Data was collected until saturation was reached. To enhance transferability, the researcher also made use of thick description. A “thick description refers to a rich and thorough description of the research setting, study participants, and observed transactions and processes” (Polit & Beck 2012:526).

Confirmability

Confirmability is the degree to which the findings are the product of the focus of inquiry and not of the biases of the researcher (Babbie & Mouton 2012:278). The researcher spent quality time with the participants. All interviews were audio taped and verbatim transcription was used during data analysis. An auditor was used to examine both the process and the product of the research and their accuracy. Creswell (2013:252) states that the function of an auditor is that of an individual not connected to the study, who examines whether or not the findings, interpretations and conclusions are supported by the data.
3.6 ETHICAL CONSIDERATIONS

Ethical considerations in qualitative research are often more subtle than those of quantitative research. This is related to the characteristics of qualitative research methodology which usually involves long term and close personal involvement, interviewing and participant observation. It is an approach based on human interaction and the researcher is the measuring instrument (Medical Research Council 2004). The Medical Research Council has identified stances regarding ethical issues in qualitative research:

- **Absolutist stance** – this is related to participants’ protection from harm either physical or psychological; prevention of deception; protection of privacy and informed consent.
- **Relativist stance** – this ethical position states that researchers have absolute freedom to study what they see fit, but they should study those problems that flow from their own experiences. It also emphasises that researchers must build an open and sharing relationship with participants in order to gain participants’ trust.
- **Deception stance** – during the research process, the researcher may use any method necessary to obtain greater understanding of a particular situation; this may involve telling lies and deliberately misrepresenting oneself.
- **Contextualistic or holistic stance** – refers to describing and understanding events, actions and processes in the natural context in which they occur and making no attempt to generalise the findings to a larger population. The sampling deliberately includes those data sources that are the richest sources of information in a specific context.

**Autonomy**

Section 12(2) of the Constitution of the Republic of South Africa, Act 108 of 1996 states clearly that every person has a right to bodily and psychological integrity including the right not to be subjected to medical or scientific experiment without informed consent. An individual is considered to be a rational, self-reliant, thinking being. Autonomy expresses respect for the unconditional worth of an individual and respect for an individual’s thoughts, actions and convictions. Respect of an
individual’s thoughts and actions means allowing people to make choices according to their own convictions (Pera & Van Tonder 2011:71). Autonomy is a participant's fundamental right and rejects researcher’s paternalism. The participant has a right to either refuse or voluntarily accept being in the study and is also free to withdraw from the study (MRC 2004). Individuals have the freedom to conduct their lives as autonomous agents, without external control, coercion or exploitation (Pera & Van Tonder 2011:332).

The participants in this study were provided with information regarding the description of the research study, purpose and procedures which would be used to collect data. The voluntary nature of participation was emphasised. This was done in such a way that they understood the situation and was able to make sound decisions about consenting to participate in the study. Their responses to the given information to participate or not were respected. Only participants who signed the informed consent forms were part of the research study and they were free to discontinue participating in the study at any time; their rights were respected. Informed consent must be free, voluntary, clear, universal and comprehensive and during the study the participant is free to withdraw at any time without any reasons being given (MRC2004).

The researcher received an Ethical Clearance Certificate from The Higher Degree Committee (Department of Health Studies) Unisa (Certificate number HSHDC/298/2014; see Annexure A). The researcher also sought permission to conduct the research study from the KZN Department of Health (see Annexure B; KZNCN (see Annexure C). Request letters were also written to the local NEIs, the two campuses from which data was collected; both principals granted permission (see Annexures D & E).

Every research participant has the right to privacy, anonymity and confidentiality. The researcher ensured that the identities of the participants were protected by not recording the names of the participants and not disclosing the names of the participants during the publishing of the findings of the study. The researcher also informed all research participants that their responses would be recorded with a tape
recorder for data collection purposes, and no unauthorised person would have access to these recorded conversations.

Pera and Van Tonder (2011:336) emphasise the duty of the researcher to protect the institutions that are participating in the study. In this study the institutions were protected by ensuring that it was impossible to relate particular data to a particular person in an institution or to the institution itself. The statements made by participants were represented as personal opinions and not those of the participating institutions. During the process of the study in Campus A and Campus B, the researcher did not utilise the services of the institution for the research study. She provided her own equipment and material for the purpose of the study. The researcher also did not interfere with the day-to-day operations of the campuses, and interviews took place in the free time of the participants. Feedback on the research results will be given to the Department of Health, KZNCN and the selected campuses and participants. This is a form of recognition of and gratitude for the approval and participation.

Non-maleficence and beneficence

Non-maleficence requires practitioners not to harm clients intentionally, through lack of knowledge or by negligence. The researcher must preserve the sanctity and quality of life of the participants (Pera & Van Tonder 2011:55).

Beneficence—the researcher has an obligation to prevent evil or harm and promote good (Pera & Van Tonder 2011:55). This principle implies that participants must be protected at all times from physical and emotional harm. Qualitative interviews on sensitive topics may provoke powerful emotional responses from participants. One of the aspects in this study deemed sensitive was the question relating to participants’ experiences in providing intimate care to patients of opposite gender. The researcher was aware that some participants might have had negative experiences and should be referred to the Employee Assistance Programme (EAP) which is an organised, systematic programme of counselling, advice and assistance, operating within the organisation. This is designed to help employees with personnel and work related problems (KZN DoH 2014).
The participants in this study voluntarily decided whether to participate in the study or not. The researcher avoided questions that intruded on the personal space of the participants. Interviews were conducted during the students’ days off or after work. Some students who did not reside in the nurse’s residence required travelling fees and they were reimbursed to prevent financial burden to them.

Justice

Justice refers to fair treatment of all participants in the study; avoidance of discrimination and exploitation. In this study, male and female student nurses who were knowledgeable about gender attributes in the nursing profession were recruited to participate in the study and selection was based on the inclusion requirements. Data collection was kept in strict confidence in a locked cupboard by the researcher and all information was used for research purposes only. Real names of participants were not used during the data collection, analysis and report of findings; participants would remain anonymous to prevent relating of data to a particular student or institution. The participants were not discriminated against on bases of colour, gender, language or creed. All male and female student nurses enrolled for R.425 and R.683 programmes were recruited to participate in the study. The researcher respected and upheld the principles of the institution and did not exploit the services of the institution for the gain of the study. The institutions were protected by not using real names on the research data collection and findings. The names of the two institutions and other identification particulars were also deleted on the consent forms (see Annexures B, C, and D &E).

3.7 CONCLUSION

In this chapter, qualitative research design was discussed as it was perceived to be the appropriate approach for the development of a meaningful construction of male and female nurses’ socio-cultural perceptions of the nursing profession, their influence on the recruitment and retention of men and their experiences in providing intimate care to patients of opposite gender. The application of qualitative techniques to the purposive sampling of suitable participants, semi-structured interviews and unstructured observation and data analysis were described. An attempt was made to
elucidate the trustworthiness of the study and ethical issues which were to be considered during this phase of the study.
CHAPTER 4
RESULTS AND DISCUSSION

4.1 INTRODUCTION

This chapter attempts to answer the research questions and objectives which aimed at identifying and describing male and female student nurses’ insights into and perceptions of the socio-cultural influences on the recruitment and retention of men in the nursing profession. It also describes their experiences in providing intimate procedures to patients of the opposite gender. This chapter presents the data management and analysis, research results and the overview of the findings.

4.2 DATA MANAGEMENT AND ANALYSIS

This study adopted a generic qualitative design allowing the researcher to study participants in their natural settings and attempt to make sense of the phenomena in terms of the meaning the nursing students brought to the study (Creswell 2013:43). Data management in qualitative research is reductionist in nature involving converting masses of data into smaller, manageable segments. Data analysis is constructional because it involves putting segments together into meaningful conceptual patterns. It involves discovering persistent ideas and searching for general concepts through inductive processes (Polit & Beck 2012:562).

Data collection was done in the natural setting of the nursing students at KZNCN: Campus A and Campus B. Semi-structured interviews were conducted and the infrastructure was observed for male friendliness.

4.2.1 Data management

Interviews

The researcher collected data till saturation was reached. Of the 27 student nurses who participated in the study, 16 were males. The interview guide (see Figure 4.1) was used for writing notes during the interview. Prior to the interview, the participant was requested to fill in the Demographic Questionnaire (See Annexure E) and informed consent form (See Annexure F). The interviews were audio taped using a digital audio recorder. As soon as the interview was over, before the participant left,
the recording was tested for functionality. Creswell (2013:175) suggests some principles to be adhered to when storing data, such as developing backup copies of computer files; using high-quality tapes for audio-recording information during interviews; developing a master list of types of information gathered; protecting the anonymity of participants; and developing a data collection matrix as a visual means of locating and identifying information for a study. In this study, a file with divisions was created and the following hard copy documents were filed: signed informed consent form, completed demographic questionnaire, notes made during the interviews, field notes and draft transcriptions and analysis.

The typed interview transcriptions and field notes were stored on a USB flash drive. This USB flash drive was only to be used for research purposes and was stored in a locked cupboard. Data was saved using each participant’s code as the name of the file.

<table>
<thead>
<tr>
<th>Topic: Socio-cultural perceptions of the nursing and their influence on the recruitment and retention of men in the nursing profession – KZN province.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Time:</td>
</tr>
<tr>
<td>Venue:</td>
</tr>
<tr>
<td>Researcher:</td>
</tr>
<tr>
<td>Participant’s code:</td>
</tr>
<tr>
<td>Programme:</td>
</tr>
<tr>
<td>Level of training:</td>
</tr>
<tr>
<td>QUESTIONS:</td>
</tr>
<tr>
<td>Q1. Please describe your perception of the nursing profession.</td>
</tr>
<tr>
<td>Q2. Please describe your experience as a male/female student nurse.</td>
</tr>
</tbody>
</table>
Q3. Which factors do you think may contribute to or influence the recruitment and retention of men in NEIs?

Q4. What intimate procedures have you provided for female/male patients in the clinical area?

Q5. Can you tell me about your experience when you were required to provide intimate procedures to female/male patients?

*Thank you for participating in this study*

**FIGURE 4:1 INTERVIEW GUIDE (Adopted from Creswell 2013)**

### 4.2.2 Data analysis

Creswell (2013:187) describes qualitative research data analysis as the process of interpreting data that begins with the development of the codes, the formation of themes from the codes and then the organisation of themes into large units of abstraction to make sense of the data. Data analysis reports on how the data was managed, organised and analysed in preparation for writing up and presenting data. In qualitative research, data analysis is the non-numerical examination and interpretation of interviews and observation for the purpose of discovering underlying meanings and patterns of relationships. It takes the form of narrative material as verbatim dialogue between an interviewer and a participant and field notes or diaries kept during the study. The purpose of data analysis is to organise, provide structure to and elicit meaning from data (Brink et al 2012:193; Polit & Beck 2012:556).

The following steps were followed during the data analysis procedure:

**Step 1: Verbatim transcription**

The verbatim transcription is a procedure for producing a written version of an interview or conversation. It is a full script of the interview or conversation. The audio-taped interviews were transcribed and after the transcription of the interviews were proofread for their accuracy.
Step 2: Developing category scheme

This is a process of aggregating the text into small categories of information seeking evidence from the code of different data used in the study (Creswell 2013:184). It is also described as finding patterns and producing explanations using both inductive and deductive reasoning to categorise data into segments (Brink et al 2012:193). The researcher carefully read the data with an eye to identifying underlying concepts and clusters of concepts. Important concepts that emerged from the close examination of each question separately were given labels that formed the basis for a category. These concepts were given abbreviated titles that classified words or phrases.

Step 3: Formulation of themes

A theme is an abstract entity that brings meaning and identity to a current experience and has variant manifestations. A theme captures and unifies the nature or basis of the experience into a meaningful whole (Polit & Beck 2012:562). Themes are also broad units of information that consist of several codes aggregated to form a common idea (Creswell 2013:186). At this phase, the researcher continually compared collected data from one participant with that of another participant in the determination of the final theme. These themes were organised into larger units of abstraction that made sense of the data and provided meaning from the participants’ perspectives. These themes were derived from the narrative material; they were validated and refined by using quasi-statistics, the tabulation of the frequency with which certain themes are supported by data, and they were interpreted in reference to personal ideas and the literature.

4.3 RESEARCH RESULTS

4.3.1 Sample characteristics

KwaZulu-Natal College of Nursing (KZNCN)

The KZNCN received full accreditation from SANC and South African Qualification Authority (SAQA) in October 2004; the single KZNCN with a uniform curriculum came into effect on the 1st of July 2005 which was marked by the first intake of
student nurses for R.425. There are 25 NEIs comprising of 11 campuses and 14 sub-campuses. The KZNCN affiliates with the University of KwaZulu-Natal (UKZN) and the University of Zululand (UniZulu). The academic affiliation agreement with the two universities excludes the 14 sub-campuses because they do not offer the R.425 training programme (Nkonzo-Mtembu [a.s.]. The vision of the KZNCN is “to lead Nursing Education and to achieve excellence in nursing through education and training of nurses and midwives registerable with SANC and SAQA at basic and post registration level” and the mission is “to produce caring and competent nurses and clinical nurse specialists who will be responsive to the current and future health care needs of the people of KZN by empowering them with nursing education” (KZN DoH 2014). From the 11 campuses, the researcher purposively sampled 2 campuses and data was collected until saturation was reached. The sample consisted of 27 student nurses of whom 11 were female student nurses and 16 male student nurses enrolled for R.425 and R.683 in their first and third academic years with their age analysis ranging from the ages of 21 to 44 years (see Table 4.1).

TABLE 4.1: DEMOGRAPHIC ANALYSIS

<table>
<thead>
<tr>
<th>Participant</th>
<th>Ethnic group</th>
<th>Age</th>
<th>F</th>
<th>M</th>
<th>Prog.</th>
<th>Date</th>
<th>Demotion</th>
<th>Reason</th>
<th>Level training</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2-5-2014</td>
<td>A</td>
<td>33</td>
<td></td>
<td>X</td>
<td>R425</td>
<td>July 2011</td>
<td>-</td>
<td>-</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
</tr>
<tr>
<td>2-2-5-2014</td>
<td>A</td>
<td>22</td>
<td></td>
<td>X</td>
<td>R425</td>
<td>July 2011</td>
<td>-</td>
<td>-</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
</tr>
<tr>
<td>3-2-5-2014</td>
<td>A</td>
<td>24</td>
<td></td>
<td>X</td>
<td>R425</td>
<td>July 2011</td>
<td>-</td>
<td>-</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
</tr>
<tr>
<td>4-2-5-2014</td>
<td>A</td>
<td>29</td>
<td></td>
<td>X</td>
<td>R425</td>
<td>Jan 2011</td>
<td>X</td>
<td>FNS&amp; OSCE</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
</tr>
<tr>
<td>5-2-5-2014</td>
<td>A</td>
<td>34</td>
<td></td>
<td>X</td>
<td>R425</td>
<td>July 2011</td>
<td>-</td>
<td>-</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
</tr>
<tr>
<td>1-3-5-2014</td>
<td>A</td>
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<td></td>
<td>X</td>
<td>R425</td>
<td>July 2011</td>
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<td>-</td>
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<tr>
<td>2-3-5-2014</td>
<td>A</td>
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<td></td>
<td>X</td>
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<tr>
<td>3-3-5-2014</td>
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<td></td>
<td>X</td>
<td>R425</td>
<td>July 2011</td>
<td>-</td>
<td>-</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
</tr>
<tr>
<td>4-3-5-2014</td>
<td>A</td>
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<td></td>
<td>X</td>
<td>R425</td>
<td>July 2011</td>
<td>-</td>
<td>-</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
</tr>
<tr>
<td>1-6-5-2014</td>
<td>A</td>
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### 4.3.2 Interview results

The researcher analysed each question separately and two categories were developed: socio-cultural perception of nursing and intimate care. Under socio-
cultural perception of nursing four themes emerged: nursing as women’s work, low status; stigma and caring/helping others. Four themes emerged from intimate care category: embarrassment and discomfort, fear, refusal of care and strategies. This category aimed at exploring the experiences of male and female student nurses when providing intimate care to opposite gender patients.

4.3.2.1 Socio-cultural perceptions of nursing

Career interests and decisions are attributed to the internalisation of gender roles by individuals of effective realities about gender-appropriate occupations. Societal norms and values play a vital role in the career choices of males and females, as they stipulate careers appropriate for each gender. Consequently, individuals choose occupations that society defines as masculine or feminine. The participants in this study were asked to describe the nursing perceptions of their own culture and society. All the participants except one were African (Zulu) culture. They identified four socio-cultural perceptions which regard nursing as a woman’s job with low status, stigmatised, and a caring profession.

![FIGURE 4.2: SOCIO-CULTURAL PERCEPTIONS OF NURSING PROFESSION](image-url)
Woman’s work

In the nursing history and literature (chapter 2) it is pointed out that modern nursing came into existence in the 19th century under the inspiration of Florence Nightingale, who saw nursing as an extension of women’s domestic role (Sienkiewicz 2012:13). The nursing profession reinforced this feminine image which propagated cultural understanding and societal attitudes about the occupations appropriate for men and women (Sushama & Rothstein 2009:196).

In this study the majority of male student nurses still believed that nursing is a female orientated profession. They based their perception on the grounds of African culture (especially Zulu), which distinguishes men’s and women’s roles and tasks in society.

My perception is that nursing is something that is for the females more special and because due to previously I saw only females working in nursing and (eh) like according to my culture you not allowed to see and old woman who is naked, so it is against my culture so that is why I said it’s for the females (M5-2-5-2014).

As they are in the nursing profession, there are procedures or tasks that they think should not be performed by male nurses. Interestingly enough, those responsibilities are the ones that society considers dirty work, that lower the status of a woman like serving a bed pan, changing positions and all other intimate procedures. One male participant stated that if you are a nurse society undermines you as a person and you are classified “as someone who is just for a bed pan…” (M3-2-5-2014:1)

There are some aspects on the job that I still feel should not be part of men’s job description, task not for men giving: bed pan, pressure care and to wipe women’s back. From cultural point of view men are not supposed to be wiping faeces, not supposed to be bathing even a child, [this is regarded] as women’s job. [when you do this task] it’s like you are losing your manhood and it’s like your dignity [as a man] is lost (M1-2-5-2014:1).

[Society] sees nursing as sometimes for women, because in our society the people that are caring for the sick are the women, so they view it like that as something for women. So is something that to them is inferior, you know women are like you look down upon them, so they don’t recognise this profession (F2-6-5-2014).
The few female nursing students in this study as individuals did not perceive nursing to be only a woman’s job but the society where they came from still supported the perception of nursing as a woman’s job. One participant put it beautifully:

[they] see nursing as something for women, because in our society the people that are caring for the sick are the women, so they view it like that as something for women. (F2-6-5-2014)

Clow and Ricciardelli (2011:198) dispute society’s assumptions that that there is something natural about being a woman or a man that makes them inherently suited to performing certain social roles, for example, women are assumed to be naturally better care givers and men naturally good leaders. This implies that men and women in roles that are dominated by the other gender are deviant, less qualified and lack the natural gifts possessed by the normative gender. This assumption has led to gender stereotypes which suggest that men and women are born with personalities that would be counterproductive to fulfil the social roles traditionally assumed by the opposite gender, as presently men are seen as inadequate in fulfilling tasks associated with roles traditionally fulfilled by women.

Low status

In many societies women are viewed as subordinate to men and have a low social status, allowing men control over all household activities because they have greater decision-making power than women (WHO 2008a:81). The Victorian ideology of a man as the head of the household and a woman as the handmaid (Wolfenden2011:2) has disseminated further decline of women’s status globally. In the South African (Zulu) culture a man is the head of the family; he is the decision maker whether educated or not and even in cases where a man is not working, the working class woman has to respect the decisions made by her husband. Both male and female nursing students in this study believed that society still perceives nursing as a low status job. This is based on the low status of women in society and the duties or procedures provided by nurses to their patients are seen as an extension of the domestic role of women.

Society considers a person providing nursing care, cleaning up after patients who cannot help themselves and serving bed pans as doing dirty work. These duties are
seen as lowering the status of the nursing profession because they are also classified as women’s jobs.

...honestly speaking from the people that I know and I have been talking to, they just think that nursing you don’t do anything, if you are a nurse you just give bed pans, you wipe patients after passing stools that is your job to clean the patient up. So we don't get given what is due to us, (pause). They don't realise what is expected of us and what we put in... (F1-6-5-2014)

...so [nursing] is something that to the [society] is inferior,...women are looked down upon so they don’t recognise this as a profession. (F2-6-5-2014)

“...nursing is considered as work for everyone, which can be done by anyone.” (M5-6-5-2014)

Some they use offensive names when you go pass by, in our communities those drunk they will use names, is it possible to mention the names? They will use like we eat faecal matters when we are at work, our job is to wipe people, the old people’s bums all these. It doesn’t feel right when you are offended by other people and community and that’s why most of the males don’t take nursing as a male dominant thing. (M1-12-5-2014)

There are 2-3 times when I was travelling in the bus wearing my nurse’s uniform (white) I felt so embarrassed because people ask me “how many bums have you wiped today” and being asked such questions in front of a full bus, it was embarrassing for me. [Society need to] stop looking down at nursing as profession, regard it with respect. I think that way we will be able to attract male applicants. Because for now they are too scared or either look down at nursing saying it’s a women’s job... (M1-2-5-2014)

Sienkiewicz (2012) highlights that in the history of nursing little value, respect and pay has been associated with this profession. These attributes give little incentive to men to desire to become nurses. Men require successful careers that offer them great value, respect and pay in order to support themselves, their family and honour their social roles.

It is clear that the status of any profession is judged according to the dominating gender. Women’s prestige in society is still low; therefore, the status of female-
dominated professions remains low (Magadze 2011:36). This will be the case until such times that gender roles are equally distributed among men and women in society. Globally, nursing is a low status profession which is staffed predominantly by women (Govender & Penn-Kekana 2007:11). The study of Liminana-Gras et al (2013:136) clarifies the notion that within the health system, care is considered to be a female activity; therefore, it is expected that a caring profession will be staffed by women and a curing profession by men. When a man opts for nursing as a career of choice he is considered an anomaly because he has chosen a low status female profession.

[Society] still thinks [nursing] is a lady’s job, where you just do all dirty work for everyone, you have to clean up every patient that has messed herself/himself, so people think it’s just one of those works that you have to clean after patients, you have to change diaper. (F1-8-5-2014:1).

**Stigma**

When a female enters a male-dominated field or a male enters a female-dominated field, the assumed masculinity or femininity of the job and the person are perceived to be in conflict. This perceived incongruity results in stereotypes that masculinise women and feminise men in these professions or in perceptions that an individual’s behaviour is not consistent and he or she is viewed as inappropriate for his or her gender (Clow & Ricciardelli 2011:192). Based on societies’ perception that nursing is a women’s work and statistically female dominated, males who enter the profession are labelled as homosexuals, weak or even as being not real men.

The male participants in this study strongly believed that society deemed them as homosexuals and not real men. These findings are congruent with those of Harding’s study (2007:639) of 18 men which agrees that the public still perceive men in nursing as being gay. This construction of men in nursing as gay originates within the patriarchal ideology that describes gender appropriate roles; therefore, men in feminine professions do not conform to the characters of hegemonic masculinity.

… nursing is not just a male thing because nursing we take it like is for soft people, people who are feeling for others, people who care, we tend to say men are strong people we don’t share our feelings. (M1-9-5-2014:3).
...they take male nurses as they are half males, they think maybe you are gay, because this is a profession for women, maybe they think you are not a full men if you are a male nurse. (M8-12-5-2014)

... the society where I come from as a male, [nursing] is seen as female job, [...] you will find that they will say that it was meant for the females and males were not meant to be nurses because sometimes you will find that they consider those who are being nurses as homosexuals, gays and what not. And sometimes you find that they say if you are a male enrolled in nursing you will end up being a soft person who is not able to care for the patient whom you are supposed to care for (M5-6-5-2014).

Society when [they] talk about a nurse they refer to a lady and that’s what they are talking about and when you say you are a nurse they will see you as a women. Because it is stemming from the time Florence Nightingale and she started nursing (F7-12-5-2014)

In an ideal African culture a real man is the one who does not cry (Ntibanyane 2008), because crying is a sign of weakness and crying in public or even showing caring emotions is seen as loss of control. The members of the SABC 3 “3 Talk” show hosted by Noeleen Maholwana-Sangqu whose theme was: “understanding the South African men”, the men on the show were in agreement that men exhibit aggression. The emphasis was that South African men are angry and they are numb. This view was based on the changes that have taken place in South Africa in the past 20 years of democracy, on the exceptional rise of women above society’s expectations; the policies that support women’s achievements, and the increased statistics of domestic violence and child sexual abuse. But the final word of the discussion was that men don’t cry. Those who want to cry can do so but not in public (SABC 3, 22 January 2014, 16:35). This illustrates that men in emotional labour like nursing will be judged on the grounds of their gender not on their competencies in the profession.

**Helping others and caring**

Caring has been historically and traditionally associated with women and femininity. O’Lynn and Tranbarger (2007:122) describe three perspectives of caring. The first,
The perspective of caring is that it is a human trait; this implies that caring is innate and essential to human existence. Therefore, it is not uniform and it is influenced by socio-cultural variables and personal experiences. The second perspective of caring is an affect; meaning that emotional feelings are involved to motivate actions and behaviour. The affectionate nature of caring can be prevented by the environment in which one finds oneself and by relational barriers. The third perspective emphasises that caring is a fundamental value; it strives to maintain the dignity and integrity of the clients/patients. These authors have summarised the core of all nursing activities or procedures that assist patients to reach self-actualisation. They advocate that as caring is a human trait, men are also capable of caring.

Interestingly enough, none of the male nursing students in this study perceived nursing as a caring profession. Female nurses embraced the term “caring” and male student nurses the term “helping”. These findings are congruent with those of Harding et al (2008:85) and Dyck, Oliffe, Phinney and Garrett (2009:649), as in both studies male nurses chose the nursing profession because they wanted to help others like their female colleagues in the profession. Two male students tried to express what nursing meant to them:

…to be able to provide help, [nursing] has given me a chance to help another person (M2-2-5-2014) and

It is a nice profession because you give something back to the community. It is also uplifting in terms of human approach to be able to give some help to a person. To see someone smiling because you have given them some help, especially because when they leave the hospital they have been healed. (M1-2-5-2014)

Reading carefully through these statements, one has a glimpse of the men’s world of caring. The absence of the word “caring” may lead prematurely to the conclusion that male nurses do not care, whereas the mere fact that they are helping others is a form of caring for them. This idea of men caring may be challenged by a study by Bartfay et al (2010:7) whose results show that 93% of female nursing student participants agree that nursing is more appropriate for women than for males because they are more caring and compassionate as a result of their inborn nature. This study is congruent with the findings of Clow and Ricciardelli (2011:192) who
maintain that female nurses are more caring and nurturing than male nurses. It is interesting to note that all these scholars do not dismiss the idea of men being caring but emphasise that women are exceptionally good at caring for others. Ozdemir et al (2008:1) remind us the origins of this ideology as reinforced by the social construction of what it means to be a nurse; it means caring, hard working women, nurturing and self-sacrificing.

... my perception of nursing profession. I think the nursing profession is the profession that is basically for those people who are dedicated and have passion for nursing people, for helping people. And I think is the profession that is different from other professions, it needs people who are dedicated, people who are not in the profession for money only, but for passion, passionate and the (pause) the love to be a nurse.(F3-3-5-2014)

In the past and even in the present, the domestic work of women has been identified as caring (O’Lynn & Tranbarger 2007:128). Nursing is considered as emotional labour as it calls for special abilities that are deemed to be possessed by women. Even though society perceives nursing as women’s work, often dirty work and as having a low status, male nurses in this study are adamant that the nursing profession exists to help others to be better and to recover from their ailments.

Nursing has always been seen as a caring profession which requires dedication and self-sacrifice and female nurses in this study affirmed this perception strongly. Two female student nurses articulated society’s expectation of female-dominated professions: commitment, letting go of your own culture and forgetting yourself in order to put others first.

There is no room for male nurses in this profession ... even in the ancient days in the times of Florence Nightingale nursing was taken as a duty of a woman. I think the reason for that; a woman is taken as a person who knows how to care for the sick person, for a child and for everything. A woman is over caring than a male... (F2-3-5-2014)

Nursing is not easy as people think, it requires you to just commit yourself ... you just forget yourself, you learn to put yourself aside and put the patient first (F1-6-5-10’4:1).
We need to come in and forget who you are, you can't come with your cultural background, and you even risk you gender (F1-8-5-2014:1).

4.3.2.2 Intimate care

Touch is a caring behaviour that is required when many tasks or procedures are carried out in the nursing profession. The Western Care Association (WCA) defines intimate care as any task of an intimate nature which the person is unable to undertake for themselves. It is associated with bodily functions and personal hygiene which necessitate direct or indirect contact with intimate parts of the body (WCA 2013:4). This type of care also involves psychological, emotional and/or physical closeness; it is a primary component and fundamental to care and is sometimes perceived as an invasion of individuals’ privacy and may be interpreted differently (Stauropouloouet al 2012: 482).

In most cultures male gender roles limit the use of touch, and violation of these roles puts men in a suspect position and increases litigation against them (O’Lynn & Tranbarger 2007:136). Presently South Africa is faced with increased child/women abuse and rape. This societal disorganisation or sickness predisposes men in nursing to a perpetrator position when they provide intimate nursing care to children and women.

Participants in this study identified four intimate procedures: catheterisation, wound dressing (groin, vagina, penis and scrotum), bed bath and pressure parts care. The researcher wanted to know their experiences when they provided one of these procedures to a patient of the opposite gender. Four themes were identified (see Figure 4.3).
Embarrassment and discomfort

Feelings of embarrassment and discomfort were expressed interchangeably by the participants in this study. Both these feelings were brought about as a result of an environment that seemed shameful and awkward. For a nurse to be in the presence of a naked stranger was the most difficult experience for both parties. Participants in this study expressed feelings of shame when they were to see a naked patient of the opposite sex. This view was also influenced by the respective ages of the nurse and patient. Both male and female nursing students supported one another’s view that in an African culture age plays an important role: an old patient is like one’s mother or father and seeing them naked is the equivalence of disrespecting one’s own parents.

*I am an African man I do respect the elderly, I see it is not good for me to undress and clean the old lady, because I respect her as my grandmother or grandfather. I know that sometimes in the profession you have to put up with that, in my culture you have to respect the elderly no matter what, as there is a saying “a child is raised by a village or a community.*(M1-12-5-2014)
Female nurse 1-3-5-2014 stated that during the procedure she was not comfortable because the patient was an old man and he was of the age of her father. She described her feeling as: “I felt like I was depersonalising the patient”; meaning that seeing him naked was like taking away his dignity. It is very important to note that it is very difficult for men to come to hospital because it seems that they are submitting to their weakness and the situation is worsened when they have to be directed by women. This power shift may lead to male patients’ feelings of humiliation when they are cared for by female nurses:

I had to dress the penis; even he[patient] was not comfortable. He asked whether I was going to do the dressing, couldn’t I call someone else to do the dressing. He was embarrassed and shocked, and I was embarrassed for him. (F1-6-5-2014)

Male student nurses also shared the same experience but they saw beyond feelings of shame and humiliation. However, they articulated their cultural beliefs that seeing an old naked person (especially a woman) was bad luck and was a sin:

… cause [she] was an older person, it is a sin to see older person naked (M2-2-5-2014).

I tried some means to change that, to shift the duty to someone else, but there was no one to do that. Because in my culture we tend to say that if you see someone naked more especially the genital part, you will tend to have black shadows (bad luck). You will have to go home and get a chicken to remove it. (M5-2-5-2014)

The two male students’ feelings of embarrassment were based on their sexual feelings as men. They acknowledged that men’s sexual organs are external; when they see female genitalia something in their body is awakened, penile erection takes place and they do not know what to do with themselves when such moments arise. This was confirmed by the WCA policy, acknowledging that clients maybe sexually aroused during intimate care; it is a normal and natural physiological response (WCA 2013:7).
I feel so uncomfortable to do those procedures because I am a man, I have got feelings. As a man if you see the private part of the opposite sex there is that feeling maybe you feel like can have sex (M8-12-5-2014).

I was not alone at the time of putting the catheter; I was with a female nurse. I was not happy because touching genitals affect my feelings as a male. The feelings of a male are quicker than females, when you see female genitals, there are something’s that happens in your body especially in your private part, you can even turn on (erection) (M4-12-5-2014).

Fear

Fear is defined as an unpleasant emotion caused by the threat of danger, pain or harm. It is also a feeling of anxiety concerning the outcome of something or the safety of someone or likelihood of something unwelcoming happening (Oxford dictionary [a.s.]). This definition enables the researcher to assess the feeling of fear. As articulated above, individuals develop a feeling of unease when they are faced with a particular situation at a given time. Nursing students during their training ought to be taught how to provide intimate nursing care to male and female clients. The provision of such care is problematic regardless of gender, meaning that both male and female students face difficulties during the execution of intimate procedures.

The majority of male participants in this study feared litigation when providing intimate care. This is based on the provision of privacy which requires that screens or curtains be drawn or closed to seclude the patient and nurse. These findings are similar to those in the studies by Le-Hinds (2010:1) and Harding et al (2008:94) that maintain that men providing intimate care are at risk of accusations of sexual misconduct and sexual inappropriateness.

You have to screen [for privacy], the things that make me a bit shaky. You have to screen, it is you and the patient, just the two of you. (M6-12-5-2014).

I needed assistance from a female person more safe if there is a female, cause of this law suits these days, it’s very difficult for a men and female [...], because when you are doing procedure you give privacy (M1-12-5-2014).

One male student nurse added the aspect of protecting the patient by having another female nurse present and at the same time protecting himself. The media has
assisted in creating awareness of woman and child abuse through education of their human rights.

A female must be there to assure that she is safe, because many people have been raped so now a woman with a male and even seeing privacy. It is also for myself because I know I am going to be alone with her, so if she screams now and no one knows what is happening there. And women are highly respected and so now the fault will be on me (M4-6-5-2014).

The fear of the few female nurses in the study was based on their youthfulness: not knowing what to do when a naked patient has an erection during a procedure especially when doing catheterisation:

As a young nurse I was afraid. I was not used to touching male patients and wondering what was going to be his reaction. As a new nurse it was also difficult because a male patient will have an erection and it is not comfortable [especially when this happens] and you are a young girl (F7-12-5-2014).

Refusal of care

The qualitative study of O’Lynn and Krautscheid(2011:29) focuses on non-nursing participants, suggesting that patients are willing to consent to intimate procedures provided they are informed and involved in decision making prior to the execution of intimate care. However, the participants in this study, both male and female nursing students, attested to the fact that although they provided information prior to the procedure, because of their gender, patients of the opposite sex rejected their nursing care. This rejection is not based on the abilities and competencies of the students but on the grounds of being male or female. These results are different from the findings of scholars such as Harding et al (2008:93), Liminana-Gras et al (2013:137), Meadus and Twomey (2011:274) and Wolfenden (2011:2) who suggest that male nurses are the ones who face bias from society. Patients accept female nurse assistance in provision of intimate care for them, but retract permission when it comes to male nurses.

The majority of female participants in this study reported numerous experiences of rejection of intimate care compared with those of male participants. Male patients are
also not comfortable with female nurses providing intimate care and they maintain the right to refuse the care based on their religious, cultural values and beliefs.

I remember [one day], [a male patient] chased me away, and he preferred to be done by male nurse. I respected that because even in our culture as black people a man is a man. In our culture a man or woman cannot just show his body like that ... Showing your body is not acceptable ... it is worse showing it to opposite sex (F2-6-5-2014:3).

The patient was not sick, he was fully awake. When I touched [the private part] he looked at me in the eyes and it was so uncomfortable. The second time bathing him, when I went to his private part, he held my hand and said “no”. He said, “Don’t take me there, please don’t touch me there. I am also a human being. I am a man”. I respected his wish and went to report to my supervisor (F3-3-5-2014:5).

Strategies

In October 2013, the WCA released a personal/intimate care policy with the purpose of supporting individuals who required assistance with intimate care needs and guiding caregivers on the provision of such care. The findings in this study showed that male nursing students have found ways or methods of dealing with the provision of intimate care to female patients. They provide patients with information regarding the procedure in order to obtain permission, provide privacy and they have a female nurse to assist during the procedure. The need to have a female nurse to assist is based on the fear of sexually related litigation:

… but in all this times I am doing it, I make sure that there is a female nurse in order to protect myself in terms of litigation (1-2-5-2014).

I still feel if I am a male nurse I must have a female nurse to assist me (3-2-5-2014).

I must have someone who is going to back me up... a female must be there (4-6-5-2014).

These findings are congruent with the study results of Liminana-Gras et al (2013:137) which state that male nurses have discovered strategies to curb fears of
litigation by using female nurses for self-protection; the assistance of patients’ relatives (Yoder 2007:68); explanation of procedures and provision of privacy (Fisher 2009:2673; Harding et al 2008:95). On the contrary O’Lynn and Tranbarger (2007:137) provide nursing education recommendations on how to guide male students when touching female patients. But they oppose the idea of automatic chaperones because it promotes the idea that male nurses are sex perpetrators. However, they leave room for automatic chaperoning for exceptional cases when a patient is unable to give informed consent.

One female participant had developed a strategy for provision of intimate care. The reason for this was not based on fear of litigation, but on fear of rejection:

*I go very cautious when I am working with a male patient, I assess his status, I assess his mentality first and if he is the kind that doesn’t want to be touched by women* (3-3-5-2014).

4.3.3 Observation results

Observation of the infrastructure and the participants during the interviews is discussed in this section. In 2010 a National Audit for Public Nursing Colleges and Schools was conducted. The findings showed that nursing education and training were poorly coordinated in South Africa and were characterised by considerable inequality regarding human resources (SANC 2013a:22). Infrastructure ranged from state-of-the-art buildings and equipment to makeshift rooms unfit for purposes of teaching and learning. An urgent need to develop building norms and standards for public nursing schools and colleges was proposed (SANC 2013a:23).

The two campuses that were purposively sampled were observed for male friendliness and safety of the nursing students.

*Campus A*

The campus is located at Umgungundlovu district (see Annexure H) with 87% female and 13% male nursing students; and 6% male and 94% female nursing educators. It offers R.425 and R.683 programmes. The infrastructure is in good condition with
sufficient classrooms and basic equipment to facilitate teaching and learning. The challenge faced by the campus is the issue of toilets. Three levels/floors are used by both students and academic staff. The ground and first floors have male toilets but the second floor has only female toilets. Altogether there are six toilets for both male nursing students and male academic staff. The problem is exacerbated when meetings or workshops are held and when all groups are on theory block. On two occasions, the toilets were dirty and polluted because some of the male nurses smoke in the toilets. At one time there was no toilet paper and when the researcher asked the cleaner she stated that male students stole toilet paper. There are four toilets on each floor for female student nurses. Although the toilets are usually clean, this is not the case at tea and lunch times.

The notice board in the entrance area had an article and news clips on Nurses Day. A picture of a female nurse in white uniform and cap was portrayed on the board. There was nothing related to men per se or even to men in the profession. Such things perpetuate nursing as feminine and the exclusion of men in the profession.

Campus B

Campus B is situated in Ugu district (see Annexure H) on private property. The NEI is in the middle of town in an old building that one can hardly identify as an academic institution. The government has rented this building since 2009 and today they are still in the process of acquiring a more suitable property. The student and nursing educator statistics are as follows: 26% male and 74% female nursing students; 100% female nursing educators. There are 7 classrooms which can accommodate fewer than 30 students per group. The building is not conducive to teaching and learning needs nor is it physically safe for the students. To begin with there is no library; a storeroom is used for keeping the books which are fairly out-dated. There are new computers not utilised because the electrical system is not working in that particular building; electric wires are exposed predisposing the students to electrical shock or electrocution. The researcher observed two working toilets for male students but one was broken awaiting repair. They were fairly clean and in the same condition as the female toilets.
O’Lynn and Tranbarger (2007:280) suggest that for the environment to be friendly for men in NEIs, male student nurses should be mentored by male nursing educators or be encouraged to meet both formally and informally to support one another on their professional journey. Both campuses are faced with the same challenge of poor toilet services for men and lack of male role models in the academic staff.

Language

All participants, male and female alike, whenever reference was made to a professional nurse, used the feminine pronoun “she” and the noun “sister”. This finding is supported by many studies in the literature such as those by Kirk (2012:98), Le-Hinds (2010:1), Mullenwise (2009:6) and O’Lynn and Tranbarger (2007:175). The researcher read the following paragraph in a prescribed book that supports the notion that a nurse is a woman, thus automatically excluding men: “Every nurse must uphold the image of nursing by always acting in a professional manner. She should do this not only in the working situation but also in the community setting, where she serves as a role model and she should become involved in community affairs” (Mellish et al 2010:200).

4.3.4 CONCLUSION

This chapter presented the journey of the researcher during data management and analysis procedures. The findings in this study showed that nursing is still strongly a feminine profession and men who have chosen it still feel insecure and alone. The image of any profession can only be redeemed or protected by its own members. As indicated in chapter 2, society and culture play an important role in the lives of people; therefore, gender roles and responsibilities need to be reviewed for their effectiveness in the social status of men and women. If this is not attended to, nursing will remain a woman’s job of low status and men in the profession will feel isolated.
CHAPTER 5
CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The analyses and findings of this study stem from the socio-cultural perceptions of the nursing profession; these were presented in chapter four. This chapter further imparts the interpretations, summaries and conclusions of the results in relation to the available literature. It also concludes the research and offers recommendations for future studies. The research study had two aims to fulfil: first to identify and describe male and female student nurses’ insights and perceptions of socio-cultural influences on the recruitment and retention of men in the nursing profession; and second to identify intimate procedures and the students’ experiences in providing this care.

5.2 RESEARCH DESIGN AND METHOD

A qualitative research design was employed to conduct this study. This is a situated design that locates the researcher in the world of the participants. It involves an interpretive and naturalistic approach. This means that qualitative researchers study phenomena in their natural environment, attempting to make sense of, or interpret the phenomena in terms of the meanings people bring to them (Creswell 2013:43).

This study began with two philosophical assumptions. Ontological assumptions focus on multiple realities which were presented as themes in the findings. Second, epistemological assumptions were based on the justification of knowledge and the relationship between the researcher and participants. In this study, the researcher spent time at both campuses in order to gain knowledge of the subject understudy. This knowledge was justified by using quotes as evidence from the participants. Generic qualitative research was the emerging approach used for sampling of participants and collecting and analysing the data.

Social constructivism theory was sought to direct the study. In this theory individuals seek to understand the world in which they live and work. They develop subjective meanings of their experiences, and they are directed toward a specific objective. The
meanings are varied and multiple in nature. Therefore, the goal of the researcher is to rely on the participants’ views of the phenomena (Creswell 2013:25).

Generic qualitative research

To study and understand the research problem and questions, the researcher used generic qualitative research. This design is a method that simply seeks to discover and understand the worldview of the people involved. Qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meaning people bring to them (Flick 2007:12; Polit & Beck 2012:14; Creswell 2013:43).

NEIs providing R.425 and R.683 programmes were purposively sampled, as well as male and female nursing students enrolled for the above-mentioned programmes. Both campus principals allowed the researcher to conduct the study (see annexures D and E). Data collection was done in the natural setting of the participants (Campus A and Campus B). The researcher was the key instrument for data collection during which individual face-to-face semi-structured interviews were conducted and observation of the infrastructure was done. Prior to conducting the interviews participants were given information about the study (see annexure F). Participating in the study was voluntary; therefore, if they chose to participate they filled in the demographic questionnaire (see annexure G) and informed consent form (see annexure H). The anonymity of the NEIs and participants was maintained by their real names not being used at any stage of the study. Each participant was given a code which indicated the number of the interview, date, month and year, for example, 1-5-8-2014. As indicated in chapter three, after data collection, the interviews were transcribed and in the final phase themes were formed. Chapter 4 presented the written report of the results which included the participants’ voices and the observations of the researcher.

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

The researcher attempted to address the problem of the low number of male nurses in South Africa as well as in KZN province. SANC statistics at the end of 2013 indicated that there were only 8% of male professional. This low percentage indicates
the major role of women in the caring profession and the socio-cultural influences on career choices for individuals, especially men. This section provides some reasons for the low percentage of men in the nursing profession, based on the participants’ socio-cultural perceptions of the nursing profession and their experiences in providing intimate care to patients of the opposite gender.

5.3.1 Socio-cultural perceptions of the nursing profession

Women’s work

The ideology of nursing as a gender role occupation exclusive to females is a deep-rooted societal belief which is based upon the traditions that nurses are females in white uniforms and caps (Armstrong et al 2013:247; Twomey & Meadus 2008:30). This idea of nursing is well supported by the media and reinforced through the images of nursing solely based on feminine attributes. Many people rush home from work to sit comfortably and watch their favourite soapy and in all these series a nurse is portrayed as a woman:

- Soul city – drama series female professional nurses working hard to make a community clinic function (SABC 1, Tuesday 20:30)
- Muvhango – a drama series that embraces the traditional Venda and urban culture. The king’s first wife is the nurse in the community clinic (SABC 2, Monday – Friday 21:00).
- Rhythm city – a soapy well loved by young people, “Sis B” is the nurse who is active at church and talks a great deal (e-TV, Monday – Friday 18:30).

This portrayal in the media strengthens society’s beliefs of nursing as women’s work and perpetuates the cycle of bias that limits the role of men in the nursing profession.

The male participants in this study still perceive nursing as women’s work; their perceptions are based on their cultural socialisation which segregates male and female gender roles and status in their society. This is well enforced in the African Zulu culture where a man is seen as the head of the family, the provider and a woman as the handmaid of the man (Wolfenden 2011:2; Sushama & Rothstein 2009:196). Therefore, few men opt for nursing as a career of choice, allowing female dominance in the profession.
As indicated in chapter two, social constructivism theory advocates that knowledge and reality are negotiated by society within a specific context. As gender is socially constructed and gender roles communicated during primary socialisation, different genders learn at this early stage which career is appropriate for them. These individuals choose careers that do not conflict with their gender roles and social status. The findings of Mkhize and Nzimande (2007:18), based on South African school grades 11 and 12, affirm the primary socialisation aspects. The findings show that 71.4% of girls were convinced that they would pursue a nursing profession. These findings suggest that nursing will continue to be dominated by women as long as male school leavers do not see nursing as a career of choice.

Low status

Mellish et al (2010:29) acknowledge the vital role of society in developing the status of women in the wider community; they state that when women are assigned a low status in a community, this directly affects the development of nursing and the types of nurses that emerge. Meiring (2010:18) indicates that the ministering angel and good nurse image is rooted in the history of nursing in South Africa and this image supports society’s perception that nursing is not only a woman’s job, but is also religious, unselfish, obedient, unquestioning, submissive and compassionate in nature.

Presently the nursing profession is female-dominated and women in society are classified as subordinate to men; this places them in a low social status. Women’s low status in society is based on gender and automatically subjects the female-dominated professions to a low status. The findings of this study suggest that nursing is still undermined by society. The participants believe that society still perceives nursing as a job that can be done by anyone and when people fail to pursue their dream careers they come to nursing as something to fall back on. These findings are congruent with those of Neilson and Lauder (2008:684) whose study participants were high academic achieving school pupils. These participants viewed nursing as not having high levels of cognitive aspects related to it, but as very practical in nature; therefore nursing did not require any degree of intelligence.
The salaries earned by nurses are disappointingly low while they have to work long hours caring for the sick in overcrowded health facilities under poor physical working conditions. These aspects also lead people to perceive nursing as an undignified profession (Mkhize & Nzimande 2007:17).

When an individual is sick and family members are unable to cope with the ailment, they automatically seek medical assistance in health care institutions. They expect their loved one to be taken care of by nurses who ought to provide basic nursing care including physical/hygienic needs (serving bed pans, changing linen, and pressure care). Interestingly, this basic nursing care is classified by society as dirty work.

Nurses are bound by their Scope of Practice (R.2598) and Acts and Omission (R.387) to provide basic nursing care to patients or clients in order to meet their physical, social and psychological needs. Should nurses fail to meet the stipulations of these regulations, they automatically violate the Nurses Ethical Code of Conduct. The audacity of society to classify nursing tasks or procedures as dirty work may influence nurses to question their commitment to provide these tasks resulting in ethical dilemmas. R.2598 requires nurses to maintain the personal hygiene, elimination and nutritional status of the patient and should a nurse fail to perform such tasks because of the unfair societal influences, there are possibilities of her or him being charged by SANC for negligence.

Stigma

Society has slowly begun to tolerate cross gender occupations for women but not for men. When men are sensitive they run the risk of being called soft, exposing their vulnerability, and their manhood is questioned. This deters men from sharing their feelings and emotions (Wallace 2007:16). Nursing is considered as an emotional labour because a patient is nursed holistically: physically, socially and psychologically. In this study, male participants strongly believed that society would still judge them as gay because of their choice of work. This made them feel that they had constantly to prove themselves as nurses.
The participants in the study of Neilson and Lauder (2008:684) hold stereotypical images of both male and female nurses. Female nurses are viewed as sexual objects (Wallace 2007:19); male nurses are viewed as homosexuals, gays (Clow&Ricciardelli2011:193; Harding 2007:639). These stereotypical images of nursing discourage men from choosing nursing as a career. When men enter the profession, they have to deal with the commonly held stereotype that they are gay (Meiring 2010:19).

Helping others and caring

To nurse someone symbolises care and when a male nurse provides basic care such as a bed bath or fulfils the ward routine it is a simple gesture of caring. Even though in this study female participants embraced the term “caring” and male participants referred to “helping others”, both male and female nursing students in their clinical environment fulfilled their pledge of service. These findings are supported by Moore and Dianemann (2014:87) whose study suggests that men who choose the nursing profession are driven by an intrinsic motivation to help others. This motivation is similar to that of women when they enter the nursing profession.

Zamanzaden et al (2013:54) remind us of the core reason for the ability of men who care to be questioned. This is based on the caring nature of the nursing profession which has always been used to express the essence and quality of femininity. Men and women have different abilities when caring and this is influenced by their backgrounds, experiences and environments conducive to expressing such care. Men in nursing need to be provided with a non-judgemental environment, in which they can provide care as men, not as men imitating the care provided by women in the profession. Should men start caring as women, they would be exposing themselves to be judged as homosexuals.

5.3.2 Intimate care

Intimate care encompasses the physical, emotional and psychological closeness between a nurse and patient (Stauropoulouet al 2012:481). Providing such care requires touch; this method of care has always been used in nursing to holistically care for the patient. This touch may be perceived as an invasion of an individual’s
space and privacy and may also be interpreted differently by different people. As indicated in the literature, touch is gender defined, meaning that touch is limited to gender roles in society. The NEIs have to provide the intimate care content in their curriculum and failure to give instruction on such care poses problems to all students. However, many scholars have focused on men (Harding et al 2008:88; O’Lynn & Tranbarger 2007:136). The study of Griffith (2007:264) provides the legal requirements that nurses must follow when carrying out intimate care to patients. The patient must be respected and the patient’s bodily dignity and integrity must be protected at all times. The following requirements are outlined for intimate procedures in order to protect the patient:

- A suitably qualified person should undertake the procedure
- Consent of the patient must be obtained prior to providing such care (Fisher 2009:2674; Harding et al 2008:95)
- The procedure must be deemed to be proper and such procedure must be done for the good of the patient

Embarrassment and discomfort

Male and female participants in this study still respected adult persons as their parents. They regarded adult patients coming to their care as their mothers or fathers. Being socialised in a culture of respect for adults and seeing a naked person of the age of their parents, they felt embarrassment and discomfort. To see someone naked and to be naked in front of someone was a degrading exposure and experience. These procedures might also cause embarrassment not only to nurses but also to the patients receiving the care (Griffith 2007:269).

This feeling of embarrassment and discomfort can also be related to a Christian perspective. This originates in the book of Genesis 9:18-27, when Noah was drunk and lay naked in his tent. His son Ham saw the nakedness of his father but did not cover him; instead he told his two brothers outside the tent. The two brothers laid a garment on their shoulders and walked backward and covered their father’s nakedness. Their faces were turned away and they did not see the nakedness of their father. When Noah heard of this incident he cursed Ham and his generation.
Culturally and religiously the body of a person is sacred and it needs to be respected at all times.

Culture and religion emphasise aspect of respect; therefore feelings of embarrassment and discomfort will generally be present as long as older people seek help from health institutions. What is important is to know how to deal with such situations and have times of debriefing.

Fear

Fear is an overwhelming, uneasy feeling of anxiety; provision of intimate care brings about such feelings. The findings of this study revealed that both male and female participants had experienced such moments of helplessness and fear in their clinical placements. This clearly indicates that provision of intimate care is problematic regardless of gender. It must be made clear that an emotional outburst of fear is not based on incompetence as such. Even though participants’ reasons differed according to gender, they all felt knowledgeable about and skilled enough to provide such care.

The male participants’ fear was based on the idea of being alone with a female patient and of being wrongly accused of sexual harassment and assault while performing the procedure according to set standards. These findings are congruent with the studies of Harding et al (2008:94) who affirm that men are still at risk of being accused of sexual misconduct through the use of intimate touch being misinterpreted, leading to feelings of vulnerability. Le-Hinds (2010:1) maintains that male students still feel anxious regarding sexual inappropriateness accusations when providing care to female patients. Male nurses have to prove to themselves that they are trustworthy and knowledgeable because society, or to be specific, female patients, still expect nurses to be female.

The fear of the few female participants were based on their youth and on being alone with naked men but the worst fear was not knowing what to do when a patient had an erection during a procedure, especially catheterisation. The WCA (2013:7) agrees that male patients may experience sexual arousal during intimate care and one cannot judge the patient because it is a normal and natural physiological response to
the gentle touch of a woman. There is no available literature that deals with such experiences; one can only assume that if such literature were available it could assist these young women with strategies to implement during such encounters.

**Refusal of care**

The findings of this study showed that female participants also experienced feelings of rejection by male patients. Interestingly, when male patients refused their care, female nursing students did not give up. They explained again their reasons for the procedure as if the patient had not initially understood, and they continued to do so until the patient accepted their care. They did not walk away from their responsibility, because the patient had judged them according to their gender and not according to their competency. They depicted a sense of commitment, endurance and perseverance under trying circumstances.

The male participants in the study by Harding et al (2008:93) met with refusal of care from both female and male patients, but they accepted it as the patients’ right and refused to be bothered by such rejection. Even in this study, male nurses accepted the rejection of their care and found a female nurse to carry out the procedure. These findings clearly indicate the advantage of being a minority; female nurses are always available to assist male nurses. However, most wards/units do not have male nurses. If a male patient, therefore, refuses the intimate care of a female nurse, who will provide it? Female nurses need to pursue the male patient until he consents to the procedure. These results differ from the findings of scholars such as Liminana-Gras et al (2013:137), Meadus and Twomey (2011:274) and Wolfenden (2011:2) who suggest that male nurses are the people who face bias from society and patients accept female nurse assistance in the provision of intimate care for them, but retract permission when it comes to male nurses.

The majority of nursing scholars have focused their research interests on the experiences of men who are the minority gender in the nursing profession. This research has led to an understanding of male nurses’ struggles within the profession. Female nurses’ experiences have been neglected. Prior to arriving at premature conclusions, one needs to acknowledge that these scholars are male nurses themselves, and realise that women in the profession should write their own stories.
Strategies

The male participants in this study had developed strategies to protect themselves against false allegations and litigation by patients during provision of intimate care. These findings are supported by scholars such as Fisher (2009:2673), Harding et al (2008:95), Liminana-Gras et al (2013:137) and Yoder (2007:68). The available literature and this study show that the experience of women when providing intimate care to male patients is a field that is not well researched. In the case of a doctor who was convicted of twelve counts of indecent assault on his female patients in 2004, four definitions of a chaperone were considered:

- A chaperone provides a safeguard for a patient against humiliation, pain or distress during procedure and protects against verbal, physical and sexual abuse.
- A chaperone provides physical and emotional comfort and reassurance to a patient.
- An experienced chaperone will identify unusual or unprofessional behaviour on the part of the health professional.
- A chaperone may also provide protection for the health professional from potentially abusive patients (Cmd6298/ 2004 cited in Griffith 2007:270).

These definitions suggest that a chaperone is present during a procedure to support the patient emotionally and physically; to assess the competency of the nurse and to protect the nurse from a violent patient. The last definition may be used in the case of female nurses providing intimate care to male patients. One may assume that during these intimate procedures a young female nurse may be intimidated and sexually harassed by male patients. O’Lynn and Tranbarger (2007:137) caution against the use of an automatic chaperone as this may affirm the negative perception of male nurses as being sexual perpetrators. Therefore nurses, regardless of their gender, must be respected for their skills, knowledge and competencies.
5.3.3 Observation of NEIs for male friendliness

Campus A

The infrastructure of this campus is well suited for the teaching and learning of nursing students. The challenge of toilet facilities for male student nurses can possibly be resolved if the campus and hospital management discuss the situation and plan the way forward. Sanitation is one of the basic needs of all human beings; therefore, the campus is obliged to provide adequate toilets for all students and academic personnel. The mere fact that the academic personnel and nursing students share the toilets indicates the inability of the campus to uphold the educational status of the personnel to the highest standards. This may also contribute to the low status of the profession, as the academic staff have to wait in a queue with the students if the toilets are busy.

It is important to note that the group of nursing students who prepared the notice board for the nurses’ day were not only female nursing students; male nursing students were also involved. This shows that male nursing students adhere to society’s stereotypic image of nursing as female work. If they did not, the big picture of a female nurse in a white uniform and cap would not have been the theme for Nurses’ Day. They would have challenged the idea in order for them to be included in the celebration.

Campus B

The infrastructure and location of this campus are not ideal for teaching and learning. The campus is small and not safe for either the nursing students or the personnel. It is situated in the middle of town and it is very difficult to identify it as an academic institution. The KZNCN has been renting this property since 2009 and to today they are still searching for a more suitable property. The building on its own lowers the status of the profession and the young generation will not be attracted to the profession. The DoH and KZNC need to come up with a strategic plan to fast-track the process of searching for the appropriate property and moving the nursing students to an environment more conducive to teaching and learning. The issue of toilets in this campus can only be addressed when a new property has been found.
Male friendliness

Zamanzaden et al (2013:31) urge the NEIs to create male friendly environments. This can be achieved by developing an inclusive curriculum, provision of male role models and proper clinical preparation of male nursing students in order to overcome gender issues in the workplace. O’Lynn and Tranbarger (2007:280) further advocate the provision of mentoring of male nursing students by male nursing educators; if not, male nursing students should be encouraged to meet formally or informally to support one another on their journey of the nursing profession.

Both campuses face similar challenges regarding male nursing educators. Campus A has 6% of male nursing educators and campus B has no male nursing educators. In KZNCA, of 11 campuses and 14 sub-campuses, there is only one male principal. These statistics suggest that male nursing students will continue to be without role models in the NEIs and this will predispose them to feeling isolated in the profession.

Language

Feminine language is still used in nursing. This was indicated by all participants referring to professional nurses as “she” and “sister” regardless of gender (Le-Hinds 2010:1; Mullenwise 2009:6). The prescribed textbooks for the participants also use feminine pronouns (Mellish et al 2010:200). The study of Wolfenden (2011:2) indicates that in nursing, verbal communication is used as an indirect practice of discriminating against men in the profession. The use of feminine pronouns leads people to think that nurses must be female; if not they are an anomaly. The use of the term “male nurse” is a furtive form of downgrading men in nursing. It assumes that all nurses are female (Moore & Dianemann 2014:88); and the use of gender before the profession places greater eminence on male nurses not being aligned with the prescribed gender roles. This brings about stress and conflict to male nursing students because they have to prove that they are good, skilled and competent nurses. One may imagine the longing in their hearts to be accepted as they are in the profession, regardless of their gender or status in society.
5.4 CONCLUSIONS

It is only human for one to expect appreciation from one’s clients or even from society in general for a job well done. An expression of gratitude affirms and boosts the self-confidence and self-worth of an individual in the profession and society. Wallace (2007:28) believes that the nursing profession has been transformed from negative images such as angel of mercy, religious and servant images to independent nursing practitioners who work in partnership with other health practitioners. Wallace (2007:28) further states that nursing has become a highly skilled profession and nurses are extensively prepared in education which is rooted in human sciences and research. It was interesting to watch a short presentation of “South African Heroes” in which three nurses are regarded as heroes. None of these nurses are professional nurses. One is an enrolled nurse auxiliary and two are enrolled nurses. This snap presents nurses who are passionate and caring. Male nurse Jordan shows that male nurses have the ability to care (e-tv, 8 September 2014, 11:15).

The first aim of this study was to identify and describe male and female student nurses’ insights into and perceptions of socio-cultural influences on the recruitment and retention of men in the nursing profession. Sadly, the findings of this study suggest that society on the whole still maintains the primitive perception that nursing is a feminine profession, of low status and with stigma attached. This is disheartening because the participants are the future of the nursing profession. If they believe in such negative perceptions, there are high possibilities of their leaving the nursing profession soon. At present, nursing is not appreciated as a profession but is seen as cleaning up after patients who have messed themselves, serving bed pans and providing intimate care.

These negative perceptions suggest that people in the nursing profession embrace feminine characteristics of being weak, submissive, nurturing and sensitive; whereas men ought to portray masculine characteristics of independence, self-confidence, dominance and competitiveness (Clow & Ricciardelli 2011:191). This perception negatively influences the recruitment of men to the nursing profession; men will continue to be discriminated against not because of their lack of skills and
competencies but because of their gender; and because they are in a profession which is not congruent with their gender roles and status in society. The stereotypical image of nursing which classifies men in nursing as gay (Bartfay et al 2010:3; Clow & Ricciardelli 2011:193; Harding 2007:639) will lead to an increased drop out and failure rate related to their sense of manhood or masculinity. Scholars such as Kirk (2012:29), McLaughlin, Muldoon and Moutray (2010:306) and Sushama and Rothstein (2009:200) indicate that more men are leaving nursing for better salaries and working conditions. Therefore, the profession is losing competent and intelligent nurses, leading to a shortage of nurses.

The second aim was to identify intimate procedures and the students’ experiences in providing this care. Bed bath, catheterisation and wound dressing (groin, scrotum and vagina) were the procedures identified by the participants as intimate procedures. These procedures are the basic needs of patients; hygiene, wound healing and elimination form part of nurses’ scope of practice (R.2598). Therefore, nurses ought to provide such care to all patients regardless of their gender. The experience of male nurses regarding intimate care is well researched compared with that of female nurses. This poses a challenge to female nursing scholars to research their experiences in the profession.

Both male and female participants in this study experienced embarrassment and discomfort, fear and refusal of care with regard to intimate care. This study suggests that intimate care is problematic to all nurses regardless of gender. The feeling of embarrassment and discomfort when young nurses encounter the nakedness of an elderly patient brings about a feeling of reassurance because this suggests that nurses still uphold the value of respect for elderly persons in society. Male nurses fear to be wrongly accused of sexual assault during their caring services, whereas female nurses are afraid to be alone with a naked male patient because of the possibility of the sexual arousal of the patient during the procedure.

Based on the nature of intimate care, some countries have formulated policies (WCA 2013) and legal frameworks (Griffith 2007) which guide the actions of nurses and protect the patient and nurse during a procedure. In this study, the male participants had developed strategies in order to protect themselves (Fisher 2009:2673; Harding
et al 2008:95; Liminana-Gras et al 2013:137). O’Lynn and Tranbarger (2007:137) also provide nursing education recommendations for when male students touch female patients. But they warn against automatic chaperonage because it could give the idea that male nurses are sexual perpetrators. The challenge with these strategies is the maintenance of confidentiality and trust between male nurses and their patients and society at large. Male nurses must remember that female nurses also need support when they provide intimate care to male patients. Male nurses should be thinking of ways to improve society’s understanding of their presence in the nursing profession.

5.5 LIMITATIONS OF THE STUDY

The study was conducted in one province and focused on public NEIs, thus excluding private NEIs. Qualitative research design was used coupled with non-probability sampling to select the sites for the study and enrolment of participants. Two campuses were purposively sampled from 11 campuses and 14 sub-campuses. Male and female nursing students enrolled for R.425 and R.683 programmes were included in the study. Other nursing students not enrolled in these programmes were excluded and they might have provided rich, valuable information. Therefore, the results are not generalizable to other provinces and countries. The researcher was known by some participants at one campus; this may have influenced their responses and contributions to the study. There were some challenges regarding data collection. A few nursing students who had accepted participation in the study and interview dates withdrew from their participation agreement or did not turn up. They did have the right to withdraw at any phase of the study, but at the same time it wasted time and finance. It would have been much better if they had withdrawn prior to the interview schedule date.

5.6 CONTRIBUTION OF THE STUDY

The negative socio-cultural perceptions of the nursing profession affect both male and female nurses whether in training or already qualified. Nurses are required to provide intimate care to patients of opposite gender; this poses a challenge for any nurse regardless of gender. The contributions of this study will be to assist nurse educators to better their understanding of gender-related issues in nursing
education. As in the literature, there is evidence of high attrition rates of male students compared with those of female students (Dyck et al 2009:649; McLaughlin et al 2010:303; Sienkiewicz 2012:29). This study will assist in the development of strategies to improve the number of male nurses in the nursing profession and decrease the attrition rate. The demonstration or teaching of intimate procedures in relation to gender has been neglected; this was articulated in the experiences of the participants in this study when providing intimate care to patients of the opposite gender. Therefore, this study will empower nurse educators in their methods of teaching and demonstrating intimate procedures to male and female nursing students.

5.7 RECOMMENDATIONS

The department of Public Service and Administration in 2009 issued the National Gender Equality Strategic Framework which aimed at creating an enabling environment, equality of opportunities and creating a barrier-free workplace. The framework proposed that each department establish women’s and men’s forums at a provincial, district and institutional level (KZN DoH 2012). Therefore, men in the nursing profession can also form their forums at NEIs and health institutions in order to discuss issues that affect them as men in nursing. As it will be long before they have visible role models, this forum will assist them to be role models for one another. This will also make male nurses visible to the public and media, eliminate the perception that nursing is a woman’s job and encourage more males to opt for nursing as a career of choice.

This study was conducted in one province and in public NEIs. Future studies are recommended in different provinces and inclusive of private NEIs. There is no available literature that deals with the preparation of male and female nursing students when providing intimate care to patients of the opposite gender. The experiences of female nurses – the dominant gender in the profession – in providing intimate care to male patients is not well researched and it is of vital importance to explore their experiences in order to assist them in developing strategies or methods for providing intimate care to male patients.
5.8 CONCLUDING REMARKS

The image of any profession can only be shaped or converted by the members of the profession. This study presented the participants’ insights and socio-cultural perceptions of the nursing profession and their experiences in providing intimate care to patients of the opposite sex. The identified perceptions display negative images which will consequently limit the recruitment and retention of men in the nursing profession. Even the NEIs do not provide male friendly environments. This view is based on the use of feminine pronouns, lack of role models and inadequate toilets. These reasons also contribute to male nurses not opting for nursing as a career of choice and not remaining in the profession. Society needs to be educated about the complexity of the nursing profession in order to elevate the status of nursing and introduce diversity into the profession.

Provision of intimate care or procedures is problematic for all nurses regardless of their gender, but as indicated vast research has focused on men who are a minority in the profession. Therefore, this study suggests that female nurses need to be supported in their endeavours to provide holistic and intimate care to male patients.
REFERENCE LIST


Medical Research Council. See MRC


National Institute for Health Research. See NIHR


SABC 1, 2014. Soul City. Mondays, 20:30

SABC 2, 2014. Muvhango. Monday – Friday, 21:00


SABC 3, 2014. 3 Talk. Wednesday, 16:35.

South African Nursing Council. See SANC


SANC. 2013b. *Strategic plan for nurse education, training and practice 2012/13 – 2016/17.* From:


World Health Organization. See WHO.


UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

Date: 30 January 2014
Student No: 4198-137-5

Project Title: Socio-cultural perceptions of nursing and its influence on the recruitment and retention of male student nurses in the Nursing Education Institutions (NEIs) - KwaZulu-Natal Province.

Researcher: Simangile Shakwane

Degree: MA in Nursing Science

Supervisor: Prof JH Roos
Qualification: D Lit & Phil
Official Supervisor: -

DECISION OF COMMITTEE
Approved [✔] Conditionally Approved [ ]

Prof L Roos
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRIES
ANNEXURE B: KZN HEALTH APPROVAL LETTER

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953159
Fax: 033 – 394 3762
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 28/14
Enquiries : Mr X Xaba
Tel : 033 – 395 2805

Dear Ms S. Shakwane

Subject: Approval of a Research Proposal

1. The research proposal titled ‘Socio-cultural perceptions of nursing and its influence on the recruitment and retention of male student nurses in the Nursing Education Institutions (NEIs) – KwaZulu Natal province’ was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby approved for research to be undertaken at campuses of the KwaZulu Natal College of Nursing.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200 and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 24/02/2014

uMnyango Wezempilo, Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope
ANNEXURE C:  KZNCCN APPROVAL LETTER

KWAZULU- NATAL COLLEGE OF NURSING
P/Bag X9089, Pietermaritzburg, 3200
Tel.: (033) 254 7800, Fax: (033) 394 7238
E-mail: joan.mkahathini@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Mrs. S. Maharaj
Telephone: 033 – 254 7806
Date: 12 March 2014

Principal Investigator: Shakwane Simangele
University of South Africa
Student Number: 4198-137-5

Dear Madam

RE: PERMISSION TO CONDUCT RESEARCH AT THE KZN COLLEGE OF NURSING NEI's.

TITLE: SOCIO-CULTURAL PERCEPTIONS OF NURSING AND ITS INFLUENCE ON THE RECRUITMENT AND RETENTION OF MALE STUDENT NURSES IN THE NURSING EDUCATION INSTITUTIONS (NEI'S) – KWAZULU-NATAL PROVINCE

I have the pleasure in informing you that permission has been granted to you as per the above request by the Acting Principal of the KZN College of Nursing.

Data Collection sites : Campus
                      Campus

Please note the following:

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This Research will only commence once this office has received confirmation of approval from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. Permission is therefore granted for you to conduct this research at the identified campuses of the KZN College of Nursing.
5. The KwaZulu-Natal College and its NEI's will not provide any resources for this research.
6. You will be expected to provide feedback on your findings to the Acting Principal of the KwaZulu-Natal College of Nursing.
7. You are expected to make the necessary arrangements with the respective campus principals.

Thanking You

Ms JT Makhathini
Acting Principal: KwaZulu-Natal College of Nursing

uMnyango Wenzepilo. Departement van Gesondheid
Fighting Diseases, Fighting Poverty, Giving Hope.
27th March 2014

Mrs. S. Shaikwane

Dear Mrs. Shaikwane

Re: Request to collect data

Your request dated 26/03/2014 refers.

Permission is granted for you to collect data at Grey's Campus.

Kindly liaise with the relevant Head of Department for both the R425 and R683 programmes to facilitate your data collection.

You are wished all the best with your research.

Yours Faithfully

E.N. Hlongwa (Miss)
Campus Principal

uMnyango Wezempilo. Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope
ANNEXURE E: CAMPUS B APPROVAL LETTER

Attention: Ms S. Shakwane

P.O. Box 1636
DURBAN
4600

Dear Ms S. Shakane

RE: REQUEST FOR PERMISSION TO CONDUCT STUDY

Your letter dated 15 April 2014 is hereby acknowledged and refers:

Permission is hereby granted for you to conduct your study at the uMngeni Campus. Please take note of the conditions as stated by the Kwa-Zulu Natal College of Nursing. Please note that it may not be always possible to have students for the period of time you requested due to the congested teaching timetables. Please make arrangements well in advance to avoid disappointment.

Best wishes

MR N.B. GWALA
CAMPUS PRINCIPAL

uMnyango Wazempilo, Departement van Gesondheid
Fighting Disease, Fighting Poverty, Giving Hope
ANNEXURE F: INFORMATION ABOUT THE STUDY

Dear participant

Warm greetings to you. You are invited to take part in a research study which will be conducted by Ms S Shakwane. It is important for you to participate in this study, but also important that you understand why the research is being done and what it will involve. Please take time to read through the following information carefully, and ask the researcher if there is anything you need more information about.

DETAILS OF RESEARCH STUDY

Title of the research study:

The socio-cultural perceptions of nursing and their influence on the recruitment and retention of male student nurses in the Nursing Education Institutions (NEIs) – KwaZulu-Natal province.

PRINCIPAL RESEARCHER: SIMANGELE SHAKWANE

SUPERVISOR: PROFESSOR JH ROOS

PURPOSE OF THE STUDY:

The purpose of the study is to identify and describe male student nurses’ insights into and perceptions of the socio-cultural influences on the recruitment and retention of men in the nursing profession.

INCLUSION CRITERIA

- Male student nurses enrolled for the R.425 and R.683 programmes at Grey’s and Port Shepstone campuses.

- METHOD OF DATA COLLECTION:
  - Once you have signed the informed consent form, you will be interviewed for approximately 40-60 minutes. The interview will be tape recorded.
SIGNIFICANCE OF THE STUDY

Male student nurses participating in this research study will have a podium to express their views about being men in a female-dominated profession. Knowledge generated from this study will assist nurse educators to better understand gender-related issues in nursing education, especially from the male perspective. It will also assist in decreasing the attrition rate of male student nurses in the nursing profession. It will empower nurse educators with regard to their methods of teaching and demonstration of intimate procedures to male students.

REMUNERATION:

There will be no remuneration for the participant as participation is voluntary.

COST OF STUDY:

The participants will not be expected to cover any costs for the study.

CONFIDENTIALITY:

You will be expected to fill in a consent form. Your anonymity will be guaranteed; you are not required to write your name on the informed consent and demographic questionnaires. No identifying information will be included when your interview is transcribed. All documents and tape recorded interviews will be stored in a locked cupboard and will be destroyed after the research report is completed and accepted. As a participant you have a right to withdraw from taking part in this research at any stage of the research study.
ANNEXURE G: DEMOGRAPHIC QUESTIONNAIRE

(This form will be filled in together with the informed consent form prior to the commencement of interview)

RSPN\(^1\):

Ethnic group: .................................................................

Age: .................................................................

Gender: .................................................................

Programme enrolled for: .................................................................

Year of commencement (month & year): .................................................................

Level/year in training (e.g. 1\(^{st}\), 2\(^{nd}\) or 3\(^{rd}\)): .................................................................

Year failed/demoted: .................................................................

If demoted state reason:
.................................................................................................................................
.................................................................................................................................
.................................................................................................................................
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.................................................................................................................................

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\(^1\) Research Study Participants Number – real names of nursing student nurses will not be used during data collection, analysis and reporting. Each participant will be given RSPN as a form of identity.
ANNEXURE H: INFORMED CONSENT

I understand that I am being asked to participate in a research study at Grey’s /Port Shepstone campus of the Kwazulu-Natal College of Nursing. This research study will explore the socio-cultural perceptions of male student nurses and their influences on the recruitment and retention of men in NEIs. I agree to participate in the study. I am aware I will be interviewed for approximately 40-60 minutes.

The interview will be tape-recorded and take place in a private office. No identifying information will be included when the interview is transcribed. I understand I will not be paid for participating in the study. There are no known risks associated with this study. I realise that my participation in this study is entirely voluntary and I may withdraw from the study at any time I wish.

I understand that all study information will be kept confidential. However, this information may be used in nursing publications or presentations.

The study has been explained to me. I have read and understood this consent form; I agree to participate in the study. I understand that I will be given a copy of this signed consent form.

________________________  __________________________
Participant signature                  date

________________________  __________________________
Witness                  date

________________________  __________________________
Signature of researcher                  date
ANNEXURE I: MALE FRIENDLINESS OBSERVATION CHECKLIST

CAMPUS A

<table>
<thead>
<tr>
<th>OBSERVATION</th>
<th>YES</th>
<th>NO</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Male students toilets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Number enough</td>
<td>√</td>
<td></td>
<td>6 toilets for male students and academic staff</td>
</tr>
</tbody>
</table>
| 1.2 Hygiene | √   |    | • 2 occasions toilets were dirty and polluted because some male students smoke in the toilet  
|             |     |    | • No toilet paper – cleaner stated that some male students steal the toilet paper. |
| 2. Notice board & poster |     |    |             |
| 2.1 Relevance to male student nurses | √   |    | College entrance: news clip on nurses day – big picture of female nurse in white uniform and cap |
| 3. Buildings & Equipment |     |    |             |
| 3.1 friendly classroom environment | √   |    | Clean and well ventilated |
| 3.2 sufficient classrooms | √   |    | ± 15 classrooms |
| 3.3 classroom size | √   |    | Each class accommodates ± 50 students |
| 3.4 safety of nursing students | √   |    | The environment is safe for teaching and learning |
| 3.5 Library facility | √   |    | Share the facility with the neighbouring hospital |
| 3.6 computer usage | √   |    | Computer room available, awaiting installation of computers |
good afternoon

afternoon

how are you?

I am fine and how are you?

fine, so thank you very much for being participant of this study and today we are starting our interview on the 6th of May 2014. I am having 5 questions that I would like you to answer them as honestly as possible.

ok

the first question I would like you to describe your perceptions of nursing profession>

(my perceptions of nursing (ok) before I came here I had different perception as I have now. At first I thought nursing entails giving injections, nursing sick people, just simple staff. I did not understand that you had to nurse people’s emotions and cultures and their personal beliefs into nursing perspectives. When I started working here I learned that nursing is not as easy as people think it is and what I thought it was. I realised there is a lot you put it, as a person there is a lot that you put in to the job. It requires you to just commit yourself, that’s how is see nursing now, you forget you learn to put yourself aside and put pt first.

in the society where you come from how do they perceive nursing?

honestly speaking from the people that I know and I have been talking to, they just think that nursing you don’t do anything, if you are a nurse you just give bed pans, you wipe pt after passing stools that is your job to clean the pt up. So we don’t get given what is due to us, (pause). They don’t realise what is expected of us and what we put in.

how do you feel about that?

it makes me angry (laughs) to have someone saying you are a nurse and you can’t be working very hard, you sit all that, you don’t do anything, nurses are rude. They base their opinions based on their experiences and kind of put us all in a same box. It makes me angry to realise that I am giving so much of myself but I am not appreciated.

since you have been in the college as a student, in the clinical are how has been your experience?

good and bad?

nodded

good in such a way that you get to a ward where you learn so much, where the staff is so welcoming and the staff is willing to teach you, if you ask questions you are able
to get clarity on what you are asking, to feel that you are getting something done even the allocation you know I have been trusted with amount of responsibility, someone has faith on me. And you get to the wards where if something goes wrong and when they explain to the doctor, “maybe it was a student”, as if I am a student it then I don’t know anything. It’s like ja, you get to wards where staff treat you in such a way that they are not willing to help you, even though some have the knowledge they will just ask you what you were taught at college. Do what you are taught at college and in some instances yes we do get to see the things done in practical, so that you can be sure and have the clarity, you need someone to show you.

Res: ok, thank you, now we are looking at the statistics of male nurses it is low, so what do you think are the factors that contribute the recruitment and retention of men?

Part: I think the problem is the society’s perception of nurses and how they view males when they are nurses. It seems as if or it like he is not straight or they are but you are a men how can you be a nurse and then think male nurses become afraid to be judge by that. They feel it is now (ah what’s the word) is not a respectable job for a men to do it because of the way the society perceive nursing.

Res: how do they perceive it?

Part: it’s a women’s job (laughs), it’s a women’s job to bath a patient, it’s a women’s job to clean up people, only a women can do it, while they don’t realise that sometimes some of the best nurses you come across are males from what I have seen and sometimes pts find some are more comfortable to be nursed by males, they actually say male nurses are kinder than female nurses ja.

Res: so do you think there is a room for male nurses in the profession?

Part: I think there is a room and there is a need for male nurse for our profession because they bring a lot to the table. You find that sometimes in the ward you find yourself in a situation because (ok) as much as its shouldn’t be used to our advantages – men are stronger, sometimes you get to a pt you need someone with a lifting of a pt, sometimes some female pt are more comfortable nurse by males rather than females. I never understood (laughs) but ja. They bring that testosterone to the unit too you know, you feel safer as we work with male patients some of them you don’t know so at least you know if there is a male he will be helping you with something, you will be working hand in hand. If you need something you will be working hand in hand, whereas some pts who need about 6 nurses to life on pt whereas when you have a male you don’t need as many (laughs).

Res: now we are looking at intimate procedures that you have done, which procedures have you done that are intimate?

Part: procedures that are intimate I was a bit uncomfortable with that, I had to do a dressing to a pt who had an insertion done on his penis. I had to dress the penis, even himself was not comfortable. He even asked whether I was going to do the dressing, couldn’t I call someone else to do the dressing?
Res: why were you not comfortable?

Part: I suppose in a way I was uncomfortable for him also, because I could tell that this was not normal for him, he wasn’t used to something like that touching his private part. I told him it was my job and it has to be done. He said ‘ol”. It was just, I felt like maybe because he was embarrassed so now I should be embarrassed with him. I actual wanted to laugh because I could tell that he was embarrassed and he was shocked when I came in with a trolley, because at first he thought I was joking when I told him I was coming to do his dressing. Its jus an unusual thing, you can bath, do the whole bed bath but the dress is completer different, its intimate. Whereas when bathing a pt if they are able to reach the intimate areas they are able to was themselves there.

Res: then how did you continue?

Part: (laugh) I basically just continued, tried to make him as comfortable as possible, try to explain to him that I had to do the dressing and he needed the dressing to be done, because he can’t go how with a dirty dressing and there were no male nurses at the time. So no one else was going to do the dressing except for me. I just told him that this is my job, I am used to this and he just need to relax and will do the dressing as fast as possible and I was able just to do it and I completed the dressing, I just needed to relax. I relaxed with him relaxing, I also relaxed.

Res: ok, thank you very much, anything you would like to add?

Part: mm (pause) just went out of my head (pause) I think, I don’t know if this is relevant but just the fact that if maybe the, hopeful it will change with the new generation of nursing into the field. The way society perceives nursing maybe the care that we gave and the way that we spoke with people because you notice the difference. I am not saying this institution is perfect but you notice the way pts are treated here and on the way patients are treated in another institution like maybe ja, even the patients notice the difference in the nurses. They say I was in this hospital I was left on my own to sort myself out, but here I feel I am going to get better because you are so caring.

Res: why is it so?

Part: why did they care less?

Res: no why are patients feeling comfortable with the nurses here?

Part: I think it’s because we have lesser patients here, so they are able to be given that extra attention and nursing care that they are unable to get from the other hospital where they were. A lot of patients and few nurses, maybe also that contribute to the nurses behaviour because of that stressful environment and they end up forgetting what they should be doing.

Res: ok, thank you very much

END