A Mixed Methods Study of Ontario Male Nursing Students' Perceptions of Their Learning Experiences in Perinatal Health Nursing

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List of Acronyms

CAPWHN:	Canadian Association of Perinatal and Women's Health Nurses
CMNRP:	Champlain Maternal-Newborn Regional Program
CNA:	Canadian Nurses Association
CNS:	Clinical Nurse Specialist
CNSA:	Canadian Nursing Students Association
CNO:	College of Nurses of Ontario
GRAMMS:	Good Reporting of Mixed Methods Studies
LDRP:	Labour, Delivery, Recovery, and Post-partum
MMR:	Mixed Methods Research
NP:	Nurse Practitioner
OB-GYN:	Obstetrician/Gynecologist
PHN:	Perinatal Health Nursing
PRN:	Practical Registered Nurse
RN:	Registered Nurse
RNAO:	Registered Nurses Association of Ontario
TOH:	The Ottawa Hospital

Definitions of Terms

Clinical Practicum:	"A course of study designed especially for the preparation of teachers and clinicians that involves the supervised practical application of previously studied theory" (Merriam Webster Dictionary, 2020)
Curriculum:	"The subjects taught are included in a course of study or taught in a school, college, etc." (Oxford Learner's Dictionary, 2019)
Experience:	"The things that have happened to someone that influence the way they think and behave" (Oxford Learner's Dictionary, 2019)
Gender:	"The state of being male or female as expressed by social or cultural distinctions and differences, rather than biological ones; the collective traits associated with a particular sex, or determined as a result of one's sex" (Oxford Learner's Dictionary, 2019)
Nursing Student:	A student enrolled in third or fourth year of undergraduate studies at the School of Nursing at the University of Ottawa
Perception:	"An idea, belief, or image you have as a result of how you see or understand something" (Oxford Learner's Dictionary, 2019)
Perinatal Health Nursing:	"Care provided across the childbearing continuum. This journey starts with planning the pregnancy (pre-conception), and continues through to antenatal, intra-partum, postpartum, and healthy newborn care for the first 3 months" (Canadian Association of Perinatal and Women's Health Nurses, 2018, p. 6). This term may also be referred to as perinatal nursing, maternity nursing,

maternal-child nursing, maternal-newborn nursing, childbearing nursing, nursing in childbearing, and childbearing family nursing.

Sex: "Biological differences between males and females such as their genitalia and genetic differences" (Oxford Learner's Dictionary, 2019)

Summary of the Thesis

Background: Perinatal health nursing (PHN) which is a core component of undergraduate nursing education includes the theory and clinical practicum (laboratory, simulation, clinical placement) courses. The aim of this research study is to explore the perceptions of male nursing students' learning experiences in regard to PHN at the University of Ottawa.

Methodology: This mixed methods research was completed using the Convergent Parallel Mixed Methods Research Design. The data were collected from nine participants through an online questionnaire and an in-depth qualitative interview guide.

Results: The theory and clinical practicum courses in PHN were overall positive learning experiences for the male nursing students, yet there is still room for improvement. Their comfort level with the clinical placement was statistically significant (before and after the clinical placement). The participants identified five facilitators: the clinical instructor, nursing staff, patients and their family members, the two male nurses working in PHN, and the comradery of other students. Three barriers were identified by them: the nursing staff in the hospital settings, the female patients, and specific situations deemed as 'awkward'. Gender did have an impact on the participants' PHN learning experiences, however, the positive support of the clinical instructors did facilitate this.

Discussion: The male nursing student' PHN learning experiences can be divided into positive and negative ones. This study's findings are consistent with those of previous studies, however, this is the first study to assess both the PHN theory and clinical practicum courses in Ontario. Although Andragogy was used as the theoretical framework, it did have its limitations. The Andragogy in Practice Model was introduced to expand Andragogy into practice.

Conclusion: Gender bias and fear of rejection crosses all three levels of the contributing factors (individual, institutional and societal). Recommendations include continuing to raise awareness of how gender normative behaviour and social standards impact the PHN learning experiences of male nursing students, and integrating a confidence building workshop in the PHN courses.

Résumé de la thèse

Contexte: Les soins infirmiers en périnatalité (SIP) qui est une composante essentielle de la formation infirmière comprennent les cours théorique et clinique (laboratoire, simulation, stage). Le but de cette étude de recherche est de décrire les perceptions des étudiants en sciences infirmières concernant leur expérience d'apprentissage relative aux SIP à l'Université d'Ottawa.

Méthodologie: Cette étude de recherche sur les méthodes mixtes a été réalisée à l'aide du devis mixte concomitant simultané. Les données ont été recueillies auprès de neuf participants au moyen d'un questionnaire en ligne et d'un guide d'entrevue.

Résultats: Les cours théorique et clinique en SIP ont été des expériences d'apprentissage assez positives pour les étudiants, mais il y a encore place à l'amélioration. Leur niveau de confort pendant le stage clinique a été statistiquement significatif (avant et à la fin du stage). Cinq facilitateurs ont été identifiés par les participants: les professeures cliniques, le personnel infirmier, les patientes et leur famille, deux infirmiers œuvrant en périnatalité, et les camarades de classe. Ils ont aussi identifié trois barrières : le personnel infirmier en milieu hospitalier, les patientes, et des situations spécifiques et délicates. Le genre a eu un impact sur les expériences d'apprentissage relatives aux SIP pour les participants, cependant, le soutien des professeures cliniques a facilité ces expériences.

Discussion: Les expériences d'apprentissage des étudiants relatives aux SIP peuvent être divisées en deux : positives et négatives. Les résultats de cette étude concordent avec ceux présentés dans la littérature. Cependant, cette étude est la première qui fait l'évaluation des deux cours théorique et clinique relatifs aux SIP en contexte ontarien. Bien que l'Andragogie ait été utilisée comme cadre théorique, celle-ci avait ses limites. Le Modèle d'Andragogie dans la Pratique a été introduit afin d'élargir l'Andragogie dans le contexte de la pratique clinique.

Conclusion: Les préjugés du genre et la peur du rejet traversent les trois niveaux des facteurs contributifs (individuel, institutionnel, et sociétal). Les recommandations comprennent la poursuite de la sensibilisation à la manière dont le comportement normatif de genre et les normes sociales influent sur les expériences d'apprentissage des étudiants relatives aux SIP, et l'intégration d'un atelier de renforcement de la confiance dans les cours des SIP.

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Lastly, I would like to thank the participants in the study for their valuable time and insight.

Introduction

The number of men who are entering the nursing profession is on the rise even though it is still female dominant. Approximately ten percent of the Canadian nursing workforce are men (Canadian Nurses Association [CNA], 2017). However, men are more drawn towards clinical domains such as critical care, mental health, medicine, and surgery than towards perinatal health nursing (PHN) as a clinical specialty (CNA, 2017). PHN is a part of the core nursing curriculum at the University of Ottawa and is testable content on the NCLEX-RN registration exam. All students, including men, are exposed to this clinical specialty in the third year of the undergraduate program. The training of PHN is obligatory and is comprised of the theory course and the clinical practicum. The PHN clinical practicum itself has three components: laboratory activities, simulation scenarios, and a clinical placement in an Ottawa hospital.

Male nursing students appear to be more apprehensive of this clinical practicum for various reasons such as the fear of rejection by patients, the fear of being perceived as inappropriate, and the lack of clarity as to whether or not a gender bias towards male nurses still exists in PHN (Evans, 2002; Le Blanc, 2017). This situation is compounded by various social and societal factors such as gender normative behaviour and societal views impacting an individual's choice of profession (Eisenchalas, 2013), learning differences between men and women (Le Blanc, 2017), and a lack of male nursing role models in PHN (Bartfay & Bartfay, 2017). The complexities of these factors may result in negative learning experiences for male nursing students during this clinical practicum. Ultimately, these factors may contribute to the lack of men in the PHN clinical specialty itself. Therefore, the aim of this research study is to explore the perceptions of male nursing students in regard to their PHN learning experiences at

the University of Ottawa. The findings from this study will help to bridge the current knowledge gap within the nursing literature, in addition to helping inform and implement gender inclusive learning initiatives at the university and hospital levels.

The first chapter presents the research problem which involves situating the reader to the student researcher's interest for the research study, the reasons why people choose nursing as a career, the current nursing demographics in Canada and Ontario, men in perinatal health nursing (PHN), and PHN education at the University of Ottawa. The theoretical framework and the research purpose and objectives are then featured.

The second chapter which focuses on the literature review was conducted to refine the proposed research purpose and objectives. The search strategy is first presented followed by a section featuring perinatal health nursing, the organization of perinatal health care in the Ottawa region, men in the nursing profession, and men in PHN. This is followed by a description of the nursing curriculum at the University of Ottawa, an explanation of the PHN theory and clinical practicum courses, and a summary of the chapter.

The third chapter exploring the theoretical framework of this study-Andragogy, includes the major learning theories in nursing education, the chosen theory of Andragogy, how this theory applies to the present research study, and a summary of the chapter.

The fourth chapter presents the research methodology: the epistemological position; the research type and design; the population, sample, and sample size; the research setting; sampling type and recruitment strategies; the study procedures; qualitative and quantitative data collection methods; data analysis; criteria for rigor; ethical considerations; and a summary of the chapter.

The fifth chapter presents the results of this research study in seven subsections: the profile of the study participants; the results of the study's four research questions (the meaning of the PHN practicum for male students, the facilitators to their learning experiences, the barriers to them, and the solutions to improve the PHN clinical practicum); the participants' perceptions with regard to engaging in this study; and a summary of the chapter.

The last chapter presents a discussion of the research findings. The participants' PHN learning experiences can be divided into positive and negative ones: the findings in regard to the positive learning experiences of the two PHN courses are first presented followed by the ings for the negative ones. Next, the solutions for improvement of the PHN courses as provided by the participants are featured as well as reflections about the theoretical framework of Andragogy and its limitations, an explanation of the Andragogy Model for Practice, and how it can be applied to the PHN courses. The last three sections present the recommendations for nursing education, practice, and research, the strengths and limitations of this research study, and the conclusion.

Chapter 1 - Research Problem

The first chapter is divided into four sections. First, the reader will be situated to the student researcher and her interest for this research study. Next, an overview of the problem is presented that includes the reasons why people choose nursing as a career, the current nursing demographics in Canada and Ontario, men in perinatal health nursing (PHN), and PHN education at the University of Ottawa. The third section features the theoretical framework. The last section presents the research purpose and objectives for this study.

1.1 Situating the Student Researcher

This section presents how I became interested in this research topic. There are two levels of context that contributed to my interest in this research problem. The first context is in regard to my professional experience. The second one involves the greater context of the undergraduate nursing program at the University of Ottawa.

The first context comes from my personal experience as both a PHN nurse and a clinical instructor with Algonquin College and the University of Ottawa. My role as a clinical instructor is to facilitate the students' learning experiences and provide support in the PHN clinical practicum by linking the concepts presented in the theory course with those in laboratory and simulation, and applying them in the hospital setting. My patient population is almost exclusively female as they are childbearing women, and with the exception of two nurses, my colleagues are too. When I teach, approximately one in six of my students are men. When they start, they all have the same question for me, "Will patients be comfortable with me being present for their labour and birthing experience, in addition to caring for them during the postpartum period?" Interestingly, my experience has been that barring religious or cultural reasons, the greater majority of perinatal clients are comfortable to receive intra- and post-partum

care by a male nursing student. So, in this sense, most experiences for my male nursing students in PHN are positive. On the other hand, students have been rejected based on their gender, as some patients are not comfortable being cared for by a nursing student who is a man. In my experience, this happens more frequently in the PHN context. This can be a negative learning experience for certain male nursing students because they may have to deal with this rejection while gathering information about a new perinatal patient, wonder whether this rejection is personal, and whether it will affect their grade in the clinical practicum course. This may destabilize the male nursing students' clinical learning experience in PHN to the point that they may feel disoriented by the rejection.

The second context is the greater context of this phenomenon, in relation to the School of Nursing at the University of Ottawa in Ottawa, Canada. The students are all in their third year of the Bachelor of Science in Nursing program in the Anglophone stream at the University of Ottawa, or in the collaborative stream with Algonquin College. I do not have contact with the Francophone students as I only teach in the Anglophone program. All students complete their laboratory and simulation activities in the simulation laboratories at each respective campus. The Anglophone students complete their PHN clinical rotations at the General and Civic campuses of The Ottawa Hospital (TOH), or at the Queensway Carleton Hospital. The Francophone students complete their clinical placement at either the General campus of The Ottawa Hospital or at the Montfort Hospital. The laboratory component contains three activities, while the simulation component contains five scenarios. These will be described in more detail in the next chapter. When students are doing their PHN clinical placement in these hospitals, they may observe or participate in a clinical situation in which a woman is in labor and gives birth vaginally, observe a caesarean birth in the operating room, and provide mother-baby dyadic care on the postpartum

unit. For this last aspect, the students start with one mother-baby dyad and gradually increase to two mother-baby dyads. The students are encouraged to apply the principles of family-centered maternity-newborn care as published by the Public Health Agency of Canada (2018) and those as presented by the Calgary Model of Family Assessment and Intervention (Wright & Leahey, 1994; Wright & Leahey, 2013) throughout the PHN theory and clinical practicum courses.

1.2 Problem Statement

This section presents the problem statement. There are four subsections: the reasons people give for choosing nursing as a career, the current nursing situation in Canada and in Ontario, men in PHN, and the PHN training at the University of Ottawa.

1.2.1 Reasons for Choosing Nursing as a Career

Many reasons exist for why people choose to go into the nursing profession. According to Mooney, Glacken, and O'Brien (2008), there are three reasons: people have a desire to help and care for others; family or friends influence their career selection; and for others, although nursing was not their first career choice, they did seek a career which involved caring. In a more recent study conducted by Wilkes, Cowin and Johnson (2015), the students' reasons for entering nursing were both personal and career related, with personal being more prevailing. The students gave other reasons: job security, the ability to enter tertiary education, and the enjoyment or love of nursing. Men become nurses for the same reasons that women do: having a desire to care for others, job security and salary, and wanting to feel empowered (Boughn, 1994). However, there are gendered differences. According to the study conducted by Zysberg and Berry (2005), men's reasons pertain to job security, other career choices that did not work out, nursing is a respectable profession, good money, and opportunities for leadership and advancement. On the other hand,

the women in the same study reported getting messages from their social environments about their suitability for the nursing profession.

1.2.2 Current Nursing Situation

The Canadian Nurses Association (CNA) produced statistics for the total country and for each province and territory in 2017 (see Table 1). There are 310,010 Registered Nurses in Canada with a national average age of 44 years, and 92% of them are female and 8% are male. About 42.6% of practicing registered nurses in Canada have a college diploma, 59.5% of them are employed full time, 63.6 % are employed in a hospital, 77.7% are staff nurses, 6.3% are nurse managers, and 90.5% work in direct patient care. Some common practice specialties for Registered Nurses in Canada in decreasing order are the following: medical/surgical (17%), long term care (9.9%), emergency care (8.1%), critical care (7.7%), mental health (5.7%), perioperative (5.3%), community health (5.2%), and public health (3%). About 16.4% of them work in other areas (CNA, 2017).

In Ontario, there are 104,923 Registered Nurses with a provincial average age of 46 years, and 93.2% of them are female and 6.8% are male. About 40% of practicing registered nurses in Ontario have a diploma, 66.8% of them are employed full time, 63.5% are employed in a hospital, 74.2% are staff nurses, 5.6% are nurse managers, and 91.1% work in direct patient care. Some common practice specialties for Registered Nurses in Ontario in decreasing order are the following: medical/surgical (11.7%), long term care (10.5%), critical care (7.7%), emergency care (7.3%), mental health (6.5%), perioperative (4.7%), community health (5.2%), and public health (4%), and about 35.8% of them in other areas (CNA, 2017).

Regarding perinatal health nursing which is referred to as maternity/newborn nursing in the CNA report (CNA, 2017), there are 6.2% of Canadian nurses and 6% of Ontario nurses

Table 1: Statistics for Nurses in Canada and Ontario

Statistical Item	**Canada**[1]	**Ontario**[2]
Number of nurses registered	310,000	104,923
Average age (years)	44	46
Gender distribution:		
Female	92%	93.2%
Male	8%	6.8%
Educational preparation:		
Diploma	42.6%	40%
Baccalaureate	52.3%	51.9%
Graduate	5%	7.7%
Employment status:		
Full-time	59.5%	66.8%
Part-time	30%	26.3%
Casual	10.4%	6%
Work setting:		
Hospital	63.6%	63.5%
Community health	15.7%	17%
Long term	9.1%	8%
Elsewhere	11.5%	11.5%
Position held:		
Staff nurse	77.7%	74.2%
Nurse manager	6.3%	5.6%

Employed in other position	16%	20.2%
Area of responsibility:		
Direct care	90.5%	91.1%
Administration	5.5%	6.6%
Education	3.4%	2.3%
Research	0.5%	<1%
Direct care area of responsibility:		
Medical/surgical	17.8%	11.7%
Mental health	5.7%	6.5%
Pediatrics	2.6%	2.5%
Perinatal	6.2%	6%
Long-term care	9.9%	10.5%
Critical care	7.7%	7.7%
Community health	5.2%	0%
Ambulatory care	1.5%	0%
Home care	2.9%	0%
Occupational health	0.9%	1%
Perioperative	5.3%	4.7%
Emergency care	8.1%	7.3%
Oncology	1.9%	0%
Rehabilitation	1.7%	1.9%
Public health	3%	4%

Several clinical areas	2.8%	2.8%
Telehealth	0.6%	0.4%
Other	16.4%	35.8%

Source: [1, 2] Canadian Nurses Association (2017)

working in this clinical specialty. There are no known statistics about the number of men working in PHN in Canada or in Ontario.

For the statistics concerning nursing students, the Canadian Association of Schools of Nursing (CASN) published their report in 2017, representing the statistics for 2015-2016. There were 16,244 students registered in Canadian Schools of Nursing in 2015-2016 for the entry-to-practice programs. In 2016, there were 12,484 students who graduated from these programs, a 0.8% decrease from 2015 (12,579 students). In Ontario, 4,127 students graduated from entry-to-practice nursing programs, a drop of 0.3% from 2015 (4,141 students). The College of Nurses of Ontario (CNO) published a report in 2018 in which statistics are presented on new members in the general class category. In 2016, there were 3,967 new members to the CNO, of which 87.4% were female and 12.6% were male. The Canadian Nursing Students Association is the national voice of the 30,000 nursing students across Canada (CNSA, 2019). Ontario's nearly 6800 nursing students are represented by the Nursing Students of Ontario interest group that is run through the Registered Nurses Association of Ontario (RNAO, 2019). The number of nursing students who are men is increasing, although men accounted for approximately eight percent of the nursing workforce in 2019. The supply of male regulated nurses grew faster than female nurses between 2015 and 2019, with an increase of 15.4 % to 3.9%, respectively (CNA, 2019; CNO, 2018). Although the overall number of men in nursing is growing, the educational

curricula have remained fairly static, and the PHN content is testable on the NCLEX-RN registration exam.

1.2.3 Men in PHN

As stated in the previous subsection, current national gender distribution in nursing is approximately ten percent male (CNA, 2017), and this figure is expected to increase in future years. However, this gender distribution remains static among most clinical specialties in nursing. Men tend to gravitate towards critical care, mental health, medicine, and surgery rather than towards PHN which is still dominated by female nurses (CNA, 2017). Yet, there are no statistics that exist as to the number of male registered nurses in this clinical domain (CNA, 2017). At the University of Ottawa, all students who are registered in the Bachelor of Science in Nursing program are required to complete a theory course in PHN as well as a clinical practicum in it as part of the requirements of the undergraduate program. PHN is testable content on the NCLEX-RN registration exam.

It has been documented that male nursing students are apprehensive of their hospital clinical placement as part of the clinical practicum in PHN: they report fearing rejection based on gender (Eswi & El Sayed, 2011), feel unwelcome and embarrassed (Balakrishnan, Sheoran, & Bishnoi, 2013; Ha, Kim, Choi & Ahn, 2015), being perceived as inappropriate (Bartfay & Bartfay, 2017; Le Blanc, 2017), unsure of their fit on the unit based on their gender (Inoue, Chapman & Wynaden, 2006; Meyer, 2012), how they are perceived by their clinical instructors (Mitra, Philips &Wachs, 2018), experience role strain (Evans 2002; Sherrod, 1991), and the existence of gender bias towards male nurses in PHN (Patterson & Morin, 1999; Powers, Heron, Sheeler & Sain, 2018). Indeed, this situation is compounded by various social and societal factors such as gender normative behaviour and societal views impacting an individual's choice

of profession (Eisenchalas, 2013), learning differences between men and women (Le Blanc, 2017), and a lack of male nursing role models in PHN (Bartfay & Bartfay, 2017). Even in the English language, the gender normative aspect of nursing is perpetuated by the use of the terminology 'male nurse'.

As Le Blanc (2017) indicates, *gender* appears to be the underlying premise for the male nursing students' reported discomfort in PHN, and it may be the factor that influences their recruitment to this clinical specialty. Students articulated feeling unwelcome, out of place, and required different monitoring than their female counterparts. An example of different monitoring involves a restriction on independent assessment (Le Blanc, 2017). To continue in the same vein, little is known about their comfort levels between the laboratory, simulation, and clinical placement components of the PHN clinical practicum at the University of Ottawa. With gender being so prevalent as presented by the scientific literature (Le Blanc, 2017), and that it is felt in the form of discomfort by the male nursing students, then this can become a type of discrimination. Gender equality has been identified as a human rights issue by the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) (2016). Historically, women have experienced gender stereotypes and gender based discrimination. In the context of the present study, the male nursing students are in a unique position, as this may be the first societal precedent set where the reverse scenario takes place. This may also partially explain why there is such little current literature on the topic, and why there is a lack of research building on what pieces of the problem are already known. The concepts of men and students, nursing students and PHN, and men and PHN have all been studied in tandem, and individually. At this point in time, there is no current research that explores all three concepts simultaneously.

There is a dearth of studies on fully understanding male nursing students' learning experiences in regard to their PHN clinical practicum, especially in the Ontario context. The real problem resulting from this lack of current evidence is that the facilitators and barriers to the male nursing students' learning experiences are currently unknown. This lack of evidence may negatively affect their attitudes towards the PHN specialty, and therefore, impact their academic performance and future recruitment to this clinical domain. Furthermore, this apparent knowledge gap highlights various social double standards surrounding gender roles and women's health. Indeed, this lack of explicit evidence and corresponding lack of action is contradictory to educational best practices that the nursing profession strongly advocates for as well as those by the School of Nursing at the University of Ottawa.

1.2.4 PHN and Training at the University of Ottawa

Perinatal health nursing is, "a practice specialty that includes professional nursing care delivered across the childbearing continuum and based on principles of women- and family-centered maternity care, a model of care centered on treating the woman, newborn, and family as a whole within the context of their lives and their environment" (AWHONN, 2009, p. 2). Perinatal nursing is a practice specialty recognized by the Canadian Nurses Association.

Students complete their training in PHN in the third year of their undergraduate nursing program at the University of Ottawa. There are two parts to the training in PHN: the theory course, and the clinical practicum course. The PHN courses are part of the core nursing curriculum at the School of Nursing. The PHN clinical practicum course contains three components: students complete laboratory and simulation activities, as well as their clinical placement in a hospital care setting in the Ottawa region. The courses are connected because the theoretical content is learned in the theory course, and knowledge gained from the theory course

is applied in a safe learning environment in the laboratory, in simulation and in the hospital setting. The skills learned in laboratory are applied during simulations of common clinical scenarios. Finally, students apply their theoretical knowledge, as well as laboratory and simulation skills, to real patients during their clinical placement in perinatal health in the hospital. Students also complete a final consolidation practicum of their choosing, and PHN is an area where some students willingly choose for their last placement.

1.3 Theoretical Framework

The proposed theoretical framework for the present research study contains one theory, Andragogy. This section will briefly explain the theory and how it applies to the present research study. A more detailed description is provided in the Chapter 3.

Malcolm Knowles defines Andragogy as, "the art and science of helping adults learn" (Knowles, 1970, p. 55). Andragogy can also refer to adult learning principles because adults learn different than children do. There are five assumptions of Andragogy: that as students mature, they become self-directed and autonomous; they build on previous experience; their readiness to learn becomes oriented to their role; their learning style changes from subject-centered to problem-centered; and that the motivation for adults to learn is intrinsic (Knowles, 1970).

This theory will be applied to the research study to link the concepts of men, nursing students, and PHN because it is a learning theory, and the aim of this study is to determine the learning experiences of male nursing students in the PHN courses (theory and clinical practicum). Andragogy was chosen because the students will describe their learning experiences in PHN, and the data collected will be used to offer solutions for improvement of these learning experiences for future male nursing students.

Male nursing students may not have optimal learning experiences in this clinical practicum for a variety of reasons, all of which are impacted by their gender. Adult learning principles link the concepts of men and nursing students in this scenario. There is a gendered aspect to learning that connects these concepts. Severiens and Ten Dam (1998) found that there are gender related differences between men and women regarding ways of knowing and learning conceptions: men and women learn differently and show their knowledge level differently. Another reason that men may be experiencing sub-optimal learning experiences could come from the fact that their learning styles are different than those of the female clinical instructors and staff nurses. Furthermore, a large part of their PHN clinical practicum is providing health teaching to female patients.

Adult learning principles will be applied in two contexts: the first is when the students describe their learning experiences at the university and in the hospital setting, and the second will be after the study is complete, the knowledge gained will be translated to educators, staff nurses and patients in the most conducive context to their learning because they are all adults.

1.4 Research Purpose and Questions

The purpose of this research study is to explore the perceptions of the learning experiences of male nursing students in regard to their perinatal health nursing courses (theory and clinical practicum) in the Ottawa region. The findings from this study will bridge the current knowledge gap within the nursing literature, in addition to helping inform and implement gender inclusive learning initiatives at the university and hospital levels.

The research questions for this study are the following:

1) What is the meaning of the PHN courses (theory and clinical practicum) for male nursing students (QUANT and QUAL)?

2) What are the facilitators to male nursing students' learning experience in their PHN clinical practicum (QUAL)?
3) What are the barriers to male nursing students' learning experience in their PHN clinical practicum (QUAL)?
4) What are the solutions suggested by the male nursing students to the barriers identified by them to improve their PHN clinical practicum (QUAL)?

Chapter 2 - Literature Review

This chapter which focuses on the literature review was conducted to refine the proposed research purpose and objectives. This chapter is divided into five sections. In the first section, the search strategy that was used to perform the literature review is presented. The second section presenting the literature review features perinatal health nursing, an explanation of the organization of perinatal health care in the Ottawa region, men in the nursing profession, and men in PHN. The next two sections describe the nursing curriculum at the University of Ottawa followed by an explanation of the PHN theory and clinical practicum courses. The fifth section features a summary of the chapter.

2.1 Search Strategy

The search strategy began with the University of Ottawa's Health Science Library, as suggested from the Research Methodology course NSG5140 that is part of the master's program in nursing. This search was carried out between September, 2018 and February, 2019. The same filters were applied to all databases searched: articles were written in English; had available access to the abstract and full article; were published in a peer reviewed journal, and without a date filter, although articles were preferred if they were published between 2000-2019. The results yielded from the search are further presented in Table 2. A total of twenty-three articles were retained that can be considered in relation to the concepts of men, nursing students, and the PHN clinical practicum; 9 were found in the CINAHL database, and 9 were found in the PUBMED database.

Additionally, a grey literature search was completed. Polit and Beck (2017) define grey literature as, "Unpublished, and thus readily accessible papers or research reports" (Polit & Beck, 2017, p. 730). The main purpose of this type of data was to find statistics, like the national and

Table 2: Search Strategy Results

Database	Search Terms	Articles Yielded	Articles Retained	Rejection and/or Retention Rationale
University of Ottawa Health Science Database	'Men OR male, AND nursing student OR student nurse, AND maternity OR perinatal health nursing'	3710	5	Rejected for the lack of current applicability, or not all concepts were addressed.
CINAHL	'Clinical placement satisfaction AND nursing students'	140	2	Retained because these tools were most applicable to the PHN clinical practicum
CINAHL	'Men OR males AND nurse AND experience'	147	2	Retained for the most recently published article and their findings were similar to previously retained articles
CINAHL	'Nurse AND gender roles'	822	1	Retained because it provided a thorough background of gender roles and their impact on career choice
CINAHL	'Female perspective AND male nursing care'	60	1	Retained because it addressed providing intimate care and gender based discomfort
CINAHL	'Men OR male AND nursing student OR student nurse AND perinatal OR maternity nursing'	10	3	Rejected because they focused on the experiences of men as caregivers for their pregnant significant others, not the students' experiences
PUBMED	'Clinical placement satisfaction AND nursing students'	898	0	Rejected because the student researcher was satisfied with the clinical placement assessment tool that was retained from the CINAHL search
PUBMED	'Men OR males AND nurse AND experience'	653	3	Rejected because of duplicates or lack of applicability to research problem after abstract filtering

PUBMED	'Men AND nursing OR nurse AND career choice'	266	2	Rejected because of duplicates or lack of applicability to research problem after abstract filtering
PUBMED	'Nurse AND gender roles'	1330	2	Retained because they provided a thorough background of gender roles and their impact on career choice.
PUBMED	'Men OR male AND nursing student OR nursing student AND perinatal OR maternity nursing'	10	2	Rejected due to duplicates, and the majority of the rest of the articles focused on the care of a pregnant significant other by their male partner – not on the experience of the student

provincial nursing gender distribution trends, professional organizations' position statements and competencies, gender inclusive initiatives in other professions, and nursing education curricula. Twenty-five pieces of grey literature were retained from this search.

2. 2 The Literature Review

This section is divided into four main subsections representing perinatal health nursing, the PHN structure of care within the Ottawa area, and men in nursing. Each subsection is further divided into smaller subsections. Perinatal health nursing is first described as it is important to provide a clear understanding of this clinical specialty, followed by how perinatal health care is organized, and ending with a detailed explanation of men in nursing and in PHN.

2.2.1 Perinatal Health Nursing

This section is divided into five subsections that include the definition of PHN, the responsibilities of the PHN nurse, inter-professional collaboration in the context of perinatal

health care, the standards of care for this clinical specialty, and its accompanying model of nursing care for it.

2.2.1.1 Definition

Perinatal health nursing is a practice specialty that includes professional nursing care delivered across the childbearing continuum and based on principles of women- and family-centered maternity care, a model of care centered on treating the woman, newborn, and family as a whole within the context of their lives and their environment (AWHONN, 2009). Perinatal health nurses collaborate with family members in planning and providing care to promote the health of the family unit-women, fetuses, newborns, and family members through practice, education, research, and leadership in a variety of care environments. (Canadian Association of Perinatal and Women's Health Nurses [CAPWHN], 2018). These nurses not only advocate for safe, supportive, and respectful work environments, but they also advocate for organizational structures and resources that enhance professional nursing practice and that respect the contributions of all health care providers. Perinatal nursing is a practice specialty recognized by the Canadian Association of Nurses.

Furthermore, AWHONN asserts on gender bias in women's health, obstetric, and neonatal nursing in their position statement, that "nurses, regardless of gender should be employed in nursing based on their ability to provide such care. Gender is not a qualification to practice as a nurse and gender discrimination in employment in unlawful. In addition to legal requirements that bar discrimination, there is no evidence that female nurses provide superior care to male nurses in the areas of women's health, obstetric, or neonatal nursing" (AWHONN, 2016, p. 461).

2.2.1.2 Responsibilities

The perinatal health nurse has many responsibilities, which include the following: selecting nursing interventions to promote healthy parenting and family development related to attachment; caring for mother, family and baby together; confidence building; completing post-partum and newborn assessments; selecting appropriate nursing interventions to manage the actual or potential maternal conditions during the perinatal period; pain management; teaching self-care; selecting appropriate nursing interventions for the newborn related to behavioral states; and, teaching effective breastfeeding and supplementation, healthy family relationships, developmental milestones, positive coping and community resource identification (CAPWHN, 2018).

2.2.1.3 Inter-professional Collaboration

Perinatal health nurses involve colleagues in decision-making as appropriate, and strive to promote the health, safety, and well-being of all members of the health care team. Inter-professional collaboration in the perinatal context is defined as, "when multiple health care professionals from different professional backgrounds work together with childbearing persons, families, newborns, and communities to deliver the highest quality of care" (CAPWHN, 2018, p. 10). Perinatal health nurses collaborate care with obstetricians/gynecologists, perinatologists, pediatricians, neonatologists, reproductive endocrinologists, family doctors, midwives, public health nurses, lactation consultants, perinatal educators, doulas, nutritionists, perinatal psychologists, pelvic floor physiotherapists, yoga and perinatal exercise instructors, family therapists, and sexologists.

2.2.1.4 Standards of Care

There are standards that guide care within the context of perinatal health nursing. The four domains that form the bases of the CAPWHN standards are the following: relationship-

based care, inter-professional collaboration, quality and safety, and evidence informed practice (CAPWHN, 2018, p. 6). Relationship-based care is a model of delivering healthcare that involves caring for, and connecting with other human beings (CAPWHN, 2018, p. 7). Inter-professional collaboration is described when multiple health care providers from different professional backgrounds work together with childbearing persons, newborns, and communities to deliver the highest quality of care (CAPWHN, 2018, p. 8). Quality and safety place an emphasis on the system of care delivery that aims to prevent errors, learns from the errors that do occur, and relies on a culture of safety that involves all health care professionals, organizations, and patients (CAPWHN, 2018, p.8). Lastly, evidence-informed practice uses evidence to identify potential benefits, harms, and costs of any intervention and acknowledges that what works in one context may not be appropriate in another. Evidence-informed practice brings together local experience with the best available evidence from research (CAPWHN, 2018, p. 9). See Appendix 1 for a full list of the standards of care for perinatal health nursing in Canada.

These four standards of care are illustrated throughout the careers of perinatal health nurses. Students and new graduate nurses meet the entry to practice standards that have been developed by the Canadian Association of Schools of Nursing (CASN); these standards will be explored in detail in Section 2.3 of this chapter. Next, the novice nurse becomes more proficient in clinical practice, and moves through the five professional stages from Novice to Expert as described by Benner (Benner, 1984). Professional development continues to occur through further education, CNA certification, and leadership in the PHN community. Finally, the competencies and standards of practice become foundational to lifelong learning (CAPWHN, 2018, p. 4).

2.2.1.5 Compass Model for Professional Perinatal Practice

The Professional Perinatal Practice Compass Model (see Figure 1) is used to, "pictorially illustrate the key domains that guide perinatal nurses' interactions with childbearing persons, newborns, and their families" (CAPWHN, 2018, p. 5). The aim of the model is to illustrate the four domains of perinatal nursing standards, as described in the previous subsection, and how they connect to the four threads that guide the development of proficient practitioners throughout their career in Canada (CAPWHN, 2018).

The Compass Model is in the form of a star with a circle in the middle (CAPWHN,

Figure 1 - The Professional Perinatal Practice Compass Model[1]

[1] Adapted from CAPWHN (2018, p. 5)

2018). At the centre of the model are patient and family outcomes. Radiating from the centre of the model are eight points of the star. The four points that are black and white represent the four domains of perinatal health nursing standards. The other four points of the start are in the mauve

color represent the four threads that guide the development of proficient practitioners throughout their careers, namely: professional development, leadership, ethics, and environment of care. The model can be used to visualize how professional development and perinatal nursing standards work together to contribute to positive patient and family outcomes.

2.2.2 Organization of Perinatal Care in the Ottawa Region

This section is divided into two subsections which describe the community-based and the hospital-based parts of perinatal health care in the Ottawa region.

2.2.2.1 Community Based Care

Supporting the network of perinatal health care in the Ottawa region are the Provincial Council for Maternal and Child Health and the Best Start Resource Centre at the provincial level, and the Champlain Maternal Newborn Regional Program at the regional level. The Provincial Council for Maternal and Child Health is an umbrella organization that unities the maternal-newborn and child-youth sectors in order to provide the best possible beginnings for lifelong health (Hepburn & Booth, 2012, p. 56). This mission of the Provincial Council for Maternal and Child Health is as follows:

> "to be the provincial forum in which clinical and administrative leaders in maternal and child health can identify patterns and issues of importance in health and health care delivery for support and advice; to improve the delivery of maternal-child healthcare services by building provincial consensus regarding standards of care, leading practices and priorities for system improvement; to provide leadership and support to Ontario's maternal and child healthcare providers, planners and stewards in order to maximize the efficiency and effectiveness of health system performance; and to mobilize information and expertise to optimize care and contribute to a high performing system, thereby improving the lives of individual mothers and children, providers, and stewards of the system" (Hepburn & Booth, 2012, p. 56).

Also at the provincial level is the Best Start Resource Centre. This resource is a "key program of health nexus, a bilingual health promotion organization that works with diverse partners to build healthy, equitable and thriving communities. It supports service providers who work in preconception health, prenatal health and early child development" (Health Nexus, 2018). The Best Start program provides evidence based resources, keeps members connected through electronic bulletins and online networks, offers consultations to plan programs, and delivers training and professional development across Ontario (Health Nexus, 2018).

The Champlain Maternal Newborn Regional Program, "is an integrated regional program whose goal is to improve perinatal care through patient-focused planning of quality maternal and newborn services in the Champlain and South East Local Health Integration Networks" (Champlain Maternal Newborn Regional Program [CMNRP], 2019). It is composed of 13 hospitals, 4 public health units', community health centres, a birth centre, and other community agencies that provide maternal-newborn services. Its integrated program ensures consistent, standardized and evidence informed care across the region, providing mothers and babies with appropriate, timely access to clinical services at the right level of care, along the continuum from pregnancy to the post-natal period (CMNRP, 2019).

2.2.2.2 Hospital Based Care

The network of perinatal health services in Ottawa includes a community birthing centre, four birthing units, and a public health unit. The Ottawa Birth and Wellness Centre is a midwife-led, community-based health care facility which is guided by the midwifery model of care. This centre cares for normal, low risk pregnancies, which is also known as Level 1 care (Ottawa Birth and Wellness Centre, 2019). The hospital birthing units are located at both campuses of The Ottawa Hospital (TOH), The Queensway Carleton Hospital, and at the Montfort Hospital. The

General Campus of TOH provides care for high risk pregnancies and micro-premature infants in their neonatal intensive care unit; this level of care is referred to as level 3 (The Ottawa Hospital, 2018). The Civic Campus of the Ottawa Hospital provides care for both low and high-risk pregnancies, and cares for moderately premature infants in their special care nursery; this is also known as level 2 care (The Ottawa Hospital, 2018). The Queensway Carleton Hospital, which is a level 2 hospital, provides care for low risk pregnancies, and has the option of obstetric or midwife care (Queensway Carleton Hospital, 2016). The Montfort Hospital which provides level 2 care for low risk pregnancies and neonates, does offer the option of in-hospital midwifery care; it is designated as a francophone hospital offering official bilingual services in Ottawa (Hôpital Montfort, 2019). Other perinatal services in the Ottawa area include: a fertility clinic, well baby drop in centers run by Ottawa Public Health, private lactation services, and prenatal and parenting classes.

2.2.3 Men in Nursing

This section is divided into five subsections focusing on the history of men in nursing, why men choose nursing, childbearing women's perspectives on being cared for by male nurses, male nurses' perspectives on taking care of female patients, and the challenges that these nurses encounter. Although the concepts of sex and gender share some similarities, the term *gender* is retained for this study as gender is, "the state of being male or female as expressed by social or cultural distinctions and differences, rather than biological ones. It is the collective attributes or traits associated with a particular sex, or determined as a result of one's sex" (Oxford Learner's English Dictionary, 2020). On the other hand, the term *sex* focuses on the anatomy of an individual's reproductive system and secondary sex characteristics (Oxford Learner's English Dictionary, 2020).

2.2.3.1 History of Men in Healthcare

Men have always been part of health care as they have been practicing nursing since the fourth and fifth centuries (Evans, 2004). Their place in these primitive healthcare systems involved being tasked with providing care to the sick and injured; their roles in these early healthcare systems are similar to what modern-day nursing is (Evans, 2004). The original picture of female nurses comes from Florence Nightingale in the mid-1800s. She believed that nursing should only be a vocation for women (Le Blanc, 2017). When Florence Nightingale 'founded' modern nursing practice, she sought to do so in an exclusively female manner. This became problematic for the societal perception of men in healthcare because they were assumed to be the physicians, while women were portrayed as nurses (Le Blanc, 2017). That being said, men have always found ways to become nurses, such as by working in asylums because they had the physical strength to subdue violent patients (College and Association of Registered Nurses of Alberta [CARNA] 2013). As society became more accepting of men in a nursing role within the healthcare system, more men were recruited to be nurses and special interest groups emerged to show their support and solidarity for each other, for example, the special interest group of men in nursing from the Registered Nurses Association of Ontario (RNAO), namely, https://rnao.ca/connect/interest-groups/minig

2.2.3.2 Why Men Choose Nursing as a Profession

Many reasons exist for why people choose to go into the nursing profession. In general, according to Mooney, Glacken, and O'Brien (2008), the main reason why people choose nursing in the 21st century remains the desire to help and care for others. The findings from this qualitative study also indicate that although nursing was not everybody's first career choice, all participants had sought a career which involved caring. Family or friends in the profession

played a role in influencing participants' career selection (Mooney et al, 2008). In a more recent study conducted by Wilkes, Cowin and Johnson (2015), the students' reasons for entering nursing were both personal and career related, with personal being more prevailing. The reasons to enter the nursing profession were the following: being able to help and care for people, job security, the ability to enter tertiary education, and the enjoyment or love of nursing.

Men become nurses for the same reasons that women do: having a desire to care for others, job security and salary, and wanting to feel empowered (Boughn, 1994). However, there are gendered differences. According to the study conducted by Zysberg and Berry (2005), they found that men endorsed the following items more than women in the self-administered questionnaire that they developed for it: "I wanted to learn something else but was not accepted"; "I want to have a profession that is always in demand"; "Nursing is a respectable profession in the eyes of others"; "There's no unemployment in nursing"; "It's good money"; and "I think I can become a leader in this field." Women endorsed the statement: "Others always told me I could be a good nurse" more frequently than men. Moreover, men were seeking more leadership and advancement, even in a relatively 'feminine' profession, while women reported getting messages from their social environments about their suitability for the nursing profession.

In nursing, men tend to gravitate towards certain clinical domains such as psychiatry, mental health, critical care, emergency care, as well as administrative roles. They are least likely to work in pediatrics, community, or maternal-child specialties (CARNA, 2013).

2.2.3.3 Female Perspective on Being Cared for by a Male Nurse

Only one study could be found that presented female patients' perceptions on being cared for by a male nurse. Morin and collaborators (1999) conducted a study on mothers' responses to care given by male nursing students during and after birth. Utilizing focused ethnography as the

research design, a purposive convenience sample of 32 women was obtained. The study was conducted in a small community hospital in the mid-Atlantic region of the United States. Data were obtained through a semi-structured interview guide that contained three sections. The first section contained questions on socio-demographic and perinatal characteristics, while the second section contained a series of questions in regard to the rationale that the women used to decide whether to accept a male nursing student. The last section focused on contextual data associated with the interview process itself. The major findings from this study involved personal and contextual factors: the identified personal factors were the women's perceptions of their postpartum self and their personal feelings, while the contextual factors were student characteristics, establishment of relationships between student and new mother, nursing care activities, and the viewpoint of the partner. A recommendation from these findings is that nurse educators should take into account the identified personal and contextual factors while encouraging the male nursing students to provide competent and professional care. Even though this study was conducted in 1995 and published in 1999, the findings are still applicable in today's context.

2.2.3.4 Male Perspective on Caring for Female Patients

Two studies were found in which male nurses shared their perspectives on providing care to female patients.

In the first study, Inoue and collaborators (2006) examined male nurses' experiences in providing intimate care for female clients. Twelve nurses who are men participated in this study. Through semi-structured, open ended interviews, they found that providing intimate care for female clients to be challenging due to the personal nature of the care being given. This led to negative feelings for the male nurses, which resulted in different strategies that they used to

ensure that they were not perceived to be acting inappropriately. These strategies include: suppressing feelings of embarrassment in the moment and focusing on the physical task to be completed, not focusing on the gender of their patient, being chaperoned by a colleague for the nurses' protection, and developing a strong rapport with the patient prior to starting care. The study recommends that workplaces need to provide additional support and guidance for men to enable them to develop effective coping strategies and better manage these situations (Inoue, Chapman & Winaden, 2006).

In the second study, Evans (2002) explored the experiences of male nurses and ways in which gender relations structure different work experiences for men and women in the same profession. The data were collected in two rounds of semi-structured interviews with eight male nurses practicing in Nova Scotia, Canada, and were then thematically analyzed using feminist theory and masculinity theory. Evans found that the stereotypes of men as sexual aggressors is contrasted with the stereotype that male nurses are gay; therefore, both stereotypes sexualize male nurses' touch and create complex and contradictory situations of acceptance, rejection, and suspicion of men as nurturers and caregivers. This study also acknowledges that men are in a highly stigmatized role as nurses and are subject to accusations of inappropriate behavior, which causes a heightened sense of vulnerability and negatively impacts their ability to do the caring work (Evans, 2002).

This vulnerability may be further exacerbated in the current social climate of the #MeToo movement (https://metoomvmt.org, 2020), which focuses on survivors of sexual violence. Although nuanced, the social standards around this movement include women who are more likely to be victims, and men who are more likely to be perpetrators. Harding, North and Perkins (2008) suggest that a paradox exists within this context, such as there could be a sexualization of

touch and an assumption of the homosexuality of the nurse, which could contribute to the negative perception of male nurses. However, these authors do stipulate the importance of legitimizing men's involvement in physical caring (Harding, North & Perkins, 2008).

2.2.3.5 Challenges Faced by Men in Nursing

Men face many challenges in nursing. This starts with their career choice decision, and it continues through their educational training and transition into the workforce. This trajectory shares a common thread of gender normative behaviour, and its influence on social perception of men who undertake non-traditional roles. Gender impacts career choice, learning experiences in the educational context, and ease of transition into the workforce; these experiences are also exacerbated by historical, political, and cultural factors.

Le Blanc (2017) conducted a study on male nursing students' learning experiences in Ottawa, Canada. Her study was conducted in the context of her doctoral thesis. "Research questions explored male students being subjected to feminine gender performance expectations, and an inequitable exercise of power and discipline and the relation of high attrition rates of male nursing students to feminine gender performativity expectations" (p. ii). The research design that was utilized was the Van Manen phenomenological method. Interviews had been conducted with 20 current and past male and female nursing students. Three key concepts were identified from data analysis: 'constructing the ideal', 'enforcing the ideal', and 'surviving the ideal'. The findings reveal that the male nursing students have different experiences throughout their academic journey due to different marking styles, being chosen to demonstrate skills more frequently, being asked to complete labor intensive tasks, and experiencing clinical instructors asking patients for their permission to have a male nursing student. These collective experiences result in the recurrent theme of fearing rejection from female patients in the clinical setting,

especially in the perinatal health care setting. Le Blanc also discusses how men are different learners than women: men are held to different academic and clinical standards than women are because according to traditional gender roles, men are less caring and therefore perceived to be less competent nurses. Recommendations are proposed on how to create more inclusive educational environments for the male students and to develop interventions to assist them in navigating their educational experience.

Continuing in the same vein, societal acceptance of men in a nursing role has been challenging for various cultural, social, political, and historical reasons (Evans, 2002; Inoue et al., 2006; Le Blanc, 2017). Although men become nurses because they want to provide care to people who need it, traditional gender roles oftentimes may make men feel less competent or caring (Le Blanc, 2017). Eisenchalas (2013) defines gender roles as, "…society's shared beliefs that apply to individuals on the basis of their socially identified sex" (Eisenchalas, 2013, p. 2). She also defines stereotypes as, "Descriptive aspects of gender roles as they depict the attributes that an individual assigns to a group of people. This leads to interpretation, rationalization, and justification of social practices" (Eisenchalas, 2013, p. 2). Agentic qualities are traditionally masculine, such as being assertive, dominant, and taking a leadership position, while communal qualities are traditionally feminine, like being expressive, communicative, and submissive. These qualities inform traditional gender roles (Eisenchalas, 2013). Kachel and colleagues (2016) discusses masculinity within a societal context, and how traditional roles, responsibilities, interests, and qualities contribute to gender normative behaviors. Levant (2011) further explores this idea that masculine ideology contributes to traditional gender roles; however, since society is fluid and social norms are constructed, they can change over time. All of these aspects taken together may account for some of the unique challenges male nursing students face; there

appears to be a dissonance between society's traditional expectations of them as men and within the healthcare system, and what their current role is as a competent front line nurse.

It has been proposed by male nurses to implement recruitment programs like those targeted at women pursuing non-traditional professions such as the military, engineering, and police foundations (Edmonton Police Service, 2019; Engineers Canada, 2019; Government of Canada, 2019). Programs like this exist, such as the "We Saved You a Seat" initiative for women at Algonquin College (Algonquin College, 2018), but no programs like this exist that advocate for men in nursing. The closest program to this nature is called the '20x20 Project'. It is an American initiative to recruit men to nursing, with the hope of having 20% of the people in the profession as men by the year 2020 (Minority Nurse, 2013). Perhaps this is a strategy that Canada, particularly Ontario, can adopt. The fundamental problem with the lack of such programs is that it may reflect an inherent sexism in the nursing profession that is not being addressed. This could be partially due to men who have not experienced sexism traditionally, as the historic and societal precedent that has been set involves discrimination against women. This supports the continued study of gender issues in the nursing workforce and how to address them. Some strategies would be to continue to inform the public of the registered nurses' scope of practice and gender distribution, as well as having increased awareness for high school guidance counselors to properly address future students' questions about the nursing profession (CARNA, 2013).

2.2.4 Men in PHN

As the search strategy section of this chapter mentioned (see Section 2.1), there is a paucity in current research that addresses men, nursing students and perinatal health nursing all at the same time. This section presents the eight research studies that address the learning

experiences of male nursing students during their PHN clinical practicum (see Appendix 2), the themes that emerged across all studies, and a critique of the studies. Furthermore, several articles were also found regarding proposed strategies for changing the PHN curriculum for male nursing students. These strategies will also be elaborated on in this section.

2.2.4.1 Overview of Studies Concerning Men, PHN, and Student Nurses

From the search strategy that was presented earlier in this chapter, only eight research studies could be found that included all three concepts of men, nursing students and PHN (see Table 3 in Appendix 2). These research studies are the following: Balakrishnan, Sheoran, & Bishnoi, 2013; Bartfay & Bartfay, 2017; Eswi & El Sayed, 2011; Ha, Kim, Choi & Ahn, 2015; Mitra, Philips &Wachs, 2018; Patterson & Morin, 2002; Powers, Heron, Sheeler & Sain, 2018; Sherrod, 1991. Overall, these studies were conducted in just a few countries, using mostly qualitative research methods, with sample sizes ranging from seven to sixty participants, and published between 1991 and 2018. A more in-depth analysis and critique of these studies will be presented in the following subsections.

2.2.4.2 Themes from the Empirical Evidence

This subsection presents the themes that emerged from the findings reported by the eight retained research studies. The themes were divided and regrouped based on the similarities shared between the findings of these studies, after a qualitative content analysis (Elo & Kyngäs, 2008) of the articles had been conducted. Seven themes had been identified as well as the outcomes of the positive and negative PHN learning experiences of the studies' participants.

The first theme that emerged from the findings is related to the nursing curriculum. The respondents (n=37) in the Bartfay and Bartfay study (2017) indicated how the nursing curriculum was feminized in four ways: the curriculum was more geared towards the female

students than the male ones; the male students experienced discrimination from the female students while being in their nursing program as well as occasionally from faculty and nursing staff; they felt that they were being singled out by instructors and made an example of; and, within the PHN clinical placement, the instructors would ask the female patients' permission to have a male student which they did not do for the female ones. The participants in the Powers et al. (2018) study also felt that they had been singled out by their instructors. On the other hand, the participants in the Eswi and El Sayed study (2011) stipulated that: PHN should be an optional placement for the male students, they should be doing a placement in urology instead of PHN, they should be identifying with male physicians, and male students should be paired with female ones.

The second theme relates to the students' preconception of the PHN clinical placement before starting it. In both of the Mitra et al. (2018) and Patterson and Morin (2002) studies, the participants had mixed feelings before starting their placement in PHN in the hospital as they viewed it as a female domain. The instructors themselves had identified concerns prior to the commencement of the clinical rotation in PHN (Patterson & Morin, 2002).

The third theme pertains to the participants' feelings about the PHN clinical practicum which includes the placement itself. In regard to the students' feelings (third theme), they revealed their sense of isolation (Bartfay & Bartfay, 2017), loneliness (Bartfay & Bartfay, 2017), and embarrassment (Balakrishnan et al., 2013; Eswi & El Sayed, 2011). Out of the three feelings expressed by the participants in these particular studies, embarrassment was the most frequently mentioned one. Although the participants in the Balakrishnan et al. study (2013) expressed that PHN was interesting and that male nurses have an important role in relation to it, there was still embarrassment associated with it. The respondents in the Eswi and El Sayed (2011) explained

that their embarrassment was due to the abdominal and breast assessments and to giving perineal care to the new mothers. Another finding from the Bartfay and Bartfay study (2017) is that the participants could be perceived as lacking emotions or caring.

The students' fears are part of the fourth theme. Two particular fears as revealed from the findings of the Bartfay and Bartfay (2017) and Patterson and Morin (2002) studies were that the participants feared being perceived to having an inappropriate touch and that their care could be misinterpreted by the female patients.

The fifth theme pertaining to rejection was very omnipresent. Rejection was mentioned in all of the studies (Balakrishnan, Sheoran, & Bishnoi, 2013; Bartfay & Bartfay, 2017; Eswi & El Sayed, 2011; Ha et al., 2015; Mitra, Philips & Wachs, 2018; Patterson & Morin, 2002; Powers, Heron, Sheeler & Sain, 2018; Sherrod, 1991). The male participants in these eight studies shared how rejection was coming from different sources: faculty professors, clinical instructors, female students, nursing staff, other health care professionals, and female patients, their partners and family members. However, some participants in the Mitra et al. study (2018) revealed the opposite of rejection: they felt that they were welcomed in the clinical setting by both the female patients and the nursing staff; for the latter, some of the male students revealed that their nurse preceptors were eager to teach them. Some of the coping strategies identified by the male students to cope with their PHN clinical placement was to be in survival mode by surviving this clinical rotation and by working harder than their female counterparts (Patterson & Morin, 2002).

The sixth theme involves gender bias; this was present in all of the studies (Balakrishnan, Sheoran, & Bishnoi, 2013; Bartfay & Bartfay, 2017; Eswi & El Sayed, 2011; Ha et al., 2015; Mitra, Philips &Wachs, 2018; Patterson & Morin, 2002; Powers, Heron, Sheeler & Sain, 2018;

Sherrod, 1991). The sources of gender bias were connected to professional and societal norms. In regard to professional norms, the findings from the aforementioned studies reveal that nursing is considered a female dominant profession, there is a lack of male models in nursing and in academia, and PHN is dominated by female nurses who work with female patients and their partners or family members. On the other hand, in regard to societal norms, the findings affirm that a nurse is a woman, men in nursing are stereotyped as effeminate, gay or inappropriate, and how nursing is portrayed by social media and popular culture.

The last theme involves recommendations suggested by the participants in the retained studies to improve the male nursing students' learning experiences in the PHN clinical practicum (Eswi & El Sayed, 2011; Ha et al., 2015; Powers et al., 2018). Some of these recommendations from the Eswi and El Sayed study (2011) are to: make the PHN clinical practicum optional for male students, have the male students do a clinical rotation in urology, pair the male students with the female ones, change the male students' attitudes toward childbearing and fatherhood, and have them identify with male physicians. In both the Powers et al. study (2018) and the Ha et al. study (2015), the recommendations are to improve media portrayal of male nurses especially in PHN, sensitize faculty to the facilitators and barriers in regard to male students' clinical learning, and adding mentorship program to provide male role models for male nursing students in this context.

The findings from the eight retained studies also reveal the positive and negative outcomes of male students' learning experiences in the PHN clinical practicum (Balakrishnan, Sheoran, & Bishnoi, 2013; Bartfay &Bartfay, 2017; Eswi & El Sayed, 2011; Ha et al., 2015; Mitra, Philips &Wachs, 2018; Patterson & Morin, 2002; Powers, Heron, Sheeler & Sain, 2018; Sherrod, 1991). There were some positive outcomes from these studies, such as the appreciation

of the physical toll of labour, and gender based rejection did not occur all the time. The positive outcomes were far outweighed by the negative ones. Some of the negative outcomes are related to the undergraduate experience while the others pertain to the workplace. The negative outcomes that were identified in relation to the undergraduate learning experience of the male students were: their poor recruitment and retention in the undergraduate nursing programs; increased moral distress; reduced dignity; lower acceptance by female patients and their partners and by nursing staff; clinical instructors' lack of support; difficulty to attain the learning objectives and goals of the clinical practicum as the students could not always complete their postpartum assessments on the female patients; experiencing more role strain during the PHN clinical practicum compared to the female students; and limitations to learning opportunities in the clinical setting. The negative outcomes identified by the studies in regard to the workplace were: inadequate recruitment and retention to nursing, particularly to PHN; limited scope of practice; and gender bias and discrimination.

In summary, these themes can be regrouped in the following way. Some of the themes pertain to the students themselves which is at the individual level (feelings, fears). Other themes are at a greater level, that of the institutional context (undergraduate nursing curriculum, students' preconceptions of the PHN clinical practicum, recommendations for improvement). The last themes are at the level of society (gender bias, rejection). These three levels can be linked with the micro, meso, and macro domains in association with Andragogy as described by Holton, Swanson and Naquin (2001), in their article entitled, 'Andragogy in practice: Clarifying the andragogical model of adult learning'.

2.2.4.3 Critique

Although these studies provide some evidence about this research problem, the small number of studies indicates that this is a relatively new phenomenon within nursing. This section provides a critique of the retained studies, and will justify the continued exploration of this topic. The critique is presented according to the characteristics of publication, the research purpose and questions, the study design and the sample size, and the data collection methods.

First, the eight retained studies were published only in English between 1991 and 2018: one in 1991 (Sherrod, 1991), one in 2002 (Patterson & Morin, 2002), and the rest between 2011 and 2018 (Balakrishnan, Sheoran, & Bishnoi, 2013; Bartfay & Bartfay, 2017; Eswi & El Sayed, 2011; Ha et al., 2015; Mitra, Philips & Wachs, 2018; Powers, Heron, Sheeler & Sain, 2018). It is noteworthy that 75% of these studies were only published starting in 2011. Also, the origin of the country of publication is as follows: Canada (1), the United States (4), India (1), Korea (1), and Egypt (1). It is significant that five of the eight retained studies (62.5%) were published in North America; this indicates the greater interest for this topic in both Canada and the United States.

Second, there were several research purposes stated in the retained studies. Five studies explicitly posed the research question exploring the experiences of male nursing students in their PHN clinical placement (Eswi & El Sayed, 2011; Ha et al., 2015; Mitra et al, 2018; Patterson et al, 2002), two studies explored the educational experiences of male nursing students (Bartfay & Bartfay, 2017; Powers et al, 2018), and one study explored the concept of role strain in the PHN clinical practicum for male students (Sherrod, 1991). None of these studies explore the learning experiences of PHN in their entirely; the focus appears to be on the clinical component only. This leaves part of the current research problem unexplored because there is no current evidence regarding non-clinical PHN learning experiences for male nursing students at this time.

Third, a variety of study designs and sample sizes were used to actualize these studies. Five were completed qualitatively (Ha et al., 2015), with four of them specifically using the phenomenology tradition (Bartfay & Bartfay, 2017; Mitra et al, 2018; Patterson & Morin, 2002; Powers et al, 2018). Two were completed using MMR (Balakrishnan et al, 2013; Eswi & El Sayed, 2011), and one was completed quantitatively (Sherrod, 1991). Subsequently, sample size varied depending on the research type. In ascending order, the sample sizes ranged from n=7 (Mitra et al., 2018), n=8 (Patterson & Morin, 2002), n=11 (Powers et al, 2018), n=12 (Ha et al., 2015), n=18 (Sherrod, 1991), n=30 (Balakrishnan et al., 2013), n=37 (Bartfay & Bartfay, 2017), and n=60 (Eswi & El Sayed, 2011), for a total of 201 participants. Despite the various research designs used, phenomenology was the most widely used research method. This design provides very in-depth information about the lived experiences of these students, but it also fails to address the various contributing factors – such as comfort levels with the learning experiences and other socio-demographic data. This critique supports the need for continued MMR on this topic, as purely quantitative data also cannot fully explore these learning experiences. Furthermore, the findings may be difficult to generalize due to the small sample sizes in both the qualitative and quantitative studies.

Lastly, various data collection methods were used in the aforementioned studies. All of the data collection tools were appropriate, given the respective study's research type and design. The qualitative studies used face-to-face, semi-structured interviews (Bartfay & Bartfay, 2017; Mitra et al., 2018; Patterson & Morin, 2002; Powers et al., 2018) or unstructured interviews (Ha et al., 2015). The mixed methods studies used a combination of semi-structured interviews, attitude scales and questionnaires (Balakrishnan et al., 2013), or a 'research instrument' (Eswi & El Sayed, 2011). Lastly, the quantitative study used a role strain scale (Sherrod, 1991). The

qualitative studies did not specify whether interviews were conducted as a group, or individually. Moreover, the mixed methods studies did not elaborate on which questionnaires or research instruments were used to collect quantitative data, the type of MMR was not discussed, and exact statistical results were not reported from the Sherrod study (1991).

Overall, male students may face challenges upon entry into their training program and during it, and may be heightened with the PHN clinical practicum. The learning experience associated with this particular practicum may be exacerbated by the PHN context itself because this is the specialty area with the least amount of practicing nurses who are men, and the patient population is almost exclusively female. All of the articles indicate that this research problem may be more complex than it seems. Indeed, these studies do have merit, as they provide a starting point to support current research exploring this research problem in a Canadian context. However, there are limitations to their findings. The advantages and limitations of the current research study will be explored in Chapter 6.

2.2.4.4 Proposed Strategies for PHN Clinical Placements for Male Students

Some of the retained studies and articles from the literature review proposed recommendations for alternative clinical placements for male nursing students in regard to PHN and the creation of inclusive learning environments for them.

The first strategy that was proposed involves alternative PHN clinical placements for male nursing students. Eswi and El Sayed (2011) conducted a study in Cairo, Egypt regarding the learning experiences of male nursing students during their PHN clinical practicum. The authors suggest that PHN should be a female-only clinical placement. They stipulate that male students should identify with obstetricians-gynecologists (OB-GYNs) as role models, “male students should be oriented to and encouraged to identify with role model of male obstetricians.

Re-planning of some of the clinical rotations of maternity nursing to include substitute clinical experience for the male student should be considered" (Eswi & El Sayed, 2011, p. 8).

Although the above-mentioned proposed strategy appears to be effective, it does not take into account the men who actually are interested in this area. Eswi and El Sayed's (2011) proposed strategy of having PHN as a female only placement contradicts the progress that deconstructing traditional gender roles has made. This is based on the assumption that men will continue to be rejected based on their gender and are therefore uninterested in this clinical specialty. Furthermore, by encouraging male students to identify with male OB-GYNs as role models is problematic because the scope, education, and roles and responsibilities are entirely different between OB-GYNs and perinatal health nurses. This may also, more dangerously, send the message that men do not belong in women's health care unless they are a physician.

Interestingly, these same authors (Eswi & El Sayed, 2011) also state that, "Efforts should be made to give male nursing students educational opportunities equal to the opportunities given to female students. To give the students the best possible educational experience and to provide optimal nursing care, nursing faculties are urged to plan male nursing student's assignment…." (pp. 97-98). They also suggest that female patients should be provided with an option to accept or refuse being assigned to a male nursing student, and that developing strategies to change male students' attitudes toward the childbearing experience and fatherhood are crucial. These statements provide a contrary argument to the statements that were previously made about male nursing students seeking mentorship from male OB-GYNs; they also illustrate the ethical dilemma of choosing a health care provider based on gender.

The second proposed strategy involves the creation of an inclusive learning environment for the male nursing students' PHN clinical placement. This could involve developing

approaches for positive learning environments, exploring factors influencing the students' learning experiences, providing resources to them about offering care to female patients, and enabling support for them.

The first approach is suggested by Perry and colleagues (2016): they advocate for the importance of positive learning environments in clinical placements by stating that, "…a positive learning environment affects students' experiences within a clinical setting. A more positive learning environment helps students focus on learning rather than on being accepted" (p. 288). They continue by suggesting a second approach that involves the factors that influence students' learning experiences, "Nursing educators must be cognizant of their clinical education practices and the implications of different clinical models on students' learning perception. If we understand the relevant factors contributing to students' learning, we can effectively implement strategies that enrich learning" (Perry et al., 2016, p. 288). The research study conducted by Perry and colleagues addresses the importance of maximizing the learning experience within a limited but valuable clinical time.

A third approach focuses on how male nursing students can provide intimate care to female clients. Inoue, Chapman and Wynaden (2006) provide strategies that can be used to assist in the delivery of intimate care for female clients, such as: self-protection and breaking the ice. Furthermore, the findings of this study suggest the following:

> "Participants require a comfortable and supportive environment in which to express how they feel during the delivery of intimate care in clinical settings. Even though both male and female nursing students and newly Registered Nurses have an educational preparation, these programs do not take into account the support requirements of male nurses. To overcome gender difference, regarding the delivery of intimate care, it is essential that support systems for male nurses in clinical settings are developed. In this study, participants frequently felt isolated from both women nurses and clients. To address these issues and to lessen the sense of isolation, male nurses require a high level of support from their colleagues and seniors when providing intimate care for

> women clients. This suggestion is supported by the American Association of Colleges of Nursing (1997, 2003) who recommends that current educational programs need to be reviewed and that nursing education must deal with gender diversity. Current graduate programs and ongoing educational sessions, especially in clinical settings, should be developed to take account of gender issues related to nursing care. Several studies conclude that the lack of a support system and one-sided educational programs appear to be hindering the career development of male nurses…" (Inoue et al., 2006, p. 565).

Morin and colleagues (1999) continue in the same direction by stipulating that nursing faculty need to be sensitized to the various factors that affect a patient's decision about receiving care by a male nursing student.

Meyer conducted a study similar to the one by Inoue, Chapman and Wynaden (2006). Meyer (2012) conducted a research study in the context of a master's thesis on the experiences of male nurses in midwifery clinical training at a hospital in the Eastern Cape in Africa. This researcher raises the point on how male students can be guided to provide care to women clients and how to cope when female clients refuse them. The following quote explicates this:

> "…. ensure that guidelines on how to cope with providing care to the opposite sex are included in curriculum planning and endure that male students are psychologically prepared to deal with negative feelings associated with fear, discomfort, and embarrassment before they are introduced to the clinical environment. Furthermore, it is important to recognize that gender barriers exit in patient care and in order to avoid male midwives being rejected by female patients, accompanying male students when they have to perform procedures on female patients. Male students should also be encouraged to maintain high professional standards in order to gain the respect and trust of female patients. In the event that patients refuse care being provided by male students, encourage males to accept the patient's decision" (Meyer, 2012, p. 96).

Although the Meyer's study focuses on midwifery, the participants were male nursing students learning about midwifery. The suggestions provided in the Meyer's master's thesis can easily be applied to male nursing students learning about PHN in an undergraduate nursing program.

A fourth and last approach is proposed again by Inoue and colleagues (2006). They emphasize how support and support systems are necessary for male students and that gender diversity should be part of current undergraduate and continuing educational programs, thus encouraging the future careers of these male health care professionals.

2.2.5 Summary of this Literature Review

This section focused on the studies that explored the experiences of male nursing students in their PHN practicum, as well as reviewed the two proposed solutions from the literature. Interestingly to note, the findings of: embarrassment, fear of rejection, and gender were found across all retained studies-regardless of their country, or year of publication. However, based on this small amount of evidence, several gaps were noted: a lack of the Canadian context, a lack of the entirety of the PHN learning experience being explored, a lack of using a theoretical framework to guide the research study, and a lack of using a Mixed Methods Research design. Crucial pieces of information are missing, and an alarming lack of action is present. Yet, the evidence that supports the integration of gender inclusive learning initiatives within this clinical specialty is needed. Taken together, these aspects contribute to the necessity of the present study. Thus, this research is fundamental to advancing the profession and fulfilling nursing's inherent political advocacy position, especially for the future of perinatal health nursing. The next section explores the undergraduate nursing education at the University of Ottawa.

2.3 Undergraduate Nursing Education at the University of Ottawa

This section contains three subsections featuring the following: a description of the undergraduate nursing program at the University of Ottawa, the accreditation through the College of Nurses of Ontario, and lastly, the entry to practice competencies for nurses in Ontario.

2.3.1 Program Description

According to the Maclean's 2019 report that ranks the top schools of nursing in Canada, the University of Ottawa's School of Nursing was ranked tenth amongst the top 19 nursing schools (MacLean's, 2019). In the 2018 report of the top 200 schools of nursing in the world (Top Universities, 2018), the University of Ottawa's School of Nursing was ranked 41st. The School of Nursing of the University of Ottawa offers a four-year Honors Bachelor of Science degree in Nursing in collaboration with two colleges in the Ottawa region and in both of Canada's official languages. Anglophone students may study at the campus of the University of Ottawa or that of Algonquin College (Woodroffe or Pembroke campuses), while Francophone students are located only at the campus of the university. Its mandate is to prepare generalist nurses who can work in any clinical setting that provides nursing care. This program produces graduates with effective communication skills, and who use critical thinking and analytical skills in any workplace (University of Ottawa, 2020).

The program involves two years of generic health science background coursework, such as anatomy and physiology, pharmacology, pathophysiology, psychology and microbiology, before focusing on specific nursing theory courses, like nursing theory, research, statistics, ethics, politics and economics of the health care system, and inter-professional collaboration. There are also a variety of clinical practice specialty courses that each have a theoretical, laboratory, simulation, and clinical placement components, such as pediatrics, perinatal health, medicine, surgery, community, and psychiatry. The program prepares students to write the NCLEX-RN registration exam at the end of the program, and for further graduate studies.

There are two other undergraduate programs. The first is the second-entry program in which students who have a bachelor degree in science or two years of the four-year program in

sciences can apply to the undergraduate nursing program; they are required to take an initial summer term followed by continued study in the third year of the program. The other program is a bridge program for practical registered nurses who would like to continue their studies in order to become registered nurses (University of Ottawa, 2020).

2.3.2 Accreditation through CASN

The Canadian Association of Schools of Nursing (CASN) establishes and promotes national standards of excellence for nursing education, and is responsible for accrediting Canadian nursing education programs (Canadian Association of Schools of Nursing [CASN], 2018). Moreover, the College of Nurses of Ontario (CNO) is the regulatory body for nursing in Ontario. The college is accountable for public protection by ensuring that Ontario nurses are safe, competent and ethical practitioners (College of Nurses of Ontario [CNO], 2014). The College fulfills its mandate in a variety of ways, such as maintaining standards of nursing practice and education at the various schools of Nursing in the province. Each school, including the University of Ottawa, ensures that their curriculum is based on the following eight guiding principles:

> " 1) requisite skills and abilities, 2) having a strong foundation in nursing theory, concepts, and knowledge, health and sciences, humanities, research, and ethics, 3) prepared at the university baccalaureate education level as generalists to practice safely, competently and ethically in stations of health and illness, with people of all genders and across the lifespan, in a variety of practice settings, with individuals, families, groups, communities, and populations, 4) competencies of the entry level registered nurse are applicable across all practice settings, 5) entry level registered nurses are expected to practice in a manner consistent with provincial and federal legislation that directs nursing practice, in addition to the college's standards for professional practice and ethics. 6) entry level registered nurses ae responsible for critical reflection and assessment of their practice in relation to their ability to meet the competencies, 7) entry level registered nurses actively engage in inter-professional practice essential for improvement in client health outcomes, 8) entry level registered nurses are practitioners whose level of practice, autonomy, and proficiently grow through collaboration, mentoring and support from colleagues, leadership and the inter-professional health care team" (CNO, 2014, p. 4).

2.3.3 Entry to Practice Competencies

The eight guiding principles are used to ensure competency of registered nurses in Ontario. A competency is defined as "the knowledge, sill ability, and judgment required for safe and ethical nursing practice" (CNO, 2014, p. 4). These competencies are organized into a conceptual framework (see Figure 2) from a regulatory perspective that depicts five broad concepts that entry level Registered Nurses are expected to be taught and maintain (CNO, 2014, p. 4). See Appendix 3 for the full list of competencies.

Figure 2 - Conceptual Framework for Organizing Competencies[1]

[1] Adapted from the College of Nurses of Ontario (CNO, 2014, p. 5).

At the center of the framework are clients, who can be defined as individuals, families, groups, communities, and populations of people. The competencies around clients are: professional responsibility and accountability, knowledge based practice, ethical practice, service to the public, and self-regulation (CNO, 2014, p. 5).

The new graduate nurse consistently demonstrates professional responsibility and accountability in accordance with the college's standards for nursing practice and ethics; and that the primary duty is to the client to ensure safe, competent, ethical nursing care (CNO, 2014).

The new graduate nurse demonstrates a generalized body of knowledge by drawing on diverse sources of knowledge and ways of knowing, including integration of nursing knowledge from the sciences, humanities, research, ethics, spirituality, relational practice, critical inquiry, and primary health care principals. Furthermore, the new graduate nurse is competent in the application of knowledge by demonstrating the competency in the provision of nursing care, as through the nursing process of assessment, planning, implementation of care, and evaluation. The provision of nursing care is an iterative process of critical inquiry and is not linear in nature. This includes: incorporating critical inquiry and relational practice to conduct a client focused assessment that emphasizes client input and the determinants of health, planning care in collaboration with clients, integrating knowledge from nursing, health science and other related disciplines, and knowledge from practice experience, clients knowledge and preferences, and factors within the health care setting; providing holistic, individualized nursing care with clients and families across the lifespan, to meet mutually agreed upon outcomes along the continuum of care; and, collaborating with clients and members of the healthcare team while conducting an ongoing comprehensive evaluation to inform current and future care planning (CNO, 2014).

Ethical practice is demonstrated by professional judgment and practice decisions by applying the ethical values and responsibilities in the college's standards for ethics. The registered nurse also engages in critical inquiry to inform clinical decision making and establishes therapeutic, caring, and culturally safe relationships with clients and the inter-professional health care team (CNO, 2014, p. 5).

Lastly, service to the public is demonstrated by an understanding of the concept of public protection and the duty to provide and improve health care services in collaboration with clients and other members of the inter-professional health care team, stakeholders, and policy makers (CNO, 2014, p. 5).

2.4 Undergraduate Perinatal Health Nursing Courses at the University of Ottawa

This section contains three subsections: an overview of the courses in perinatal health nursing, the PHN theory course, and the PHN clinical practicum course.

2.4.1 Overview of the PHN Courses

Students complete their training in perinatal health nursing in the third year of their undergraduate program at the University of Ottawa. There are two parts to the training in PHN: the theory course and the clinical practicum course. The clinical practicum course contains three components: laboratory and simulation activities, as well as a clinical placement in a hospital care setting in the Ottawa region. The courses are connected because the theoretical content is learned in the theory course, and knowledge gained from the theory course is applied in a safe learning environment in the laboratory, in simulation and in the hospital setting. The skills learned in laboratory are applied during simulations of common clinical scenarios. Finally, students apply their theoretical knowledge, as well as laboratory and simulation skills, to real patients during their PHN clinical placement in the hospital.

The principles that underlie the theory and practicum courses are based on the Entry to Practice Competencies for Nursing Care of the Childbearing Family for Baccalaureate Programs in Nursing Developed by the Canadian Association of Schools of Nursing (CASN) (CAPWHN, 2018). There are four principles for these competencies: 1) promotes and enhances the health of the childbearing person, baby and family during the childbearing years, 2) provides safe and

appropriate care for the childbearing family from preconception through pregnancy, 3) participates in the care of the childbearing family during childbirth, and 4) cares for the childbearing family during the post-partum period (CAPWHN, 2018). The full list of competencies is presented in Appendix 4.

2.4.2 PHN Theory Course

The theory course in PHN is NSG3111 for the Anglophone program, while it is NSG3511 for the Francophone program. The general objective of the theory course is that the "student will demonstrate self-directed learning, critical thinking and knowledge of family as it applies to the nursing care of childbearing families across the perinatal continuum", both in healthy and at-risk situations (University of Ottawa, 2019-permission to use granted by Dr. Jean-Daniel Jacob, assistant director for the undergraduate nursing programs). The pass mark for the perinatal health nursing theory course is 65% or C+. These lectures are taught by graduate level prepared professors. The theory course emphasizes family-centered maternal-infant care in low risk and high-risk situations during pregnancy, childbirth, postpartum, and for the newborn. Other theoretical content may include postpartum depression, perinatal bereavement, and domestic violence. The major concepts that are taught in this course include family centered health care, transition to parenthood, family adaptation, family coping, and family resources. The Calgary Model of Family Assessment and the Calgary Model of Intervention are also included (Wright & Leahey, 1994; Wright & Leahey, 2013). These concepts are reinforced in laboratory and simulation activities, although during that time, students also learn assessment techniques, post-partum mother and newborn care, feeding support, and patient teaching.

2.4.3 PHN Clinical Practicum Course

The PHN clinical practicum courses are NSG3511 and NSG3711 for the Anglophone and the Francophone streams, respectively. The clinical practicum totaling 117 hours is divided into three components: laboratory learning, simulation and a clinical rotation in a local Ottawa hospital. Twenty-hours of the 117 hours are dedicated to the laboratory and simulation learning, while the other 93 hours are reserved for the clinical placement. The five objectives for the clinical practicum course are the following: working with childbearing families in partnership with clinical agency, the student will: 1) apply concepts of family nursing, 2) utilize the principles of health promotion in applying the nursing process of childbearing, breastfeeding and parenting as healthy life event, 3) utilize foundational knowledge relevant to childbearing in applying nursing process, 4) demonstrate effective communication, and 5) demonstrate professional behaviour (University of Ottawa, 2019). This is a pass or fail course. Some laboratory and clinical instructors are prepared at the graduate level, or are recognized as clinical experts from the number of years in perinatal health nursing practice but only have a bachelor's degree in nursing.

The laboratory component of the clinical practicum course focuses on post-partum and newborn assessment, breast and bottle-feeding, newborn care, and health teaching. There are three learning activities: post-partum assessment, care, and health teaching; newborn assessment, care, and health teaching; and breast- and bottle-feeding support. The simulations are safe spaces for students to apply the assessment skills in a controlled environment. There are five simulation activities: postpartum assessment and teaching, newborn assessment and teaching, postpartum hemorrhage, discharge teaching, and a well-baby checkup at a drop-in centre. When nursing students complete their clinical placement in the hospital, the focus of their learning is on post-partum assessment and care, newborn assessment and care, and infant feeding support. They

apply the family-centered approach according the CFAM to care within the clinical placement. They may have an opportunity to observe intra-partum care as well as other sectors of the perinatal unit in the hospital such as triage and caesarean birth, but it is not always guaranteed. The students start their clinical placement with one mother-baby dyad, eventually learning to give care to two mother-baby dyads.

2.5 Summary of the Chapter

This chapter focused on the literature review. The search strategy was presented first. Then, the second section explored the existing literature regarding perinatal health nursing, an explanation of the organization of perinatal health care in the Ottawa region, men in the nursing profession, and men in PHN. Nursing curriculum at the University of Ottawa, and an explanation of the PHN theory and clinical practicum courses were also discussed. This chapter highlighted the current knowledge gap in the literature, which further reinforced the importance of this study. The next chapter will feature the theoretical framework.

Chapter 3 – Theoretical Framework

This chapter explores the theoretical framework of this study, Andragogy. There are four subsections: major learning theories in nursing education, the chosen theory of Andragogy, and how this theory applies to the present research study. A chapter summary is featured at the end.

3.1 Background of Learning Theories

There are three major learning theories in nursing education: behaviourist, cognitive constructivist, and social constructivist.

The first learning theory focuses on behaviorism. Behaviourists, "believe that learning is a change in observable behaviour and it happens when the communication occurs between the two events, a stimulus and a response" (Aliakbari, Parvin, Heidari & Haghani, 2015, p. 1). A positive behaviour conditions a learner to perform well. Practice and repetition are necessary for the continued behaviour. Both positive and negative learning experiences have the potential to be reinforced though continued exposure and experience. An example of this in nursing education is through laboratory learning and simulated learning because, "by reinforcing the desired behavior, it is possible to increase the chance of recurrent onset and finally reach the learning goals" (Aliakbari et al., 2015, p. 4).

The second learning theory involves cognitive constructivism. Cognitive psychologists, "believe that learning is an internal process objective and they focus on thinking, understanding, organizing, and consciousness" (Aliakbari et al., 2015, p. 1). "This type of learning cannot be directly observed, and it is associated with the change in capacity and capability of the person to respond" (Aliakbari et al., 2015, p. 5). There are different types of learning and straight memorization is ineffective as it may not be applicable in real life, therefore understanding is

more effective. This is illustrated in nursing education by overlapping the content learned in a theory course with activities in the laboratory.

The last learning theory is based on humanism. “Humanists pay attention to feelings and experiences” (Aliakbari et al., 2015, p. 1). The ultimate goal of education is to reach the final limit of an individual’s growth potential as in Maslow’s hierarchy. This third learning theory is holistic and facilitates people’s maximizing their capabilities (Aliakbari et al., 2015). It is more flexible and open to the learning needs of students. Andragogy falls into the humanistic category.

3.2 Andragogy

This section explores the details of the theory of Andragogy. Its history, assumptions, principles, and outcomes will be further discussed in the next subsections.

3.2.1 History of Andragogy

Andragogy is a learning theory that originated in Germany in the 1830s. It was popularized after World War I as many soldiers returning from war were seeking educational opportunities. Andragogy came to North America as these educated workers emigrated to the United States (Henschke, 2015). Malcolm Knowles was first exposed to the concept of Andragogy in 1966. He then refined the concept to become a theory of “the art and science of helping adults learn” (Knowles, 1970, p. 55) (see Figure 3 for the visual representation of this model). The origin of the word comes from the Greek word ‘aner’, which can be translated to ‘man’; and the suffix –gogy means ‘to teach’ (Knowles, 1977, p. 206). This is contrasted to the root of the word pedagogy, which implies that children are the primary learners. The main differences between andragogy and pedagogy are: children are dependent learners while adults are independent learners (Knowles, 1970). Andragogy can also refer to adult learning principles because adults learn differently than children do.

Figure 3 – The Model of Andragogy[1]

[1] Source: https://sites.google.com/a/nau.edu/learning-theories-etc547-spring-2011/theory/adult-learning-theory

3.2.2 Assumptions of Andragogy

There are five assumptions of Andragogy: Self-concept, past learning experiences, readiness to learn, practical reasons to learn, and internal motivation (Knowles, 1970). *Self-concept* relates to the higher developmental stage of an adult learner, as opposed to a child learner. This secure self-concept contributes to self-directed learning (Knowles, 1970). *Past learning experiences* are unique to Andragogy as adults have various life experiences in which they can learn from, whereas child learners are still in the process of acquiring new experiences (Knowles, 1970). *Readiness to learn* refers to the value of education perceived by the adult learner. Adult learners thrive when they are ready and able to focus on their learning (Knowles, 1970). *Practical reasons to learn* involves the direct applicability of the content being learned

(Knowles, 1970). Lastly, *internal motivation* describes the adult's intrinsic desire to learn; this is contrasted with children's desire to learn being external, such as a reward for obtaining good grades (Knowles, 1970). These five assumptions should be applied to educators who are teaching adult learners. (Knowles, 1970).

3.2.3 Principles of Andragogy

Based on the aforementioned assumptions of adult learners, four principles of Andragogy should be considered when teaching adult learners. These principles are the following: adults are self-directed learners, their learning should augment what they have learned in the past, the content should be practical and applicable to the learners' life, and learning should be focused on problem solving instead of memorization (Aliakbari et al., 2015).

3.2.4 Outcomes of Andragogy

There are seven outcomes of adult learning: self-understanding, acceptance of others, dynamic life attitude, reaction to causes of behavior, actualizing personal potential, valuing the human experience, and directing social change (Knowles, 1977). The outcome of self-understanding involves "understanding one's needs, motivations, interests, capacities, and goals" (Boeve, 2012, p.3). Developing an attitude of acceptance of others teaches individuals to challenge ideas while maintaining empathy to the person voicing that idea (Boeve, 2012). The goal of dynamic attitude towards life is to view each experience as a learning opportunity (Boeve, 2012), while reacting to causes of behavior that involve problem solving at the root of an issue (Boeve, 2012). The learning outcomes of actualizing personal potential is to provide the educational foundation for people to optimize their individuality, and their contributions to society (Boeve, 2012). Valuing human experience refers to shared knowledge among a group of people (Boeve, 2012), while further directing social change. This is illustrated in the following

way, “every adult should know enough about diverse aspects of social order to be intelligent, effective, and productive participants in society” (Boeve, 2012, p. 3).

3.3 Application of Andragogy to this Research Study

The theory of Andragogy was retained over the behaviourist and cognitive constructivist theories. Behaviourism is unable to capture the specific nuances of this research problem as learning in this perspective is too simplistic. This context of learning focuses on continued reward of positive behaviour in order to reach learning goals. This theory negates the influencing factors of what society deems to be ‘positive behaviour’, which does influence perspective-especially in a gendered profession. Moreover, cognitive constructivist theory also does not fit with this research study as it focuses on learning as understanding. Again, this learning theory is too simplistic and does not acknowledge the factors that contribute to the understanding of learned ‘normal behaviour’, which influences the students’ learning experience and their perception by staff nurses, patients, and family members. The humanistic learning theory, Andragogy, was retained for this research study because it acknowledges the individuality of the learner and seeks to understand the learning experience holistically.

Andragogy is applied to the research study to link the concepts of men, nursing students, and PHN because it is a learning theory. Andragogy was chosen because the students will describe their holistic learning experiences in the entirety of their PHN courses, and the data collected will be used to offer solutions for improvement of this learning experience for future students.

Male students’ gender may negatively impact their learning experiences in this clinical placement. Adult learning principles link the concepts of men and nursing students in this

scenario. Furthermore, there is a gendered aspect to learning that connects these concepts. Severiens and Ten Dam (1998) found that there are gender related differences between men and women regarding ways of knowing and learning concepts. Men and women learn differently, and show their knowledge level differently, too (Severiens & Ten Dam, 1998). Another reason that men have negative learning experiences in this practicum could come from the fact that their learning styles are different than those of the female instructors, staff nurses, and female patient population.

In addition, this study gives the participants an opportunity to share their entire learning experience in PHN; namely, through the research questions regarding their learning experiences in the theory course, through laboratory learning, simulated learning, and in the clinical context. Thus far, this is the only study that holistically addresses the entire PHN learning experience, from theory to clinical placement.

Furthermore, the principles, assumptions, and outcomes of Andragogy are similar to the Bachelor of Science in Nursing program outcomes at the University of Ottawa. Students will be: effective communicators, evolving professionals, knowledge workers, critical thinkers, and self-directed learners. An effective communicator is one who understands the complex cognitive, behavioral, and cultural factors that influence communication and uses a broad range of communication skills (University of Ottawa, 2019). An evolving professional is one who provides, facilitates, and promotes the best possible professional service and continually acquires and strive to improve professional knowledge, and accepts accountability and responsibility for actions (University of Ottawa, 2019). A knowledge worker is one who provides non-repetitive and non-routine work that entails substantial levels of cognitive ability and theoretical knowledge (University of Ottawa, 2019). A critical thinker is one who engages in an

intellectually disciplines process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and evaluation information gathered from or generated by observation, experience, reflection, reasoning, or communication, as a guide to belief or action (University of Ottawa, 2019). A self-directed learner is one who controls learning through the use of self-assessment of learning style, self-reflection, and evaluation, effective management of time, information, and resources (University of Ottawa, 2019).

Andragogy is also congruent with the student researcher's epistemological position, Pragmatism. This paradigm is well suited to social, practical, problem solving in the real world (Felizer, 2010). A detailed description of Pragmatism is offered at the beginning of the next chapter. The epistemological position of this study compliments Andragogy in that it focuses on the unique learning experiences of these students, and acknowledges the various factors that contribute to these experiences. Moreover, this research problem has practical implications in terms of nursing and patient education. Adult learning principles, assumptions, and outcomes will also be applied after the study is complete, the knowledge gained will be translated to educators, staff nurses and patients in the most conducive context to their learning because they are all adults. The implications in nursing and patient education will be revisited when the results are obtained and interpreted.

3.4 Summary of the Chapter

This chapter discussed Andragogy, the theoretical framework of this study. Different learning theories within nursing education were reviewed; along with details of Andragogy, and its applicability to the study. The next chapter will explore research methodology.

Chapter 4 – Research Methodology

This chapter presents the research methodology for this study which includes eleven subsections. In the first section, the epistemological position is presented. This is followed in the next section by the research type and design. Mixed Methods Research (MMR) design was used to address the research purpose and objectives. Then, the population, sample, and sample size are described. In the fourth section, the setting in which this study was conducted is explained. In the fifth section, sampling type and recruitment strategies are explored. The study procedures for the present study are described in the sixth section. As this is a Mixed Methods study, qualitative and quantitative data collection methods are featured in the seventh section. In the eighth section, data analysis is explained for MMR, as well as for quantitative and qualitative data. In the ninth section, criteria for rigor are explained for MMR, as well as for quantitative and qualitative data. This is followed by a section on ethical considerations. Finally, a summary of the chapter is featured at the end.

4.1 Epistemological Position

This research study is guided by the principles of applied pragmatism, which combines qualitative and quantitative data (Tran, 2016). Pragmatism is a philosophy that was founded in the early 1900s by Charles Sanders Piece. Pierce (1905) (as cited by Norwell, 2015) described pragmatism as, “a method of using scientific logic to clarify meaning of concepts or ideas though investigating their potential relationship with the real world” (Norwell, 2015, p. 143). Pragmatism falls in the middle of the post-positivist to constructivist world view spectrum; and values obtaining the type of data that suits the research problem best (Norwell, 2015). Norwell asserts that, “Pragmatists reject the traditional dualist paradigms and instead endorse eclecticism and pluralism where methodological choice is based on the need to answer a research question

rather than on a philosophical alignment" (Norwell, 2015, p.145). Because Pragmatism bridges the gap between the philosophy of the singular truth in positivism, and the philosophy of multiple realities of constructivism, this paradigm is well suited to social, practical, problem solving in the real world (Felizer, 2010). Within a nursing research context, Pragmatism allows the research to consider multiple theories, perspectives, and ideas which can be combined to create practical knowledge about clinical issues (Norwell, 2015). Furthermore, Pragmatism is a relevant world view to conduct MMR because it calls for the bridging of qualitative and quantitative methods.

Mixed methods research involves, "collecting both qualitative and quantitative data in response to research questions or hypotheses" (Creswell, 2014, p. 266). This type of research is important because it recognizes that qualitative and quantitative data provide different types of information, and that each type of data has its own strengths and limitations. Creswell (2014) argues that the use of both qualitative and quantitative data in a study yields a more thorough understanding of the research problem. Using both types of data provides stronger evidence than the use of one type alone (Creswell, 2014). At the beginning, the qualitative and quantitative data can be analyzed separately and later, integrated using cross validation and triangulation. Felizer argues that the validity, or the relationship between theory and method, is the best criterion for judging the legitimacy of a chosen research method (Felizer, 2010). There is room within Pragmatism for the researcher to acknowledge the uncertainty of the human element in research (Felizer, 2010).

Brierley (2017) asserts that the epistemological and ontological positions of MMR within Pragmatism are less emphasized than they are in in other paradigms, because Pragmatism is less restrictive about how research is conducted. More emphasis is placed on how the research study

will be conducted, instead of how to determine what knowledge is and how it is acquired. This may be partially explained by the dichotomy of epistemology and ontology and the differences held between post-positivism and constructivism. As Pragmatism falls in the middle of the spectrum (Norwell, 2015), it is the responsibility of researchers to define and determine their epistemological and ontological stances within the paradigm, while considering that methodology is the focus of this research (Brierley, 2017). The student researcher strives to create knowledge for practical reasons, and recognizes that perceptions of reality are individualized. Moreover, the student researcher also acknowledges the impact of various social, political, cultural, and historical events that have shaped an individual's reality. The student researcher sees value in obtaining data from various sources because each source of data has its own strengths and limitations, but yields a more comprehensive understanding of a research problem when these data sets are integrated through MMR.

This study collected both quantitative and qualitative data, because each type of data is unique and provides specific information to explore the research problem. The quantitative piece comes from an online questionnaire about the male nursing students' characteristics and provides them with an opportunity to rate their PHN clinical practicum learning experience numerically, whereas the qualitative piece comes from an individual, semi-structured interview guide.

As the students' learning experiences are subjective and unique, their responses were considered when developing gender inclusive initiatives at the university and hospital levels. In this study, experience is defined as "the things that have happened to someone that influence the way they think and behave" (Oxford Learner's Dictionary, 2019). The word experience often is associated with a phenomenological study. Although this is a mixed- methods study, the qualitative component shares some similarities with phenomenology as the focus of the

qualitative component of the study is experiential. Male nursing students' learning experiences in their PHN courses (theory and clinical practicum) affect their perceptions of this nursing specialty. Perception, in this case, is defined as, "An idea, belief, or image you have as a result of how you see or understand something" (Oxford Learner's Dictionary, 2019). Despite the slight syntax and philosophical differences in these terms, they may be used interchangeably throughout this research study.

4.2 Research Type and Design

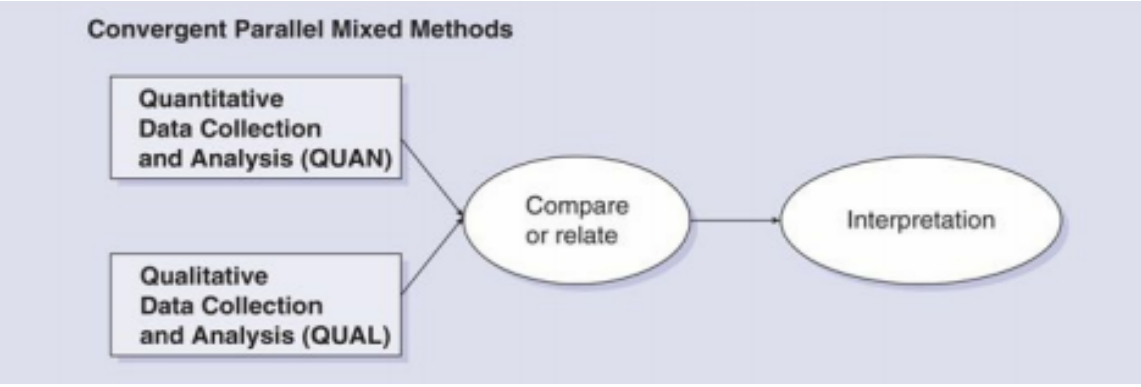
This study was conducted using a mixed methods approach. According to Creswell, MMR "involves collecting both qualitative and quantitative data in response to research questions or hypotheses" (Creswell, 2014, p. 266). This research design is important because it recognizes that qualitative and quantitative data provide different types of information, and that each type of data has its own strengths and limitations. Creswell argues that the use of both qualitative and quantitative data in a study yields a more thorough understanding of the research problem because using both types of data provide stronger evidence than the use of one type alone (Creswell, 2014).

MMR is applicable for this study because each type of data describes a different piece of this specific research problem. For example, the quantitative piece identified participants' socio-demographic characteristics as well as other data about their comfort level in the clinical placement. However, this numeric data alone would not be able to fully describe the participants' learning experiences in the PHN courses (theory and clinical practicum); hence, there is a need to include a qualitative component in order to completely capture the phenomenon under study. Conversely, the use of exclusive qualitative data is not appropriate in this situation because some factors that may influence the participants' perceptions of these courses, like their socio-

demographic characteristics, and perceived comfort levels, are more logically collected through quantitative methods. Therefore, the most relevant research design for this study is mixed methods (Creswell, 2014).

According to Creswell (2014), there are three types of MMR designs: explanatory sequential, exploratory sequential, and convergent parallel. The explanatory sequential design is more quantitatively focused: quantitative data are first collected and analyzed, then they inform the next qualitative phase of the study which is used to explain the primary, quantitative findings (Creswell, 2014). The exploratory sequential mixed methods design is essentially the opposite of the explanatory process. First, qualitative data are collected and analyzed, then the researcher builds on this data by collecting supplemental quantitative data. This research design is usually used to see if qualitative findings are generalizable to a larger population by developing research instruments (Creswell, 2014). The research design that was retained for this study is the third one, namely, the convergent parallel design (see Figure 4). This design was chosen because the data were collected from two sources: the qualitative data were collected from an online questionnaire (see Appendix 5), while the quantitative data were obtained from semi-structured interviews (see Appendix 6).

Figure 4 - Diagram of the Convergent Parallel Mixed Methods Research Design[1]



[1] Adapted from Creswell (2014, p. 270).

The data were collected in the same meeting, where the student completed the online questionnaire and subsequent semi-structured interview. Although technically the quantitative data were collected before the qualitative data, this research study still followed the convergent parallel design because it assumed that each type of data provided a different type of information that is necessary to answer the research question, and that both types of data are equally valuable. Furthermore, the student researcher was not able to analyze either data set before the next was collected. The two data sets were collected and analyzed separately, then compared and interpreted together to see if the results were similar or different throughout both data sets (Creswell, 2014).

4.3 Population, Sample and Sample Size

The population for this study involved third or fourth year nursing students registered in the undergraduate nursing program at the University of Ottawa, as well as male nurses who have recently graduated and are currently working in a Perinatal Health care setting in Ottawa. The inclusion and exclusion criteria from each subgroup will be presented next.

The inclusion criteria for *nursing students* in this study were the following:

1) Any nursing student who identifies as a male;
2) Who is registered in the undergraduate program at the School of Nursing of the University of Ottawa;
3) Who is a third-year student who is currently completing his PHN practicum in the Ottawa region, or fourth year student who previously completed his PHN practicum in the Ottawa region;
5) Is either an Anglophone or a bilingual Francophone.

The exclusion criteria for *nursing students* in this study were the following:

1) Any nursing student who does not identify as male;
2) Who has not yet completed their PHN practicum;
3) Who is enrolled in either the collaborative stream with Algonquin College or La Cite Collégiale;
4) Who is exclusively Francophone.

The inclusion criteria for *male PHN nurses* this study were the following:

1) Any nurse who identifies as a male;
2) Who has obtained CNO licensure in the past two years;
3) Has taken a perinatal health nursing clinical practicum during their nursing undergraduate education;
4) Is currently employed as a Perinatal Health Nurse;
5) Is either an Anglophone or a bilingual Francophone.

The exclusion criteria for *male PHN nurses* in this study were the following:

1) Any nurse who does not identify as male;
2) Who does not yet have CNO licensure;
3) Who is not currently employed as a Perinatal Health Nurse;
4) Who is exclusively Francophone.

The PHN courses (theory and clinical practicum) are mandatory in the third-year of the undergraduate nursing program, therefore, all students are required to complete these courses before graduation. The potential participants must have taken them in order to be part of this research study. For the clinical placement of the clinical practicum, there are usually three rotations that are part of the Winter Term, and two rotations in the Spring Term at the campus of

the University of Ottawa. A student must have completed the rotation in the PHN clinical practicum to be considered for the study.

Francophone nursing students were welcome to participate, but it is important to note that they must be bilingual because the online questionnaire and the interview were conducted in English. Participation was also open to fourth-year male nursing students because they had already completed their PHN practicum in the previous academic year. Their experiences are valuable since they would be able to share their perceptions of the practicum in PHN, and to determine if their experiences were similar or different from the third-year students. This will be described further in the next section on recruitment. Although the University of Ottawa does offer a Baccalaureate Degree in nursing in collaboration with Algonquin College and La Cité Collégiale, it is important to note that these students will not be included in this study due to a conflict of interest with the student researcher. This conflict will be elaborated on in Section 3.9 of this chapter.

Participation was also open to male nurses who are currently practicing in PHN. As outlined in the inclusion criteria, they are recent graduates and are therefore able to speak about their learning experiences in this clinical specialty. Furthermore, they are able to compare and contrast their experiences as students with their experiences as staff nurses. This may reveal a different experience related to the power dynamic differences between the role of student and staff member.

As per Creswell's guidelines for MMR (2014), the sample size depends on both the qualitative and quantitative data sets being used. A key principle for the success of this research method is that the principles of each of the qualitative and quantitative methods be implemented within the study, and should be strictly followed (Creswell, 2014). This will ensure that the

combination of both methods brings about the strengths of each to the study. Although both sets of data are necessary and of equal value in the present study, the qualitative component will be the key determinant of when data saturation is obtained (Creswell, 2014). This will be the major guiding principle for this particular study.

For the qualitative component, sample size itself may not be as important as information redundancy (Creswell, 2014). Another term for information redundancy is data saturation (Polit & Beck, 2017). Information redundancy occurs when no new information is extracted from the themes of the interviews, therefore, the data no longer contributes to the findings due to their repetition (Vasileiou, Barnett, Thorpe, & Young, 2018). Furthermore, some qualitative researchers pragmatically use information redundancy to inform their target sample size as the study is underway. This is justified according to qualitative research traditions because the findings are rigorous when in-depth information is obtained. This requires fewer participants than quantitative research, and may occur before all of the participants are interviewed (Vasileiou et al., 2018). According to Creswell (2014), approximately four to ten interview participants are required to attain data saturation. Other authors (Francis, Johnston, Robertson, Glidewell et al., 2010; Guest, Bunce, & Johnston, 2006) suggest that between six and twelve interview participants are required to attain about 97% data saturation.

Thus, approximatively 100 to 120 students are registered in the third-year of the Anglophone nursing program, of which 10 to 12 of them are male nursing students, as per the University of Ottawa Registrar's Office. For the third-year Francophone undergraduate program, there are about 75 to 85 students, of which six to ten are male nursing students. These enrollment statistics are also similar for the English and French fourth year courses. Permission to release the number of enrolled students has been obtained by Dr. Forgeron, Director of the School of

Nursing. There are currently two male nurses who are employed in a PHN setting in Ottawa, furthermore, they are employed in a venue where students can complete their PHN clinical placement. Thus, there is a sufficient number of potential male nursing students, and staff nurses, to attain the target sample size for this study of 10 to 12 participants.

Due to the COVID-19 pandemic that had started in March 2020 in Ottawa, recruitment was stopped before the target sample was obtained. Nine participants, instead of the targeted ten to twelve, were recruited to participate in this study. All of the participants who had been recruited completed both the online questionnaire and the interview.

4.4 Setting

This study took place at the School of Nursing of the University of Ottawa. The undergraduate nursing program is completed full-time in four years. Most students enter the program directly from high school, but the University also offers a second entry program where students come from different backgrounds, particularly from the sciences.

In the third year of the program, students complete the PHN theory course and the corresponding clinical practicum, along with other theory courses and practica in pediatrics, medicine, surgery, and mental health. In the fourth year, students complete another medicine or surgery practicum, a community health placement, and a consolidation final placement of their choice.

Students can complete their PHN clinical placement at four locations in the Ottawa area: The Ottawa Hospital-General Campus, The Ottawa Hospital-Civic Campus, the Queensway Carleton Hospital, and Montfort Hospital. These are the major secondary and tertiary care hospitals in the Ottawa area and most births occur in these settings. One of these hospitals also

employs male PHN staff nurses. Students complete their PHN practicum on the mother-baby units, or the combined LDRP (labor, delivery, recovery and postpartum) units of these hospitals.

4.5 Sampling Type and Recruitment

Once ethics approval was obtained from the Research Ethics Board (REB) of the University of Ottawa, different methods were utilized to recruit the participants. There are two major types of sampling: probability and non-probability. Probability sampling is defined as, "the selection of participants from a population using random procedures" (Polit & Beck, 2017, p. 740). Whereas, non-probability sampling is defined as, "the selection of participants from a population using purposeful procedures" (Polit & Beck, 2017, p. 736). Non-probability sampling was retained for this study because the student researcher purposefully recruited students who met the inclusion criteria for this study.

Polit and Beck (2017) identify four types of nonprobability sampling: convenient, snowball, quota, and purposive or judgmental. The two types associated with non-probability sampling that were utilized and retained for the study were convenience sampling and snowball sampling (Polit & Beck, 2017). Convenience sampling is defined as "the selection of the most readily available persons as participants in a study" (Polit & Beck, 2017, p. 724). An example of convenience sampling would be to advertise the study directly to the target population, have potential volunteers identify themselves, and then participate in the study. This strategy was appropriate in this situation because the study was advertised in the PHN classes where attendance was mandatory, men self-identified as recruits based on the inclusion criteria, and therefore chose to participate.

Snowball sampling is slightly different because, "participants refer other people to the study" (Polit & Beck, 2017, p. 492). This sampling strategy is akin to a chain reaction. This was

also appropriate for recruiting participants because as discussed in Chapter Two, men are a visible gender minority in nursing and have developed a sense of comradery amongst themselves. Students referred other students who fit the inclusion criteria to the study. This sampling method was also particularity useful in recruiting the two staff perinatal health male nurses, as they were referred to the study by students who were paired with them in their clinical placement. These nurses reached out to the student researcher and inquired about participating in the study to share their experiences. An ethics addendum to the University of Ottawa REB was initiated by completing the form, 'Request for REB Approval of Modification to research Project'. A new ethics approval was obtained for this change to the research study, as these nurses had been recruited outside of their work environment.

In total, six participants were recruited through convenience sampling, and three were recruited through snowball sampling.

As the PHN courses are mandatory in the undergraduate nursing curriculum at the School of Nursing of the University of Ottawa, the student researcher needed to obtain permission from the School of Nursing to conduct this study. An email was sent to the Director of the School of Nursing to obtain this permission (see Appendix 7). Once this permission was obtained, she then approached the Anglophone professor responsible for the theory course and the Anglophone and Francophone clinical instructors responsible for the laboratory courses (see Appendix 8). The Francophone professor (Dr. Polomeno) responsible for the theory course could not be approached as she is the student researcher's thesis supervisor. She then introduced herself during a third-year PHN theory lecture for the Anglophone stream, and in a PHN laboratory session in the Francophone stream. For the fourth-year class, the student researcher approached the Anglophone and Francophone professors of the politics course in order to increase visibility

and recruit fourth-year students (see Appendix 8). The student researcher described the purpose of the study, the inclusion criteria for participation, how data were to be collected, the length of the online questionnaire and the interview, and how the results of the study would help to improve students' learning experiences in PHN at the University of Ottawa. A flyer that summarizes this information was distributed to the students during the introduction (see Appendix 9).

After this introduction, any student who was interested in participating contacted her via her @uottawa.ca email which was found at the end of the flyer. Social media were used as a means to recruit participants who meet the eligibility criteria. There are Facebook and Instagram student groups for every nursing year within the undergraduate nursing program: information about the study were posted there for the third and for the fourth-year students (see Appendix 9). The posting was also uploaded on the intranet sites as part of the virtual campus (Brightspace) for the Anglophone PHN theory course and the Anglophone and Francophone laboratory courses with the permission of the professor and the clinical instructors teaching these courses (see Appendix 8). The same flyer (see Appendix 9) that was used for the distribution in class and in the laboratory was posted on Facebook and on the virtual campus. Social media have been proven to be an effective strategy for recruiting young adults in research as they are so widely used in day to day life in this population (Gelinas et al., 2018) Once the male nursing students were recruited, they proceeded to the next phase involving informed consent (this will be further described in Section 4.6-Study Procedures).

4.6 Study Procedures

Once the participant accepted to participate in the study, he reached out to the student researcher to book a mutually acceptable date to complete the questionnaire and interview. This

meeting took place in two ways: a) in a private room (work room) at the Health Sciences Library at Roger Guindon Hall of the Health Campus at the University of Ottawa, or b) online though Zoom meetings to respect physical distancing after the COVID-19 pandemic was announced. The student researcher reviewed the consent forms with the student before ensuring that they were signed in the next phase. The participant then completed the online questionnaire on the laptop provided by the student researcher. Following the completion of the questionnaire, the interview began. The student researcher asked a variety of open ended questions in order to allow the participant to answer them. Light refreshments were provided by the student researcher during the interview. The student researcher clarified the meaning of statements made by participants, as needed throughout the interview. After the interview, the participant was thanked and compensation was given in the form of a $20 Amazon gift card. A list of psychological resources was also provided to the participant, in case sharing their experiences caused more emotional distress than anticipated. This will be further explored in section 4.9 of this chapter. The next section describes the details of data collection.

4.7 Data Collection Methods

As this is a MMR study, both qualitative and quantitative data were gathered. This section presents the online questionnaire that was first used to gather the quantitative data, while the interview guide was used next to collect the qualitative data. As per the Convergent Parallel Mixed Methods Research Design, both types of data were collected and analyzed separately because they pertain to the same construct of gender (Creswell, 2014).

4.7.1 Quantitative Data

The quantitative piece of this study included a four-part online questionnaire (see Appendix 5) that took approximately ten to fifteen minutes to complete and was done after the

students had terminated their PHN clinical practicum. The questionnaire was completed during the meeting with the student researcher, after the consent was signed.

The first part of the online questionnaire collected information about the participants' socio-demographic, educational, relational and sexual characteristics. This included thirteen questions pertaining to the participants' age, level of nursing program completing, reason for choosing nursing as a profession, post-secondary education experience, whether they have completed graduate studies, marital status, parental status, sexual orientation, and gender. These characteristics were chosen because they may impact the participants' overall experience in the PHN practicum. The questions in this part of the online questionnaire were mostly close-ended, selection type questions, such as: 'What year in nursing school are you currently enrolled in?' A possible answer would be: third year, fourth year, or already graduated. The only two open ended questions were in relation to the following: age, and the ages of their children, if they had any.

In the second part of the online questionnaire, participants completed *The Nursing Student's Satisfaction with their Clinical Placement Evaluation Form*. This questionnaire, which was developed by Penman and Oliver in 2004, measures the factors influencing positive learning experiences in clinical placements for nursing students as well as their overall competency and comfort level. The instrument had been developed by Penman and Oliver, both at the University of South Australia, based on a literature review. It was then sent to stakeholders in 15 health services and agencies across rural South Australia. Following feedback from these 15 stakeholders who were considered as experts in the field of clinical teaching, iterations were made and the final twelve-item instrument was constructed and trialled in 2002. This is the only reported validation in regard to this instrument. This research instrument was also used by

Abouelfettoh and Mumtin in 2015, however, they did not report any data as to its psychometric qualities.

Permission was obtained from these authors to use their research instrument (Appendix 15). The tool has twelve items which are rated on a 5-point, Likert-type scale with responses ranging from strongly disagree (1) to strongly agree (5). An example of some items are: staff members' willingness to assist student learning, confidence in this clinical area, and the presence of many learning opportunities. The total score was obtained by calculating the mean for each item in the tool. The score was interpreted by looking at the average response for each question, and comparing the numeric value average response to its predetermined value on the Likert-type scale, with the response of 1, meaning that the students strongly disagreed with a particular statement, and with a response of 5, meaning that they strongly agreed with a particular statement. There are no subscales in this tool, thus it is a uni-dimensional scale.

The third part pertained to more specific aspects of the PHN courses (theory and clinical practicum). There were 24 questions in relation to specific components of the perinatal health nursing practicum, such as which hospital their clinical rotation took place in, their level of preparedness in the laboratory, simulation activities, and in the clinical placement, and what aspects the participants are the most and the least comfortable with in the clinical placement. The questions are either multiple-choice type, such as what parts of the laboratory, the simulation, and the clinical placement are the most helpful, or Likert type scale questions, for example, 'On a scale of 1-10 (1=being not prepared at all, and 10=being very well prepared), how much did that laboratory learning prepare you for clinical placement?'

The fourth and last part had one open-ended question which invited the male nursing student to provide additional comments.

This online questionnaire was piloted for both face and content validities before final implementation. Face validity is an assessment criterion that is defined as when a tool "intuitively looks as though it should measure what it purports to" (Rozeboom, 1966, p. 3). Content validity is defined as "the degree to which elements of an assessment instruments are relevant to and representative of the targeted construct for a particular assessment purpose" (Haynes & Richard, 1995, p. 238). The face and content validities were obtained from the thesis supervisor and from a registered nurse (see Appendix 12); no major changes were necessary as the online questionnaire was assessed to be pertinent and adequate. Next, the questionnaire was pre-tested with two male nurses who met the inclusion criteria of this study. Each nurse completed an assessment form (see Appendix 13) to obtain information on the length of time it took them to complete it, if the instructions to complete it were clear, if the items were clear and comprehensible, and for the overall presentation. The data gathered by these nurses were not included in the analysis of the other participants' data. Changes to the online questionnaire were made based on the feedback provided by them, such as, by including an open ended question about previously obtained education instead of having the question formatted as 'select all that apply'. Once the pre-test was completed and the suggested changes were made, the revised and final version was implemented for data collection.

4.7.2 Qualitative Data

After the online questionnaire was completed, the nine participants were then interviewed individually, using a semi-structured interview guide (see Appendix 6) that consisted of 26 open-ended questions divided into five parts. A semi-structured interview is an "interview in which the researcher has a list of topics to cover rather than specific questions to ask" (Polit and Beck, 2017, p. 744). Interviews lasted approximately one hour in length, was audio recorded, and took

place in a private room at the Health Science Campus of the University of Ottawa, or online through a Zoom meeting. The interview guide remained the same for the interviews with the nurses who have already graduated, with the addition of questions comparing their experiences as students to their experiences as staff.

In the first part of the interview guide, which had six questions, explored how the undergraduate nursing program was going so far, the gender distribution of the class, and general comments about the program. The second part containing five questions focused on the PHN course, the laboratory, and the simulation activities. Students had an opportunity to discuss the learning environments, their perspective as men, and any pre-conceived ideas about this clinical specialty. The third part containing nine questions focused exclusively on their experiences in their clinical practicum, like the facilitators and barriers to their experiences, and whether this is an area in which they would consider working later. The fourth part, which had four questions, featured the students' suggestions or recommendations about the program, the perinatal health nursing courses, and the clinical component. The last part which had two questions gave participants an opportunity to provide additional comments and to reflect on their feelings about participating in this study. If needed, some probing questions were used to re-direct conversation.

Similar to the quantitative piece of this study, the interview guide's face and content validities were assessed before final implementation. Face and content validities were obtained from the assessment from (see Appendix 14) and were conducted by the thesis supervisor and a registered nurse (the same as for the online questionnaire). No major changes were necessary. Following, the interview guide was pre-tested with the same two male nurses that the questionnaire was pretested with. Each nurse completed an assessment form (see Appendix 13) to obtain information on the length of time it took for the interview, if the introduction was clear,

if the questions were clear and comprehensible, and the overall flow of the questions. The data obtained from the pre-test from the two nurses were not included in the final data from the sample of nine participants. However, it is important to note that themes were shared between the pre-test and actual participants. Specifically, gender-based discrimination still occurs in PHN, and that having a supportive clinical instructor is very important. The results from the pre-test indicated that the content of the interview guide was acceptable, however, minor spelling errors were made to improve the clarity of the questions. Once the pre-test was completed and the suggested changes were made, the revised and final version was implemented for data collection.

4.8 Data Analysis

As this is a MMR study, both qualitative and quantitative data were analyzed. This section will present the strategies for Mixed Methods data analysis, quantitative data analysis, and qualitative data analysis.

4.8.1 Data Analysis in Mixed Methods Research

Side by side data analysis was used to compare both the quantitative and qualitative data (Creswell, 2014, p. 273). Both sets of data were collected and analyzed separately, before they were analyzed together through the comparison of the results. As per Creswell's Convergent Parallel Mixed Methods Research Design, "the quantitative, statistical data will be presented first, then qualitative, thematic data will be discussed, which will either confirm or disconfirm the statistical results" (Creswell, 2014, p. 273). In order to prevent bias and to let the data speak for themselves in the convergent validation of the results, several meetings were carried out between the student research and thesis supervisor to review the results and triangulation process, and to compare and agree on interpretations (Fielding, 2012). This triangulation process also increased the study's rigor.

4.8.2 Quantitative Data Analysis

There are two types of quantitative data analysis. The first type of quantitative data analysis was the application of descriptive statistics for the first, third, and fourth parts of the online questionnaire (Polit & Beck, 2017). Descriptive statistics are used to describe and summarize data (Polit & Beck, 2017). The types of descriptive statistics that were used were focused on measures of the central tendency: mean, median, mode, standard deviation, range and frequency. The second part of the online questionnaire pertains to *The Nursing Student's Satisfaction with their Clinical Placement Evaluation Form* that was developed by Penman and Oliver is 2004. For this, the same descriptive statistics were used: mean, median, mode, standard deviation, and frequency. These types of statistics were applied to the items of this research instrument in order to assess the number of people who answered a particular item, where the average responses were obtained for each item, and to assess how much the answers varied throughout the sample. Measures of central tendency are appropriate descriptive statistics to report, given that the level of data is ratio, and that the sample size for this study is small (Polit & Beck, 2017). For the significance testing of pre and post comfort levels in relation to the participants during their PHN clinical placement, a non-parametric test –the Wilcoxon Signed Ranks test, was used, because the sample size did not meet the assumptions to conduct a t-test (Polit & Beck, 2017). SPSS version 24 was used to analyze this type of data.

Other potential quantitative analyses could have been included, such as differences in comfort levels between the third-year, the fourth-year and the male perinatal health nurse participants, as well as differences in comfort levels related to age, sexuality, and having children. These subsequent analyses were not conducted because they focus more on factors

contributing to the PHN learning experiences, rather than the learning experiences themselves; which is the focus of this research study.

4.8.3 Qualitative Data Analysis

Creswell (2014) provides some guidelines on how to analyze qualitative data, however, these guidelines are very scant and superficial. In order to compensate for this, a more detailed method has to be identified and applied. The qualitative content analysis approach as developed by Elo and Kyngäs method (2008) was chosen for this purpose. There are two approaches for qualitative content analysis: inductive and deductive. Inductive analysis, "moves from more specific to the general, so that particular instances are observed and then combined into a larger whole or general statement" (Elo & Kyngäs, 2008, p.109), whereas deductive analysis is, "used when the structure of analysis is operationalized on the basis of previous knowledge and the purpose of the study is theory testing" (Elo & Kyngäs, 2008, p.109). Inductive analysis is retained for this study because the individual experiences of the students are combined into a generalizable phenomenon. This approach was used both within and between interviews (Vaismoradi et al., 2013).

There are three phases to inductive qualitative content analysis. The first phase is preparation, where units of analysis are selected. Units of analysis can be themes, words, or sentences. Then, the researcher immerses himself or herself in the data in order to make sense of the data as a whole. Next, the data are organized though open coding, where themes are coded on the transcript itself. Following, categories of similar codes are created, and data are abstracted by formulating a general description of the categories (Elo & Kyngäs, 2007).

4.9 Criteria for Methodological Rigor

This section presents the criteria for methodological rigor in three ways. First, the criteria for rigor are explained in the context of mixed methods research. This will be followed by an explanation for the criteria for rigor in the context of quantitative research followed by those in the context of qualitative research.

4.9.1 Criteria for Methodological Rigor for Mixed Methods Studies

This study used the GRAMMS guideline (Good Reporting of a Mixed Methods Study) to determine its Mixed Methods rigor (O'Cathain, Murphy & Nicholl, 2008, p. 97). The GRAMMS guideline is a six-step tool to appraise the quality of a Mixed Methods study. The first criterion is that the study, "describes the justification for using a Mixed Methods approach for the research question" (O'Cathain, Murphy & Nicholl, 2008, p. 97). This study justifies using a Mixed Methods approach because the research questions cannot be adequately answered if only a qualitative or quantitative design was used. Secondly, the study should, "describe the design in terms of purpose, priority and sequence of methods" (O'Cathain, Murphy & Nicholl, 2008, p. 97). In this study, the Convergent Parallel Mixed Methods Research Design is justified because both the qualitative and quantitative pieces are of equal value, and they will be collected immediately one after another, but during the same meeting with the participant. Third, the study should, "describe each method in terms of sampling, data collection and analysis" (O'Cathain, Murphy & Nicholl, 2008, p. 97), these criteria were described in detail in the previous sections of this chapter. Fourth, the study should, "describe where integration has occurred, how it has occurred, and who has participated in it" (O'Cathain, Murphy & Nicholl, 2008, p. 97). As previously mentioned, the qualitative and quantitative pieces were collected and analyzed separately, before comparing the results of each one. Next, the study should, "describe any limitation of one method associated with the presence of another method" (O'Cathain, Murphy

& Nicholl, 2008, p. 97). Both the quantitative and qualitative data obtained complimented each other in order to more holistically understand the research problem, therefore there was no limitation associated with the presence of another method. Lastly, the study should, "describe any insight gained with mixing or integrating methods" (O'Cathain, Murphy & Nicholl, 2008, p. 97). This criterion was presented in the first section of this chapter; both types of data provide answers to different pieces of the research problem, and the use of both types of data are stronger than one type alone. This study meets all of the GRAMMS guidelines, and is therefore a rigorous, mixed methods study.

4.9.2 Criteria for Rigor for Quantitative Component

As per Brown and colleagues (Brown, Elliott, Leatherdale & Robertson-Wilson, 2015), there are four criteria for determining rigor in quantitative studies: validity, reliability, replicability, and generalizability. *Validity* is defined as, "the degree to which an instrument is measuring the construct its purports to measure" (Polit & Beck, 2017, p. 309). This is illustrated in this research study by ensuring that the face and content validities were obtained for the online questionnaire. *Reliability* is, "the extent to which scores for people who have not changed are the same for repeated measurements in several situations" (Polit & Beck, 2017, p. 303). This is demonstrated in the study by the participants completing the second part of the online questionnaire which includes *The Nursing Student's Satisfaction with their Clinical Placement Evaluation Form* (Penner and Oliver, 2004). The participants scored this part the same way. However, this criterion is not applicable for the other three parts of the online questionnaire as the answers are individualized. *Replicability* (Polit & Beck, 2017) is the ability to repeat the study in a different environment and obtain the same quantitative results. Since this study is being completed through a Pragmatic paradigm, it is questionable as to whether this rigor

criterion can truly be met because society is fluid and one participant's experiences may be different from another's in a different time, place, culture, or environment. However, since the same online questionnaire was applied to all participants, this will be one way to partially meet this criterion. Lastly, *generalizability* is, "the degree to which the research methods justify the inference that the findings are true for a boarder group than the study participants; usually the inference is that the findings can be generalized from the sample to the population" (Polit & Beck, 2017, p. 730). Again, due to the pragmatic nature of this study, this rigor criterion may only be partially met. The target sample in this study is 10 to 12 participants, which is small, yet the number for the sample size does meet the guidelines as established in Section 4.2. However, due to the pandemic, nine participants were part of the final sample.

If the target number is obtained, then generalizability can be obtained only for the male nursing students of the University of Ottawa. On the other hand, it is arguable as to whether or not the experiences of students in Ottawa are comparable to those in other nursing programs in Ontario, the rest of Canada and elsewhere, as cultures and societal norms may vary. As mentioned in Chapter Two, men reporting feeling out of place and the lack of recruitment of men in PHN are a local, provincial, national and global phenomenon; so although it is likely that this study's findings can be generalizable, it cannot be verified without another subsequent study.

4.9.3 Criteria for Rigor for Qualitative Component

The rigor for the qualitative component of this study are determined by Lincoln and Guba's (1985) four criteria: credibility, dependability, confirmability and transferability.

Credibility is referred to as confidence in the truth of data and the interpretations of them. It can be assured by verifying the findings with the participants, and having them confirm their quotations and the researcher's interpretation of meaning before publication (Lincoln & Guba,

1985). This was completed by sending the students transcripts of the interviews and confirming the researcher's interpretation of their quotations throughout the interview.

Dependability is the stability of data over time and conditions. The data patterns proved to be consistent if replicated in similar conditions by implementing an audit trail during the research process (Lincoln & Guba, 1985). An audit trail is defined as "the systematic documentation of material that allows an independent auditor of a qualitative study to draw conclusions about trustworthiness" (Polit & Beck, 2017, p. 720). This was met by including the search strategy that informed the literature review, as well as the similar findings across previous studies that were retained from the literature.

The third criterion is *confirmability*, namely, that the data accurately represent the information that participants provided, and that interpretations are not driven by the researcher's bias (Lincoln & Guba, 1985). This was achieved again through validation in the interpretation from the research participants, through 'blind interpretation' by the thesis supervisor, as well as the student researcher reflecting on her own values and beliefs. This was done through keeping a reflective journal to self-identify biases and confirming the meaning of the quotations from the study participants.

The last criterion of *transferability* means that the findings can be applied in other settings, such as a similar group or practice setting (Lincoln & Guba, 1985). This was achieved through the use of direct quotations from the participants in this research study.

4.10 Ethical Considerations

This section will present the ethical considerations for this research study. Firstly, the context for these considerations will be explained. This will be followed by a detailed explanation of the ethical considerations for this research study.

4.10.1 Context for the Ethical Considerations

The student researcher acknowledges one potential conflict of interest or potential power imbalance in this study. A potential conflict of interest is that the student researcher is also casually employed on one of the mother-baby units where students complete their clinical placement in one of the Ottawa hospitals. This conflict was avoided by her requesting not to take the University of Ottawa male students as buddies on clinical days until data collection was completed. This aspect was discussed with an ethics officer of the Research and Ethics Board of the University of Ottawa.

4.10.2 Description of Ethical Considerations

The aspects to be considered in this section are the following: the vulnerability of the participants, and how ethics are considered throughout the research study.

This study may make participants feel vulnerable because they are sharing potentially negative experiences. In this context, vulnerability can be defined as, "the human potential to experience psychological harm, spiritual threat, and moral distress" (Tomm-Bonde, 2012, p. 3). Although participants may experience some vulnerability, it is not expected to cause extreme distress or discomfort. All participants received a list of free psychological resources (Appendix 11) that are available in the Ottawa area, should they need them. This document was attached to the participants' copy of their consent form.

The following ethical principles have been put in place in order for the participants to feel less vulnerable, decrease their discomfort, and protect their confidentiality, while participating in this present research study. Before starting recruitment, ethics approval was obtained from the Research and Ethics Board of the University of Ottawa (Certificate No. H-09-19-4947, see Appendix 18). The Director of the School of Nursing was first approached to seek her

permission to conduct this study (see Appendix 7). Once this was obtained, then the Anglophone professor and the Anglophone and Francophone clinical professors (see Appendix 8) were approached so that the student researcher could meet with the students and present her research study. A poster (see Appendix 9) was distributed to the students as well as an email (see Appendix 10) giving more details about the study. After a male nursing student or staff nurse chose to participate, he read and signed the consent form (see Appendix 11). By signing the consent form, the participant agreed to participate in both the online questionnaire and the interview. The content of the consent form included the following: voluntary participation, the purpose of the study, benefits and risk of participation, and how the data will be protected. Once the online questionnaire was complete, the participant was interviewed. Confidentiality and anonymity were maintained throughout the research study in the following way: the participant's personal information was not included, instead, he was identified by a unique numerical code. This same code was applied for the online questionnaire, the recording of the interview, the transcription of the interview, and the consent forms. All electronic data were stored on a password protected, encrypted computer and a USB stick that only the student researcher and research supervisor had access to. Paper data were kept in a locked cabinet in the office of the thesis supervisor at the University of Ottawa. The data will be kept for five years (starting on September 1, 2019 and terminating on September 1, 2024), and will then be destroyed according to the procedures at the University of Ottawa.

4.11 Summary of the Chapter

This chapter presented the research methodology of the present study. The epistemological position of Pragmatism was first presented. Then, MMR and its tie to Pragmatism were explored. This was followed by an explanation of the population, sample, and

sample size. This was followed by the sections on the setting, the sampling strategy, and the recruitment procedures. The study procedures were then described. How the data were collected and analyzed was then explained, for the context for MMR and for the quantitative and the qualitative data. The rigor criteria for mixed methods research, along with quantitative and qualitative data, were presented. Lastly, the ethical considerations for this research study were discussed. The next chapter presents the results of this study.

Chapter 5 – Results

This chapter presents the results of this research study. There are seven subsections to this chapter. In the first section, the profile of the study participants is presented. In the following four sections, the results of the study's four research questions are explored: the meaning of the PHN practicum for male students, the facilitators to their learning experiences, the barriers to them, and the solutions to improve the PHN clinical practicum (globally, the laboratory, the simulations, and the clinical placement). The sixth section highlights the participants' perceptions with regard to engaging in this study. The last section presents the summary of this chapter.

5.1 Participants' Profile

This section describes the participants' profile. There are two subsections: one which describes the profile of the participants' in the present study, followed by a comparison of the participants' profile in this study and those from the retained literature.

5.1.1 Participants' Profile of the Present Study

There were nine participants in this study (see Table 4). The socio-demographic, parenting and sexual characteristics are presented here. The mean age of the sample population is 23 years old (*SD*=3.5). The youngest participant is 20 years old, and the eldest participants are 29 years old. Regarding marital status, four of the participants (44%) are single, one (11%) is married, and the other four (44%) are in a relationship. The data on ethnicity were not explicitly posed in either the online questionnaire or the interview guide; rather, each of these participants noted how their ethnicity and culture impacted their perception of the PHN practicum. One participant is of African descent, one is Middle-Eastern, and one is Asian; the rest of the sample is Caucasian. Regarding parenting, only one participant (11%) has a child under the age of 12

Table 4: Summary of Participants' Profile

Characteristics	Frequencies (n / %) N=9	Average
Age (years)		
Average		23
Standard deviation		3.5
Age range		20-29
Marital Status		
Single	4/9 (44%)	
Married	1/9 (11%)	
In a relationship	4/9 (44%)	
Ethnicity		
African-Canadian	1/9 (11%)	
Middle Eastern	1/9 (11%)	
Asian	1/9 (11%)	
Caucasian	6/9 (67%)	
Parental Status		
Has one child	1/9 (11%)	
Does not have children	8/9 (89%)	
Gender		
Male	9/9 (100%)	
Sexual Orientation		
Homosexual	3/9 (33%)	
Heterosexual	6/9 (67%)	
Language Stream		
French stream	2/9 (22%)	
English stream	7/9 (78%)	
Program Level		
Already graduated PHN nurses	2/9 (22%)	
Fourth-year students	5/9 (56%)	
Third-year students	2/9 (22%)	

Post-Secondary Education Experience		
First post-secondary education experience	8/9 (89%)	
Previously obtained a graduate certificate in project management	1/9 (11%)	
Rationale for Choosing Nursing as their Profession		
See it as a meaningful career	4/9 (44%)	
Want to help people	3/9 (33%)	
Were encouraged by someone in their social network	2/9 (22%)	
PHN Hospital Placement Location		
Queensway Carleton Hospital	1/9 (11%)	
The Ottawa Hospital –General Campus	6/9 (67%)	
Montfort Hospital	2/9 (22%)	

months. All of the participants identify as male. Regarding sexual orientation, three (33%) of the participants identify as homosexual, while the rest are heterosexual (67%).

This section presents the education characteristics: in which language stream the participants are, level of program completion, post-secondary education, and clinical PHN placement venue. Two of the participants (22%) were in the Francophone stream, while the rest were in the Anglophone program (78%). In regard to the level of the program completion, two of the participants (22%) had already graduated and are now PHN nurses, two (22%) were in the third-year of the program, while the other five (56%) were in the fourth-year. For the two PHN nurses, one is currently employed in the birthing unit of a regional Ottawa hospital, while the other works on the mother-baby unit of the same hospital. For eight of the participants (89%), this was their first post-secondary education; the ninth one (11%) had a bachelor's degree in

human kinetics and a graduate certificate in project management. For the PHN clinical placement venue, six of the participants did it at The Ottawa Hospital (67%), two (22%) at Montfort Hospital, and the last one (11%) at the Queensway-Carleton Hospital.

Lastly, the participants shared their reasons for choosing to study nursing: four of them (44%) considered nursing as a meaningful career, three others (33%) wanted to help people, and the last two (22%) were encouraged by their social network.

5.1.2 Comparison of Participants' Profile of this Study to Those from the Retained Literature

The average age of the sample in the present study is similar to the ages of the samples in the eight retained empirical evidence studies (Balakrishnan, Sheoran, & Bishnoi, 2013; Bartfay & Bartfay, 2017; Eswi & El Sayed, 2011; Ha, Kim, Choi & Ahn, 2015; Mitra, Philips &Wachs, 2018; Patterson & Morin, 1999; Powers, Heron, Sheeler & Sain, 2018; Sherrod, 1991) (see Table 5). Most of the participants in the present study are of Caucasian ethnicity as compared to those reported in three studies, the gender is mostly male (for seven of the eight studies), the majority of them are single (in four studies only), English was the language of training for five of the eight studies, and all participants had a clinical placement in PHN (n=8). In regards to the level of training, in the present study, seven of the nine participants were in their third or fourth year of the undergraduate program at the University of Ottawa; six samples in the retained studies had been recruited while still in their undergraduate program but post-PHN clinical placement, while in two others, the participants had been recruited either in their last year of undergraduate studies and/or immediately after graduation. In terms of post-graduate education, only one participant in the present sample had this characteristic; however, only one study reported on this characteristic, where a part of that sample either had a previous degree or were planning on

Table 5: Comparison of Current Sample with Samples from 8 Retained Empirical Evidence Studies

	Present study	**Balakrishnan et al.. 2013**	**Bartfay et al. 2017**	**Eswi et al. 2011**	**Ha et al. 2015**	**Mitra et al. 2018**	**Patterson et al. 2002**	**Powers et al. 2018**	**Sherrod 1991**
Age	23	20-25 (96.7%)	24.6	21.7	23-27	N/A	22-46	20-40 years, 55% between 20-29	23.83 years (23.8 Female, 22.9 Male)
Marital status	44% single 11% married 44% in relationship	N/A	N/A	100% single	100% single	N/A	4/12 married 4/12 single	N/A	67% single
Ethnicity	11% African 11% Middle Eastern 11% Asian 67% Caucasian	N/A	N/A	N/A	N/A	N/A	7/12 White 1/12 Black	73% White	89% White
Parental status	89% do not have children 11%-1 child	N/A	N/A	N/A	N/A	N/A	4/12 has 1-4 children	N/A	N/A
Gender	Male	Male	Male	Male	Male	Male	Male	Male	Male and Female
Sexual orientat-ion	67% Heterosexual	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	33% Homosexual								
Language stream	78% English 22% French	N/A	English	Arabic	Vietnamese	English	English	English	English
Program Level	22% PHN nurses 56% 4th year BSCN students 22% 3rd year BSCN students	17 final year BSCN program 13 already completed BSCN program	All 4 years of BSCN program represented. Study completed post-PHN program	N/A- study completed post-PHN placement	N/A- study completed post-PHN placement	N/A- study completed post-PHN placement	N/A- study completed post PHN placement	All participants graduated BSCN program	N/A- study completed post PHN placement
Post-secondary education	89% first post-secondary 11% graduate certificate project management	N/A other than BSCN education	N/A other than BSCN education	N/A	N/A other than nursing education	N/A other than nursing education	N/A other than BSCN education	36% had previous degree 75% enrolled or planned to enroll in grad school in nursing	N/A
Reasons for choosing nursing	44% meaningful career 33% help people	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	22% encouraged by network								
PHN Placement	TOH General – 67% Monfort- 33% QCH- 11%	PHN	PHN	PHN	PHN	PHN	PHN	PHN	PHN

enrolling in graduate nursing studies. With regards to parental status, only one participant in the present study was a parent; only one of the eight retained studies reported on this characteristic, namely, that four of the 12 participants in that study had from one to four children.

The sample in the present study presented data on two characteristics that had not been reported in the eight retained empirical evidence studies: reasons for choosing nursing and sexual orientation. None of the eight retained studies reported the reasons why their participants choose to go into nursing, yet in the present one, the participants expressed how nursing was a meaningful career, they wanted to help people, and were encouraged by their social network (see Section 4.1.1). Also, in regard to sexual orientation, none of the retained studies reported on this characteristic, whereas in the present study, two-thirds of the participants identified as heterosexual while the other third identified as homosexual.

5.2 Participants' Perceptions of PHN Theory Course and Clinical Practicum

This section presents the results to the first research questions, "What is the meaning of the PHN courses (theory and clinical practicum) for male nursing students?" The results that are presented here are considered in terms of the overall undergraduate nursing program, the PHN theory course, the clinical practicum globally, and then more specifically, the three components of the clinical practicum: the laboratory, the simulation, and the clinical placement in the Ottawa hospitals.

5.2.1 Participants' Overall Perceptions of the Undergraduate Nursing Program

The first aspect to be considered in regard to the first research question is the participants' overall perception of the undergraduate nursing program. The qualitative results presented here were obtained from Questions 1 to 6 of the interview guide (see Table 6). No quantitative data were obtained to answer this research question.

Table 6: Summary of Qualitative Results to Interview Guide

Categories	Subcategories
Meaning of the Perinatal Health (PHN) practicum for male nursing students	Undergraduate program PHN theory course PHN practicum PHN laboratory PHN simulation PHN clinical placement
Facilitators to male nursing students' PHN clinical practicum	Clinical instructor Nursing staff Patients and their family members Two male nurses working in PHN Comradery of other students
Barriers to male nursing students' PHN clinical practicum	Nursing staff Female patients Specific situations deemed as 'awkward' Strategies used to deal with these barriers
Solutions and recommendations suggested by male nursing students to improve PHN practicum	PHN clinical practicum PHN laboratory PHN simulations PHN clinical placement

The nine participants' overall perceptions of the undergraduate nursing program (Question 1 of the Interview Guide) were positive, neutral, and negative. Six of the nine participants (67%) expressed that the nursing program went well for them. They shared how this

was partly due to the quality of the instructors and to that of the course content, specifically in the first-year science courses. However, the other three participants (33%) did voice some constructive critiques; two of them had neutral perceptions while the other had a negative one. For example, two participants described feeling overwhelmed and scared, especially in the transition to the clinical setting, as well as finding that the curriculum had overly-strict rules and less clear or consistent communication. One participant suggested having truly frontloaded theory classes before even starting laboratories, simulations, or the clinical placements, as "theory is taught to a perfect standard and that doesn't exist in clinical. This contributes to the theory practice gap and has had to navigate as a student" (Participant 7). Another participant (Participant 8) encouraged more consistency and clarity among university policies, specifically regarding the perineal assessment policy; he had been told the following, "male students must have a female with them when completing the perineal assessment". Yet, the rationale behind this policy and the consistency among various clinical groups and venues had not been clarified for him.

The class sizes (Question 2) range from 80 to 120 students, averaging about 100 students per class. The gender distribution in the classes is approximately 5 to 10% male, but is otherwise female dominated (Participants 1 to 9). The participants shared that this gender distribution (Question 3) reinforced the notion that nursing is a female dominated profession. They described that men face stigma for choosing nursing, they experienced 'othering' or feeling disconnected, out of place, isolated, and self-conscious of their career choice at the beginning, but are now proud to be nurses. They also felt unclear of the role of the nurse given the influence of Florence Nightingale and that of social norms (Participant 3). However, although men are a minority, the fact that there are some men means progress for non-traditional gender roles is being made, and

it also improves team dynamics (Participant 7). It is also interesting to note that the feminization of the nursing profession is more apparent in the North American context. One participant (Participant 8) explained that different social standards for male nurses exist in different countries, such as in the Philippines, where nursing is a strategic career for both genders as it is transferrable to most countries. However, in the North American context, most students expected the gender distribution within nursing to be what it is.

The participants reported that their favourite theory courses (Question 4) were the first-year science courses, health assessment, pediatrics, perinatal, mental health, medicine-surgery, and complex care. Both the professors and their teaching styles impacted the participants' choice. Conversely, the least favourite theory courses reported by the participants included: ethics, politics, inter-professional seminar, philosophy, mental health, and community health. Interestingly, the professors and their teaching styles impacted the participants' choices in this regard, too.

The participants' favourite clinical placements (Question 5) generally corresponded to their favourite theory courses, such as: medicine-surgery, complex care, and pediatrics. Three participants (Participants 1, 8, 9) (33%) named perinatal health nursing as their favourite clinical placement, specifically during their shadow day in labour and delivery. Furthermore, the participants (Question 6) noted the influence of a positive instructor on their overall clinical learning experience. They described how a friendly instructor, who finds various learning opportunities, and is present, to "make or break the placement" (Participant 7).

5.2.2 Perinatal Health Nursing Theory Course

This subsection presents the results in regard to the participants' perceptions of the PHN theory course. The results will be presented under three headings, namely: qualitative data,

quantitative data, and the comparison of both types of data. As this research study follows the Convergent Parallel Mixed Methods Research design (Creswell, 2014) and the majority of the data obtained for this research question comes from the interview guide, the qualitative data will be presented first.

5.2.2.1 Qualitative Data

The qualitative results for this subsection come from Question 7 in the interview guide (see Table 6). There were three reactions to the theory course: positive, neutral, and negative. Five participants (56%) reported that the PHN theory course was a good learning experience due to the professor, content, and logical sequencing of the course. Participant 1 recalled that, "I did like it, but it was a lot for someone new. It's like a new world of nursing." Two participants (22%) expressed a neutral learning experience as the course offered a great deal of new information, could have been better organized, and that some content was not applicable. Participant 6 states that, "I guess I'm just not interested in it. It was good information, but I knew I wasn't going into maternity so a lot of it wasn't pertinent to me". The last two participants (22%) shared negative learning experiences in relation to the PHN theory course. Participant 5 states that, "when she was teaching, she would include stuff like how this area of nursing isn't popular with men because of its background", and suggested that hearing the professor speak negatively about male students in this clinical area set a negative tone about this clinical area from the beginning of the semester. The other negative learning experience in the PHN theory course was regarding course sequencing. Participant 7 suggested that the theory course should have been completely frontloaded before moving on to the laboratory, simulations, and clinical hospital placement, in order to reduce the theory-practice gap.

5.2.2.2 Quantitative Data

The quantitative results are from Questions 27 and 28 of the online questionnaire (see Table 7). All of the participants (100%) agreed that the PHN theory course prepared them for the corresponding clinical practicum. The participants reported the average degree of preparation for the clinical practicum from the theory course as being 6.4, on a scale from 0=’Not prepared at all’, to 10=’Very well prepared’ (*SD*=1.88). Four participants (44%) reported the degree of preparation for the clinical practicum from the theory course as 6 or less on 10, while five participants (56%) reported the level of preparation to be 7 or more on 10.

Table 7: Quantitative Results for the PHN Theory Course

Questions from Online Questionnaire	**Response, Frequency, Percentage (n=9)**	**Statistics of Central Tendency**
27. Did the PHN theory course prepare you for the PHN practicum?	Yes: 9/9 (100%) No: 0/0 (0%)	N/A
28. How much did the PHN theory course prepare you for the PHN practicum?	2 on 10: 1 (11%) 6 on 10: 3 (33%) 7 on 10: 2 (22%) 8 on 10: 3 (33%)	Mean = 6.4 Median = 7 Mode = 6.8 SD = 1.88

5.2.2.3 Comparison of Both Sets of Data

The qualitative results suggest that the theory course was an overall positive learning experience for the participants that did contribute to a degree of preparation for the corresponding clinical practicum. However, they do suggest that there is some room for improvement, especially for the course content. On the other hand, the quantitative results suggest that although the theory course did prepare the participants for the clinical practicum, half of the participants did not feel as prepared for it, as their ratings were 6 or less on 10. These results could be attributed to the suggested improvement of course content from the qualitative

data set. This instance where there is a divergence between the qualitative and the quantitative results may be related to the lack of front-loaded course sequencing, better course organization and presentation of the content, and the inclusion of a discussion about men in PHN. Otherwise, the quantitative results support the qualitative results in that the PHN theory course was overall a positive learning experience and prepared the students for their clinical practicum.

5.2.3 Perinatal Health Nursing Practicum

The qualitative results obtained for this section come from Questions 10, 11, 17, 18, 19, and 20 of the interview guide (see Table 6). No quantitative data were gathered for this particular aspect.

Before starting their PHN clinical placements, all participants (100%) reported various fears (Question 10 of the Interview Guide). The first type of fear involved experiencing gender-based rejection: the participants felt like men do not belong in this clinical area (Participants 1 and 3), and reported that previous students had shared that female students had more opportunities in this clinical area than the male ones. Participant 3 states that, “Yeah, you hear horror stories a lot before you go in-of girls having way more opportunities to see things. So that was a big thing, I wanted to see a birth, and I wanted to see a C-section but I was scared that the patients wouldn’t want me there.” (Participant 3). Furthermore, one participant verbalized fears of gender based rejection being exacerbated by his appearance and sexual orientation. He states that, “I feel like homosexual males did better, like the only men on the floor were gay. I don’t know that it really matters but maybe it does make people more comfortable” (Participant 6). The last fear before starting the PHN practicum was the fear of being perceived as inappropriate, or starting conflict with the partner (Participant 9).

Interestingly enough, despite the negative perception of the clinical practicum, 7 participants (78%) agree that this is an applicable course for male nursing students (Question 11). Participant 3 states that,

> "oh yeah for sure. Because I found a lot of men in the program- just in life and in general- are really awkward about that subject, like 'it's none of by business, I don't want anything to do with it yeah! Like, not even when you talk about birth, but even when you talk about periods or stuff like that, men just get really awkward. And they don't want to talk about it,' it's none of my business." And they get so awkward they don't want to hear about it. And they get all jittery, and for me it wasn't a big deal-but yeah-it's super important. It's a human, its health, you need to – even if you're working in the ER, you still need to know this stuff" (Participant 3).

Participant 1 further explains that:

> "I strongly believe that when you're a nurse or when you're in a hospital environment gender does not matter, ethnicity does not matter, religion does not matter. Nothing matters so you're like a - there should not even be a gender associated to you. That's how I feel, even though I'm man, I know I'm a man but when you're in the hospital, a patient should accept any nurse and a nurse should accept any patient. That's it, that's all [same with physicians]" (Participant 1).

The participants cited exposure to this unique patient population, promoting a gender inclusive learning environment, and challenging social norms as grounds supporting the applicability of this course for male nursing students. However, two participants (22%) believe that this course should be optional for male nursing students. These participants advocate for making PHN an optional course for those male students who are interested in it. Participant 6 does state that obstetric and urology courses should be mandatory for physicians, but nursing students should have the option of opting out. He states that, "I guess I'm contradicting myself with it being optional for nursing students [but not for doctors]. I feel like for physicians it may be more applicable because they might have a pregnant patient wherever, but I guess you could say the same for nursing. I don't know" (Participant 6).

There were two answers to the question (Question 17) as to whether the participants would consolidate in this clinical area: yes (56%), and no (44%). Of the participants who would complete their final consolidation practicum in PHN, two (22%) actually did, despite being discouraged by various members of their social networks (Participants 1 and 2). Of the participants who would not consolidate in this clinical area, their rationale included: this area being too specialized (Participants 3 and 8), having more interest in the birthing unit instead (Participant 9), experiencing too many social barriers (Participant 6), and being discouraged to do so by a member of the participant's social network. Participant 8 states that, "There's still the connotation of being a man in maternity and you never know what a woman went through in terms of trauma or assault, so sometimes it's hard to be in man in such a setting" (Participant 8). Furthermore, Participant 2 states that,

> "In my consolidation I wanted to try the experience, so I went to the coordinator and I was like 'can I have my consolidation in maternity' and she's like 'first of all I cannot choose, it will randomly be chosen. Plus, I don't recommend for you to put it as your first option because you want to put your first option as a place where you want to get a job, and in maternity- I don't think so. Your chance to get the job there as a male nurse are limited'" (Participant 2).

In a similar question (Question 18), there were two responses as to whether the participants would work in this clinical area as a staff member afterwards: yes (78%) and no (22%). Of the seven participants who would work here, two (22%) are currently employed in this area (Participants 1 and 2). Although one participant would work as a nurse in perinatal health, he would prefer to work in the birthing unit as opposed to the mother-baby unit (Participant 9). The other participants are interested in working in this area to increase male visibility as perinatal health nurses (Participant 8), to use this opportunity as a test-run for fatherhood (Participant 7), and to be a 'trailblazer' (Participant 8). The participants who are interested in working in this area also highlighted the difference in power dynamics between being a student

and a staff nurse. As for the participants who would not work in PHN as a staff nurse, their rationale involved: disliking the patient population (Participant 6), experiencing too many social barriers (Participant 5), and being frustrated with being held to different standards than female nurses (Participant 1).

Eight participants (89%) stated that their gender impacted their perception on the unit (Question 19), and it did so in five ways. The one participant (22%) who denied the impact of their gender states that, "for me I don't think it did, but I can see how it would. I think the two other guys in my group had a harder time with it than I did. I think because they were big guys and they had a 'macho' look" (Participant 3). Participant 4 also explains the detriment of 'not looking the part'. He states that, "The patients would be expecting a blond haired, white girl nurse. A lot of the times when I walked through the door as a black man, you could see it on their face" (Participant 4). The remaining participants cited five implications of their gender. The first involves its impact on institutional policies. Participant 1 recalls that:

> "The floor doesn't hire men... I think they said that once they had a PSW or something like that that was inappropriate with one of the women, so they decided not to hire any more men. I don't know how- or if its written in stone or if they say it out loud, but my cousin told me… my manager now is completely open minded about everything. And she actually told me that she wanted to be the first manager to hire a male nurse over in labour and delivery, so I'm definitely going to hire you. If she wouldn't be my manager I wouldn't be working there today" (Participant 1).

Participant 8 further corroborates this experience by recalling his experience with the perineal assessment policy and feeling that "men can't do things alone" (Participant 8).

The second impact of gender involves the participants' feeling that they had to prove themselves, and that they were held to different standards than the female students were. Participant 2 states that, "Maybe, you still have to as a woman-it doesn't mean that as a woman you automatically get the job. You still have to prove your skills and knowledge. But yes, as a

male nurse – I have to prove that it won't be an issue" (Participant 2). Moreover, Participant 1 shared his fears about experiencing so much gender based rejection in this practicum that he would not be able to meet his clinical learning objectives. He states that, "Some [female] friends said that…Not that I shouldn't do it, but just like 'are you sure you're going to do it' and you know you're scared that if you get rejected from all patients and you're really doing bad that you can fail because you're not meeting requirements" (Participant 1). This theme was also reinforced with breastfeeding, due to the participants' lack of breast tissue (Participants 7 and 9).

The third impact of gender was on the reactions received by staff members, patients, and partners. Participant 6 states that, "some nurses are more receptive to female nursing students. Like you can just tell that they're really friendly with female nursing students, but when it comes to you they're different" (Participant 6). Participant 4 recalls that,

> "The thing that speaks loudest is the attitude of the significant other or family members, because maybe if you're the mother and you're the focus of the attention -you're trying really hard not to show what you're feeling- but everyone else is easier to read like 'they don't want this guy'" (Participant 4).

Participant 5 was even asked, "What are you doing here, it's weird" by a partner; which led to a verbal altercation.

The fourth impact of gender involves fearing being perceived as inappropriate. This resulted in their hyper-vigilance when obtaining consent from the female patients for procedures, and is exacerbated by the social climate following the #metoo movement. Participant 9 states that:

> "It was definitely on my mind all the time. There's definitely a part of me that worries about how I was being perceived, like if I was being perceived as being predatory. Honestly I just combat that by being as honest as I can be about what to expect. That's the only real way, I don't have control over anything else…For sure it was worse in maternity, but anytime I had a female patient in any placement- I was really diligent about getting consent. I went out of my way to be extra empathetic, trusting, and then

> obtain consent. It's definitely on my mind more when they deal with female patients, than when I deal with male patients" (Participant 9).

Participant 4 further explains that he found himself "overemphasizing consent in everything you do…I definitely didn't want to come across as 'one of those guys.'" Interestingly, this participant also highlighted the differences in obtaining consent as a male nursing student versus obtaining consent as a male physician. He states that, "The history of the healthcare system is that physicians are male-dominated and nursing is female-dominated. They just don't have a reason to ask because it status quo for doctors" (Participant 4).

The last impact of gender dealt with the sexuality; specifically, the sexualization of touch, of women's bodies, and of being a male nurse. Participant 4 describes his experience as a heterosexual man, in his peak sexuality, caring for women in their childbearing age. He states that:

> "In terms of dealing with female patients, up until that point I had only practiced in geriatrics and on an orthopedic floor, which had an older population so I really only saw older women's bodies. And a lot of them don't care about the gender of their nurse because they're past that age for their prime and they've accepted that that men are going to see them like this. It's different when dealing with women in their reproductive years… To be honest, I'm a virgin and I guess it's not really normal for men to be 21 and a virgin anymore. So to be heterosexual, 21, and a virgin -and to have your first experiences with the female body in a professional setting- it's kind of overwhelming to the honest. It made the placement more complicated, it was something I was really nervous about specifically -in this placement" (Participant 4).

Given the impact of gender, the participants' reported two categories of hospital activities: the ones they were the most comfortable completing, and the ones they were the least comfortable completing (Question 20). The most comfortable tasks include: newborn assessment (56%), as well as taking health history and teaching (33%). The least comfortable tasks include: breastfeeding support (78%), perineal assessment (56%), and urinary catheter insertion (11%). Participants described how these tasks were too intimate, uncomfortable, and awkward.

5.2.4 Perinatal Health Nursing Laboratory

This subsection explores the participants' learning experiences in the PHN laboratory. The results will be presented under three headings, namely: quantitative data, qualitative data, and the comparison of both types of data. As this research study follows the Convergent Parallel Mixed Methods Research design (Creswell, 2014) and the majority of information obtained for this research question comes from the online questionnaire, the quantitative data will be presented first.

5.2.4.1 Quantitative Data

The quantitative data come from Questions 29, 32, 33, 34, and 35 of the online questionnaire (see Table 8). The participants reported the average preparedness for the PHN laboratory as being 6.8 (*SD*=1.3), from 0='Not prepared at all', to 10='Very well prepared'. Four of the nine participants (44%) rated their preparedness for the laboratory to be 6 or less on 10, while the remaining five (56%) rated their preparedness to be 7 or more on 10. Five participants (56%) noted that the post-partum assessment and care were the most useful laboratory activities, one participant (11%) reported newborn assessment and care to be the most useful activities, two participants (22%) described health teaching to be the most useful laboratory activity, and one (11%) participant selected all of the activities to be the most useful. Conversely, seven participants (78%) reported infant feeding to be the least useful laboratory activity, while the remaining two participants (22%) cited health teaching and the Calgary Family Assessment Model (CFAM) to be the least useful tasks, respectively. Eight participants (89%) of the sample agreed that the laboratory prepared them for the clinical practicum, while the remaining participant (11%) disagreed. As one of the participants (11%) did not feel that the laboratory prepared him for the clinical practicum, he was unable to answer the follow-up question

regarding the level of preparedness for the clinical placement. The remainder of the eight participants (89%) reported that the laboratory contributed to the average of clinical preparedness as 6.4 *(SD*=1.6), from 0=’Not prepared at all’, to 10=’Very well prepared’. Half (50%) of the participants rated the laboratory as less than 6 or below on 10, while the remaining half (50%) rated the laboratory as 7 or more on 10 in terms of the degree of preparation for the clinical practicum.

Table 8: Quantitative Results for the PHN Laboratories

Questions from Online Questionnaire	**Response, Frequency, Percentage (n=9)**	**Statistics of Central Tendency**
29. Rate your preparation for the PHN laboratory.	4 on 10: 1 (11%) 6 on 10: 2 (22%) 7 on 10: 3 (33%) 8 on 10: 3 (33%)	Mean=6.8 Median=7 Modes=7.8 SD=1.30
32. What were the most useful PHN laboratory activities? -Post-Partum assessment and care -Newborn assessment and care -Health teaching	 5/9 (56%) 1/9 (11%) 2/9 (22%)	N/A
33. What were the least useful PHN laboratory activities? - Infant feeding - Health teaching - CFAM	 7/9 (78%) 1/9 (11%) 1/9 (11%)	N/A
34. Did the PHN laboratory prepare you for the PHN clinical placement in the hospital?	Yes 8/9 (89%) No 1/9 (11%)	N/A
35. How much did the PHN laboratory prepare you for the PHN clinical placement in the hospital?	No response: 1/9 (11%) 3 on 10: 1 (11%) 6 on 10: 3 (33%) 7 on 10: 2 (22%) 8 on 10: 2 (22%)	Mean=6.4 Median=6 Mode=6 SD=1.60

5.2.4.2 Qualitative Data

The qualitative results for this section come from Question 8 in the interview guide (see Table 6). There were mixed results in regard to the PHN laboratory. Five participants (56%) reported that the PHN laboratories were a positive learning experience. The participants reported that they were the best laboratories in the program, they were taught over the summer so they followed a truly frontloaded theory course (Participant 7), and were focused on teaching and communication (Participant 8), as well as finding the content as being applicable (Participant 2) with adequate equipment (Participant 4). One participant states that, "I did my placement in the summer- which meant that I had the theory behind me. I structured it intentionally that way, and I found it much easier having a whole semester already behind me" (Participant 7). Another participant states that he,

> "actually found that the labs for maternity were one of the best of the whole program, like not that the others were bad, but maternity had more sims and it was a lot more teaching based-so it was nice going into the hospital - I had all of my speeches about post-partum depression and stuff down pat so I didn't have to think of it on the spot. It just came out the way it did in lab. I found that the teaching was awesome" (Participant 3).

On the other hand, four participants (44%) mentioned that there was still some room for improvement. Namely, more breastfeeding information is needed (Participants 1 and 2), the Calgary Family Assessment Model (CFAM) is outdated and should be removed (Participant 9), and there are some limitations of the equipment. Participant 9 recalls that "One thing I didn't like…nobody liked…was the Calgary Family Assessment Model. Nobody thought it was relevant, not even the lab instructors thought it was relevant." For example, the fundal trainer used in the laboratory feels slightly different than how a fundus feels on a real patient. Furthermore, the fundal assessment is physically uncomfortable for some patients, and a limitation of the fundal trainer is that the students cannot experience a patient's reaction to their

assessment. This causes some students to be caught off guard by a postpartum patient wincing during their assessment in the clinical setting because it cannot be replicated in a laboratory setting with the current equipment. He further explains that,

> "I found the labs were really informative, but they didn't really give us a good sense of feeling the fundus. Like it's not quite the same, and the mannequin doesn't prepare you for the mom's reaction, because for some moms it's quite painful. So I would say that we weren't really prepared for that kind of reaction" (Participant 8).

5.2.4.3 Comparison of Both Sets of Data

The quantitative results suggest that the participants were adequately prepared for the laboratory itself, and that the laboratory provided adequate preparation for the corresponding clinical practicum. The post-partum assessment was the most useful laboratory activity: post-partum assessments are one of the most frequently completed tasks in the clinical setting. Conversely, infant feeding was the least useful laboratory activity. Infant feeding was also rated to be the least comfortable activity completed in the hospital. This topic will be further explored in section 5.2.6 of this chapter.

The qualitative results suggest that the laboratory provided a mostly positive learning experience, which is consistent with the overall quantitative results. However, the qualitative results regarding the need for more infant teaching activities in the laboratory do not support the quantitative results that infant feeding was the least useful laboratory activity. In addition, the qualitative results about the difference between the fundal assessments completed on the laboratory equipment and those completed on a patient in the hospital support the quantitative results that the participants were not adequately prepared for this part of their clinical practicum.

5.2.5 Perinatal Health Nursing Simulation

This subsection explores the participants' learning experiences in the PHN simulations. The results will be presented under three headings, namely: quantitative data, qualitative data, and the comparison of both types of data. As this research study follows the Convergent Parallel Mixed Methods Research design (Creswell, 2014) and the majority of information obtained for this research question comes from the online questionnaire, the quantitative data will be presented first.

5.2.5.1 Quantitative Data

The quantitative results come from Questions 30, 36, 37, 38, and 39 of the online questionnaire (see Table 9). The average preparation for simulation was rated to be 7 on 10 (*SD*= 1.32). Three participants (33%) reported their average preparation to be 6 or less on 10, while six participants (67%) reported their average preparation to be 7 or more on 10. Four participants (44%) reported that the post-partum hemorrhage simulation was the most useful activity, while two participants (22%) cited discharge teaching, and the remaining three participants (33%) selected all of the responses. Difficult breastfeeding (44%) and the well-baby drop in (44%) simulations were both scored to be the least useful simulation activities, each receiving four responses, while one participant (11%) did not choose a response. Seven of the nine participants (78%) reported that the simulations did prepare them for clinical, while the remaining two participants (22%) disagreed. The average preparedness for clinical that the simulations contributed to was rated at 6 on 10 (*SD*=1.29). Five participants (55%) rated the simulation to prepare them for clinical 6 or less on 10, two participants (22%) rated the simulation to prepare them for clinical 7 or more on 10, while the two remaining participants (22%) did not provide an answer.

5.2.5.2 Qualitative Data

The qualitative results for this section come from Question 9 in the interview guide (see Table 6). The participants reported both positive and negative perceptions in regard to the PHN simulations. Three participants (33%) reported that the PHN simulations were positive learning

Table 9: Summary of Quantitative Results for the PHN Simulations

Questions from Online Questionnaire	**Response, Frequency, Percentage (n=9)**	**Statistics of Central Tendency**
30. Rate your preparation for the PHN simulations.	5 on 10: 1 (11%) 6 on 10: 3 (33%) 7 on 10: 1 (11%) 8 on 10: 3 (33%) 9 on 10: 1 (11%)	Mean=7.0 Median=7 Modes=6.8 SD=1.32
36. What were the most useful activities in the PHN simulations? - Hemorrhage - Discharge teaching - All responses selected	 4/9 (44%) 2/9 (22%) 3/9 (33%)	N/A
37. What were the least useful activities in the PHN simulations? - No response - Difficult breastfeeding - Well baby drop in	 1/9 (11%) 4/9 (44%) 4/9 (44%)	N/A
38. Did the PHN simulations prepare you for the PHN clinical placement in the hospital?	Yes 7/9 (78%) No 2/9 (22%)	N/A
39. How much did the PHN simulations prepare you for the PHN clinical placement in the hospital?	No answer: 2/9 (22%) 4 on 10: 1 (11%) 5 on 10: 1 (11%) 6 on 10: 3 (33%) 7 on 10: 1 (11%) 8 on 10: 1 (11%)	Mean=6.0 Median=6 Mode=6 SD=1.29

experiences. One participant states that, “they were good, everyone we did was different… we had fun and learned a lot (Participant 3). The participants reported learning the most from the post-partum hemorrhage and difficult breastfeeding scenarios, and were satisfied with the teaching and communication focus of the simulations. Six participants (67%) reported some negative learning experiences in the PHN simulations. Specifically, Participant 4 reported feeling “intimidated and embarrassed by the facilitator as she was impatient and was overly critical of his performance” (Participant 4). One participant reported that the simulations were redundant based on their timing throughout the placement (Participant 8), and that the content was too easy (Participant 2). One participant also reported that they were, “not reflective of the reality in clinical, which contributed a gap between theory and clinical” (Participant 7). Furthermore, one participant recalls that, “there was something missing between the labs, the simulation, and real life, I feel. The content in the labs and sims are ok, but because it’s not deep enough, it’s not quite what happens in real life” (Participant 1).

5.2.5.3 Comparison of Both Data Sets

The quantitative results suggest that the PHN simulations provided an overall positive learning experience. The most learning opportunities came from the post-partum hemorrhage simulation, while the least learning opportunities came from the difficult breastfeeding and well-baby drop scenarios in simulations. Perhaps this can be attributed to the frequency of post-partum hemorrhages observed in the hospital clinical placement; while breastfeeding was cited to be the most uncomfortable activity completed in the hospital clinical placement. Overall, the simulations did prepare the participants for the hospital clinical placement, but the degree of preparation was mostly reported to be 6 or less on 10.

The qualitative results suggest that there was room for improvement in the PHN simulations. This feedback comes mostly from a content and timing perspective, in that the content was described to be too superficial, or different than the practices observed in the clinical setting.

The qualitative results support the quantitative results. Although the simulations provided a positive learning environment and safe space to master skills, the content and timing were inadequate. This decreased the overall efficacy of the information and contributed to lower scores for the degree of satisfaction and preparation for the hospital clinical placement.

5.2.6 Clinical Hospital Placement

This subsection explores the participants' learning experiences in the PHN clinical hospital placement. The results will be presented under four headings, namely: The Clinical Placement Evaluation Form (Penman and Oliver, 2004), quantitative data obtained from the online questionnaire, qualitative data, and the comparison of all three data sets. As this research study follows the Convergent Parallel Mixed Methods Research design (Creswell, 2014) and the majority of information obtained for this research question comes from quantitative data, these results will be presented first.

5.6.2.1 Clinical Placement Evaluation Form (Penman and Oliver, 2004)

This subsection reviews the participants' responses for the Clinical Placement Evaluation Form (Penman and Oliver, 2004). The results were obtained from questions 14-25 of the online questionnaire (see Table 10)**.**

Eight participants (88%) either agreed or strongly agreed that the placement was a pleasant learning experience, while the remaining one participant (11%) strongly disagreed. All participants (100%) either agreed or strongly agreed that they met their learning objectives. All

Table 10: Results from the Clinical Placement Evaluation Form-Adapted for PHN (Penman and Oliver, 2004)

Questions from the Online Questionnaire	Response, Frequency, Percentage (n=9)	Statistics of Central Tendency
1. Overall the placement was pleasant learning experience.	Strongly disagree 1/9 (11%) Agree 6/9 (67%) Strongly agree 2/9 (22%)	Mean=3.9 Median=4 Mode=4 SD=1.17
2. I felt well prepared for clinical.	Disagree 1/9 (11%) Neutral 1/9 (11%) Agree 5/9 (55%) Strongly agree 2/9 (22%)	Mean=3.9 Median=4 Mode=4 SD=0.93
3. My objectives were met to my satisfaction.	Agree 4/9 (44%) Strongly agree 5/9 (56%)	Mean=4.6 Median=5 Mode=5 SD=0.53
4. The placement assisted my learning.	Agree 6/9 (67%) Strongly agree 3/9 (33%)	Mean=4.3 Median=4 Mode=4 SD=0.50
5. The placement enhanced my clinical skills.	Agree 5/9 (56%) Strongly agree 4/9 (44%)	Mean=4.4 Median=4 Mode=4 SD=0.53
6. The placement was supportive of my growth.	Agree 6/9 (67%) Strongly agree 3/9 (33%)	Mean=4.3 Median=4 Mode=4 SD=0.50
7. Adequate orientation was provided.	Neutral 1/9 (11%) Agree 7/9 (78%) Strongly agree 1/9 (11%)	Mean=4.0 Median=4 Mode=4 SD= 0.5
8. I was expected by the venue.	Neutral 3/9 (33%) Agree 4/9 (44%) Strongly agree 2/9 (22%)	Mean=3.9 Median=4 Mode=4 SD=0.78
9. Staff were willing and available to help.	Agree 4/9 (44%) Strongly agree 5/9 (56%)	Mean=4.6 Median=5 Mode=5 SD=0.53
10. I feel confident working here after clinical.	Disagree 2/9 (22%) Neutral 1/9 (11%) Agree 4/9 (44%) Strongly agree 2/9 (22%)	Mean=3.7 Median=4 Mode=4 SD=1.19

11. There were many opportunities in clinical.	Strongly disagree Neutral Agree Strongly agree	1/9 (11%) 4/9 (44%) 2/9 (22%) 2/9 (22%)	Mean=3.4 Median=3 Mode=3 SD=1.24
12. This clinical would benefit other students.	Neutral Agree Strongly agree	1/9 (11%) 4/9 (44%) 4/9 (44%)	Mean= 4.3 Median=4 Modes=4.5 SD=0.71

participants (100%) either agreed or strongly agreed that the placement enhanced their clinical skills. All participants (100%) either agreed or strongly agreed that the placement was supportive of their growth. Eight participants (89%) either agreed or strongly agreed that adequate orientation was provided, while the remaining participant (11%) provided a neutral response. Six participants (67%) either agreed or strongly agreed that they were expected by the venue, while three participants (33%) reported a neutral response. All participants (100%) agreed or strongly agreed that the staff members were willing and available to help. Six participants (67%) either agreed or strongly agreed that they would feel confident working in this area after their clinical placement, one participant (11%) provided a neutral response, and two participants (22%) disagreed. Four participants (44%) agreed or strongly agreed that there were many opportunities in clinical, four participants (44%) provided neutral responses, and one participant (11%) strongly disagreed. Eight participants (89%) either agreed or strongly agreed that this placement would benefit other students, while one participant (11%) reported a neutral response.

5.2.6.2 Other Quantitative Data

The quantitative results for this section come from Questions 31, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49 and 50 of the online questionnaire (see Table 11). Eight participants (89%) rated their preparation for the hospital placement to be 7 or higher on 10, while one participant (11%) rated his preparation for clinical to be 6 or less on 10. The average was 7.8 on 10 (*SD*=1.09).

Four participants (44%) rated a combination of post-partum and newborn assessments to be the most useful activities completed in the clinical placement, while three participants (33%) named only post-partum assessments, one participant (11%) named only newborn assessments to be the most useful clinical activity, and one participant (11%) did not answer the question. Five participants (56%) rated infant feeding to be the least useful clinical activity, while one participant (11%) rated postpartum assessment, one participant (11%) rated newborn assessment, and one participant (11%) rated health and discharge teaching to be the least useful clinical hospital activities.

Eight participants (89%) rated their comfort in the clinical placement at the beginning of the placement to be 6 or less on 10, while only one participant (11%) rated his comfort to be 7 or more on 10. The average of the participants' comfort level at the beginning of the clinical placement was 3.2 (*SD*=1.48). Conversely, at the end of the placement, eight participants (89%) rated their comfort to be 7 or higher on 10, while only one participant (11%) rated his comfort to be 6 or less on 10. The average of the participants' comfort at the end of the clinical placement was 7.8 (*SD*=2.13). A Wilcoxon Signed Ranks test (Polit & Beck, 2017) was completed to test the difference of means between these groups. This test was chosen because the groups are dependent, the level of data is ratio, but the values are not normally distributed; therefore, the assumptions to calculate a paired t-test were not met. The value of W is zero, which is less than the critical value of eight for a sample size of nine, at the confidence level of 0.05. Therefore, the null hypothesis is rejected and the results are statistically significant.

One participant (11%) rated his relationship with the nursing staff to be 6 or less on 10, while the remaining eight participants (89%) rated their relationships with the nursing staff to be 7 or higher on 10. The average is 8.2 on 10 (*SD*=1.92). One participant (11%) rated his

Table 11: Summary of Quantitative Results for PHN Clinical Hospital Placement

Questions from Online Questionnaire	Response, Frequency, Percentage (n=9)	Statistics of Central Tendency
31. Rate your preparation for placement	6 on 10: 1 (11%) 7 on 10: 3 (33%) 8 on 10: 2 (22%) 9 on 10: 3 (33%)	Mean=7.8 Median=8 Modes=7.9 SD=1.09
40. Most useful hospital activities - No response -Post-partum assessment and care - Newborn assessment and care -All responses selected	 1/9 (11%) 3/9 (33%) 1/9 (11%) 4/9 (44%)	N/A
41. Least useful hospital activates - No response - Post-partum assessment and care - Newborn assessment and care - Feeding assistance - Health teaching	 1/9 (11%) 1/9 (11%) 1/9 (11%) 5/9 (56%) 1/9 (11%)	N/A
42. Comfort at beginning of hospital placement	2 on 10: 2 (22%) 3 on 10: 6 (67%) 7 on 10: 1 (11%)	Mean=3.2 Median=3 Mode=3 SD=1.48
43. Comfort at end of hospital placement	4 on 10: 1 (11%) 7 on 10: 2 (22%) 8 on 10: 1 (11%) 9 on 10: 5 (56%)	Mean=7.8 Median=5 Mode=9 SD=2.13
44. Relationship with nursing staff	4 on 10: 1 (11%) 7 on 10: 1 (11%) 8 on 10: 3 (33%) 9 on 10: 1 (11%) 10 on 10: 3 (33%)	Mean=8.2 Median=8 Modes=8.10 SD=1.92
45. Relationship with other health care providers	4 on 10: 1 (11%) 7 on 10: 3 (33%) 8 on 10: 1 (11%) 9 on 10: 3 (33%) 10 on 10: 1 (11%)	Mean=7.8 Median=8 Modes=7.9 SD=1.79
46. Relationship with mother	4 on 10: 1 (11%) 6 on 10: 1 (11%) 7 on 10: 1 (11%) 8 on 10: 3 (33%)	Mean=7.6 Median=8 Modes=8.9 SD=1.67

	9 on 10: 3 (33%)	
47. Relationship with partner	3 on 10: 2 (22%) 6 on 10: 1 (11%) 7 on 10: 3 (33%) 8 on 10: 1 (11%) 9 on 10: 2 (22%)	Mean=6.6 Median=7 Mode=7 SD=2.24
48. Relationship with social support network	3 on 10: 1 (11%) 5 on 10: 2 (22%) 6 on 10: 1 (11%) 7 on 10: 2 (22%) 8 on 10: 3 (33%)	Mean=6.3 Median=7 Mode=8 SD=1.73
49. Relationship with baby	5 on 10: 1 (11%) 7 on 10: 1 (11%) 8 on 10: 3 (33%) 9 on 10: 2 (22%) 10 on 10: 2 (22%)	Mean=8.2 Median=8 Mode=8 SD= 1.56
50. Relationship with instructor	9 on 10: 1 (11%) 10 on 10: 8 (89%)	Mean =9.9 Median=10 Mode=10 SD=0.33

relationship with other health care providers to be 6 or less on 10, while the remaining eight participants (89%) rated their relationship with other health care providers to be 7 or more on 10. The average is 7.8 on 10 (*SD*=1.79). Two participants (22%) rated their relationship with the mothers to be 6 or less on 10, while the remaining seven participants (78%) rated their relationship with the mothers to be 7 or more on 10. The average is 7.6 on 10 (*SD*=1.67). Three participants (33%) rated their relationship with the partners to be 6 or less on 10, and 6 participants (67%) rated their relationship with the partners to be 7 or more on 10. The average is 6.6 on 10 (SD=2.24). Four participants (44%) rated their relationship with members of the mothers' social network to be 6 or less on 10, while five participants (56%) rated their relationship to be 7 or more on 10. The average was 6.3 on 10 (*SD*=1.73). The relationship with the baby was rated to be 6 or less on 10 for one participant (11%), while the rest of the sample (89%) rated it to be 7 or more on 10; with an average of 8.2 on 10 (*SD*=1.56). Lastly, all

participants (100%) rated their relationship with their instructor to be 7 or more on 10, with an average of 9.9 on 10 (*SD*=0.33).

5.2.6.3 Qualitative Data

The qualitative results for this section come from Questions 12 and 13 from the interview guide (see Table 6). The participants named three categories of expectations before starting their clinical placement in the hospital: being rejected, feeling uncomfortable, and caring for high-acuity patients. Eight participants (89%) feared experiencing rejection based on their gender in their PHN clinical placement. Participant 9 states that, "I was expecting there to be a lot of tension, and I was really nervous about that. Especially with the family's response to a male nurse, doing the assessments, breast-feeding, stuff like that." Participant 8 further explores this idea by recalling that:

> "I was able to ask a colleague-like another male student-about it beforehand. He was in the first cohort and I was in the second. He was at TOH and he said some families rejected him already because he was a man, so by that time I got to the hospital-I was expecting to be rejected at least 2 to 3 times. So I was scared, and I kept asking the clinical instructor if she had any negative experiences with male students. But my instructor was really reassuring me that most of the time, patients are okay with male students. So I don't know, maybe this is something unique to the Queensway. But for the first two weeks of clinical I was really scared to enter my patients' rooms because I thought they would see me-see that I'm a male-and tell me that they don't want me." (Participant 8).

Participant 4 states a similar fear,

> "There wasn't a specific picture I have in mind, but I was worried about being rejected, being uncomfortable, not knowing enough, or not handling the baby well. I didn't really like doing the maternity assessments or the baby baths- I really felt like getting out of there. Just knowing how how young the baby was and how fragile they were, was too much for me" (Participant 4).

The participants also noted that they were expecting to be uncomfortable in the clinical placement. Specifically, they were expecting to feel uncomfortable with breastfeeding assistance, perineal assessments, and dealing with the partner. Participant 9 explores that,

> "It was pretty uncomfortable, especially when you had a new patient. Because you have no idea what you're walking into, you have no idea what her expectations are, what her history was, or what her comfort level is - with any nurse, let alone a male. And then there's the family too, especially the fathers-they're very protective. It was definitely nerve-racking experience" (Participant 9).

Lastly, one participant (11%) was expecting to care for patients of higher acuity who had more complicated pregnancies and deliveries. Participant 3 states,

> "Yeah [I was expecting this placement to be more intense], for the birthing part I was doing more breathing exercises with the patients- but actually breastfeeding teaching was way more complicated than the physiology we learned about in class. You think like "there's milk in a duct, it comes out and baby drinks it" but in reality the baby needs to learn how to do it first. So the whole process is way more complicated than I thought and is way more complex than the theory" (Participant 3).

In regard to the clinical placement itself, reactions were positive, neutral, and negative. Three participants (33%) reported an overall positive learning experience. They cited the influence of a good clinical instructor (Participants 7 and 8), having many learning opportunities (Participant 3), having the continuity of care between the birthing and post-partum units (Participant 3), being happy to be in this particular clinical placement (Participants 1 and 3), and being rejected less than anticipated. Participant 1 states that,

> "You know, I just wanted to-I was just hoping that every patient I had wasn't going to reject me. But, today I know that they're going to reject me. Some reject, but, if you show that confidence and you say that you are capable of it, then they don't reject you. You-not prove yourself- but have that confidence" (Participant 1).

The decreased rejection rated increased the participants' overall confidence levels, and therefore facilitated their learning experiences in their PHN clinical placement in the hospital setting.

Three participants (33%) reported neutral learning experiences in their PHN clinical placement, due to a mix of positive and negative experiences. Participant 2 describes his experience in consolidating on the mother-baby unit and trying to balance gender inclusive learning opportunities while maintaining cultural sensitivity.

> "So when I started [in consolidation], again I hear from people- from all the males that went, that "you're not going to have a good experience, a lot of patients are going to reject you" stuff like that which was my biggest fear- and failing because it's not my fault that patients are refusing me, I'm going to fail my clinical. So I read a lot of culture, about male and female nurses, I read a lot of female not accepting a male nurse or stuff like that. First of all, I found two things, patient does not look at nurses as professionals, that's why you need to present yourself more professionally. You see, we used to work together – outside the room I'm outside the room I joke, but inside the room I'm different. The other thing is respecting the culture, like, when you see a woman- especially in the Muslim community who wear a hijab- 90% of them still refuse me but I go to the room and notice she's wearing a hijab I go "is it ok to have a male nurse for religious purposes? By just acknowledging this they're like 'we're fine'" (Participant 2).

Another participant explained how he enjoyed the clinical placement, but had some uncomfortable experiences with patients. He described feeling awkward during his assessments, and wondering if the patient was perceiving him unprofessionally due to the mutual similarity in age. He states that:

> "Like you can't see them [patients] in a romantic light, and obviously it's not romantic in the hospital- but if I was a female, and I was being taken care of by a straight or gay guy- it would be less anxiety provoking to have a gay guy. Obviously the possibility isn't actually there, but there is a switch that could be turned on in certain people. And then their partner is beside them and that can cause conflict even- if it's just for a split second. I also think a lot into these things" (Participant 7).

The remaining three participants (33%) had negative learning experiences. Participant 4 states that,

> "Overall it was not enjoyable. It was it less enjoyable than MedSurg and geriatrics. Like for MedSurg and geriatrics it was the instructor that did not make it enjoyable, but for this one it was the opposite- the instructor was great but the placement itself wasn't enjoyable. It was everything. Just being a man influenced a lot of things, even with the interactions of other staff. I think there was only one man on the unit, and he wasn't heterosexual. So I feel like a lot of them didn't know how to interact with a straight man because it's different. I just think that being a man influence a lot of things" (Participant 4).

Another heterosexual participant reported a similar situation. Participant 5 experienced an aggressive altercation with a partner who was very uncomfortable with a male nursing student assessing his wife. He states that:

> "We just find it weird how you're a male student and you're here to assess my wife" so then I like "well could you explain to me why you find it weird" and he said "man well you're a guy and I don't want another guy looking at my wife blood and piss and stuff I'm a veteran, I'm in the infantry, and I don't have any girls in the infantry" which is definitely something that's false. And then he's like" I just find it weird that you're guy and you're on this floor with other moms" and I'm trying to tell him it's just part of the curriculum, then it just got extremely hostile he would just raise his voice at me or change his tone, so I apologized and said "sorry that you feel this way, I'll get my instructor now and another nurse who's a female do your wife's assessment" (Participant 5).

Lastly, one participant (11%) reported inconsistent standards in practice with the perineal assessment policy. He explains that:

> "So it was on orientation day. My clinical instructor said 'when you go and do the lochia or perineal check, you have to get a female colleague, myself, or female staff to be with you at that time- for your own protection'… I was kind of dumbfounded. Like what happened in the past for the university to put this policy in place? And then I thought like 'okay I'll get over it. This isn't a big deal; I just won't think about it past today' But it turns out that I thought about it every shift until the rotation was over. It was so awkward to stop my assessment halfway through and be like 'I'm sorry but as per university policy I have to go get the female colleague, and she needs to be present in the room -just to observe- while I do the rest of the check for your perineum and lochia'. And a lot of the patients were fine about it, but some of them looked at me and wondered if I wasn't capable of doing it on my own, or if I didn't know what I was doing. I honestly have no clue. We weren't given any rationale or background; we were just told that this is what we have to do. But I also asked around with my male classmates in other clinical placements, and they said that they weren't doing it. And I was like 'oh, I thought we all had to do it'…It's hard to say (whether this policy protected me during the #metoo movement) because all the patients I had were really open and understanding that I'm a male student- so I can see how some women my feel like that, especially if they had a traumatic experience. But personally, none of the patients I had had this experience, or thought like 'this is a male checking my perineum'" (Participant 8).

5.2.6.4 Comparison of Three Data Sets

The quantitative results obtained through the Clinical Placement Evaluation Form (Penman and Oliver, 2004) suggest that the PHN clinical placement in the hospital was an overall positive learning experience, and that the participants were prepared for the clinical placement. These results are consistent with those from the rest of the online questionnaire and the interview guide; specifically, in terms of meeting learning objectives, the placement assisting

the participants' learning, enhanced their skills, supporting their growth, providing adequate orientation, and availability of staff to help. The one neutral response for adequate orientation provided may be attributed to the lack of acknowledgement of the male students' discomfort or unique learning experiences, as expressed in the interview guide. Furthermore, two participants disagreed that they would be comfortable working in this area afterwards, perhaps their experiences of gender based rejection that were shared in the interview guide contribute to their scores. It is also noteworthy to highlight the increased standard deviation in the scores for learning opportunities; as some participants described experiencing more gender based rejection and discomfort than others during their interviews.

The quantitative results obtained through the online questionnaire suggest that the majority of participants (89%) were prepared for their clinical placement in the hospital. The most useful activities included the post-partum and newborn assessments, as they were the most frequently completed activities in the hospital. Conversely, the least useful activity was breastfeeding assistance. In their interviews, the participants described discomfort with obtaining consent, viewing breasts in a non-sexual context, and not having breast tissue themselves. The participants' comfort levels increased throughout the duration of their hospital placement. The relationship with the staff members was mostly positive, which facilitated the participants' learning experiences. Other positive relationships included: other health care providers and mothers. As corroborated by the qualitative findings, the relationships with the partners and social networks were scored lower and had higher standard deviations; again, attributed to the varying qualitative experiences that the participants shared. The positive influence of the clinical instructor is validated through the qualitative data as being a facilitator of the participants' learning experience.

The qualitative results regarding the expectation of gender based rejection and discomfort are supported by the quantitative findings about the relationship with the partner and the least useful activity being breastfeeding. Contrary to the participants' expectations, their actual clinical placement experiences were mostly positive. These experiences were facilitated by the clinical instructor, which is supported by the quantitative results in both the Clinical Placement Evaluation Form (Penman and Oliver, 2004), and in the reported relationship with the instructor. The participants who did have negative learning experiences cited gender, awkwardness and discomfort, fearing being perceived as inappropriate, being a similar age to the patient, and the partner's discomfort with a male health care provider. These complex social standards negatively influence the participants' learning experiences in the PHN clinical placement; yet paradoxically, these factors are the 'expected' experiences of male students and contribute to the lack of research in this area.

5.3 Facilitators to PHN Learning Experiences

This section explores the facilitators to the participants' learning experiences in their PHN clinical practicum, by answering the second research question, "What are the facilitators to male nursing students' learning experience in their PHN clinical practicum?". The qualitative data obtained for this section come from question 14 of the interview guide (see Table 6). No quantitative data were obtained to answer this research question. The participants identified five facilitators: the clinical instructor, nursing staff, patients and their family members, the two male nurses working in PHN, and the comradery of other students.

The *first* facilitator identified by the participants relates to the clinical instructors. Six participants (67%) identified the instructor as being the most important positive influence on their learning experiences. One participant states that, "My instructor for sure, she was number

one I think. I just got lucky, I had good patients too, they didn't have great experiences with male students before me. But the instructor, the patients, and staff were good" (Participant 5). Another participant notes that the instructor was, "always there if we were uncomfortable or needed something…she was always available" (Participant 6). Participant 9 further explained how a good clinical instructor facilitates learning experiences. He states that,

> "She [the instructor] was really in-tune with the students' competencies, and where you needed more direction. She was really good at that balance. She gave you the independence, when you both felt like you needed it, but she also trusted you to seek her out when you needed assistance. She was never judgmental, or added an unnecessary amount of stress. And the staff nurses were amazing" (Participant 9).

A positive instructor was described to have a teaching style that complimented the students' learning style, fostered student confidence, found many learning opportunities, was present, and did not focus on the gender of students.

The *second* facilitator pertains to the nursing staff in the clinical hospital setting. Three participants (33%) explained that when staff members did not focus on the students' gender upon introduction to patients and family members, they were rejected less and had increased confidence. Participant 8 states that,

> "The nurses' words and actions [were positive]. They might have been thrown off that there is a male nurse in maternity, but they were very supportive of me. One of the ways to help me through my entire placement, especially because I really want learn about this and I really wanted to take care of women and families on this unit. So because I wanted to be there and the nurses could tell, it became a positive feedback cycle, and I kept learning more and they kept showing things" (Participant 8).

The *third* facilitator relates to the patients and their family members. Two participants (22%) named the patients and family members as facilitators to their learning experiences, in conjunction with their clinical instructor. Participant 7 states that, "I would always get the dads to help bathe the child. And it's hilarious because there are these big guys that don't know how to hold their kids, and they think they're so fragile. But I'm just like 'you know they just survived

being pushed out a little hole. This isn't going to hurt them'. It was a good experience" (Participant 7). Participant 3 enjoyed working with the neonatal population, and Participant 8 used the amount of teaching and communication skills accumulated in this placement to facilitate personal and professional growth.

The *fourth* facilitator involves the two male nurses who work in PHN in a regional Ottawa hospital. Five participants had the opportunity to work with either of the two male staff nurses; they reported that it was positive to work with a male nurse in this clinical area. Participant 4 states that, "the instructor and having the peer support from men" were the biggest facilitators to the PHN learning experience in the clinical hospital setting.

The *fifth and last* facilitator was identified by Participant 8 who recalls how the comradery of the other students had a positive influence on his learning experience in this clinical placement. He states that, "lastly, it was my colleagues in my rotation. They were very supportive of me. Like the time I had a patient who didn't want my help with breast-feeding, they told me that it's okay and not to take it personally. It made sense that I'm uncomfortable."

It is also noteworthy to mention that all nine participants (100%) reported the positive effects of these facilitators, regardless of the year in the program, the role as staff nurse, or sexual orientation.

5.4 Barriers to PHN Learning Experiences

Contrary to section 5.3, this section explores the various barriers to the participants' learning experiences in their PHN clinical practicum, by answering the third research question, "What are the barriers to male nursing students' learning experience in their PHN clinical practicum?". The qualitative results for this section come from questions 15 and 16 of the interview guide (see Table 6). No quantitative data were obtained to answer this research

particular question. The three main barriers that were identified by the participants are related to the nursing staff in the hospital settings, the female patients, and specific situations deemed as 'awkward', as well as the four strategies used to deal with these barriers.

The *first* barrier that the participants identified involved nursing staff. Two participants (22%) reported that although staff members had the potential to positively impact their learning experiences, they also had the potential to negatively do so. They shared that the gender distribution, namely that the nursing staff was female dominated in this area, was a barrier to their learning experiences. It is noteworthy to mention that the students noticed that the gender distribution of staff physicians was not female dominated; in fact, they were mostly men. Participant 3 explored this notion by stating:

> "Most nurses were women [in maternity] but on the other floors there were about 25% men. A lot of the doctors were men. I found it weird in maternity that there weren't any men on the floor. I think there's only one man in maternity in Ottawa and I think he works at TOH. But I found it off at Monfort that there were no male nurses in maternity, but a lot of the physicians were men. So it was ok that the doctors are men in maternity but its weird for a nurse- even though they're kind of the same…I think people see doctors as a science, they're there to deal with the diseases and stuff like that. Whereas nursing people see more as caring. I think people associate care with women, a lot of the time when I walk into the room and say I'm a student, they patients assume I'm a med student. And I have to correct them that I'm a nursing student, and then they would ask if I was going to be a doctor after. And I don't want to- and caring traditionally comes with the female gender." (Participant 3).

Similarly, some participants who identified as heterosexual described working with either of the two male perinatal health nurses as being a barrier, as they both openly identify as being homosexual. According to Participant 4, although having a male nursing presence in perinatal health was positive, it was also isolating; the lack of a male heterosexual nursing presence in this area contributed to this perception of isolation.

The *second* barrier identified by the participants focused on the female patients themselves. The female patients also had the potential to both positively and negatively influence

the participants' learning experiences. The participants identified the following barriers in relation to the patients themselves: mistaking the participants for medical students instead of nursing students (Participants 2 and 3), making comments such as 'what are you doing here, it's weird' (Participant 5), being an exclusively female patient population and the intimacy of the assessments involved (Participants 4, 5, 6 and 7), and the discomfort voiced by the partner during the assessments (Participants 4, 5, and 9). The discomfort from the partner was always described to be a male partner who was uncomfortable with another man, namely the male nursing student, who was touching his wife; again, this was in terms of the intimacy of the physical areas of the new mother's body being assessed. Male students identifying as heterosexual reported feeling more discomfort in the perineal assessment of the new mother and being perceived as 'encroaching on the partner's territory' than their homosexual counterparts. In his wife's birthing experience, participant 9 recalls that:

> "…I would've said absolutely [I would be more comfortable with my wife receiving care from an openly gay male nurse as opposed to a straight male nurse]. If my wife had to have a male healthcare provider, I would've preferred that he was openly gay. I would've told you that I would've been far more comfortable with a gay man, because that way you know that there's no chance of him being attracted to her. But it's not like that for me anymore, I don't feel like that anymore. This is a professional experience, I've met a lot of really caring, really empathetic, really professional male practitioners. You just know that that's not a concern for them, they're there for the health and well-being of their patients. They're obviously not looking other patients like that at all. But now, having gone through this experience with my Wife-I really don't think there's a difference. It just comes down to the attitude, professionalism, and concern for the patients." (Participant 9).

The *third and last* barrier identified by the participants involved five specific situations that were deemed as 'awkward': doing physical assessments on the patients, gender- and ethnicity-based rejection, breastfeeding assistance, perineal assessment policy, and negative stories from previous students. Participants feared being perceived as inappropriate while completing their assessments or providing care; this phenomenon was exacerbated while

obtaining consent for the assessment given the social climate of the #metoo movement (Participants 1, 4, 5, 7, 8 and 9). Participant 5 describes that:

> "Straight male students…are attracted to women. You're not used to seeing someone of the opposite sex like that [exposed for a perineal assessment] unless you're in a relationship or something. It's hard to explain, but a man who is heterosexual is attracted to females, and it's awkward because if you're a male student assessing a female patient- I feel like sometimes the patient gets worried that I'm asking to see something because I want to see it- even though I have to see it as part my assessment. So I think that's the reason the whole stereotype of maternity is that you get to see a whole bunch of female's intimate areas- but in reality I got nervous because I didn't want them to think I'm just looking for the sake of looking. Especially new moms, they may be ignorant of how a postpartum assessment works and they may not know what needs to be assessed. I guess that ties into the fear of being sexually accused or something…men who are gay don't have to worry about don't have to worry about patients thinking the nurse just wants to see something or thinking that they just want to check them out. I don't know, maybe that's really far-fetched" (Participant 5).

The participants expressed how they had been rejected based on gender or ethnicity. Gender-based rejection pushed the students to reflect on the ethical dilemma of providing culturally sensitive care while accounting for gender inclusive learning environments (Participants 1 and 2). Providing breastfeeding assistance was described as awkward due to the male students' lack of female body parts (Participants 2, 3, 4, 5, 6, 7, 8 and 9), and obtaining consent to touch. Participant 8 describes:

> "This is part of our job- how to teach breast-feeding, and how to support moms while breast-feeding. I came into the placement wanting to know more about breast-feeding, I thought it was going to be more challenging for me as a man because I don't have breasts, and chances are that a lot of women would probably say that 'you don't have the parts, so how can you teach me how to do it'" (Participant 8).

Participants identifying as homosexual and heterosexual felt awkward about providing breastfeeding support, but heterosexual participants were less comfortable given their age, that society sexualizes women's bodies and breasts, and that this is the first time that they have had to touch a young woman's body without sexual context. Furthermore, Participant 8 described that there was inconsistency and limitations in terms of independent perineal assessment at certain

clinical sites; specifically, that this practice is in place at some host clinical institutions but not at others. The students' role is restricted and they are unable to complete an independent perineal assessment. He explained how this was a significant barrier to his learning experience. He presented various reasons for this: 1) he was unsure of the history of, or the rationale behind this practice, as he was just told to 'do it for your own protection'; 2) there was inconsistency between the clinical groups as other male students were able to complete independent perineal assessments; 3) having to get another female student in the middle of this particular type of assessment made it awkward to complete it as it severely interrupted the flow; 4) he was concerned with being perceived as being less competent as there was no such practice for female nursing students; and 5) he was unable to articulate if this practice is really protective of the male students in light of the #metoo movement. Consequently, such a policy may set an expectation of male nursing students as being inappropriate and must be supervised. He highly recommended removing this practice in future rotations. Lastly, Participant 7 reported how hearing about negative experiences from previous male students who had done the PHN clinical placement had negatively impacted their learning experiences. This particular placement is often the topic of discussion amongst the male students in the undergraduate nursing program. The participants described it as being 'hyped up' to be a very awkward, negative experience. This sets a negative expectation for them, but interestingly, most of the participants reported that it was not as negative as they were expecting it to be. Some participants also reported that the hype came from professors themselves or members of their social support network.

Despite these barriers, the participants reported using four main strategies to deal with them in the PHN clinical placement in the hospital. The *first* strategy involved increasing professionalism to decrease the perception of inappropriate behaviour: this involved wearing

gloves during the breast assessment or helping with feeding (Participant 2) to reinforce the professional encounter. The participants were also hyper-vigilant about their choice of terminology, giving instructions during assessments, and when explaining the perineal assessment policy to patients and partners (Participants 4, 5, 7, 8, and 9). The *second* strategy involved focusing on building rapport with the patients, such as by slowly introducing themselves and easing into the assessment (Participant 2). An example of this is when Participant 9 shared that he has children of his own in order to give him more credibility with the patients. The *third* strategy was about building confidence, or faking the amount of confidence, because this would make the patients feel more comfortable, let the students do more, and decrease being rejected. By doing do, this turned into a positive feedback cycle (Participants 1, 2, and 3). Unfortunately, rejection still happened sometimes. When it did, the participants did not take it personally (Participant 7). Buffers to counter the rejection included for a clinical instructor not asking a patient's permission to have a male nursing student, but asserting that the patient will have a nursing student and not focusing on the gender. The *last* strategy involved being in survival mode. Participant 4 found the PHN clinical placement to be very uncomfortable and he got through it by being in 'survival mode' and compartmentalizing his experience in order to move forward.

5.5 Solutions for Improvements

This section presents the results to the fourth research question, "What are the solutions suggested by the male nursing students to the barriers identified by them to improve their PHN clinical practicum?". The participants suggested solutions for each of the three parts of the PHN clinical practicum: laboratory, simulation and clinical placement. The qualitative results for this section come from questions 21, 22, 23, and 24 of the interview guide (see Table 6). No

qualitative data were obtained to answer this research question. This section is divided into four subsections: the overall PHN practicum, the laboratory, the simulations, and the hospital placement.

5.5.1 PHN Clinical Practicum

Eight participants (89%) stated that the overall PHN experience needs to be improved for male students. Six suggested changes were offered; half of which are at the institutional level, and the remainder are at the societal level. At the institutional level, integrating a confidence building workshop for male students was addressed by four participants (Participants 5, 6, 7 and 8). They suggested incorporating this optional learning opportunity at the beginning of the PHN clinical practicum. They suggested the following content to be included: phrasing about professionalism, use of correct terminology, and obtaining consent before procedures in order to reduce the chance of being perceived as inappropriate. The other suggestions for overall improvement of this practicum included: incorporating better training for instructors (Participant 4), and removing the inconsistent perineal assessment practice (Participant 8).

At the societal level, acknowledging male discomfort (Participants 5 and 9), and not focusing on the gender of the student upon introduction (Participants 1, 2, 5, and 9) were solutions offered. One participant states that, “I know you can't change the way patients perceive things, but maybe teaching certain ways that males can cope with it better, or like how they can approach the patient. Maybe something to help males specifically?” (Participant 5). Furthermore, Participant 8 suggested including an option for male students to opt out of certain clinical activities that cause significant discomfort and therefore, negatively impact their learning experiences, specifically with breastfeeding assistance (Participant 9). Interestingly, Participant 1 states the opposite. He believes that:

> "Yes, I think it's more like the attitude around it, not like if there's a male nurse they should have it easier because in maternity because-its ok if you don't do the fundal check or check the bleeding because you're uncomfortable with it. No, you're going to go into that room and you're going to have it as hard as the other students. I've heard friends do a catheter on a man and they say its uncomfortable but they do it. They have to do it. You're going to do it in your career, unless you're working labour and delivery! But you know, you're going to do it. So why should men be like 'this placement, I'm just going to pass because I'm a guy and I have it easy.'" (Participant 1).

This statement alludes to the fact that sometimes, male students have different learning experiences than female students, and they are held to different standards than their female counterparts are. Additionally, it highlights the various complexities that contribute to this clinical practicum, and that one rigid course of action cannot be taken.

Participant 3 was the only participant (11%) who stated that the PHN practicum cannot be changed or improved for male students. He explained that the aforementioned interventions would likely help, but this particular practicum will always be awkward because of the way North American society is socialized around women's health and nursing, "…honestly I had a good experience and I don't know that there's a lot to change – it's more the attitude and I don't know if the school can really change that. The whole female reproductive system is so taboo for men, so I think that's the problem."

5.5.2 PHN Laboratory

Seven participants (78%) noted some areas for improvement in the PHN laboratory, while the remaining two participants (22%) thought that they were adequate, and no changes were needed (Participants 2 and 3). Three recommended changes were suggested; two of which are at the institutional level and one is at the societal level. The following recommendations at the institutional level were suggested: integrating more complex scenarios to improve critical thinking skills (Participant 7), and removing the CFAM model as it is outdated material and is no

longer relevant (Participant 9). At the societal level, one participant described that acknowledging the male students' discomfort and the double standards with female students, such as when instructors point out male discomfort with skills like breastfeeding, would be a positive change. He states,

> "How do you ask the patient permission to touch? How do you obtain consent properly? I think addressing it is really important, even if there's only one male nursing student in the group, because that's something that male students might face- women may not be comfortable with a man touching their breast to help them breast-feed. I think really honing in on the differences that male nursing students might have to communicate with moms and families" (Participant 8).

5.5.3 PHN Simulation

One participant (11%) was unable to recall the PHN simulations and was therefore unable to offer any suggestions for improvement. However, the other eight participants (89%) did offer some constructive feedback to improve the PHN simulations for male students. They suggested five changes; four of which are at the institutional level and one is at the societal level. At the institutional level, the participants suggested integrating a confidence building workshop for male students (Participants 4, 5, and 9), timing the simulations to be completed before the start of the clinical placement (Participant 8), including more complex scenarios to improve critical thinking skills (Participant 7), and having more empathetic, patient instructors (Participant 4). Participant 4 also highlighted that performance anxiety will likely always be a part of simulations and cannot be changed; this is similar to the discomfort that the men face in PHN because of social norms. At the societal level, one suggestion includes acknowledging the awkwardness that male students face (Participants 4 and 7). Participant 7 states that, "I say the same thing as before, like acknowledging that it might be awkward-and offering solutions us to do with that." Although these suggestions would positively impact male students' learning

experiences in the PHN simulations, these parts of it cannot be quickly or easily changed. The acknowledgment of these various complexities is not a solution, but it is a feasible starting point for change.

5.5.4 PHN Hospital Placement

All participants (100%) agreed that the PHN hospital placement needs to be improved for male students. There are four suggestions on how to improve the PHN hospital placement; three of which are at the institutional level, and one is at the societal level.

At the institutional level, the participants recommended acknowledging the discomfort that male students experience during their clinical placement, and how the discomfort impacts their learning experiences. Participant 4 describes this in the following way:

> "Once in my four years of nursing school did we talk about gender, but it wasn't much - maybe a three or four minutes talk about the history of it and its result… Talk about it so that it exists. So that if it happens to you, you know where to turn to. By not talking about it, it continues to be an invisible issue. And because of that [it's not explicitly stated anywhere], no one's listening. This is something that needs to be said at some point. Like maybe in orientation or something like that. Maybe talking with the guys and seeing where they're at in the program-maybe we can prepare them differently or prepare them better; let them know that the doors open for them in case there's anything that happens" (Participant 4).

Another suggestion at the institutional level included recruiting better instructors, specifically, those who are aware of the challenges that male students face and actively integrating gender inclusive learning opportunities to their teaching style. Participant 4 explains that:

> "I feel like they're just desperate, like they look for anyone to be a clinical instructor. And a lot of them are great clinical instructors, but we should have a way of giving instructors feedback like on rate your professor or something. If they're just on the unit they're in the dark and there's no accountability or follow-up- so this will be a way to increase accountability. Maybe it would also prevent instructors from being power-hungry" (Participant 4).

Lastly at the institutional level, one student would also remove the inconsistent perineal assessment practice. He states that:

> "If I were an instructor, I would just make sure the families knew, and the patients knew what was expected of the students. It really helps build the students confidence. It makes it less awkward the first time I had to go get another colleague because I'm really starting to question myself. The other thing is, would it be possible is to have a sim with just the male students on how to communicate with the patient and family? Just because there may be a difference between how females communicate and males communicate." (Participant 8).

The most frequently reported suggestion at the societal level is not to focus on the gender of the student on introduction (Participants 1, 2, and 4). Participant 2 states:

> "Not focusing on gender of student during introduction. Do not say "he's a male". Don't put it in their heads that they're going to get rejected and they're going to struggle. Because we don't say that to a male nurse that 'you're going to struggle in medicine'. By putting it in their heads- because it was in my head-… It's like going to a party, if someone says 'it's boring, the people are boring' it might be the most lit party, but in your head you're like 'I don't like the people, I want to go'" (Participant 2).

5.6 Participants' Perceptions on Participation in this Study

This section explores the participants' perceptions of engaging in this research study, as well as any additional comments they provided. The qualitative results presented here come from the interview guide and the online questionnaire.

The qualitative results for this section come from questions 25 and 26 of the interview guide. All nine participants (100%) stated that engaging in this research study was a positive experience. They re-iterated the importance of this study because, "it is ahead of the curve for gender diversity within nursing" (Participant 7), it is "impactful because of the lack of current research in this topic" (Participants 6 and 8), and it has the ability to positively impact nursing students, educators, and nursing curricula. This study acknowledges gender based differences in learning, within the nursing profession, and within PHN. The participants shared that it was

therapeutic to share their stories and felt reassured that a researcher was exploring this phenomenon.

The qualitative results for this section come from question 51 of the online questionnaire. Four participants (44%) added additional comments to the end of the online questionnaire. One participant (11%) shared that the PHN clinical practicum was uncomfortable for both him and his patients (Participant 4). Two participants (22%) re-iterated the importance of the clinical instructor fostering student confidence (Participants 2 and 7). One participant (11%) reinforced the negative learning experience associated with the perineal assessment policy, as it, "makes male nursing students appear less than their female counterparts because we are not allowed to complete assessments alone" (Participant 8).

These results suggest that participating in this research study was a positive experience because of the acknowledgement, and critique, of the complexities of how gender, social norms, and the North American socialization of women's health impact the learning experiences of male nursing students in their PHN clinical practicum at the University of Ottawa. Also, the results confirm the gender-based discomfort experienced by both the nursing students and families, the importance of the clinical instructor, and the negative learning experiences associated with the perineal assessment policy. Finally, this study offered the participants the opportunity to have their voices heard.

5.7 Summary of the Chapter

This chapter presented the results of the research study. The profile of the study participants was presented, along with the answers to the study's research questions and the perceptions of the participants' engagement in this study.

The major results that emerged from this research study include:

1) The participants had already obtained a certain level of knowledge base and practical skills from their previous theory courses, laboratories, simulations, and clinical placements before they entered the PHN courses.
2) The overall perceptions of the PHN theory and clinical practicum courses were positive.
3) The PHN theory course prepared the students for the corresponding laboratories, simulations, and clinical placement in the hospital.
4) The PHN laboratories and simulations prepared the students for the clinical placement in the hospital.
5) The PHN clinical placement was determined to be an overall positive learning experience.
6) There was a statistically significant difference in the male nursing students' comfort level before and after the PHN clinical placement, with the participants being more comfortable at the end of the clinical placement.
7) The discomfort experienced by the male nursing students before the placement needs to be acknowledged.
8) Five facilitators were identified by the participants in regard to their PHN learning experiences.
9) Three barriers were identified by the participants to their PHN learning experiences, however, they reported four strategies on how to deal with these barriers.

The next chapter discusses the findings from this research study and a reflection on the theoretical framework, as well as highlights its implications for nursing education, practice and research, and the study's strengths and limitations.

Chapter 6 – Discussion

This chapter presents a discussion of the research findings. The purpose of this study is to determine male nursing students' perceptions of their learning experiences in the PHN courses (both theory and clinical practicum). The participants' PHN learning experiences can be divided into positive and negative ones. The first section discusses the findings in regard to the positive learning of the two PHN courses. The second section discusses the findings in relation to the negative learning experiences of these courses. Next, the solutions for improvement of the PHN courses as provided by the participants is featured. The subsequent section highlights reflections of the theoretical framework of Andragogy and its limitations, an explanation of the Andragogy Model for Practice, and how it can be applied to the PHN courses. The sixth section presents the recommendations for nursing education, practice, and research. The seventh section describes the strengths and limitations of this research study. Lastly, the conclusion is featured in regard to the major findings for this present study.

6.1 Positive Learning Experiences in PHN

This section elaborates on the positive PHN learning experiences reported by the study participants. These findings will be discussed under eight subsections, namely: the positive aspects of the Pre-PHN courses, the PHN theory course, the overall PHN clinical practicum, the PHN laboratory, the PHN simulation, the PHN hospital placement, and the facilitators to the learning experiences. Finally, a section summary is featured at the end.

6.1.1 Pre-PHN Learning Experiences

This section explores the various factors that contributed to positive learning experiences before the students arrived in PHN training.

Firstly, the participants cited several reasons for choosing nursing as a profession: it is a meaningful career, they want to help and care for sick people, and they were encouraged by their social network. All of these three reasons contributing to their drive to become nurses was a positive recruiting factor. These reasons were also found by Boughn (1994), Mooney et al. (2008), Wilkes et al. (2015), and Zysberg and Berry (2005). Secondly, these future nurses were retained in the first two years of the undergraduate training at the University of Ottawa due to the quality of the content of the courses, being exposed to various disciplines in the lectures, and experiencing 'University Life' on the main campus. According to Smith-Wacholz, Wetmore, Conway, and McCarley (2019), interventions to decrease attrition of nursing students include: effective teaching methods and styles; utilization of an advisor, clinical coach, or mentor; stress reduction; faculty support; students' background; and perceptions of nursing. Thus, the positive promotion of the nursing profession and the positive promotion of the undergraduate nursing program contributed to recruitment of the male nursing students and their retention with the nursing undergraduate program at the University of Ottawa. Thirdly, these students are arriving in their PHN coursework with two years of previous nursing knowledge and practical, clinical skills and experience. These aspects are supported by Andragogy as these learners build on previous knowledge (Knowles, 1970). Overall, these experiences set a positive tone for both PHN courses, and the students are entering their PHN training with some knowledge and clinical competence under their belts.

6.1.2 PHN Theory Course

Most of the participants (56%) reported that the PHN theory course was an overall positive learning experience. They attributed this to the quality of the professors' teaching, the interesting content, and the logical sequencing of the topics. They also related how the PHN

theory course had prepared them for all three components of the clinical practicum (laboratory activities, simulation scenarios, and the clinical placement in the hospital), thus setting the tone not only for the week (the theory course is taught on Monday mornings of the winter semester) but also for the semester. It is noteworthy that the participants particularly mentioned how the content in the PHN theory course was very useful and enriching for their overall clinical practicum. This is also the first course where the students are exposed to content related to a healthy patient population before learning about high-risk obstetric scenarios.

Drake (2016) mentions some of the core nursing concepts and skills that should be part of the maternal-child health courses and clinical experiences (see Table 1 of this article). Some examples of the core concepts are health promotion, patient and family teaching, patient safety, nutrition, sexuality, mental health screening, pain management, smoking cessation, and cultural competence. The participants in the Balakrishnan et al. (2013) study revealed how they had found the content of the obstetric course as interesting. In the Eswi and El Sayed (2010) study, the most satisfying aspects of studying maternity nursing as reported by the students were the comprehensiveness of theoretical contents (71.7%), and learning how to deal with high risk pregnant mothers (61.6%).

Thus, the content learned in this course appears to prepare the students to practice according to the Perinatal Nursing Standards in Canada (CAPWHN, 2018), in addition to preparing the students for entry to practice competencies in the perinatal context as specified by the Canadian Association of Schools of Nursing (CASN, 2017), as well as the CAPWHN Professional Perinatal Practice Compass Model (CAPWHN, 2018). The course appears to meet its objective by giving the students an adequate knowledge base for the subsequent clinical practicum.

6.1.3 Overall PHN Clinical Practicum

The overall perception of the PHN clinical practicum as reported by the participants was positive and that it is applicable for male nursing students. It was considered such a positive experience for some participants that 56% would consider consolidating and working in this clinical area. Two participants actually chose this area for consolidation and as a career choice after graduation. Most of the participants (78%) agreed that this is relevant content to know in order to be a proficient generalist nurse, as perinatal patients are a unique population, and pregnant women and new mothers can be found in other health care services. All of the participants noted that their positive learning experience in the clinical practicum can be attributed to the quality of their clinical instructors. The role of the instructor is to facilitate learning experiences and bridge the gap between theory and practice. Curran (2014b) found a significant positive correlation among academic role preparedness, hours of professional development training related to adult learning theory, nursing professional development certification status, years of nursing professional development, and use of adult learning theory. This statement reinforces the importance of recruitment, training, and retaining quality instructors as they have the potential to recruit new PHN nurses based on the quality of their teaching.

6.1.4 PHN Laboratory

The participants rated the PHN laboratories to be an overall positive learning experience. They felt prepared for the laboratory as a result of their theory course, and also felt that the laboratory prepared them for simulations and their hospital placement. This course sequencing of building is a concept of Andragogy in that adult learners build on previous experience (Knowles, 1970). The most useful activities include post-partum assessment and care and its corresponding

health teaching, which are supported by Pragmatism and Andragogy. Pragmatism advocates for useful, real life application of knowledge (Felizer, 2010), while one of the principles of Andragogy is that adult learners are motived to learn when material is imminently pertinent (Knowles, 1970).

6.1.5 PHN Simulation

The simulations also contributed to positive PHN learning experiences as revealed by the participants in this study. The simulations continued to build on the consistency and the content learned in theory and laboratory, which is supported by the principles of Andragogy (Knowles, 1970). The simulations contributed to perceptions of preparedness rated to be 7 on 10 (on a scale from 1=’Not Prepared at All’ to 10=’Very Well Prepared’) for the hospital placement, especially in the content surrounding postpartum hemorrhage scenarios. Hemorrhages are one of the most commonly witnessed emergencies on the post-partum unit (Simonelli & Gennaro, 2012), so it makes sense from an andragogic perspective that this scenario was rated to be the most useful, because it is the most practical. Drake (2016) and Simonelli and Genarro (2012) both found that simulations are an effective teaching strategy in PHN education as they augment the content taught in the laboratory and theory. Shin, Kim and Lee (2017) conducted a study of male nursing students’ simulation experiences in PHN in Korea. They found that, “Simulation for maternal and newborn care tailored for male nursing students in Korea demonstrates its value in developing empathetic understanding of pregnancy and childbirth within the psychosocial and cultural spectrum of Korean society. Specifically, simulation training provides the male nursing students with educational, professional, and personal growth” (p. 100). This strategy has already been adopted with good effect by the PHN professors and clinical instructors at the University of Ottawa.

Conversely, the lowest rated simulation was the breastfeeding centre. Pragmatically, this makes sense given the impact of social norms and the discomfort reported around breastfeeding. This discomfort comes from gender, and results in stigmatization in the role (Evans, 2002). This role strain also can lead to stereotyping, which continues to reinforce a false notion that men are less competent bedside nurses than their female counterparts in a PHN setting. This precedent is contrasted with the AWHONN position statement on gender bias in PHN (AWHONN, 2016), and furthermore in the context of the PHN learning outcomes through CAPWHN (2018) and CASN (2017) standards and competencies. Inoue et al. (2004) suggest providing additional support for male nurses when providing intimate care for women, like in the context of breastfeeding.

6.1.6 PHN Hospital Placement

Overall, the PHN clinical placement in Ottawa hospitals provided a positive learning experience as reported by the participants, based on the findings from three sources of data. From the Clinical Placement Satisfaction Questionnaire (Penman and Oliver, 2004), this placement was found to be pleasant, positive, and contribute to meeting learning objectives. Nine of the twelve items as part of the Clinical Placement Satisfaction Questionnaire were rated to be positive. These findings are similar to those reported by Abouelfettoh and Mumin (2015). This positive trend was also consistent with the findings of the online questionnaire and those with the interviews. In regard to the findings from the online questionnaire, support from different sources was important for the participants. The findings from the interviews revealed that some of the participants had many learning opportunities, and liked the continuity of care between the birthing and postpartum units. The reasons cited for this positive learning experience include the information sharing among the PHN faculty in order to provide consistency in messaging.

It appears that providing an optimal learning experience in the clinical setting (Drake, 2016) increases the students' positive perception of the PHN clinical placement. Drake (2016) explains how "the inpatient perinatal setting can present students with numerous opportunities for learning" (p. 180), and how the students can be exposed to "challenging ethical, legal, and social issues that can increase the complexity of care in this area" (p. 180). These findings are consistent with one of the principles of Andragogy (Knowles, 1970) in that the learners need to know the rationale as to why they are being taught something (Holton et al., 2001).

Furthermore, there is a statistical significant difference in the participants' comfort level between starting and completing the PHN clinical placement. The participants reported how the postpartum and newborn assessments were the most useful activities completed in the clinical placement. According to Holton and colleagues (2001), comfort appears to be a successful outcome of adult learning as it applies the learning principles of self-concept and orientation to learning.

6.1.7 Facilitators to Positive Learning Experiences in PHN

The participants identified five facilitators for their PHN training during the interviews: the clinical instructor, nursing staff, patients and their family members, the two male nurses working in PHN, and the comradery of other students. All five facilitators are centered on human factors.

6.1.7.1 Importance of Clinical Instructors

The clinical instructors for the three components of the PHN clinical practicum (laboratory, simulation, clinical placement) were deemed to be very important by the participants. Clinical instructors are, "experienced professionals who teach, supervise, and act as role models for students in degrees involving clinical placements. They must therefore have

qualities such as work experience, leadership, collaboration, and consulting skills" (Martinez-Linares, Parra-Saez, Tello-Liebana & Lopez-Entrambasaguas, 2019, p. 2).

All of the participants cited the teaching style of the clinical instructors as contributing to their positive perception of the three components of the PHN clinical practicum. Martinez-Linares and colleagues (2019) determined that effective clinical instructors should have the following aspects: teaching skills, nursing competencies, good interpersonal relationships and personality, good clinical organizational skills, and they must be approachable able to provide an adequate clinical orientation (Martinez-Linares et al., 2019). Collier (2018) determined that the interpersonal skills and approachability of clinical instructors are the most important traits in their efficacy (Collier, 2018). On the other hand, Reising, James and Morse (2018) indicate that clinical instructors need to be mentored on how to effectively teach. There is research to support the attributes of effective clinical instructors and their teaching style, but there is no literature in regard to male students or within PHN.

6.1.7.2 Quality of Nursing Staff

Another effective PHN educational strategy involves the support of the staff nurses at the clinical venues in the Ottawa hospitals. Overall, they were reported to enhance the male nursing students' learning experiences. They advocated for the students, were willing and available to help on the unit, and were interested in increased gender diversity within PHN. They also offered encouragement to the students who were interested in this clinical specialty by reassuring them that the precedent of hiring male PHN nurses in some areas had already been set. Drake (2016) stipulates that educators need to continue to develop and maintain flexible and creative ways of delivering education that will positively impact the students' clinical learning. Furthermore, AWHONN (2016) asserts that gender diversity within PHN is crucial to

professional evolvement, and advocates for increased gender diversity within PHN. The positive attitude from the staff nurses supports the diversity recommendations that AWHONN suggests. Lastly, Mitra et al. (2018) reveal how, "Unit staff members who are welcoming and enthusiastic to teach are instrumental in providing a positive maternal nursing experience for students and promoting a comfortable environment for all parties involved" (p. 333).

6.1.7.3 Already Employed Male Nurses in PHN

The participants in this study reported feeling relieved to know that two male nurses were already employed in this clinical specialty in a regional Ottawa hospital. Three participants had the opportunity to work with them during their clinical rotation as they were employed at one of the clinical venues. In this particular clinical setting, the precedent has been set that male nursing staff can be hired in order to work there, either in the birthing unit or in postpartum. To date, no male PHNs are employed in any of the nurseries in Ottawa. These male nurses were able to share their unique experiences with the participants and relate to them on a level that the female nurses were unable to do.

As per Bartfay and Bartfay (2017), there is a lack of male role models in nursing, more so within PHN. This may negatively affect the recruitment of future male nurses to this clinical specialty. In the Buthelezi, Fakude, Martin, and Daniels' study (2015), there is a minor reference to the experience of male nursing students doing a clinical placement in a 'maternity setting', however, the context was more generalized. The male nursing students reported how, "The presence of male nurses in the clinical setting helped students to feel part of the team and to become comfortable within the nursing team. This increased the level of students' participation in learning in the clinical environment" (p. 5). Golden (2018) writes that, "Recruitment of male RNs to labor and birthing units may be aided by nurse managers working with educators to

correct the impression that maternity nursing is feminine" (p. 367), and that, "…recruitment of male nurses to an area of practice where men are grossly underrepresented. Once again, here is an opportunity to talk about and use the unique perspectives that males could bring to a largely female-dominated specialty" (p. 371). Indeed, AWHONN (2016) states that gender bias exists, and that the female gender is not a requirement to be a nurse in PHN.

6.1.7.4 Support from Patient and Family Members

Some patients and their family members were very supportive of the male nursing students' presence by being understanding of the students' unique situation. They allowed the students to complete their assessments and teaching, and fostered their confidence. This was done through displaying patience and empathy. Only one study has been published to date that presents female patients' perceptions on being cared for by male nursing students (Morin et al., 1999). The mothers in the Morin et al. study (1999) used their personal feelings to guide their decision to accept nursing care from a male nursing student during the birthing and postpartum experiences. The mothers' psychological comfort was the determining factor. Also, certain partners who were present in the rooms when the mothers were being interviewed shared their feelings, "Most fathers stated that as long as their partner was being cared for it did not matter to them if the person was a man or woman" (p. 86).

6.1.7.5 Comradery of Other Students

The participants expressed how the other students in their clinical groups were a source of support. The participants explained how some of their female colleagues were empathetic and offered additional support during assessments, bathing, and teaching, and if the participants asked for it. Furthermore, other participants noted the comradery of other students in different clinical cohorts. The participants spoke with other students who shared success strategies and

gave an overview of the clinical placement so that the participants had realistic expectations and weren't blindsided. It is interesting to note that although having another male classmate in any of the three components of the PHN clinical practicum was helpful, the female students were also considerate. One participant described the female students as being willing and available to provide him with additional support during the clinical placement, and were able to assist him in being present in the room as per the perineal assessment policy. This was an asset mostly in the hospital setting, although some moral support was offered by female nursing students in the laboratories and the simulations. In the Balakrishnan et al. (2013) study, the male nursing students shared how peer support during their clinical rotation in PHN was very helpful, as it was a good moral support, increased their confidence, and helped them to give care to their clients. Additionally, males are a visible minority within nursing and often show extra comradery for each other as evidenced by being members of certain clubs (CARNA, 2013), and by having other male nursing students at the same time during their clinical placement (Powers et al., 2018).

6.1.7.6 Summary of Facilitators

The facilitators of the instructor, staff, patients and family members, and male PHN nurses are all human factors that are related on an institutional level. The importance of the clinical instructor was the most apparent in the interviews. The role of the instructor is to bridge the gap between the institution of the school and the institution of the hospital. Mahlmeister (2008) asserts that the PHN clinical practicum is more high risk than acknowledged, as this may be the students' first clinical placement in the hospital and stresses the importance of appropriately trained clinical instructors. Furthermore, Draganov and collaborators (2013) suggests that scaffolding learning and sequencing courses to build on previous knowledge, as the University has done and is doing, better prepare students for a clinical environment (Draganov

et. al, 2013). Another area of previous knowledge that participants built on were the age, and previous life experience of the students; as well as having a child to build rapport with the patient and increase perceived validity. Powers et al (2018) supports these findings by stating that, "…some participants were able to care for maternity patients, especially those participants who were older or who had children of their own" (p. 478). These positive factors also account for gender inclusive learning opportunities as they advocate for the acceptance of people in non-traditional gender roles. This facilitates meeting the CAPWHN (2018) and CASN (2017) PHN standards of care. Andragogy is applied in this context as common stereotypes are broken down, social norms begin to change, and society becomes more accepting of men's non-traditional roles.

6.1.8 Section Summary

This section explored the participants' perceptions of their positive PHN learning experiences in the context of the pre-PHN learning experiences, the theory course, the three components of the clinical practicum (laboratory, simulation, and clinical placement), and facilitators of the PHN learning experience. There are five main facilitators: the importance of the clinical instructor, the quality of the PHN staff, already employed male nurses in PHN, support from patients and family members, and the comradery of other students. Taken together, these experiences account for the participants' positive perceptions of their PHN learning. Faculty, clinical instructors and others need to be reminded that the PHN courses (theory and clinical practicum) are part of the third year of the four-year undergraduate nursing curriculum, just one of several courses where the students acquire new clinical knowledge and skills. According to Landers, O'Mahony, and McCarthy (2020), third year students are Advanced Beginners and are in the phase of 'Identification', meaning, "The student has acquired the

necessary theoretical and clinical knowledge/skills commensurate with third year of the program" (p. 162). Their mastery of clinical learning continues to evolve and progress with time. The next section explores the contrary, negative learning experiences.

6.2 Negative Learning Experiences in PHN

This section provides a different perspective than Section 6.1 as it explores the participants' negative learning experiences in PHN. Any learning experience that is considered neutral is integrated with the negative ones. This section which mirrors Section 5.1 will present the following: the pre-PHN learning experiences, the PHN theory course, the overall PHN clinical practicum, the PHN laboratory, the PHN simulations, the PHN clinical placement, and the barriers to the participants' learning experiences. A section summary is featured at the end.

6.2.1 Pre-PHN Learning Experiences

This section explores the participants' negative learning experiences prior to the PHN courses at the University of Ottawa. Although the overall training thus far has been reported by the participants as being a positive experience, three participants (33%) did report feeling out of place in relation to their gender. They reported that the gender distribution of students reinforces the idea that nursing is a female dominated profession, and the stigma male nursing students face as a result. It is interesting that the male nursing students in the Patterson and Morin (2002) study also reported feeling 'out of place'.

Kouta and Kaite (2011) conducted a literature review on gender discrimination within nursing and found that some contributing factors to this type of discrimination include: gender roles, using the term 'male nurse', and that the nursing curricula is feminized (Kouta & Kaite, 2011). They also found that the following had an impact: negative stereotypes of male students, no male faculty, educators using the word 'she' to describe nurses, limited role models, no

resonation of the role of men in nursing history, lack of guidance on use of touch, being treated differently by faculty, lack of gendered aspect of learning, feelings of isolation and exclusion, and not prepared to provide intimate care to women. Using the term 'male nurse' continues to reinforce gender norms for the profession because it specifies the perceived difference between caring capabilities between genders. This reinforces negative stereotypes of male providers and can perpetuate gender based discrimination within the nursing profession (Eisenchlas, 2013). Kouta and Kaite (2011) indicate that one way to counteract these factors is by nursing faculties giving accurate information about the impact of gender, stereotypes, and learning to students, and acknowledging the complexities and nuances of the aforementioned factors (Kouta and Kaite, 2011).

Furthermore, Kouta and Kaite (2011) explain that certain clinical domains such as PHN have a higher incidence of gender bias, and that gender impacts male nursing students' learning experiences, especially in PHN. They partially attribute this to a lack of proper educational training to assess female patients. In order to combat this stereotyping, Kouta and Kaite (2011) recommend providing role modeling opportunities for appropriate intimate care. They write,

> Nursing educational programs need to be reviewed and provide equal opportunities for all nursing students. Faculty should create a climate of acceptance for student's differences and empower male nurses in providing intimate care for women clients. One method of empowering male nursing students could be sharing stories about caring instances involving male nurses providing intimate care and role modeling…role modeling the therapeutic relationship with clients is another strategy to help male nursing students prepare for intimate cases…using humor and giving a full-detailed guidance for intimate procedures to women clients could help both male nurses and women clients (p. 62).

6.2.2 PHN Theory Course

Although the PHN course was overall rated to be a positive learning experience by the participants, four of them (44%) shared that the quantity of information was too much, some of

the content was not applicable, and the theory course could be better organized. However, the two findings that they revealed to be the most negative were how faculty mentioned that PHN was not popular with male nursing students because of its background, and that the clinical placement was spoken of in a negative a manner. The impact of these findings is that it set up a negative tone for the clinical practicum, especially the clinical placement in the hospital, for certain participants.

The education system reflects the higher rules of social life. Ostrouch-Kamińska and Vieira (2016) state that, "the educator or the facilitator of learning should not ignore the potential effects of gender as a social category that are entrenched in how individuals evaluate themselves including their expectations of success as learners and the meaningfulness of possible subject matters to learn" (p. 45). Educators are in a powerful position to set the tone of the upcoming clinical placement in PHN. This aspect is supported in the Patterson and Morin (2002) study in that faculty are "setting the tone" (p. 270). This tone can affect the male nursing students' learning experiences by inadvertently continuing to reinforce negative stereotypes. The same authors argue that, "The task of adult educators who have a critical approach to teaching is to stop transmitting stereotypical divisions of gender statuses and roles through transformation of the content of the awareness of the adults" (p. 49). These stereotypes may also confirm the students' fears prior to starting the rotation, which may lead to higher expectations of discomfort, gender bias and rejection.

6.2.3 Overall Clinical Practicum

All of the participants (100%) reported various fears before starting their PHN clinical practicum (laboratory, simulation, clinical placement) that were gender based rejection: they did not feel that they belonged in this setting, they felt that the female students had more learning

opportunities, felt that they had to prove themselves more and were held to higher standards than their female counterparts, felt being perceived negatively or inappropriately by nursing staff, patients, and partners, and that their appearance and sexual orientation would be a deterrent. All of the aforementioned fears share the common thread of gender. Kouta and Kaite (2011) assert that different clinical domains have different levels of gender bias, but there appears to be more of it in PHN. Gender bias can lead to gender based discrimination, and that gender norms continue to be reinforce for the nursing profession because these student and nurses are different (Kouta & Kaite, 2011). It is noteworthy that gender bias was present in all eight of the studies that were retained for empirical evidence as featured in Chapter 2 (Balakrishnan, Sheoran, & Bishnoi, 2013; Bartfay &Bartfay, 2017; Eswi & El Sayed, 2011; Ha, Kim, Choi & Ahn, 2015; Mitra, Philips &Wachs, 2018; Patterson & Morin, 1999; Powers, Heron, Sheeler & Sain, 2018; Sherrod, 1991). In the Eswi and El Sayed (2011), one of the themes that emerged from the findings involved the male nursing students' training attitude toward mothers during their clinical training. Eswi and El Sayed (2011) write, "None of the study sample had a rejecting attitude toward pregnant women" (p. 95). Thus, gender bias appears to exist toward the male nursing students, but not from these male nursing students toward the perinatal female clients. Indeed, Balakrishnan and colleagues (2013) write that, "One of the most important things to remember about nursing is that it is a profession; it is not a gender" (p. 3).

Also, the participants in the present study revealed how the following tasks were the least comfortable for them to carry out: breastfeeding assistance, perineal assessment, and urinary catheter insertion. The male nursing students in the Balakrishnan et al. (2013) study share this, "Most of the participants loved to study obstetrical nursing but they had problems when it came to clinical practice" (p. 5). Some of these aspects that were not comfortable for them related to

touching parts of the women's bodies during the postpartum assessment, and assisting with breastfeeding. In the Patterson and Morin (2020) study, the male nursing student participants expressed concern about the postpartum assessment, "…concerns about meeting maternal-child clinical objectives and personal goals surfaced for the students because they felt that because of their gender they may not be able to complete a postpartum assessment successfully" (p. 269). Golden (2018) wrote about his experience as a male nursing student in PHN, "Admittedly, I found the aspect of touch and intimate care the most daunting part of my maternity clinical rotation; however, I attribute that more to a lack of education and my inexperience as a student than to the idea that I am an inherent liability because I am male" (p. 369), yet he was able to do the following, "In fact, because of my knowledge of breastfeeding, I assisted three of these women and their newborns with latching and nipple shield use, and I answered many questions about breastfeeding and pumping" (p. 368).

6.2.4 PHN Laboratory

Four participants in the study mentioned that the PHN laboratory was a negative learning experience. They attributed this to a lack of breastfeeding information, the CFAM was outdated, and limitations to the equipment, especially with the uterine funder trainer. The least useful activity in the PHN laboratory was rated to be infant feeding. It is worthy to note that the participants revealed that the least useful activity in the hospital setting was also infant feeding. In the hospital setting, the part of infant feeding that the participants are the least comfortable with is providing breastfeeding support to the new mothers. They attribute this to the lack of these body parts, the social context of breasts, and the fear of being perceived as inappropriate. These societal level influencing factors negatively impact the students' willingness and ability to learn these skills.

Terzioğlu and collaborators (2016) explain how, "…professional training…requires the integration of knowledge and practice…The educational environments that are frequently used in transferring knowledge to practice are the nursing skills laboratories, the standardized patient laboratories and the clinical environments" (p. 104). The findings from the Terzioğlu et al. (2016) study reveal how the scores from the participants' (both female and male) psychomotor skills were the lowest in the nursing skills laboratory than those in the standardized patient laboratory (simulation) and the clinical practice environment. Thus, the laboratories are important, yet are a part of the students' practicing their acquired knowledge and different clinical skills. Taking all of the aforementioned findings together, as per Andragogy, adult learners are motivated to learn when there is a practical reason to do so (Knowles, 1970). From an Andragogic perspective, the consistent low scores for the usefulness of breastfeeding assistance as revealed by the participants in the present study are understandable. However, infant feeding assistance is one of the CAPWHN's (2018) entry to practice competencies, and students are therefore expected to have some exposure to this skill.

Indeed, in the O'Lynn and Krautscheid (2014) quasi-experimental study, male nursing students were exposed to an intimate touch laboratory. These laboratories were initiated as male nursing students voiced more concerns about intimate area assessment than female students do, as a result of gender roles and negative stereotypes. The findings from this study reveal that the participants were significantly more comfortable assessing intimate areas and were less apprehensive about being misperceived as sexual and inappropriate after having been trained in the intimate touch laboratory (O'Lynn & Krautscheid, 2014). Expanding the PHN laboratory to include a section on intimate touch is suggested for the male nursing students at the University of

Ottawa preparing for their clinical placement, and thus increase their confidence in this area (Inoue et al., 2004; Kouta & Kaite, 2011; Morin et al., 2018).

6.2.5 PHN Simulation

Although the majority of the participants did report that the PHN simulation was a positive learning experience, two of them indicated that this second component of the PHN clinical practicum did not prepare them for the PHN clinical placement. The two learning scenarios that were rated to be the least useful were difficult breastfeeding and the well-baby clinic. The lower scores were reflected through the timing of the simulations, as sometimes they were scheduled after the students had been in the hospital environment. Also, these findings are similar to those reported in the laboratory component of the PHN clinical practicum.

The Canadian Association of Schools of Nursing [CASN] (2017) have encouraged and supported the incorporation of simulated learning experiences (simulations) into curricular design. In more recent times, simulations in PHN have been developed and integrated into practical clinical education (Kennedy, Jewell, & Hickey, 2020; Kim, Ko & Lee, 2012; Shin, Kim, & Lee, 2017). According to Kim, Ko and Lee (2012),

> "Simulation-based education consists of various forms of education including multimedia technology, anatomical models, and simulators of the human body. It is a new education strategy that improves the safety of patients. This education is designed to mimic real-life situations and provide opportunities for health professionals and students to find solutions for clinical problems" (p. 313).

These authors continue by stipulating that simulations in PHN can be considered as an educational alternative than can overcome any limitations in the PHN clinical practicum. Indeed, Andragogy allows adult learners to build on previous learning experiences (Knowles, 1970). Andragogy is being incorporated into the theory by guiding and supporting simulations. Clapper (2010) explains the relationship between simulations and Andragogy. He writes, "Some

educators may not be aware that adult learners bring into the learning environment frames of references that are varied, both positive and negative" (p. e8). Some of the participants may be bringing some of their negative learning experiences to the PHN simulations, as the laboratories may have been somewhat negative in regard to the aforementioned aspects (difficult breastfeeding and the well-baby clinic). Also, the lack of frontloading the simulation schedule goes against this principle of Andragogy because the students have already practiced these skills in a clinical environment on a real patient; these aspects can also be challenging already in the hospital setting. The usefulness of the safe learning environment in the simulation could be decreased as a result of this timing. Indeed, in the Kennedy, Jewell, and Hickey (2020) study,

> "…due to social and cultural norms in this predominantly Muslim country, male nursing students are prohibited from practicing with mothers and babies in Qatar. In order to address this need, we developed a fully simulated clinical practice module for these male students" (p. 1).

According to these authors, the simulations provided an opportunity for the participating male nursing students to bridge the theory to practice gap through application of knowledge and reflection about their skills. The findings from this study reveal that, "Participants felt that learning in simulations was effective, brought the concepts to life, and gave them opportunities to learn that they would otherwise never receive" (p. 4).

6.2.6 PHN Hospital Placement

Three participants (33%) indicated that they did have negative learning experiences in regard to their PHN clinical placement in the hospital. The findings from the online questionnaire reveal that the relationship with the partner and with the new mother's social network had been rated the lowest. Additionally, the participants cited the following contributing to these negative perceptions: gender, awkwardness and discomfort, fearing being perceived as

inappropriate, being a similar age to the patient, and the partner's discomfort with a male health care provider. Newborn assessment, care and feeding were amongst the challenges that the participants had to deal with.

These complex social standards negatively influence the participants' learning experiences in the PHN clinical placement; yet paradoxically, these factors are the 'expected' experiences of male nursing students and contribute to the lack of research in this area. In the Sherrod (1991) study, "…the results of this study suggest that male nursing students experience more role strain in the obstetrical area than female students" (p. 500). Other studies abound in this sense that the PHN clinical placement can be challenging for these students (Patterson & Morin, 2002; Powers et al., 2018). Kouta and Kaite (2011) explore the idea that certain parts of nursing care may be limited for the students, "…it is inappropriate for men to provide certain types of nursing care- ie: female catheterization" (p. 61), on the basis of their gender, normative roles, and agentic qualities (Eisenchalas, 2013). Furthermore, Ostrouch-Kamińska and Vieira (2016) state the following:

> "...the way we understand gender as a social construct influences our daily lives and pervades the organization of educational institutions… what learners and teachers have experiences and believe about gender can have power over educational practice, curricula choices and priorities for research and intervention, and public policy" (p. 40).

Indeed, Sherrod (1991) writes that, "…the findings suggest that concerted efforts be made to delineate specific measures to reduce role strain for male nursing students in obstetrics (p. 501). In order to promote positive PHN learning experiences for male nursing students, educators are encouraged to acknowledge the impact of gender (Ostrouch-Kamińska & Vieira, 2016), and integrate a confidence building workshop for these students at the beginning of their PHN clinical practicum.

6.2.7 Barriers to PHN Learning Experiences

The participants noted three main barriers to their PHN learning experiences: nursing staff, female patients, and awkward situations. These barriers will be explored, along with the five strategies that they used to deal with them. A section summary is featured at the end.

6.2.7.1 Nursing Staff

The participants reported how the nursing staff had an impact on their learning experiences in the hospital setting. The relationship with staff was negatively affected by gender. The participants noted gender distribution in nurses and physicians in PHN, namely that the nursing staff were predominantly Caucasian females and that the physician staff were predominantly older, Caucasian males. This gender distribution of staff continues to reinforce gender normative behaviour, its impact on career choice, and the perceived acceptance of this choice (Eisenchlas, 2013). This theme is also portrayed in popular culture as male nurses are stereotyped to be effeminate, gay, or inappropriate caregivers (Bartfay & Bartfay, 2017; Powers et al., 2018). There is little current evidence regarding the experiences of nurses who have a different sexual identity than heterosexual. There is some evidence to support various paradoxes regarding the stereotypes of sexuality and clinical speciality (Harding, 2007). Balakrishnan and collaborators (2013) reported similar findings in that male nurses have an important role in obstetric nursing but there is low acceptance by the clients and staff. “Most male nurses are interested to work in this area, but due to the less demand and acceptance in our country, they don’t choose to work in obstetrical units” (p. 5-6). Ha and collaborators (2015) continued to find that the main barrier to male students’ learning experience was gender and gender based rejection. It is interesting to note that the impact of gender and the fear of gender based rejection appears to be a global phenomenon, given the similarity in experiences, despite the year and

country of publication of the articles. Mitra and collaborators (2018) discuss unit culture and male students' perception of being welcomed by the staff. In regard to the maternity culture as presented in the Mitra et al. (2018) study, "Some participants perceived an organizational culture on the OB units. Whether it was regional, religious, or created by the staff's work dynamic, the participants sensed the culture's influence on their rotation experience" (pp. 332-333). Staff nurses in teaching hospital are also facilitators of learning experiences, and feeling unwelcome by staff members does not provide a conducive environment for learning.

6.2.7.2 Female Patients

In regard to this barrier, seven participants (78%) reported on the following four aspects: being mistaken for medical students, female patients questioning the male nursing student's presence in the perinatal health care setting, the intimacy of the assessments, and the partner's discomfort. For the first aspect in which the participants were being mistaken for medical students, this is consistent with Bartfay and Bartfay's (2017) findings in which male nursing students were assumed to be 'want to be physicians'. This may contribute to role strain, which in turn negatively affects their learning experiences (Sherrod, 1991). For the second aspect, female patients were doubtful of the presence of the male nursing students. In the Mitra and collaborators (2018) study, certain male nursing students reported being rejected by the female patients to the point of being made to feel like an intruder. Other reported being glared at by the patients. The Kennedy, Jewell, and Hickey (2020) study was conducted in Qatar, male nursing students are not permitted in the perinatal health setting, "In Qatar, a predominantly Muslim country, social and cultural norms prohibit male BN students from practicing in maternity settings. However, male physician and paramedic students, although limited in scope, are permitted to practice in this setting" (p. 1).

For the third and fourth aspects, the intimacy of assessment involved and being mindful of the partner's discomfort negatively affected the participants' learning experiences. Mitra and colleagues (2018) further explore the phenomenon as the patient and the (male) partner were both found to have potential for discomfort and rejection. This study acknowledges how culture and social norms affected the male nursing students' learning experiences; this study was completed in a rural town in Tennessee, where it was mostly seen as inappropriate for a male health care provider to care for another man's wife in this intimate setting. The participants in the Mitra et al. (2018) study also reported on the verbal abuse that they had received from the female patients. This idea becomes problematic because it also continues to reinforce Bartfay and Bartfay's (2017) assertion that men are inappropriate caregivers. The undertones of this argument appear to have a sexual undertone, in that the partners may feel uncomfortable by a male health care provider providing intimate care and assessment on their wives. This behaviour may be contrasted with the seeming misfit for men in a perinatal health care setting as society feels that a nurse is always female (Balakrishnan et al., 2013).

There is another context of sexual undertone in this phenomenon, as the female body may be seen as a sexual object in a non-sexual context. This may reflect social norms regarding the objectification and ownership of women's bodies, especially in a North American context (Davis, 2018). Furthermore, due to biological differences between the students and patients made it hard to relate to the patient. This is consistent with the findings reported by Ha and collaborators (2013) of gender based barriers to learning experiences in PHN, specifically that, "participants found it difficult to sympathize with a laboring woman due to gender roles and it was difficult to build rapport" (p.3). Mitra and collaborators (2013) found similar findings in that participants reported experiencing the preconceived notion that PHN is female-dominated

because women are better suited to care for pregnant women, therefore men are not welcome in this area. All of these authors advocate for clinical instructors and educators to be aware of this discomfort and sensitive to the learning needs for male students in maternity (Ha et al., 2013; Mitra et al., 2018).

6.2.7.3 Awkward Situations

There were five specific awkward situations that were reported by the study participants: gender based rejection, providing breastfeeding support, the variation in perineal assessment practices, fearing being accused of being inappropriate, and hearing about previous students' rejection stories. These situations often overlap, and are connected at the societal levels of the *Andragogy in Practice Model* (Holton et al., 2001) (see Section 6.4) through the shared themes of gender and rejection.

One of the reported scenarios regarding gender based rejection came from introducing the student, or asking permission to be cared for by a 'male nurse'. Kouta and Kaite (2011) argue that specifying the gender of the nurse continues to promote gender norms and confirms that male nurses are different than female nurses, which also perpetuate stereotypes and discrimination. Feeling awkward while providing breastfeeding support is also understandable given societal perceptions around breasts, women's bodies, and the role of a male health care provider in women's health. This activity was found to be the least useful activity in the PHN laboratory. Students are uncomfortable with this skill in the laboratory and the clinical placement. So as per Andragogy (Knowles, 1970), this may not be deemed to be a useful skill to learn, yet in the reality of the PHN clinical practicum, it is one of the skills that all students must master. How to help male nursing students to become comfortable with breastfeeding and assisting new mothers with it should be considered.

The variations in independent perineal assessment practice were deemed to be awkward. Kouta and Kaite (2011) assert that, "…it is inappropriate for men to provide certain types of nursing care-ie: female catheterization" (p. 61). Yet, at the University of Ottawa, all students are expected to master this clinical skill (female catheterization). This may set the example that male nursing students must be chaperoned while completing these tasks because of a pre-emptive fear of being inappropriate (Balakrishnan et al., 2013; Bartfay & Bartfay, 2017; Patterson & Morin, 2002; Powers et al., 2018; Sherrod, 1991). The inconsistency among host organizations in the Ottawa region for this practice also contributes to negative learning experiences: the students share their experience and some may feel less competent in their skills, if one instructor insists on being present during these tasks, while others allow their students to complete their skills independently. Lastly, the participants in the present study revealed how other male nursing students' experiences in the clinical setting had been negative, some of them using the term, 'horror studies'. In the Powers and collaborators (2018) study, participants revealed how sharing stories, "…with other males in his cohort and described a sense of belonging from being able to talk to others in [the] same situation". (p. 481)

The findings of this study have made it clear that there are various cultural, historical, political, and social factors that profoundly influence the male nursing students' learning experiences; these factors remain relatively unexplored at this time. Holton and collaborators (2001) refined the theory of Andragogy (Knowles, 1970) to reflect these factors. Their revised model, the *Andragogy in Practice Model* (Holton et al., 2001), explicitly accounts for the factors that shape Andragogy to fit in a learning situation at micro, meso, and macro levels. This model will be further explored in section 6.4 of this chapter.

The next subsection addresses the four strategies the participants used to deal with these barriers.

6.2.7.4 Strategies to Deal with these Barriers

All of the participants reported using some of the following four strategies to address the three major barriers to their learning experiences: being hyper-vigilant about their professionalism, building a strong rapport with their patients, increasing their confidence, and being in 'survival mode'. In the context of the present study, it can be argued that the participants did indeed work harder than their female counterparts, as they felt the need to go out of their way to increase their professionalism, build a strong rapport and a therapeutic relationship with their patients before starting care in the clinical placement, be extra mindful of the terminology used with patients and how to give instructions, give the impression of being confident, and sometimes, being in survival mode in order to be able to cope with the clinical placement.

It is noteworthy that several studies present the male nursing students' strategies for dealing with their PHN clinical placement (Balakrishnan et al., 2013; Bartfay & Bartfay, 2017; Inoue et al., 2006; Patterson & Morin, 2002). Although female students may also integrate these strategies into their PHN clinical learning experiences, they do so to a lesser extent, because they do not share the same negative stereotypes and barriers that male nursing students do. Maintaining a professional demeanor and establishing a good relationship with female patients in the perinatal health care setting were important strategies for the participants so that they could do their assessments and provide care. In the Balakrishnan et al. (2013) study, the participants used various strategies to provide care which included maintaining a professional attitude and explaining the procedure to the clients. In the Patterson and Morin (2002) study, "…the students tried to be "extra" professional to avoid any misinterpretation…they did find that their

professional demeanor helped put themselves and the patients at ease during postpartum assessments" (p. 270). These male nursing students in this study were particularly sensitive to the personal and private nature of the postpartum assessments. Through these various strategies, the participants were able to have self-confidence and to portray it to and in front of the perinatal clients (Balakrishnan et al., 2013; Patterson & Morin, 2002). Ha and collaborators (2015) indicate how nurse educators and clinical instructors should encourage male nursing students' professionalism while in the perinatal health care setting.

The last strategy reported by the participants involved being in survival mode, and doing whatever had to be done to get through the clinical placement, not so much for the laboratory and simulations components of the PHN clinical practicum. The only article that could be found that describes this particular strategy being used and applied by male nursing students is the Patterson and Morin (2002). This phenomenological study with eight male nursing students was conducted after they had finished their clinical rotation in maternal-child nursing. Three theme clusters emerged: preconceptions about the maternal-child rotation, enduring the clinical experience, and surviving the clinical rotation. For the last theme, 'surviving the clinical rotation', "The male student nurses expressed relief at the completion of this rotation. Surprisingly, the maternal-child rotation was perceived as a "great experience". The students enjoyed observing births and learning to care for newborns. They were delighted when they successfully passed course objectives and "were done"" (pp. 270-271). This strategy is underexplored yet it emerged in the findings in the present study. Does such clinical learning have to be this way for the male nursing students? This is so contrary to the principles of Andragogy as conceptualized by Knowles (1970).

6.2.8 Section Summary

This section reviewed the participants' negative experiences in the pre-PHN courses, in the PHN theory course, the overall PHN clinical practicum, the PHN laboratory, the PHN simulations, the PHN hospital placement, the barriers to their learning experiences, and the strategies that they used to address these barriers. Although the PHN training was rated to be an overall positive learning experience, this section highlighted the various factors that contributed to the participants' negative learning experiences. It is interesting to note that all of these barriers can be grouped into the societal level of the *Andragogy in Practice Model* (Holton et al., 2001). These barriers, specifically gender, are contrasted with the AWHONN (2018) position statement on gender bias.

As adult learners, educators need to be aware of these factors that impact learning experiences for these students, and curriculum needs to continue to develop to acknowledge the impact of gender on learning. Kouta and Katie (2011) and Powers and collaborators (2018) assert that nursing schools need to promote equal gender obstetric training and appropriate mechanisms to deal with intimate assessment, and for hospitals to include anti-discrimination policies in obstetrics. Ostrouch-Kamińska and Vieira (2016) encourage educators to reflect on the impact of gender on learning experiences. They state that, "the task of adult educators who have a critical approach to teaching is to stop transmitting stereotypical divisions of gender statuses and roles through transformation of content of the awareness of adults" (p. 49). This is congruent with the participants of the present study suggesting the faculty acknowledge the impact of social norms in nursing and within PHN.

6.3 Solutions for Improvement in PHN

This section explores the areas for improvement as suggested by the participants. There are four main areas for improvement in PHN education at the University of Ottawa: the clinical practicum overall, the laboratory, the simulations, and the hospital placement.

For the PHN clinical practicum itself, it is noteworthy that eight participants indicated that it needs to be improved. One of the ways that the PHN clinical practicum could be improved is by the integration of a confidence building workshop. However, before discussing this suggestion, it is important to understand the role that confidence plays in the training of student nurses. Confidence was present in the research findings in this present study in different ways. Certain participants expressed how they had confidence before the start of the PHN courses, others chose to establish an internal attitude of confidence and portraying it outwards, other participants indicated to fake it so that it helped to establish the professional relationship with the clinical instructor, the nursing staff, and the patients and their partner/family members. On the other hand, certain participants stated that the clinical instructors and the nursing staff were the ones to give them confidence so that they eventually had this confidence. According to Porter, Morphet, Missen, and Raymond (2013), the clinical practicum is an essential component of the undergraduate program that offers nursing students the opportunity to practice their previously learnt clinical skills, linking theory to practice, and thus, helps to develop their self-confidence. Also, students' confidence levels improve with further exposure to clinical placement. Two studies refer to male nursing students' confidence during the PHN clinical practicum. In the Balakrishnan et al. (2013), study, "46.67 % [of the participants] agreed to the important role of female faculty in providing confidence while performing clinical procedures during obstetrical clinical postings" (p. 8). Patterson and Morin (2002) also reinforced this, "The faculty were

perceived as "setting the tone" by creating a learning environment and offering students the confidence they lacked in this setting" (p. 270).

Thus, confidence appears to be important for male nursing students doing a clinical placement in PHN. Furthermore, four participants (44%) suggested specifically that a confidence building workshop could be implemented at the beginning of the PHN clinical practicum. They provided examples of content that could be part of this workshop: phrasing about professionalism, use of correct terminology, and obtaining consent before procedures in order to reduce the chance of being perceived as inappropriate. Two articles provided more content and strategies that could be incorporated into such a workshop. For example, Patterson and Morin (2002) suggest exercises to help students clarify their personal perceptions of the clinical setting (i.e., a woman's world) and then place these perceptions within a professional context, role playing, case studies, and small group discussions. Powers and colleagues (2018) provide other ideas such as having a support group for the male nursing students, inviting male PHN nurses as guest speakers, and integrating a mentorship program and role modeling for these students.

The laboratory activities are the first component of the PHN clinical practicum. There are three learning activities associated with it, namely, postpartum assessment, care and its corresponding health teaching, newborn assessment, care and its corresponding health teaching, and breast and bottle feeding. Seven participants stated that this component needed to be improved. According to Ewertsson, Allvin, Holmstrom, and Blomberg (2015), clinical skills laboratories are important as they can optimize students' learning for development of professional knowledge and skills, and are necessary for quality nursing practice and for patient safety. The 16 participants who were nursing students in this qualitative, descriptive study shared their perceptions through semi-structured interviews. The overall theme that was identified

through inductive qualitative content analysis was ‘walking the bridge’, in which the clinical skills laboratories formed a bridge between the university and clinical settings, allowing the students to integrate theory and practice and develop a reflective stance. For the present study, the main constructive critique for the laboratory activities involved adding more complex scenarios into its curriculum. As self-directed adult learners, students build on previous knowledge (Knowles, 1970), and need to be challenged by the material they are learning. The other area for improvement included removing the Calgary Family Assessment Model (CFAM) model as it appeared to be outdated and not used in the clinical setting. This is another application of Andragogy in that the students learn what is deemed to be useful and applicable in the clinical setting (Holton et al., 2001; Knowles, 1970). If this information is indeed not current, Andragogy would support removing it and replacing it with more relevant information. A broader interpretation and application of a family-centered approach to perinatal health care could be suggested: the Public Health Agency of Canada has recently updated the philosophy and principles for family-centered maternity and newborn care in Canada (2017).

The simulations which are the second component of the PHN clinical practicum could also be improved. This second component contains five simulation scenarios: postpartum assessment and teaching, newborn assessment and teaching, postpartum hemorrhage, discharge teaching, and a well-baby checkup at a drop-in centre four scenarios. Eight participants stated that this second component could be improved. According to Simonelli and Gennaro (2012), simulation can be used to provide experiences for which students need skill prior to actual clinical experiences, provides a safe environment to hone skills and foster teamwork for the rare but critical situations, and reduce students’ anxiety in the clinical setting itself. As indicated by Knowles (1970), adult learners build off of their previous learning experiences, and simulations

can contribute in this way (Simonelli & Gennaro, 2012). Indeed, simulation provides a safe learning space to make mistakes before students practice on real patients in the clinical setting. On the other hand, the PHN simulations may be scheduled and completed while the hospital placement is occurring. This is contrary to the core principles of Andragogy and can result in poorer learning outcomes for the students. It is suggested by the participants, as much as possible, that the simulations be front-loaded as part of the PHN course sequencing.

Lastly, all of the participants (100%) agree that the hospital placement needs to be improved. They recommend not focusing on the gender of the student, acknowledging their discomfort, and standardizing perineal assessment practices among host institutions. Gender bias does exist in PHN (Balakrishnan et al., 2013; Bartfay & Bartfay, 2017; Eswi & El Sayed, 2011; Ha et al., 2015; Golden, 2018; Mitra et al., 2018; Patterson et al, 2002; Powers et al, 2018; Sherrod, 1991) and identifying students on the base of their gender may set the precedent that they are less knowledgeable and competent than their female counterparts. Focusing on their gender may actually continue to promote these negative stereotypes which can lead to rejection. Acknowledging the students' discomfort validates some of their experiences and provides a starting point for curriculum change. As part of the clinical placement, standardizing perineal assessment practice among host institutions provides the same learning experiences for all students. The lack of consistency among clinical groups is an example of a situational difference in the *Andragogy in Practice Model* (Holton et al., 2001), which will be explored further in Section 6.4 of this chapter. This inconsistency negatively contributes to learning experiences as some students have different experiences than others, which is then disseminated to future students, and can continue to create a negative expectation from the start of the semester.

Although the participants reported an overall positive learning experience in their PHN courses, this section did highlight the four main areas of improvement. The next section offers reflections of the theoretical framework of this study, Andragogy.

6.4 Reflections on the Theoretical Framework for This Study

This section presents a review of the theoretical framework that was used for this research study, namely, Andragogy. Although it had several advantages, there were also limitations to it. The limitations are addressed in a separate subsection followed by the *Andragogy in Practice Model* (Holton et al., 2001) which expands on Andragogy into clinical practice, and how this model can be applied to PHN.

6.4.1 Original Theoretical Framework

This research study was completed through a pragmatic worldview (Felizer, 2010). This paradigm fits well with the research problem and research questions because Pragmatism is conducive with mixed methods research (Creswell, 2014). The qualitative and qualitative data sets each have their strengths and limitations, and when combined, they provide a more holistic understanding of the phenomenon that is being examined research-wise, than the use of one or the other alone (Creswell, 2014). This present study utilized mixed methods (Creswell, 2014), and collected both quantitative and qualitative data through an online questionnaire and an interview guide.

To continue in the same vein, this research study's theoretical framework was informed by Andragogy, which is an adult learning theory (Knowles, 1970) in the humanistic group of learning theories. According to Felizer (2010), Andragogy is associated with Pragmatism. Curran (2014a) links Pragmatism, Humanistic Learning Theory, and Andragogy. This author asserts that Andragogy can be applied in multiple domains by focusing on adult learning goals, finding

purpose for learning, and taking into consideration the individual and situational differences of learners, such as gender and social norms (Curran, 2014a). Furthermore, it is stated that, "RNs must be prepared to be lifelong students, reflective practitioners, and expert learners" (p. 234). This can become problematic for some clinical instructors who are 'content experts' in their field of practice, but are not necessarily lifelong learners. This may account for different learning experiences among the male nursing students, and may account for variation in learning outcomes within the same program. In Part II of Curran's article (2014b), there is a significant positive correlation among academic role preparedness, hours of professional development training related to adult learning theory, nursing professional development certification status, and use of adult learning theory with positive learning outcomes of students. This concept is further connected to the requirements needed to become a clinical instructor. Mahlmeister (2008) asserts that PHN may be a more high-risk learning environment than anticipated because of the lack of student familiarity with this specialized clinical environment. She reinforced the importance of the proper training of instructors, staff nurses, and students regarding the scope of practice, and safety of the learning environment (Mahlmeister, 2008). For these reasons, Andragogy and its relationship with Pragmatism were a logical fit for the research problem.

There are several advantages to applying Andragogy (Knowles, 1970) as a theoretical framework for this study. Firstly, Andragogy as a model for adult learning has gained global acceptance and has endured throughout time. Long (1991) explains that the humanistic ideas underlying Andragogy appeal to adult educators in general, and that Knowles was flexible in his revision of the concept and the model as he was supportive of the criticism that he had received. This author continues by stating that the inclusion of Knowles' concept of Andragogy into the adult education knowledge base, has provided a framework for integrating several potentially

useful ideas about adult learners, including self-directed learning. Secondly, this model has recently started to be considered and integrated into nursing education as a foundation for nursing students' learning, both theoretically and clinically, and both at the undergraduate and graduate levels (Draganov, Andrade, Neves & Sanna, 2013; Henschke, 2015). Draganov and colleagues (2013) conducted a literature review of Andragogy in nursing education. They explain, "It is important to note that andragogy brings together a set of principles which, if used appropriately, contribute to the learning's success and, consequently, promote improvement in Professional Training, Continuing Education, and Health Education" (pp. 87-88). Thirdly, this model was a good fit with this research study which focused on male nursing students' perceptions of their learning experiences in relation to their PHN courses (theory and clinical practicum). This model linked the concepts of men, nursing students, and PHN, because the participants described their learning experiences, the factors contributing to and taking away from their experiences, and offered solutions for improving the PHN learning experiences for both the theory and clinical practicum courses. Fourthly, since the participants are themselves adult learners, the five assumptions, four principles and seven outcomes in relation to Andragogy, were applied throughout the research study. The assumptions of Andragogy were applied in that the participants shared their self-concept, past learning experiences, readiness to learn, practical reasons to learn, and internal motivation to learn within the PHN context. The principles of Andragogy were applied in the shared learning experiences of the participants. They are self-directed learners who build on previous learning experience, they are learning applicable content, and are working towards problem solving styles of learning instead of memorization. Lastly, the seven outcomes of Andragogy were incorporated into the study as the participants were given an opportunity to reflect on their learning experiences and develop: self-

understanding, acceptance of others, a dynamic life attitude, react to causes of behaviour, actualize personal potential, value their experience, and direct social change.

However, after having analyzed and interpreted the research findings, it became evident that there are limitations to this particular theoretical framework, which are discussed in the next subsection.

6.4.2 Andragogy in Practice Model and Its Application to PHN

Although both Pragmatism and Andragogy were good fits with this research problem, there were some limitations.

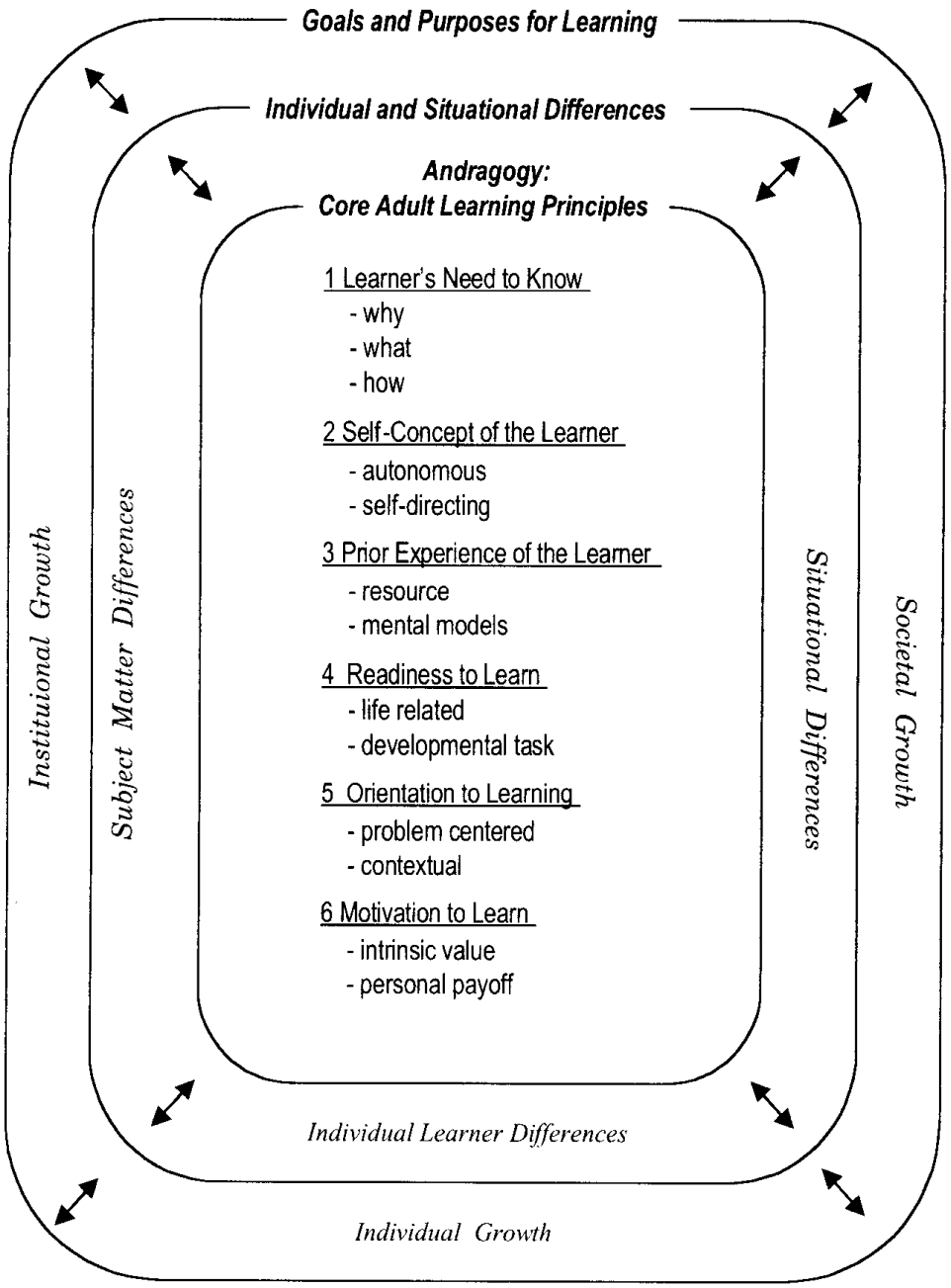
Firstly, Andragogy itself does not necessarily include how *gender* can contribute to the male nursing students' different learning styles, though it did emerge as an important finding in this research study. Ostrouch-Kamińska and Vieira (2016) discuss how educators need a greater understanding on how gender is related to adult education as, "…gender still constitutes one of the basic categories used by people to understand and explain [the] social world and also to evaluate themselves as learners" (p. 40). According to these authors, gender can impact power over relations in educational groups, andragogical practices, curricular choices and priorities for research and intervention. Also, the individual's perception of competence, the appropriation of previous knowledge and the acquisition of new information all can affect the process of adult learning. Not only is gender not explored in relation to the adult education research agenda, but what is not taught is just as significant as what is taught (Ostrouch-Kamińska & Vieira, 2016). They continue, "Although educational programs - for adults or for younger generations - must have a focus, omitting the approach of specific questions more related to men or to women in some areas of knowledge, that, one knows, prevent them of having similar opportunities of success in pursuing related careers…." (p. 43). It appears that inequalities in learning

opportunities still prevail and are still maintained, not only by the instructors, but by the learners themselves. Educators can no longer ignore the impact of gender on adult education, particularly in nursing and in PHN.

Secondly, Andragogy is still important, however, there is a greater *context* that has to be taken into account: although the learning opportunities were available in the clinical placement component of the PHN clinical practicum and were considered positive by the majority of the participants, there were still inequities present, mostly related to context. Although Knowles (1970) refers to the *situation* in which a learner learns, more recent articles refer to the *context* of learning (Merriam, 2017). According to Merriam (2017), the context in which adult learning occurs needs to be made more explicit. There are three factors associated with the context of adult learning, "…the people in the context, the tools at hand…, and the particular activity itself" (Merriam, 2017, pp. 27-28). Furthermore, learning needs to be maximized as much as possible, but in contexts that are deemed as 'authentic' (Merriam, 2017). Authentic learning contexts involve identifying how decisions are made on what learning should be going on, and who has access to the learning, both of which impact a student's ability to learn.

Holton, Swanson and Naquin (2001) expand on the idea of context and how andragogy is applied in practice itself. One of the critiques of Andragogy is that much has been written about it (assumptions, principles and outcomes), but not so much on how it is applied to practice itself. The findings from the present research study suggest that a more precise model of andragogy in the context of practice is needed. Holton, Swanson and Naquin (2001) explain that, "There seems to be a need to clarify andragogy further by taking into account more explicitly key factors that affect the application of andragogical principles" (p. 129). These authors not only propose the *Andragogy Model in Practice* (see Figure 5), but they also consider context in relation to

Figure 5: The Andragogy in Practice Model[1]



[1] Holton, E.F., Swanson, R.A., & Naquin, S. (2001), p. 121.

three levels: pertaining to the students themselves individually, at the institutional level (School of Nursing and hospitals), followed by societal norms.

The *Andragogy Model in Practice* was first published by Knowles, Holton and Swanson in 1998, but then it was retaken and reproduced in the 2001 by Holton, Swanson and Naquin in their article. The *Andragogy Model in Practice*, "…is offered as an enhanced conceptual framework to apply andragogy more systematically across multiple domains of adult learning principles.

"The three dimensions of Andragogy in Practice, shown as rings in the figure [see Figure 5], are: 1) Goals and Purposes for Learning, 2) Individual and Situation Differences, and 3) Andragogy: Core Adult Learning Principles" (p. 129). The Goals and Purposes of Learning ring involves individual growth, institutional growth, and societal growth (Holton et al., 2001). The second ring, Individual and Situational Differences, encompass various factors that contribute to learning experiences. Some examples of these factors include: subject matter differences, individual learner differences, and situational differences. The six core adult learning principles of andragogy are at the centre of the model (Holton et al., 2001).

How does the *Andragogy in Practice Model* apply to the learning of PHN? This model was chosen as it acknowledges the various social factors that can shape the male nursing students' experiences and interactions with their environment. The outer ring of Goals and Purposes for Learning is applied in the PHN learning context as follows. The individual level represents the students themselves, especially their feelings and fears in regard to the PHN courses. The institutional level represents both the nursing curriculum at the School of Nursing as well as the hospitals: the nursing curriculum contains content and practice, the educators and clinical professors, while the hospitals pertain to the nursing staff, other health care

professionals, and the female patients and their partners. The last level explores societal norms that influence the students' learning experiences such as social constructs, societal precedents, and gender normative behaviour. The middle ring of Individual and Situational Differences is applied in the following manner. Subject matter differences are highlighted in variations among clinical groups, namely with the perineal assessment practice at one of the clinical institutions. Individual learning differences represent the variation in intellectual capabilities of the students. Lastly, situational differences are explored in the differences in learning experiences among certain sub-populations of the sample; specifically, those who identified as having a heterosexual sexual orientation, those who have other post-secondary experience, those who have their own children, and those who are not Caucasian. The inner ring of the Andragogy Core Adult Learning Principles are applied as follows. Students need to know this content as it is part of the core nursing curriculum and is testable content on the NCLEX-RN registration exam, students create their own learning goals, they build on previous learning experiences in the program and from other clinical rotations, they are ready and motivated to learn as they need to complete this course before moving into their final year of nursing school.

It is noteworthy that Holton, Swanson and Naquin (2001) present a table called the *Andragogical Learner Analysis* (p. 137 of Holton et al., 2001 article). This table is a needs assessment that uses the *Andragogy in Practice Model* to determine the extent to which andragogical principles of the inner ring (represented in the left column of the *Andragogical Learner Analysis* table) fit a particular situation by assessing the Individual and Situational Differences (middle ring) and the Goals and Purposes for Learning (outer ring). This can be easily adapted for the PHN learning experience context. Table 13 that is presented in Appendix 16 features this adaptation. The student researcher took the findings of the present research study

and inserted them into the *PHN Andragogical Learner Analysis Table* (see Table 14 in Appendix 17). This is to demonstrate how the analysis can be conducted. All professors and clinical instructors involved with the two PHN courses can use the *PHN Andragogical Learner Analysis Table* to keep track of their courses and of their students' learning experiences.

Interestingly, according to the research findings, gender bias and rejection are two aspects that were found to be present at all three levels (individual, institutional, societal). This brings these two aspects full circle in the reflections of Andragogy in relation to the PHN learning experience. In regard to gender bias, O'Lynn and Tranbarger (2007) describe the phenomenon of 'reverse gender bias', as there is a historic precedent that women experience gender bias and gender based discrimination, not men. Furthermore, these authors state that:

> "The changes in the [nursing] profession, especially with regard to role, parallel development in the women's' movement. As women become more equitably related to social institutions, there is a disproportionate emphasis on enhancing opportunities for women. This is especially significant when the normative fallout from such an undertaking is somewhat disadvantaging to men. This, of course, is true not just for nursing, but for all areas in which women have been seeking equal opportunities. It often appears that equality suffers as a result, and some of what ensues doesn't necessarily feel fair. The challenge for men in nursing is to recognize the existence of gender bias. While the majority of both men and women like to believe it just doesn't exist, that would be naïve" (O'Lynn & Tranbarger, 2007, p. 147).

In relation to rejection, it also crosses all three levels, and compliments gender bias as it can occur for individuals (male nursing students), within their program of studies and in the hospitals, and societally. DeMayo (2018) describes how gender bias and rejection are related in the maternal-newborn field of nursing as gender stereotypes impact the men's perception to be less caring and nurturing than their female counterparts; which are qualities deemed to be especially important in the PHN context. Furthermore, Golden (2018) also reiterates that this 'reverse discrimination' caused by normative social roles and stereotypes contributes to role strain in this environment. He advocates for a balance of honoring the patient's preference of the

sex of the health care provider while integrating gender inclusive initiatives in the hospital setting (Golden, 2018). Also, Biletchi (2013) recommends the following, "…incorporating communication techniques for men dealing with gender bias and fears of rejection into nursing, or therapeutic communication coursework and lectures" (p. 53). These findings validate the importance of acknowledging the discomfort of male nursing students in this clinical specialty, and advocate for the inclusion of a confidence building workshop into the curriculum.

In summary, this section reviewed the original theoretical framework of Andragogy, discussed its limitations, and introduced the *Andragogy in Practice Model*. This model was applied in the PHN context and explored the various factors that contributed to the participants' positive and negative learning experiences in the form of the *PHN Andragogical Learner Analysis Table*.

6.5 Recommendations for Nursing Education, Practice, and Research

This section offers recommendations for future nursing education, practice, and research based on the findings from this study.

6.5.1 Nursing Education

This study recommends two initiatives from a nursing educational perspective.

The first recommendation involves the PHN professors and clinical instructors. The participants in this study reported that the professors and instructors often did not acknowledge the discomfort that male students can face in this clinical area, which can contribute to the continued invisibility of this issue. Based on the findings of this study, the student researcher recommends acknowledging this discomfort and how it can impact male nursing students' learning experiences. This would continue to raise awareness of the issue, increase visibility, and thereby, slowly start to deconstruct gender normative behaviour. Addressing the male nursing

students' dis/comfort with the PHN clinical placement was provided by both the Ha et al. (2015) and the Mitra et al. (2018) studies. By addressing this particular issue, both studies explain how educators and instructors can consequently encourage the male nursing students' professionalism and create positive learning environments for them. Furthermore, the participants in this study reported that the PHN professors or instructors sometimes inadvertently discouraged students from expressing interest in this clinical specialty by saying things like, 'Not many men work here', or, 'Men generally don't like this area'. These comments set a negative tone for the clinical placements within the hospital settings and contribute to pre-clinical worries and negative expectations; which can ultimately lessen the students' learning experience in PHN. Mitra et al. (2018) suggest addressing male nursing students' preconceptions of their PHN clinical practicum and that certain of them will not choose PHN as a career:

> "Clinical educators can assess students' preconceptions and how it will affect their experience in OB rotations, and then address these preconceptions and better prepare their students to have a positive experience. Clinical educators and nursing preceptors can promote a comfortable experience by understanding that there are students whose nursing career interests are not maternity nursing. Having this knowledge will enable educators and preceptors find commonalities between OB nursing and students' fields of interest to keep the students still engaged in the maternity setting" (p. 333).

The second educational recommendation involves integrating a confidence building workshop into the PHN curriculum (see Table 12). The participants in this study suggested this intervention because fostering confidence was found to facilitate their learning experiences, particularly in relation to PHN. The participants articulated that having an extra opportunity to work though professionalism, wording instructions, and teaching terminology to appear less 'awkward', would have been beneficial. Moreover, this intervention could be akin to an open laboratory, which is already integrated into the curriculum; so it could be feasible to implement. The Patterson and Morin (2002) and the Powers et al. (2018) studies abound in this sense. Both

Table 12: Template for Confidence Building Workshop

Title of Workshop:	Confidence building workshop for male nursing students for PHN clinical practicum
Purpose of the Workshop:	To increase male nursing student confidence in their PHN clinical practicum
Activities in the Workshop:	1. Purpose of this workshop and its organization 2. Overview of men in nursing and men in PHN 3. What is confidence as a student nurse and how has it changed since the beginning of your studies? 4. Male nursing students' fears and feelings before the start of the clinical practicum 5. Sharing of colleague and friends' experiences with the clinical practicum: what worked and what did not work 6. Invite a male PHN nurse as a guest speaker to talk about his experience as a student and in the perinatal care setting, and advice are dealing with the clinical placement 7. Specific topics: -Terminology in PHN -Professionalism: relationship with clinical professors, nursing staff and other health care professionals, female patients, their partners and family members -How to manage postpartum assessment and care

	-Obtaining consent before the start of procedures -Experiencing discomfort and embarrassment and how to deal with them -How to manage intimacy and female patients -Gender bias and rejection: reasons for them and strategies for coping with them -Other topics as per the needs of the group 8. Evaluation of workshop

of these studies suggest having a preclinical activity for the male nursing students and/or faculty, instructors and hospital staff, include a presentation of literature centered on the experiences and challenges of male nursing students, and promote opportunities for mentorship and peer support.

6.5.2 Nursing Practice

There are four recommendations for nursing practice from this research study.

The first recommendation involves the dissemination of the findings through conferences, workshops, and journals to nursing schools, hospital clinical educators, and patients and their families as part of the student researcher's knowledge translation plan. This increased awareness and shared knowledge will continue to break down gender normative behaviour from various levels, and may also allow nursing schools to revise their PHN curriculum (Balakrishnan et al., 2013; Patterson & Morin, 2002; Sherrod, 1991).

The second practice recommendation involves recruiting clinical educators who are aware of the uniqueness of the male nursing students' learning experiences in this specialty but also sensitive to their needs. This would require faculty to have some training on these aspects

(Ha et al., 2015; Patterson & Morin, 2002). They would not only be more supportive of the male nursing students but optimize their clinical learning in PHN. As Mitra et al. (2018) stipulate in their article, "…thus an effort must be made to ensure that students have an optimal learning environment…" (p. 333).

The third recommendation is to continue to increase awareness of this issue. The findings from this study acknowledge and validate the learning experiences of the male nursing students in PHN. The participants verbalized 'feeling heard' and 'relieved to share' their experiences. Increasing awareness, and translating this awareness to educators through liaison with host clinical institutions, instructors and nursing staff, will increase the male nursing students' comfort levels in the PHN clinical practicum, which may contribute to recruitment and retaining more male nurses to PHN. In particular, Patterson and Morin (2002) suggest, "Certainly the presence of male nurse role models in maternal-child settings can contribute to students' consideration of this specialty for practice." (p. 271). Powers et al. (2018) propose another strategy in connection with this recommendation, "It would also be helpful for media to portray male nurses in maternity settings in an effort to change perceptions of both the public and nurses…" (p. 480).

Lastly, there should be a theoretical framework that underlies the teaching of PHN, not only for the theory course, but also for all three components of the clinical practicum (laboratory activities, simulation scenarios and clinical placement). Andragogy (Knowles, 1970) has been determined to be useful as a theoretical framework. However, Knowles' Model of Andragogy can be enhanced by the *Andragogy in Practice Model* (Holton et al., 2001). All professors, clinical instructors and the hospital nursing staff can unite their efforts promoting a humanistic approach to the students' learning experiences in PHN by learning about Andragogy and

applying its assumptions, principles and outcomes at both the school and hospital levels. Also, they can be encouraged to learn about the *Andragogy in Practice Model* (Holton et al., 2001) and how it can be applied from an educational perspective in all three components of the PHN clinical practicum.

6.5.3 Nursing Research

Lastly, there are two recommendations for nursing research based on the findings of this study.

First, the impact of the proposed confidence building workshop could be researched. This could be completed through a quantitative, a quantitative, or a mixed-methods research approach (Creswell, 2014). From a qualitative research viewpoint, future participants could be asked about their experience participating in such a workshop and its impact on their PHN clinical practicum. From the quantitative research viewpoint, the participants would rate their pre- and post-confidence levels; other variables could be considered such as their comfort or stress levels. Framing this future research study using mixed methods, which would include both qualitative and quantitative data, would provide a unique approach to exploring the impact of such a workshop.

The second nursing research suggestion is slightly different. This research suggestion would involve a future critical discourse analysis study (Van Dijk, 1993). Critical discourse analysis is defined as, "an analysis of text that presuppose relations of discourse, power, dominance, social inequality and the position of the course analyst in such social relationships" (Van Dijk, 1993, p. 249). This research approach is being suggested so that the use of terminology chosen to describe the experiences of male nursing students in relation to their PHN clinical practicum, and the attitudes expressed by people in contact with these students, namely,

the PHN staff nurses, patients, partners or family members, and educators, would be obtained. Furthermore, the data obtained from the different aforementioned perspectives (the PHN staff nurses, patients, partners or family members, and educators), could be compared and contrasted (Patterson & Morin, 2002). This particular research lens would be beneficial due to the influence of the various social, political, and historical events that have shaped the current social norms around nursing, particularly PHN, in other parts of Ontario, in the rest of Canada and internationally (Balakrishnan et al., 2013; Powers et al., 2018).

The current research study provides an interesting starting point for further nursing education, practice, and research in regard to the PHN courses at the University of Ottawa.

6.6 Strengths and Limitations

There are several strengths and limitations of this study; they will be described in this section.

There are eight strengths of this study. The first strength is that this study is the first of its kind in the Ottawa area, and even in Ontario. As mentioned in the first two chapters, parts of this research problem have been studied in the past (Balakrishnan, Sheoran, & Bishnoi, 2013; Bartfay & Bartfay, 2017; Eswi & El Sayed, 2011; Ha et al., 2015; Mitra, Philips &Wachs, 2018; Patterson & Morin, 1999; Powers, Heron, Sheeler & Sain, 2018; Sherrod, 1991), but this study includes pieces that the previous studies did not. For example, this study exclusively focuses on understanding the unique experiences of male nursing students during their PHN clinical practicum. The previous studies researched similar concepts of men, nursing students, and perinatal health nursing; but these concepts were not studied together. Second, this study is also the only one to date that includes the perspectives of male nurses working in the PHN specialty. These participants had the opportunity to compare and contrast their experiences as students with

their experiences as staff members. Third, Andragogy (Knowles, 1970) is used as the theoretical framework in this study. This theory has not been used in previous studies and this uniqueness provides a different perspective than other studies; furthermore, this theory allows for the exploration of adult learning opportunities within this compulsory clinical practicum. Fourth, this study permitted the participants to share their experiences in the entirety of the PHN courses (theory and clinical practicum) at the undergraduate level, whereas previous studies have only focused on the clinical component. By only studying the clinical component, there is a chance that the previous researchers may have missed other parts of the learning experience, because the PHN theory course informs the laboratory and simulation activities; all of which cumulatively can influence the students' experiences in the hospital clinical placement. Fifth, the University of Ottawa is a bilingual institution, and both English and French stream students were invited to participate. Sixth, the participants not only shared their perceptions of the PHN clinical practicum, but they offered suggestions for improvement of the PHN theory course as well as the three components of the clinical practicum itself. Seventh, this research is being conducted using a mixed methods approach (Creswell, 2014). Mixed methods research, in combination with the Andragogy theoretical framework, and the opportunity for the male nursing students to share their perceptions about all aspects of the PHN courses (theory and clinical practicum) at the University of Ottawa, provided the most thorough understanding of the current situation of the PHN learning experience. Lastly, the findings of this study explicitly highlight the covert societal level factors, such as age and sexuality, which influence male nursing students' perceptions of their learning experiences in PHN.

However, there are four limitations to this study, too. The first limitation concerns the small sample size. Although the small sample size is acceptable for mixed methods research

(Creswell, 2014), it may be difficult to generalize the findings to other PHN curricula in the Province of Ontario or elsewhere. Furthermore, due to the COVID-19 Pandemic, recruitment had to be stopped sooner than anticipated. This led to only nine participants being recruited instead of the ten to twelve participants that were originally planned for. Despite the small sample size, qualitative data saturation was obtained (Vasileiou et al, 2018), and the themes extracted from data analysis in this study supported other findings reported from the literature review as presented in Chapter 2.

Second, the sample's distribution of sexual orientation was slightly skewed. In regard to sexual orientation, the majority of the sample (67%) identified as heterosexual: these six participants had lower comfort scores in the PHN clinical placement than the three homosexual counterparts. Some research is starting to emerge on sexual orientation in relation to nursing, but up to now, little or no research on sexual orientation has been reported in relation to PHN (Minority Nurse, 2013).

Third, the sample was also slightly skewed in regard to language. This study was conducted in English as the online questionnaire and the interview guide were only available in this language. Also, two of the nine participants were enrolled in the French stream. Although a minority, this distribution is reflective of the smaller number of students enrolled in the Francophone program compared to those in the larger Anglophone program at the School of Nursing of the University of Ottawa. If Francophone male nursing students wanted to participate in this study, they had to be bilingual. There is a possibility that other Francophone students had different perceptions of their PHN learning experiences due to their language and culture.

A fourth limitation is that only students at the University of Ottawa campus were considered, even though the University offers collaborative programs with Algonquin College

and La Cité Collégiale. The student researcher chose to exclude these students because she is employed at Algonquin College, teaches the perinatal health nursing laboratory and simulation components there, and supervises students in the clinical placement for that campus. Therefore, recruiting these students would have presented an ethical conflict. Although including the collaborative students would have given more global findings from the University of Ottawa and increased the sample size, ethical research procedures took precedent in this situation.

6.7 Conclusion

The aim of this study was to determine the perceptions of male nursing students' learning experiences in regard to their PHN courses at the University of Ottawa (theory and clinical practicum). The first research question explores the meaning of the PHN practicum for male nursing students. The findings suggest that the current PHN curriculum at the University of Ottawa is overall positive. The content in the PHN theory course, and two of the three components in the PHN clinical practicum course, namely, the laboratory activities and the simulation scenarios, prepare the male nursing students to some degree for their clinical placement in the hospital. However, the clinical instructors may inadvertently contribute to negative learning experiences by not acknowledging the impact of gender, or setting a negative expectation for this clinical specialty for male nursing students.

The second research question involves the facilitators to the male nursing students' perceptions of their learning experiences in the PHN clinical practicum. The five identified facilitators were: the clinical instructor, nursing staff, patients and their family members, the two male nurses working in PHN, and the comradery of other students. Indeed, these particular findings emphasize the importance of the clinical instructors, as their teaching style and student advocacy, have the most potential to positively impact these students' learning experiences. The

presence of male nurses working in PHN was also important for the students to consolidate in the perinatal hospital setting and to consider this specialty as a future career choice.

Conversely, the third research question explores the barriers to students' learning experiences. Three barriers were identified by the participants: the nursing staff in the hospital settings, the female patients, and specific situations deemed as 'awkward'. These barriers were found to be both overt and covert, at the individual, institutional, and societal levels. An overt example of a barrier would be the gender based differences male nursing students face in this clinical placement, such as the perineal assessment practice limitation, or nursing staff asking patients their permission to be cared for by a male nursing student. On the other hand, a covert barrier would be the awkwardness experienced by these students related to the intimacy of assessment required, the fear of being perceived as inappropriate, and the partner's reaction. The participants did share the strategies that they used to cope with these barriers.

The findings in regard to the last research question suggest that fostering confidence in students by means of integrating a workshop into the PHN curriculum, acknowledging gender based discomfort, and not focusing on the students' gender in the clinical placement, are feasible recommendations to improve the learning experiences for future male nursing students.

Indeed, this research problem was more complex than it seemed on first glance, and it is clear that learning experiences are heavily impacted by gender, culture, as well as historical, social, and political events. These societal level influencing factors remain relatively unexplored, despite their apparent importance. The findings of this study continue to highlight the effects of gender normative behaviour within nursing, and the various societal double standards within women's health care, especially for PHN.

In conclusion, the overall learning experiences for male nursing students in their PHN clinical practicum are positive. Yet, there is also room for growth in the profession and educational preparation. This study acknowledges the various social norms and behaviours that contribute to male nursing students' learning experiences in regard to the PHN courses (theory and clinical practicum). Acknowledgement provides a starting point to question these learned 'normal' behaviours, and reflect on their influence on learning experiences. This acknowledgment also allows the profession to continue to evolve. Just as Florence Nightingale evolved the nursing profession to be more feminine, nursing education now can continue to evolve to become more gender inclusive, especially in the context of perinatal health nursing.

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Appendices

Appendix 1: Perinatal Nursing Standards in Canada (CAPWHN, 2018, pp. 7-10)

Standard 1: Relationship Based Care
Perinatal nurses: 1. Recognize that each childbearing person and family is physically, socially, culturally, psychologically, and spiritually unique and that all bring individual strengths to the childbearing experience. 2. Provide person and family-centered care that empowers the person to acknowledge their strength, competence, confidence and capability as parents who trust themselves. 3. Develop and implement individualized care plans that acknowledge the importance of safety for childbearing persons and families, including the recognition of culture and diversity. 4. Empathize with persons and their families to understand the power of childbearing experiences and the influence of other significant life events on the childbearing experience. 5. Provide a supportive physical and emotional presence to childbearing persons, newborns, and families. 6. Affirm the dignity of childbearing persons, newborns, and families by providing care with honour and respect, recognizing that the childbearing person or family members may have experienced trauma. 7. Provide physical privacy and minimize intrusions that are not related to necessary care. 8. Support active participation of the family in the childbearing journey, as desired by the childbearing person. 9. Promote family development by facilitating the passage of childbearing persons, newborns and families through new life and role transforming events experienced through the perinatal continuum. 10. Intervene with, and report, colleagues who may be providing disrespectful or incompetent care to childbearing persons and families.
Standard 2: Inter-professional Collaboration
Perinatal nurses: 1. Direct or participate in the coordination of care with families. 2. Work together to create an individualized plan of care with families. 3. Collaborate with all health care team members.

4. Assign or delegate tasks based on the needs of the childbearing person, newborn, and family.
5. Collaborate with nursing colleagues and other members of the health care team and families in the implementation of the plan of care to include community resources and system supports as appropriate.
6. In collaboration with other health care providers, identify and participate in guiding nursing actions in emergency situations. This includes participation in debriefing and subsequent quality review activities.
7. Participate in inter-professional team work and education such as simulation exercises and skill drills to mitigate/reduce the risk of adverse perinatal outcomes.
8. Work with interdisciplinary colleagues, students, and nursing leaders in a collaborative and respectful way, recognizing the power differentials inherent in various provider roles.

Standard 3: Quality and Safety

Perinatal nurses:

1. Participate in data collection through comprehensive documentation/charting based on improving the care of childbearing persons and families that includes:
    i. Unit-based, institutional, provincial, or national data requirements.
    ii. Research or knowledge translation initiatives.
    iii. Measurement of outcomes and dashboards to monitor quality initiatives.
2. Collaborate with childbearing persons/ families in development of a plan of care that is:
    i. Individualized based on the social determinants of health such as socioeconomic status, education level, culture, gender, religious beliefs and personal care preferences, including indigenous social determinants of health such as racism, colonization, and political marginalization.
    ii. Confidential and shared only within the circle of care and asking permission if information/care needs to be shared for the safety of the patient/infant.
    iii. Evidence-informed and continuously validated and updated based on childbearing persons/family care needs, experiences and preferences.
3. Are responsible for their own lifelong professional development plan which includes:

i. Participating in annual professional reviews (institutional requirements, provincial nursing association/college).

ii. Practicing at all times within current legislation, institutional policies/ procedures, and use of evidence-based information.

iii. Providing ongoing evidence of competence by maintaining a professional practice portfolio with current education (e.g. conferences, workshops, rounds, self-study) and leadership opportunities (e.g. mentoring).

iv. Participating in inter-professional teams working toward advances in perinatal care

4. Understand the importance of safety initiatives within clinical practice and actively participate in:

i. Teaching persons/families about safety that aligns with the tenets of health promotion and prevention, such as immunization practices, hand hygiene, routine perinatal and postpartum health care appointments.

ii. Safety reporting when serious clinical situations happen or "near misses" occur.

iii. Following up with recommendations from near misses or breaches in safety.

Standard 4: Evidence Informed Practice

Perinatal nurses:

1. Model professionalism with childbearing persons, families, and health providers by:

i. Delivering nonjudgmental care that is sensitive to individual care needs. Individualized care is based on the social determinants of health such as socioeconomic status, education level, culture, gender, religious beliefs and personal care preferences.

ii. Achieving and maintaining certification within the specialty area.

2. Strive to create or maintain healthy work environments by:

i. Providing individual coaching and mentoring.

ii. Respecting the diversity of colleagues.

iii. Creating an ethical climate (shared values, high ethical standards).

iv. Providing peers with constructive feedback.

3. Demonstrate a commitment to lifelong learning for self and others by utilizing best evidence to guide practice.

4. Provide direct care or participate in the coordination of care by:

i. Prioritizing clinical assessments and subsequent care requirements to childbearing persons and families with the most acute needs.

ii. Creating individualized plans of care for families.

iii. Collaborating with health care team members.

iv. Assigning or delegating tasks based on the needs of the childbearing person, newborn and family.

5. Serve in key roles in the work setting by:

i. Participating in research activities that are appropriate to the nurse's position.

ii. Participating in committees or unit-based councils.

Appendix 2: Studies that Explore the Experiences of Men in Perinatal Health Nursing (Table 3)

Author Year Country	**Research Purpose and Research Question**	**Study Design and Sample Size**	**Data Collection Methods**	**Findings**	**Limitations**
Balakrishnan, Sheoran, & Bishnoi 2013 India	To explore the perception of male nursing students towards obstetrical nursing clinical experience at the college of nursing in Haryana	Concurrent triangulation design (mixed methods research) 30 male nursing students	Attitude scale to assess the attitude of male nursing students towards obstetrical nursing clinical experience and open ended questionnaire to explore the perception of male nursing students regarding obstetrical nursing clinical experience	Most participants thought perinatal nursing was interesting, although they found the clinical component to be very embarrassing (p. 5); this embarrassment may limit the perceived scope of practice for men and lower their dignity. This could also lower their job satisfaction and cause moral distress, thereby contributing to poor recruitment and retention. Male nurses have an important role in obstetric nursing but there is low acceptance by the clients. "Most male nurses are interested to work in this area, but due to the less demand and acceptance in our country, they don't	Only clinical learning experiences explored Type of MMR and integration of 2 data sets not specified Data collection time not specified Data collected in a setting that traditionally values modesty, which could have affected results

				choose to work in obstetrical units" (p. 5-6). "They [society] feel that a nurse is always a female" (p. 6).	
Bartfay & Bartfay 2017 Canada (Ontario)	To examine the lived experiences of male nursing students in Ontario and their perception of reported educational and practice barriers, and social stereotypes	Phenomenology 37 male nursing students	Face-to-face, semi-structured interviews using open ended questions	Barriers to recruitment and retention of males in nursing schools included the feminization of nursing curriculum, reverse discrimination by female nursing students, faculty, and nursing clinical staff, a lack of positive male role models in academia, and negative social stereotypes including that men in nursing are effeminate, gay or labelled as inappropriate caregivers. The active recruitment and retention of males to schools of nursing may help address, in part, the predicted global shortages facing the profession, while also helping to promote gender diversity and social equality in this critical health care profession.	Not explicitly a PHN study, although the results were heavily focused on PHN

				Themes voiced by students include: feelings of being secluded and lonely in the program, being stereotyped to lack of emotions or caring, being labelled as effeminate or gay, experiencing the feminization of nursing culture, the fear of being perceived to have an inappropriate touch, being viewed as want-to-be physicians, being singled out and made an example of, and negative portrayal of men in nursing by social media and popular culture. Specifically, in the perinatal context a student reports that, "when I had an OB rotation, the instructor went to ask the patient if it was ok to have me. She didn't ask any of the girls in my rotation for sure. In addition, I'm sure they never ask patients if it's ok to have a male OBGYN medical student" (p. 5).	
Eswi & El Sayed	To explore the learning	Mixed methods research	Semi-structured interview and	Curriculum re-structuring should be undertaken to	Type of MMR not specified

2011 Egypt	experiences of Egyptian male nursing students during their maternity clinical rotation at Cairo University Maternity Hospital	60 undergraduate male students participated	research instrument scale to collect both qualitative and quantitative data	make maternity clinical placement optional for male students and offer a rotation in male urological health instead, pairing male students with female students during the clinical rotation, positively developing strategies to change male students' attitudes towards the childbearing experience and fatherhood is crucial. Students should be orientated to and encouraged to identify with the role model of male obstetricians. 11% reported experiencing an unfavorable attitude from their instructor, 34% of women refused to be cared for by a male nursing student. The most embarrassing procedures were abdominal and breast assessments, and perineal care. The most interesting procedures were attending caesarean section, providing health teaching, while 39%	Quantitative research instrument not specified Data collection time not specified Collected data in a setting where the value of modesty could have impacted results

				described the entire course as very embarrassing.	
Ha, Kim,, Choi & Ahn 2015 Korea	To explore the experiences of male nursing students during the maternal nursing clinical practice	Qualitative study 12 male students participated	Individual, unstructured interviews	Four main themes were identified: barrier by gender framework, understanding female psychology during childbirth, new perspective on women, and opportunity to gain insight into the role of the nurse. Patients' and partners' comfort levels with male students contributed to gender based rejection, so participants found it difficult to sympathize with a laboring woman due to gender roles and it was difficult to build rapport (p.3). Participants were impressed with the physical and psychological stress that laboring women had to overcome to deliver their baby. This made them more empathetic to their future partners if they were to have a baby because they understand the process more (p. 3).	Data collection time not specified

				This educational experience impacted the students' perception of PHN nurses, they described it as a legitimate nursing specialty after seeing the workflow and roles and responsibilities of a labour and delivery nurse (p. 4). Overall, this was a positive learning experience for the students, however, the major barrier continues to be gender based rejection. This study advocates for "nurse educators and clinical instructors to be aware of male student discomfort, and to sensitize faculty members to the needs of male students in maternity clinical practice" (p. 4).	
Mitra, Philips & Wachs 2018 USA	The purpose of this study is to describe the experiences of nursing students who are men	Existential phenomenology 7 students participated	Individual, semi-structured interviews	Four major themes were discovered: preconceptions, welcoming, perceived rejection (of and by participants) and maternity unit culture	Completed in a rural setting where cultural influence about respecting modesty could have impacted results

	before, during, and after their obstetrical clinical rotations			Participants reported several preconceptions: OB is female-dominated because women are better suited to care for pregnant women, therefore men are not welcome in this area In terms of welcoming, some participants did not experience gender-based discrimination and that their expectations of being rejected were not met in reality-which was pleasantly surprising Some participants did face gender-based rejection by both the patients and family members (mostly a male partner or family member). This rejection negatively impacted the participants' interest in working as an OB nurse The participants acknowledged how culture and social norms affect their learning experiences (ie: this study was completed in a rural town in Tennessee,	

				where it was mostly seen as inappropriate for a male health care provider to care for another man's wife in this intimate setting).	
Patterson & Morin 2002 USA	To understand the nature and quality of the discomfort experienced by male students associated with beginning their maternal-child clinical rotation	Phenomenology 8 male nursing students	Semi-structured interviews	Students reported preconceptions about the maternal child clinical rotation. They had mixed feelings before starting their rotation as it is viewed as a woman's domain and they were visitors. Identification of concerns by faculty before starting the rotation may enhance student learning. Surviving the clinical rotation was another theme reported, students felt that they had to work harder to meet their clinical objectives because of their gender and possible misinterpretations of their care, this therefore affected their post-partum examinations.	Only focused on the discomfort associated with beginning the placement No follow-up for facilitators or barriers to comfort throughout the rotation
Powers, Herron, Sheeler & Sain	To explore the lived experience of former male	Phenomenology 11 male students who	Semi-structured interviews	Themes from the data include: gender bias exists, being singled out, doing manly stuff, limitations in	Data collection timing not reported

2018 USA	nursing students	were formerly enrolled in a pre-licensure, baccalaureate nursing program participated		clinical settings, and no male role models. Based on study findings, recommendations to promote male nursing students' retention and success include improving media portrayal of male nurses (especially in obstetrics), providing faculty development to heighted self-awareness of gender bias and understanding of barriers and facilitators in nursing education for male students, addressing negative experience in the maternity clinical rotation and implementing mentorship programs to provide male role models for male students.	
Sherrod 1991 USA	To determine if there is a significantly greater reported role strain for male baccalaureate nursing	Quantitative study 18 male and 18 female nursing students participated	Participants completed the Sherrod Role Strain Scale to test the hypothesis that male students experienced more role strain than females did in obstetrics	The hypothesis was supported that men do experience more role strain than women do during their obstetric clinical rotation.	No exact statistical tests reported Small sample size for quantitative study

	students in the obstetrical area				

Appendix 3: Definitions of the College of Nurses of Ontario Entry to Practice Competencies (CNO, 2014, p. 5-10)

Professional Responsibility and Accountability
Consistently demonstrates professional conduct in accordance with the College's standards for nursing practice and ethics; and that the primary duty is to the client to ensure safe, competent, ethical nursing care.
Competencies for the entry-level registered nurse:
1. Demonstrates accountability and acceptance of responsibility for one's own actions and decisions.
2. Recognizes individual competence within legislated scope of practice and seeks support and assistance as necessary.
3. Articulates the role and responsibilities of a registered nurse as a member of the nursing and health care team.
4. Demonstrates a professional presence and models professional behavior
5. Consistently identifies self by first and last name, and appropriate professional designation (protected title) to clients and the health care team.
6. Displays initiative, confidence and self-awareness, and encourages collaborative interactions within the nursing and health care team, with the client as the centre of the health care team.
7. Advocates for clear and consistent roles and responsibilities within the health care team.
8. Demonstrates effective collaborative problem solving strategies, including conflict resolution.
9. Advocates and intervenes, as needed, to ensure client safety.
10. Demonstrates critical inquiry in relation to new knowledge and technologies that change, enhance or support nursing practice.
11. Promotes current evidence-informed practices.
12. Identifies actual and potentially abusive situations and takes action to protect the client, self and others from harm.
13. Reports unsafe practice or professional misconduct of a health care provider to appropriate authorities.

14. Questions and takes action on unclear orders, decisions or actions made by other health care team members that are inconsistent with client outcomes, best practices and health safety standards.
15. Protects clients through recognizing and reporting near misses and errors (the RN's own and others) and takes action to stop and minimize harm arising from adverse events.
16. Utilizes a systems approach to patient safety and participates with others in the prevention of near misses, errors and adverse events.
17. Continuously integrates quality improvement principles and activities into nursing practice.
18. Participates in the analysis, development, implementation and evaluation of practice and policy that guide delivery of care.
19. Exercises professional judgment when using organizational policies and procedures, or when practicing in the absence of organizational policies and procedures.
20. Organizes own workload and develops time-management skills for meeting responsibilities.
21. Demonstrates responsibility in completing assigned work and communicates work that is completed and not completed.
22. Fulfills the self-assessment requirements of the College's Quality Assurance Program.
23. Demonstrates professional leadership by:
    a) building relationships and trust with clients and members of the health care team
    b) creating healthy and culturally safe practice environments
    c) supporting knowledge development and integration within the health care team
    d) balancing competing nursing care values and priorities.

Knowledge-Based Practice

This competency category has two sections:

Specialized Body of Knowledge and Competent Application of Knowledge.

Specialized Body of Knowledge

draws on diverse sources of knowledge and ways of knowing; including the integration of nursing knowledge from the sciences, humanities, research, ethics, spirituality, relational practice, critical inquiry and primary health care principles.

Competencies for the entry-level registered nurse:

24. Demonstrates knowledge of the way in which registered nursing practice can facilitate positive client health outcomes.

25. Demonstrates a body of knowledge from nursing and other disciplines concerning current and emerging health care issues (e.g., health care needs of older adults, vulnerable and/or marginalized populations, health promotion, obesity, pain prevention and pain management, end-of-life, addiction, mental health)

26. Demonstrates a body of knowledge in the health sciences, including anatomy, physiology, pathophysiology, psychopathology, pharmacology, microbiology, epidemiology, genetics, immunology and nutrition.

27. Demonstrates a body of knowledge in nursing science, social sciences, humanities and health-related research (e.g., nursing theories; leadership and change theories; communication and learning; crisis intervention; loss, grief and bereavement; systems theory; diversity; power relations)

28. Demonstrates a body of knowledge about safe and healthy work environments (e.g., ergonomics, safe work practices/techniques, prevention and management of disruptive behaviour, issues of horizontal violence or aggressive behaviour, patient safety principles).

29. Demonstrates knowledge of relational practice by utilizing relational skills as the foundation for nursing practice.

30. Demonstrates knowledge about human growth and development, role transitions and population health, including the social determinants of health.

31. Demonstrates knowledge of the role of primary health care in health delivery systems and its significance for population health.

32. Demonstrates knowledge about emerging community, population and global health College of Nurses of Ontario Entry-to-Practice Competencies for Registered Nurses 7 issues and research (e.g., pandemic, mass immunizations, emergency/disaster planning, food and water safety).

33. Proactively seeks new information, knowledge and best practices for use in the provision of nursing care.

34. Contributes to a culture that supports involvement in nursing or health research through collaboration with others in conducting, participating in and implementing research findings into practice.

35. Demonstrates knowledge of and utilizes nursing informatics and other information and communications technology in promoting and providing safe nursing care.

Competent Application of Knowledge

Demonstrates competency in the provision of nursing care. The competency statements in this section apply to the four areas of nursing care: Assessment, Planning, Implementation of Care and Evaluation. The provision of nursing care is an iterative process of critical inquiry and is not linear in nature.

i) Ongoing Comprehensive Assessment.

The entry-level registered nurse incorporates critical inquiry and relational practice to conduct a client-focused assessment that emphasizes client input and the determinants of health.

Competencies for the entry-level registered nurse:

36. Uses appropriate assessment tools and techniques in consultation with clients and other health care team members.

37. Facilitates client engagement in identifying their health needs, strengths, capacities and goals.

38. In collaboration with the client, conducts an assessment of physical, emotional, spiritual, cognitive, developmental, environmental, social and learning needs, including the client's beliefs about health and wellness.

39. Collects information on client status using assessment skills such as observation, interview, history taking, interpretation of data and physical assessment, including inspection, palpation, auscultation and percussion.

40. Analyzes and interprets data obtained in client assessments to draw conclusions about client health status.

41. Incorporates knowledge of the health disparities and inequities of vulnerable populations (e.g., sexual orientation, persons with disabilities, ethnic minorities, poor, homeless, racial minorities, language minorities) and the contributions of nursing practice to achieve positive health outcomes.

42. Coordinates collaboration with clients and other health care team members to identify actual and potential client health care needs, strengths, capacities and goals.
43. Documents assessment data in accordance with evidence-informed practice.
44. Uses existing health and nursing information systems to manage nursing and health care data during client care.

ii) Collaborating with Clients to Develop Health Care Plans.

The entry-level registered nurse plans nursing care in collaboration with clients, integrating knowledge from nursing, health sciences and other related disciplines, as well as knowledge from practice experiences, clients' knowledge and preferences, and factors within the health care setting.

Competencies for the entry-level registered nurse:

45. Uses critical inquiry to support professional judgment and evidence-informed decision making to develop health care plans.
46. Uses principles of primary health and client centered care in developing health care plans.
47. Facilitates the involvement of clients in identifying their preferred health outcomes.
48. Negotiates priorities of care and desired outcomes with clients while demonstrating an awareness of cultural safety and the influence of existing positional power relationships.
49. Anticipates potential health problems or issues for clients and their consequences and initiates appropriate planning.
50. Collaborates with other health care team members to develop health care plans that promote continuity for clients as they receive conventional, social, complementary and alternative health care.
51. Coordinates the health care team to address clients' health challenges and identify strategies for health care planning.
52. Collaborates with other health care team members or health-related sectors to assist clients in accessing resources.
53. Facilitates client ownership of direction and outcomes of care developed in their health care plans.

iii) Providing Registered Nursing Care.

The entry-level registered nurse provides holistic individualized nursing care with clients and families across the lifespan, to meet mutually agreed upon outcomes along the continuum of care.

Competencies for the entry-level registered nurse:

54. Utilizes knowledge of theories and frameworks relevant to health and healing as rationale for providing nursing care.
55. Provides nursing care that is based on critical inquiry and evidence-informed decision making.
56. Coordinates and provides timely nursing care for clients with various co-morbidities, complexity and rapidly changing health statuses.
57. Determines and implements preventive, therapeutic and safety strategies based on ongoing client assessments, to prevent injury and the development of client complications.
58. Applies nursing knowledge when providing care to clients with acute, chronic, and/or persistent health challenges (e.g., stroke, cardiovascular conditions, mental health and addiction, dementia, arthritis, diabetes).
59. Applies workplace health and safety principles, including bio-hazard prevention and infection control practices, and appropriate protective devices when providing nursing care to prevent harm to clients, self, other health care workers and the public.
60. Recognizes, seeks immediate assistance and helps others in a rapidly changing client condition affecting health or patient safety (e.g., myocardial infarction, surgical complications, acute health events and crises).
61. Performs therapeutic interventions safely (e.g., positioning, skin and wound care, management of intravenous therapy and drainage tubes, and psychosocial interaction).
62. Implements safe and evidence-informed medication practices.
63. Implements evidence-informed practices of pain prevention and pain management with clients while using pharmacological and non-pharmacological measures.
64. Collaborates with clients to implement learning plans that address identified client learning needs.

65. Supports clients through developmental and role transitions across the lifespan (e.g., pregnancy, infant nutrition, well-baby care, child development stages, family planning and relations, geriatric care).
66. Applies principles of population health to implement strategies that promote health and disease prevention (e.g., promoting hand washing, immunization, helmet safety, safe sex).
67. Assists clients to understand how social and lifestyle factors impact health (e.g., physical activity and exercise, sleep, nutrition, stress management, personal and community hygiene practices, family planning, high risk behaviours).
68. Works with clients and families to identify and access health and other resources in their communities (e.g., other health disciplines, community health services, rehabilitation services, support groups, home care, relaxation therapy, meditation, information resources).
69. Provides pain and symptom management, psychosocial and spiritual support, and support for significant others to meet clients' palliative care or end-of-life care needs.

iv) Ongoing Evaluation of Client Care

The entry-level registered nurse collaborates with clients and members of the inter-professional health care team while conducting an ongoing comprehensive evaluation to inform current and future care planning.

Competencies for the entry-level registered nurse:

70. Utilizes a critical inquiry process to continuously monitor the effectiveness of client care.
71. Utilizes the results of outcome evaluation to modify and individualize client care.
72. Verifies that clients have an understanding of essential information and skills to be active participants in their own care.
73. Reports and documents client care and its ongoing evaluation clearly, concisely and accurately.
74. Advocates for change where optimum client care is impeded.

Ethical Practice

Demonstrates competency in professional judgment and practice decisions by applying the ethical values and responsibilities in the College's standards for ethics. The registered nurse also engages in critical inquiry to inform clinical decision-making, and establishes therapeutic,

caring, and culturally safe relationships with clients and the inter-professional health care team.
Competencies for the entry-level registered nurse: 75. Demonstrates honesty, integrity and respect in all professional interactions. 76. Identifies the effect of own values, beliefs and experiences in relationships with clients, and recognizes potential conflicts while ensuring culturally safe client care. 77. Establishes and maintains appropriate professional boundaries with clients and other health care team members, including the distinction between social interaction and therapeutic relationships. 78. Promotes a safe environment for clients, self, health care providers and the public that addresses the unique needs of clients within the context of care. 79. Provides care for clients while demonstrating respect for their health/illness status, diagnoses, life experiences, spiritual/religious/cultural beliefs and practices and health choices. 80. Demonstrates knowledge of the difference between ethical and legal considerations and their relevance when providing nursing care. 81. Ensures that informed consent is provided as it applies to multiple contexts (e.g., consent for care; refusal of treatment; release of health information; consent for participation in research). 82. Supports clients in making informed decisions about their health care. 83. Advocates for clients or their representatives, especially when they are unable to advocate for themselves. 84. Respects and preserves clients' choices based on an ethical framework. 85. Uses an ethical framework and evidence informed decision-making process to address situations of ethical distress and dilemmas. 86. Demonstrates ethical responsibilities and legal obligations related to maintaining client privacy, confidentiality and security in all forms of communication, including social media.
Service to the Public Demonstrates an understanding of the concept of public protection and the duty to provide and improve health care services in collaboration with clients and other members of the inter-professional health care team, stakeholders and policy makers.

Competencies for the entry-level registered nurse:

87. Utilizes knowledge of the health care system to improve health care services at the:
    a) national/international level
    b) provincial/territorial level
    c) regional/municipal level
    d) agency level
    e) point of care or program level.

88. Recognizes the impact of organizational culture on the provision of health care and acts to promote the quality of a professional and safe practice environment.

89. Demonstrates leadership in the coordination of health care by:
    a) advocating for client care in the client's best interest
    b) delegating and evaluating the performance of selected health care team members in carrying out delegated nursing activities
    c) facilitating continuity of client care

90. Participates and contributes to nursing and health care team development by:
    a) recognizing that one's values, assumptions and positional power affects team interactions, and uses this self-awareness to facilitate team interactions
    b) building partnerships based on respect for the unique and shared competencies of each team member
    c) promoting inter-professional collaboration through application of principles of role. clarification, team functioning, conflict resolution, shared problem-solving and decision-making
    d) contributing nursing perspectives on issues being addressed by the health care team,
    e) knowing and supporting the full scope of practice of team members
    f) providing and encouraging constructive feedback,
    g) demonstrating respect for diversity.

91. Collaborates with the health care team to proactively respond to changes in the health care system by:
    a) recognizing and analyzing changes that affect one's practice and client care
    b) developing strategies to manage changes affecting one's practice and client care

c) implementing changes when appropriate d) evaluating the effectiveness of strategies implemented to change nursing practice. 92. Manages resources in an environmentally and fiscally responsible manner to provide effective and efficient client care. 93. Advocates and promotes healthy public policy and social justice. 94. Participates in emergency preparedness and disaster planning and works collaboratively with others to develop and implement plans that facilitate protection of the public.
Self-Regulation Demonstrates an understanding of professional self-regulation by advocating in the public interest, developing and enhancing one's own competence, and ensuring safe practice.
Competencies for the entry-level registered nurse: 95. Articulates the scope, authority and regulation of nursing practice as outlined by legislation (e.g. Regulated Health Professions Act, 1991 and Nursing Act, 1991). 96. Practices within the scope of registered nursing practice as defined in the Nursing Act, 1991. 97. Articulates and differentiates between the mandates of regulatory bodies, professional associations and unions. 98. Articulates the concept and significance of fitness to practice in the context of nursing practice, self-regulation and public protection. 99. Articulates the significance of continuing competence requirements within professional self-regulation. 100. Demonstrates continuing competence and preparedness to meet regulatory requirements by: a) reflecting on one's practice and individual competence to identify learning needs, b) developing a learning plan using a variety of sources (e.g., self-evaluation and peer feedback), c) seeking and using new knowledge that may enhance, support, or influence competence in practice,

d) Implementing and evaluating the effectiveness of one's learning plan and developing future learning plans to maintain and enhance one's competence as a registered nurse.

Appendix 4: Perinatal Nursing Standards: Entrance to Practice Competencies for Nursing Care of the Childbearing Family for Baccalaureate Programs in Nursing Developed by the Canadian Association of Schools of Nursing (CASN) (CAPWHN, 2018, p.14-16)

Perinatal Nursing Standards Competency 1: *Promotes and enhances the health of the childbearing person, baby, and family during the childbearing years*.
1.1 Articulates how the social determinants of health, health trends, and challenges affect the health of the childbearing person and family. 1.2 Articulates awareness of ethical issues related to childbearing, and reflects on the implications of caring for childbearing families. 1.3 Collaborates with the childbearing person and family to identify strengths and mobilize resources to promote health, and respond to health challenges during pregnancy, childbirth, and postpartum/newborn periods. 1.4 Engages in relational practice and uses client-centered approaches when interacting with the childbearing person and family to promote health and facilitate learning during the childbearing years. 1.5 Provides responsive and culturally safe nursing care to Indigenous and other diverse childbearing families related to pregnancy, childbirth, and postpartum transitions. 1.6 Demonstrates an awareness of diverse forms of gender identities, including LGBTQ2S families. 1.7 Collaborates with the inter-professional healthcare team in the assessment, planning, implementation, and evaluation of care with the childbearing person and family. 1.8 Evaluates the childbearing person and family's responses to care, and adapts appropriately. 1.9 Advocates for the childbearing person and family to promote sexual health, and enhance health and health care. 1.10 Demonstrates awareness and understanding of grief and loss across the perinatal continuum. 1.11 Identifies the principles of family-centered, trauma-informed care for the childbearing person and family.

1.12 Describes potential implications of trauma and violence on the responses and needs of the childbearing person and family.
Perinatal Nursing Standards Competency 2: *Provides safe and appropriate care for the childbearing family from preconception through pregnancy*.
2.1 Demonstrates awareness of and understands the social construction and impact of fertility/infertility on the childbearing person and childbearing family. 2.2 Describes family planning options and acknowledges the childbearing person's choices. 2.3 Promotes health during the preconception period and during pregnancy. 2.4 Demonstrates a holistic approach to the assessment of the childbearing person and family's responses to pregnancy and childbearing. 2.5 Identifies potential risk factors and warning signs during pregnancy. 2.6 Provides evidence-informed nursing care in relation to common perinatal health concerns during pregnancy. 2.7 Promotes access to the resources needed for health during pregnancy (e.g. nutritious foods, appropriate housing, and folic acid supplements).
Perinatal Nursing Standards Competency 3: *Participates in the care of the childbearing family during childbirth.*
3.1 Participates in a comprehensive assessment of the childbearing person and fetus/baby throughout the stages of labour and birth. 3.2 Participates in assessing and meeting the learning and support needs of the childbearing person and family, including those related to labour progress, coping strategies, and procedures (e.g. induction of labour, or caesarean birth). 3.3 Collaborates with the healthcare team to provide care for the childbearing person and family during childbirth. 3.4 Collaborates with the healthcare team in identifying and responding to potential and actual complications during childbirth. 3.5 Promotes parental and family responsiveness and interaction with the newborn.

3.6 Provides nursing care that reflects the understanding of physiological and psychological processes and common challenges that occur during childbirth.
Perinatal Nursing Standards Competency 4: *Cares for the childbearing family during the postpartum period*.
4.1 Conducts a physical and psychosocial assessment of the childbearing person following childbirth during the postpartum period. 4.2 Conducts a physical assessment of the healthy term baby, and recognizes and responds to abnormal findings. 4.3 Provides nursing care to the childbearing person and family in the postpartum period that demonstrates an understanding of physiological and psychosocial processes and potential complications. 4.4 Promotes the health of the childbearing family during the postpartum transition period (e.g. enhances confidence during early parenting experiences). 4.5 Facilitates the parents' learning and confidence related to caring for the baby. 4.6 Provides evidence- informed support for infant feeding that respects family decision-making about breastfeeding and alternatives.

Appendix 5: Online Questionnaire

Hello, my name is Rachael Connie Moutoussidis. I am a Registered Nurse and a student in the Master's program at the School of Nursing of the University of Ottawa. I am presently conducting a research study on Ontario male nursing students' learning experiences in perinatal health nursing. There are two parts to this research study. The first part, which involves the completion of an online questionnaire, will take about ten minutes to complete. The second part focuses on an individual interview which take about one hour of your time. This study has received ethics approval from the Research and Ethics Board of the University of Ottawa (Ethics Certificate No. H-09-19-4947).

Part 1: Socio-Demographic Characteristics

1. How old are you? _____

2. What year in nursing school are you currently enrolled in?

   □ Third-year

   □ Fourth year

   □ I have already graduated

3. Why did you decide to go into nursing?

   □ I want to help people who are sick

   □ I was encouraged by a member in my social network (family, friends)

   □ I see this as a meaningful career for me

   □ Other (please specify): _____

4. Is this your first post-secondary education experience?

   □ Yes (If yes, go to Question 6)

   □ No (If no, go to Question 5)

5. What other post-secondary education do you have? _____

6. Have you done graduate studies?

   □ Yes (If yes, go to Question 7)

   □ No (If no, go to Question 8)

7. What is your graduate degree in? _____

8. What is your marital/civil status?

□ Single

□ Married

□ Common-law

□ Divorced

□ Other (please specify): _____

9. Do you have children?

□ Yes (If yes, go to Questions 10 and 11)

□ No (If no, go to Question 12)

10. If you do have children, how many do you have?

□ 1 child

□ 2 children

□ 3 children

□ 4 or more children

11. How old is your child/ how old are your children? _____

12. Do you consider yourself to be:

□ Heterosexual or straight

□ Homosexual

□ Bisexual

□ Prefer not to answer

□ Other

13. What is your gender?

□ Male

□ Female

□ Prefer not to answer

□ Other (please specify)

Part 2: Clinical Placement Evaluation Form (Penman and Oliver, 2004).

For the second part, you are being asked to give your **global or overall perception** of your practicum in perinatal health nursing. There are twelve items for this second section. Read each one and assess your level of agreement with it. Answer each item on a five-point Likert scale from 1 = 'Strongly disagree' to 5 = 'Strongly agree'.

Item #	Item	Strongly Disagree 1	Disagree 2	Neutral: Neither disagree nor disagree 3	Agree 4	Strongly Agree 5
14.	Overall, the clinical placement was a pleasant learning experience.					
15.	I felt well prepared for the clinical placement.					
16.	I met my objectives to my satisfaction.					
17.	The placement assisted my learning.					
18.	The placement enhanced my clinical skills.					
19.	The placement was supportive of my professional growth.					

20.	There was adequate orientation provided.					
21.	I was expected by the venue.					
22.	The staff members were very willing and available to assist my learning.					
23.	As a result of my experience, I feel confident working in this venue.					
24.	There were many opportunities for me in this venue.					
25.	The clinical experience would benefit the other students.					

Part 3: Specific Assessment of the Perinatal Health Nursing Practicum

In this third part, you are being asked to give your assessment of each of the three components of the perinatal health nursing practicum: laboratory, simulation and clinical placement in the hospital.

26. Where did you do your clinical placement in perinatal health nursing?

□ Queensway-Carleton Hospital

□ Ottawa Hospital-Civic Campus

□ Ottawa Hospital-General Campus

□ Montfort Hospital

□ Other (please specify) _____

27. Did your maternity and child-bearing family theory course prepare you for the three components of the perinatal health nursing practicum (laboratory, simulation and clinical placement in the hospital)?

□ Yes

□ No

28. When considering the preparation of the theory course for the three components of the perinatal health nursing practicum (laboratory, simulation and clinical placement in the hospital), how would you rate the degree of preparation on a scale from 1 'Not prepared at all' to 10 'Well very prepared'?

Not prepared at all									Very well prepared
1	2	3	4	5	6	7	8	9	10

29. How would you rate the laboratory component: how prepared were you on a scale of 1 (not prepared at all) to 10 (very well prepared)?

Not prepared at all									Very well prepared
1	2	3	4	5	6	7	8	9	10

30. How would you rate the simulation component: how prepared were you on a scale of 1 (not prepared at all) to 10 (very well prepared)?

Not prepared at all									Very well prepared
1	2	3	4	5	6	7	8	9	10

31. How would you rate the clinical placement in the hospital: how prepared were you on a scale of 1 (not prepared at all) to 10 (very well prepared)?

Not prepared at all									Very well prepared

1	2	3	4	5	6	7	8	9	10

32. For the laboratory, what parts of the laboratory were the most useful or the most helpful? Choose all that apply.

□ Postpartum assessment and care
□ Newborn assessment and care
□ Infant feeding
□ Adult learning principals and health teaching
□ Other: _____

33. What parts of the laboratory were the least useful or the least helpful? Choose all that apply.

□ Postpartum assessment and care
□ Newborn assessment and care
□ Infant feeding
□ Adult learning principals and health teaching
□ Other: _____

34. Did the laboratory prepare you for the clinical placement in the hospital?

□ Yes, go to Question #36
□ No, go to Question #37

35. On a scale from 1 to 10, how much did the laboratory learning prepare you for clinical (1 not prepared at all to 10 very well prepared)?

Not prepared at all									Very well prepared
1	2	3	4	5	6	7	8	9	10

36. For the simulation component, what parts of the simulation activities were the most useful or the most helpful? Choose all that apply.

□ Post partum hemorrhage
□ Difficult breastfeeding
□ Bottle feeding teaching
□ Discharge teaching and car seat safety
□ Well baby drop in center/ post partum depression
□ Newborn head to toe exam
□ Other : _____

37. What parts of the simulation activities were the least useful or the least helpful? Choose all that apply.

□ Post partum hemorrhage
□ Difficult breastfeeding
□ Bottle feeding teaching
□ Discharge teaching and car seat safety
□ Well baby drop in centre / post partum depression
□ Newborn head to toe exam
□ Other: _____

38. Did the simulation activities prepare you for the clinical placement in the hospital?

□ Yes, go to Question #40
□ No, go to Question #41

39. On a scale from 1 to 10, how much did the simulation activities prepare you for the clinical placement in the hospital (1 not prepared at all to 10 very well prepared)?

Not prepared at all									Very well prepared
1	2	3	4	5	6	7	8	9	10

40. For the clinical placement, what parts of the perinatal health nursing clinical placement were the most useful or the most helpful? Choose all that apply.

□ Postpartum assessment and care
□ Newborn assessment and care
□ Infant feeding support
□ Health and discharge teaching
□ Other: _____

41. What parts of the perinatal health nursing clinical placement were the least useful or the least helpful? Choose all that apply.

□ Postpartum assessment and care
□ Newborn assessment and care
□ Infant feeding support
□ Health and discharge teaching
□ Other: _____

42. Please rate your comfort level at the beginning of your clinical placement in the hospital on a scale of 1 ‘not comfortable’ to 10 ‘very comfortable’.

Not comfortable									Very comfortable
1	2	3	4	5	6	7	8	9	10

43. Please rate your comfort level at the end of your clinical placement in the hospital on a scale of 1 ‘not comfortable’ to 10 ‘very comfortable’.

Not comfortable									Very comfortable
1	2	3	4	5	6	7	8	9	10

44. How would you rate your relationship with the nursing staff, from 1 ‘very poor’ to 10 ‘very good’?

Very poor									Very good
1	2	3	4	5	6	7	8	9	10

45. How would you rate your relationship with the other health care professionals, from 1 ‘very poor’ to 10 ‘very good’?

Very poor									Very good
1	2	3	4	5	6	7	8	9	10

46. How would you rate your relationship with the mothers, from 1 ‘very poor’ to 10 ‘very good’?

Very poor									Very good
1	2	3	4	5	6	7	8	9	10

47. How would you rate your relationship with the mother’s significant other, from 1 ‘very poor’ to 10 ‘very good’?

Very poor									Very good

1	2	3	4	5	6	7	8	9	10

48. How would you rate your relationship with the members of the mother's social support network, from 1 'very poor' to 10 'very good'?

Very poor									Very good
1	2	3	4	5	6	7	8	9	10

49. How would you rate your relationship with the baby, from 1 'very poor' to 10 'very good'?

Very poor									Very good
1	2	3	4	5	6	7	8	9	10

50. How would you rate your relationship with your clinical instructor in the hospital, from 1 'very poor' to 10 'very good'?

Very poor									Very good
1	2	3	4	5	6	7	8	9	10

Part 4: Additional Comments

51. Do you have any other comments that you would like to add?

_____

_____

_____

Thank you for your collaboration.

Appendix 6: Individual Interview Guide

Introduction:

My name is Rachael Connie Moutoussidis. I am a Registered Nurse and a student in the Master's program at the School of Nursing of the University of Ottawa. I am conducting a research study on Ontario male nursing students' learning experiences in perinatal health nursing. This is the second part of two parts for this research study. The first part involved completing an online questionnaire. This part is an individual interview, which will take about one hour of your time. It will be audio-recorded. This study has received ethics approval from the Research and Ethics Board of the University of Ottawa (Ethics Certificate No. H-09-19-4947). This interview guide is divided into five parts: the first part focuses on your experiences in the nursing program in general, the second part on your experiences in the perinatal health nursing courses, and the third part on the perinatal health nursing practicum, the fourth part gives you an opportunity to discuss your recommendations about the perinatal health nursing courses offered at the University of Ottawa, and the last section will be an opportunity to give any other feedback or comments you may have.

Part. 1: Experience in the Program in General

1. Tell me how the program is going so far (how the program went).
2. Tell me about your class. How many students are (were) in your year? How many are (were) men and how many are women? (when did you graduate, where did you graduate from)
3. What does (did) the current gender distribution in the program mean for you? (what does the current gender distribution on the floor mean to you)
4. How have (were) the theory classes been so far? Which courses were your favorite ones and why? Which were the ones that were your least favorite ones and why?
5. How have (were) the clinical placements been so far? Which were your favorite ones and why? Which were the ones that were your least favorite ones and why?
6. Do you have any other general comments about the program?

Part 2: Experience in Perinatal Health Nursing (Theory course, laboratory and simulation)

7. Tell me about your perinatal health nursing theory course. What do you like about it? What do you not like about it?
8. What is (was) your perspective about the laboratory component in the perinatal health nursing practicum?
9. What is (was) your perspective about the simulation training component in the perinatal health nursing practicum?
10. Did you have any fears or worries about the practicum in perinatal health nursing? If yes, what were they? How did you deal with them?
11. Do you feel that this is an applicable course for male nursing students given the nursing statistics in this area and the patient population? Please explain your answer.

Part 3: Experience in Clinical Placement in Hospital Setting

12. What is (was) your perspective about the hospital placement component in the perinatal health nursing practicum?
13. What were you expecting this placement to be like before you started? Did your assumptions match your actual experience on the unit? Why or why not?
14. What facilitated your learning experiences in the perinatal health nursing practicum?
15. What are (were) the barriers to your learning experiences in the perinatal health nursing practicum?
16. What are some strategies you used or applied to deal with these barriers?
17. After completing your perinatal health nursing clinical practicum, is this an area where you see (saw) yourself doing your consolidation? Why or why not?
18. After completing your perinatal health nursing clinical practicum, is this an area where you see (saw) yourself working in the future? Why or why not?

19. Do you feel that your gender impacted your perception on the unit or competence in this clinical specialty? Why or why not? How so?
20. Describe your experience as a male nursing student doing the perinatal health nursing practicum. Which aspects of the practicum, or which tasks were you the most comfortable with? Which aspects of the practicum, or which tasks were you the least comfortable with? Why? (which areas as a staff nurse are you the most or least comfortable with)

Part 4: Suggestions or Recommendations

21. From a general viewpoint, do you feel that the perinatal health nursing practicum needs to be improved for male nursing students? What are your suggestions or recommendations on how the perinatal nursing practicum can be improved?
22. Does the laboratory component need to be improved? What are your suggestions or recommendations on how the laboratory component of the perinatal health nursing practicum can be improved?
23. Does the simulation component need to be improved? What are your suggestions or recommendations on how the simulation component of the perinatal health nursing practicum can be improved?
24. Does the clinical placement in the hospital setting need to be improved? What are your suggestions or recommendations on how the clinical placement in the hospital setting can be improved? *does your orientation as a staff nurse need to be improved? What are your suggestions or recommendations on how the orientation to this area could be improved, what would you tell other male students about this clinical practicum or working here*

Part 5: Additional Comments

25. Do you have any other comments that you would like to add for this study?
26. How did you find your experience in participating in this study? The online questionnaire? The interview?

Thank you for your participation in this study.

Appendix 7: Email Sent to the Director of the School of Nursing

To whom it may concern,

My name is Rachael Connie Moutoussidis. I am a registered nurse and a master's student in nursing at the School of Nursing of the University of Ottawa. I am conducting a research study on the learning experiences of male nursing students in perinatal health nursing. They are in a unique position in this clinical practicum because they are a visible gender minority as students, are doing a practicum in a clinical specialty that is female dominated, and are working with an exclusively female patient population.

Some male students still report being anxious about this particular clinical area, and fear rejection based on gender- and unfortunately, sometimes this still does happen.

The goal of my study is to explore these student's experiences as a visible gender minority. The findings will be used to continue to de-construct gender normative behavior and advocate for gender inclusive initiatives at the university and in the hospital settings.

I would like to ask your permission to recruit male students from the School of Nursing in their third or fourth year who are doing their practicum in perinatal health nursing. At this stage, they are either currently taking, or have previously taken their perinatal health nursing practicum, in addition to other clinical placements; therefore, they are in a prime position to speak about their experiences. The data will only be collected after they have terminated a clinical rotation in perinatal health nursing.

Please do not hesitate to contact me if you have any questions. My thesis supervisor, Dr. Viola Polomeno, is also available to answer any of your questions or to provide more information about this study.

Thank you,

Rachael Connie Moutoussidis, R.N., B.Sc.N.

Appendix 8: Email to Course Professors

To whom it may concern,

My name is Rachael Connie Moutoussidis, I am a registered nurse and a student in the master's program in nursing at the School of Nursing of the University of Ottawa. I am conducting a research study on the learning experiences of male students in perinatal health nursing. They are in a unique position in this clinical practicum because they are a visible gender minority as students, are doing a practicum in a clinical specialty that is female dominant, and are working with an exclusively female patient population.

Some male students still report being anxious about this particular clinical area, and fear rejection based on gender- and unfortunately, sometimes this still does happen.

The goal of my study is to explore these student's experiences as a visible gender minority. The findings will be used to continue to de-construct gender normative behavior and advocate for gender inclusive initiatives at the university and in the hospital settings.

I would like to ask your permission to recruit male students from the School of Nursing in their third or fourth year. At this stage, they are either currently taking, or have previously taken their perinatal health nursing practicum, in addition to other clinical placements; therefore, they are in a prime position to speak to their experiences. Would it be possible for me to take 5 minutes at the beginning or at the end of one of your lectures, labs, or simulations, to introduce myself and my study?

Please do not hesitate to contact me if you have any questions. My thesis supervisor, Dr. Viola Polomeno, is also available to answer any of your questions or to provide more information about this study.

I look forward to your response.

Thank you,

Rachael Connie Moutoussidis, R.N., B.Sc.N.

Appendix 9: Poster for Recruitment for Research Study (to be distributed in class and in laboratory and to be posted on Facebook and on the Virtual Campus-Brightspace)

A Mixed Methods Study of Ontario Male Nursing Students' Perceptions of their Learning Experiences in Perinatal Health Nursing

Are you a third or fourth year male nursing student at the University of Ottawa?

Are you a male nurse working in the Perinatal Health clinical area?

Are you currently completing, or have previously completed, a practicum in perinatal health nursing? What was your learning experience like?

Would you like to make a difference in gender inclusive initiatives at the School of Nursing of the University of Ottawa?

Are you interested in sharing your experience?

Here are the inclusion criteria for the study:

- Any nursing student, or recent graduate, who identifies as a male;
- Who is registered in the undergraduate program at the School of Nursing of the University of Ottawa;
- Who is a third-year student who is currently completing his perinatal health nursing practicum in the Ottawa region;
- Who is a fourth year student who completed his perinatal health nursing practicum in the Ottawa region during the previous academic year;
- Who is a recent graduate who has obtained CNO licensure in the past two years and is currently practicing in perinatal health nursing
- Is either an Anglophone or a bilingual Francophone.

If you are interested in participating in this study, please contact the Student Researcher Rachael Connie Moutoussidis, R.N., B.Sc.N. to complete a 10 minute online survey, and book a one-hour interview with her.

A $20 Amazon gift card will be offered for your time!

This study has received ethics approval from the Research and Ethics Board of the University of Ottawa (Ethics Certificate No. H-09-19-4947).

Appendix 10: Invitation to Participate in the Research Study Entitled: "A Mixed Methods Study of Ontario Male Nursing Students' Perceptions of their Learning Experiences in Perinatal Health Nursing"

Dear Nursing Student or Recent Graduate,

I am conducting a research study to understand the learning experiences of male nursing students during their perinatal health nursing training, with a goal to support them better as a visible gender minority in this clinical specialty. As a male third or fourth year nursing student or recent graduate, you are in an ideal position to give us valuable first-hand information from your own perspective.

The study has two parts: an online questionnaire and an interview. The questionnaire only takes 10 minutes to complete. The interview will take approximately one hour and is very informal. I am simply trying to capture your perspectives on being a visible gender minority in a female dominated environment and female dominated clinical specialty. Your responses to the questions will be kept confidential. Each online questionnaire and interview will be assigned a number code to help ensure that personal identifiers are not revealed during the analysis and write up of findings.

As compensation for your time for participation, a $20 Amazon gift card will be provided to you. If you are willing to participate, please suggest a day and time that suits you best. The questionnaire and interview will both be completed during out meeting, I'll do my best to be available. If you should have any questions, please do not hesitate to ask me. My thesis supervisor is also available to answer your questions.

Thanks!

Rachael Connie Moutoussidis R.N., B.Sc.N.

Appendix 11: Consent Form and List of Psychological Resources

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School of Nursing

A Mixed Methods Study of Ontario Male Nursing Students' Perceptions of their Learning Experiences in Perinatal Health Nursing

Thesis Supervisor:

Dr. Viola Polomeno, R.N, Ph.D.
Associate Professor
University of Ottawa
Faculty of Health Sciences
School of Nursing
451 Smyth Road, Ottawa, On K1H 8M5
Email: vpolomen@uottawa.ca
Tel. 613 562 5800 ext. 8736

Master's Student Researcher:

Rachael Connie Moutoussidis, R.N., B.Sc.N.
University of Ottawa
Faculty of Health Sciences
School of Nursing
451 Smyth Road, Ottawa, On K1H 8M5

Invitation to Participate:

You are being invited to participate in the above mentioned research study conducted by Rachael Connie Moutoussidis as part of her Master's Thesis and supervised by Dr. Viola Polomeno because you are a third year or a fourth year student in nursing at the University of Ottawa, or are a recent graduate who is currently working in this clinical area.

Purpose of the Study:

The purpose of the study is to explore the learning experiences of male nursing students during their clinical practicum in perinatal health nursing, in order to understand their unique position as a gender minority and further support them in this particular learning experience.

Participation:

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School of Nursing

Once you have terminated your rotation in the perinatal health nursing clinical practicum, your participation will consist of two parts that will take place consecutively, on the same day. The first part will consist of completing a four-part online questionnaire: the first section consists of questions pertaining to your socio-demographic and educational background; the second section focuses on a global assessment of the practicum; the third section focuses on more specific questions in relation to the practicum; and the fourth section asks about additional comments. It will take about ten to fifteen minutes to complete the online questionnaire.

The second part will involve a one-hour interview that will be audio-recorded. You will be asked general and specific questions about the clinical practicum in perinatal health nursing, including its three components (laboratory, simulation and clinical placement in the hospital), or about your work experience in this area (if applicable). You understand that in order to participate in this research project, you must complete both the online questionnaire and the interview.

Once the data are collected and analyzed, you may be contacted by the student researcher after the data collection period is terminated to provide any feedback on the data collected.

Risks:

Your participation in this study will entail that you describe your experience during your perinatal health nursing clinical practicum (or work experience) and this may cause you to feel uncomfortable. You have received assurance from the student researcher that every effort will be made to minimize these risks for both the online questionnaire and for the interview. You can refuse to answer any question that you do not feel comfortable with. A list of psychological resources will be available at the end of this document, should you need professional help at any point throughout this study.

Benefits:

Your participation in this study will help inform gender inclusive initiatives in the university and in the hospital setting because men are a minority in the perinatal health nursing specialty. The findings will help to improve this particular learning experience for future male nursing students who will also complete a practicum in this area.

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Withdrawal from the Study:

Your participation in this study is voluntary. You are free to withdraw from the study at any time and for any reason. You may also have any data collected about yourself withdrawn from the study. If you should have any concerns about the study, you can discuss them with the student researcher at any point during the study.

Confidentiality and Anonymity:

You have received assurance from the student researcher that the information that what you will share will remain strictly confidential. The only people who will have access to the data will be the student researcher and her thesis supervisor. You understand that the contents will be used only for the purpose of this study and that your confidentiality will be protected by not using your name in any presentation or publication. The results will be published in pooled (aggregate) format. Anonymity is guaranteed since you are not being asked to provide your name or any other personal information.

Anonymity will be protected as much as possible, but you understand that the following information will be known about yourself: that you are a man in the third year or fourth year of the BSCN program at the University of Ottawa, or that you are a recent graduate currently working in this clinical speciality. Your personal information, like your name, age, sexual orientation, and parental status will remain anonymous.

Conservation of Data:

The data collected through the online questionnaire will be kept on an encrypted USB stick. The audio recording of the interview will also be kept on the encrypted USB stick, but the transcribed interview will be stored in paper form. Only the researcher and her thesis supervisor will have access to the data. The USB stick and paper data will be kept in a locked filing cabinet in the office of the supervisor-Dr. Viola Polomeno-at the University of Ottawa for 5 years at which time they will be destroyed according to University of Ottawa policy.

Compensation:

You understand that you will receive a $20 CAD Amazon gift card as compensation for your participation after the completion of both the online questionnaire and the interview.

Voluntary Participation:

You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences such as your experience being shared with your clinical instructors, professors, clinical managers, or colleagues. If you choose to withdraw, all data gathered until the time of withdrawal will not be included in the study, and disposed of in a

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Information about the Study Findings:

Information about the study findings will be available upon request.

Acceptance:

You, _____, agree to participate in the above research study conducted by Rachael Connie Moutoussidis, R.N., B.Sc.N., of the University of Ottawa, Faculty of Health Sciences, School of Nursing, which research is under the supervision of Viola Polomeno, R.N., Ph.D.

If you should have any questions about the study or require more information about the study itself, you may contact the researcher or her thesis supervisor.

If you have any questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5, Tel.: (613) 562-5387
Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is yours to keep.

Thank you for your time and consideration.

Participant's signature: *(Signature)* Date:

Researcher's signature: *(Signature)* Date:

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Faculty of Health Sciences
School of Nursing

List of Professional Psychological Resources –

Liste des ressources psychologiques professionnelles

In English/En anglais:

1. Psychological Services-Montfort Hospital: 613-746-4621
2. Mental Health Crisis Line (24 hours/day):

-Telephone: 613-722-6914 or 1-866-996-0991 (Toll Free)

-By email at: info@crisisline.ca

3. Ontario Mental Health Hotline:

-By telephone: 1-866-531-2600

-By chatting:

http://livechat.connexontario.ca/ECCChat/MHHchat.html

-By email:

http://www.mentalhealthhelpline.ca/Home/Email

4. TOH Psychiatric Emergency Services (24 hours/day)

-Telephone: 613-798-5555 or 1-866-996-0991 (toll free)

5. QCH Emergency Consultation (Emergency Room 3045 Baseline Rd. Nepean, ON)

En français/In French:

1. Services psychologiques-Hôpital Montfort: 613-746-4621
2. Ligne d'urgence en santé mentale (24 heures) :

-par téléphone : 613-722-6914 or 1-866-996-0991 (sans frais)

-par courriel: info@crisisline.ca

3. Ligne d'urgence de l'Ontario :

-par téléphone : 1-866-531-2600

-par clavardage (seulement en anglais)

-par courriel:

http://www.mentalhealthhelpline.ca/Accueil/Courriel

Appendix 12: Face and Content Validities for Online Questionnaire - Assessment Form

Since Part 2 contains a validated research instrument entitled, *Clinical Placement Evaluation Form (Penner and Oliver, 2004 (Items #15 to #26)),* only Parts 1, 2 and 4 need to be assessed for face validity and for content validity.

Face Validity Assessment		
Overall, do the items contained in the online questionnaire relate to male nursing students' perceptions in regard to their practicum in perinatal health nursing?	Yes _____ No _____	Please explain your answer:
Content Validity Assessment Form		
Online Questionnaire Question	Is the question well written, clear and concise? Please indicate "Yes" or "No".	Comments about the online questionnaire question.
Part 1: Socio-Demographic Characteristics		
1. How old are you?		
2. What year in nursing school are you currently enrolled in? □ Third-year □ Fourth year		
3. Why did you decide to go into nursing? □ I want to help people who are sick □ I was encouraged by a member in my social network (family, friends) □ I see this as a meaningful career for me □ Other: _____		
4. Is this your first undergraduate degree? □ Yes (If yes, go to Question 6) □ No (If no, go to Question 5)		
5. What other undergraduate degree(s) do you have? □ Health sciences □ Psychology □ Pure sciences □ Other: _____		
6. Have you done graduate studies? □ Yes (If yes, go to Question 7) □ No (If no, go to Question 8)		

7. What is/was your graduate degree in? □ Health sciences □ Pure sciences □ Psychology □Other: _____		
8. What is your marital/civil status? □ Single □ Married □ Common-law □ Divorced □ Other: _____		
9. Do you have children? □ Yes (If yes, go to Questions 10 and 11) □ No (If no, go to Question 12)		
10. If you do have children, how many do you have? □ 1 child □ 2 children □ 3 children □ 4 or more children		
11. How old is/are your child/children? _____		
12. Do you consider yourself to be: □ Heterosexual or straight □ Homosexual □ Bisexual □ Prefer not to answer		
13. Do you consider yourself to be transgender? □ Yes □ No		
Part 3: Specific Assessment of the Perinatal Health Nursing Practicum		
26. Where did you do your clinical placement in perinatal health nursing? □ Queensway-Carleton Hospital □ Ottawa Hospital-Civic Campus □ Ottawa Hospital-General Campus □ Montfort Hospital		
27. Did your theory course prepare you for the three components of the perinatal health		

nursing practicum (laboratory, simulation and clinical placement in the hospital)? □ Yes □ No		
28. When considering the preparation of the theory course for the three components of the perinatal health nursing practicum (laboratory, simulation and clinical placement in the hospital), how would you rate the degree of preparation on a scale from 1='Not prepared at all' to 10= 'Well very prepared'?		
29. How would you rate the laboratory component: how prepared were you on a scale of 1 (not prepared at all) to 10 (very well prepared)?		
30. How would you rate the simulation component: how prepared were you on a scale of 1 (not prepared at all) to 10 (very well prepared)?		
31. How would you rate the clinical placement in the hospital: how prepared were you on a scale of 1 (not prepared at all) to 10 (very well prepared)?		
32. For the laboratory, what parts of the laboratory were the most useful or the most helpful? Choose all that apply. □ Postpartum assessment and care □ Newborn assessment and care □ Infant feeding □ Adult learning principals and health teaching □ Other: _____		
33. What parts of the laboratory were the least useful or the least helpful? Choose all that apply. □ Postpartum assessment and care □ Newborn assessment and care □ Infant feeding □ Adult learning principals and health teaching □ Other: _____		

34. Did the laboratory prepare you for the clinical placement in the hospital? □ Yes, go to Question #36 □ No, go to Question #37		
35. On a scale from 1 to 10, how much did the laboratory learning prepare you for clinical (1 not prepared at all to 10 very well prepared)?		
36. For the simulation component, what parts of the simulation activities were the most useful or the most helpful? Choose all that apply. □ Postpartum hemorrhage □ Difficult breastfeeding □ Bottle feeding teaching □ Discharge teaching and car seat safety □ Well baby drop in center/postpartum depression □ Newborn head to toe exam □ Other : _____		
37. For the simulation component, what parts of the simulation activities were the least useful or the least helpful? Choose all that apply. □ Postpartum hemorrhage □ Difficult breastfeeding □ Bottle feeding teaching □ Discharge teaching and car seat safety □ Well baby drop in center/postpartum depression □ Newborn head to toe exam □ Other : _____		
38. Did the simulation activities prepare you for the clinical placement in the hospital? □ Yes, go to Question #40 □ No, go to Question #41		
39. On a scale from 1 to 10, how much did the simulation activities prepare you for the clinical placement in the hospital l(1 not prepared at all to 10 very well prepared)?		
40. For the clinical placement, what parts of the perinatal health nursing clinical placement		

were the most useful or the most helpful? Choose all that apply. □ Postpartum assessment and care □ Newborn assessment and care □ Infant feeding support □ Health and discharge teaching □ Other: _____		
41. What parts of the perinatal health nursing clinical placement were the least useful or the least helpful? Choose all that apply. □ Postpartum assessment and care □ Newborn assessment and care □ Infant feeding support □ Health and discharge teaching □ Other: _____		
42. Please rate your comfort level during the clinical placement in the hospital on a scale of 1 'not comfortable' to 10 'very comfortable'.		
43. How would you rate your relationship with the nursing staff, from 1 'very poor' to 10 'very good'?		
44. How would you rate your relationship with the other health care professionals, from 1 'very poor' to 10 'very good'?		
45. How would you rate your relationship with the mothers, from 1 'very poor' to 10 'very good'?		
46. How would you rate your relationship with the mother's significant other, from 1 'very poor' to 10 'very good'?		
47. How would you rate your relationship with the members of the mother's social network, from 1 'very poor' to 10 'very good'?		
48. How would you rate your relationship with the baby, from 1 'very poor' to 10 'very good'?		
49. How would you rate your relationship with your clinical instructor in the hospital, from 1 'very poor' to 10 'very good'?		
Part 4: Additional Comments		

50. Do you have any other comments that you would like to add?		

Appendix 13: Assessment Form for Pretest with Nursing Students

Hello,

The purpose of this assessment is to obtain your comments about the online questionnaire and the interview.

Part 1: Online Questionnaire

1. How long did it take you to complete the online questionnaire? _____ minutes

2. Was the introduction to the online questionnaire clear?

   □ Yes
   □ No
   □ Please explain your choice of yes or no: _____

   _____

3. Was the online questionnaire easy to navigate on the survey monkey platform?

   □ Yes
   □ No
   □ Please explain your choice of yes or no: _____

   _____

4. Were the questions clear?

   □ Yes
   □ No
   □ Please explain your choice of yes or no: _____

   _____

5. Were the questions easy to understand?

   □ Yes
   □ No
   □ Please explain your choice of yes or no: _____

   _____

6. Were the questions easy to answer?

□ Yes
□ No
□ Please explain your choice of yes or no: _____

_____

7. Did the questions capture your perception about your practicum in perinatal health nursing?

□ Yes
□ No
□ Please explain your choice of yes or no: _____

_____

8. Do you have suggestions on how the online questionnaire can be improved?

_____

_____

Part 2: Interview Guide

9. How long was the interview? _____ minutes

10. Was the introduction clear for the interview?

□ Yes
□ No
□ Please explain your choice of yes or no: _____

_____

11. Were the questions clear?

□ Yes
□ No
□ Please explain your choice of yes or no: _____

_____

12. Were the questions easy to understand?

□ Yes
□ No
□ Please explain your choice of yes or no: _____

_____

13. Were the questions easy to answer?

□ Yes
□ No
□ Please explain your choice of yes or no: _____

_____

14. Did the questions capture your perception about your practicum in perinatal health nursing?

□ Yes
□ No
□ Please explain your choice of yes or no: _____

_____

15. Do you have suggestions on how the interview can be improved?

_____

_____

Part 3: Additional Comments

16. Do you have any other comments that you would like to add about the online questionnaire and the interview?

_____

_____

Thank you.

Appendix 14: Face and Content Validities for Interview Guide-Assessment Form

Face Validity Assessment		
Overall, do the items contained in the interview guide relate to male nursing students' perceptions in regard to their practicum in perinatal health nursing?	Yes _____ No _____	Please explain your answer:
Content Validity Assessment Form		
Interview Guide Question	Is the question well written, clear and concise? Please indicate "Yes" or "No".	Comments about the interview question.
Part 1: Experiences in the Program in General		
1. Tell me how the program is going so far.		
2. Tell me about your class. How many students? How many are men and how many are women?		
3. Is the gender distribution in the program what you were expecting? Why or why not?		
4. How have been the theory classes been so far? Which courses were your favorite ones and why? Which were the ones that were the least favorite ones and why?		
5. How have the clinical placements been so far? Which were your favorite ones and why? Which were the ones that were the least favorite ones and why?		
6. Do you have any other general comments about the program?		
Part 2: Experience in Perinatal Health Nursing (theory course, laboratory and simulation)		
7. Tell me about your perinatal health nursing theory course. What do you like about it? What do you not like about it?		
8. What is your perspective about the laboratory component in the perinatal health nursing practicum?		

9. What is your perspective about the simulation training component in the perinatal health nursing practicum?		
10. Did you have any fears or worries about the practicum in perinatal health nursing? If yes, what were they? How did you deal with them?		
11. Do you feel that this is an applicable course for men based on their gender? Please explain your answer.		
Part 3: Experience in Clinical Placement in Hospital Setting		
12. What is your perspective about the hospital placement component in the perinatal health nursing practicum?		
13. What were you expecting this placement to be like before you started? Did your assumptions match your actual experience on the unit? Why or why not?		
14. What are the facilitators to your experience in the perinatal health nursing practicum?		
15. What are the barriers to your experience in the perinatal health nursing practicum?		
16. What are some strategies that you used or applied to deal with these barriers?		
17. After completing your perinatal health nursing clinical practicum, is this an area where you see yourself doing your consolidation? Why or why not?		
18. After completing your perinatal health nursing clinical practicum, is this an area where you see yourself working in the future? Why or why not?		
19. Do you feel that your gender impacted your perspective on the unit or competence in this clinical specialty? Why or why not? How so?		
20. Describe your experience as a male nursing student doing the perinatal health		

nursing practicum. Which aspects of the practicum or which tasks were you the most comfortable with? Which aspects of the practicum or which tasks were you the least comfortable with? Why?		
Part 4: Suggestions or Recommendations		
21. From a general viewpoint, do you feel that the perinatal health nursing practicum needs to be improved for male nursing students? What are your suggestions or recommendations on how the perinatal nursing practicum can be improved?		
22. Does the laboratory component need to be improved? What are your suggestions or recommendations on how the laboratory component of the perinatal health nursing practicum can be improved?		
23. Does the simulation component need to be improved? What are your suggestions or recommendations on how the simulation component of the perinatal health nursing practicum can be improved?		
24. Does the clinical placement in the hospital setting need to be improved? What are your suggestions or recommendations on how the clinical placement in the hospital setting can be improved?		
Part 5: Additional Comments		
25. Do you have any other comments that you would like to add for this study?		
26. How did you find your experience in participating in this study? The online questionnaire? The interview?		

Appendix 15: Permission to Use the Clinical Placement Evaluation Questionnaire

Joy Cayetano-Penman <Joy.Pen… Aug 23, 2019, 12:45 PM (8 days ago)
to Viola, me, joy-penman@monash.edu

Yes, that is fine, Viola. I am giving Rachael my permission to use my Clinical Placement Evaluation questionnaire.
Best wishes
Joy

•••

--
Dr Joy Penman
Senior Lecturer
Stream Lead and Coordinator: Australian Nursing Studies
MNM Counsellor: Psi Zeta at-large Chapter, Sigma Theta Tau International

Nursing and Midwifery
Monash University
Room D334
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T:+ 61 3 99050010
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Appendix 16: Table 13-Andragogical Learner Analysis for PHN Learning Experience

Andragogical Principles for PHN Learning	Applies to learner for PHN?	Expected influence of:					
		Individual and Situational Differences in PHN Learning			Goals and Purposes for PHN Learning		
		Subject matter	Individual learner	Situational	Individual	Institutional	Societal
1. Learner's need to know PHN							
2. Self-concept of the learner in PHN							
3. Prior experience of the learner: before PHN							
4. Readiness to learn PHN							
5. Orientation to learning for PHN							
6. Motivation to learn PHN							

Appendix 17: Table 14-Applied Example of PHN Andragogical Learner Analysis at the University of Ottawa

Andragogical Principles for PHN Learning	Applies to learner for PHN?	Expected influence of:					
		Individual and Situational Differences in PHN Learning			Goals and Purposes for PHN Learning		
		Subject matter	Individual learner	Situational	Individual	Institutional	Societal
1. Learner's need to know PHN	Yes	Core curriculum and testable content	Core curriculum and testable content	Core curriculum and testable content	Core curriculum and testable content	Core curriculum and testable content	Questionable for some students, patients, partners and family members
2. Self-concept of the learner in PHN	Yes	Subject matter may cause discrepancy with self concept given post #metoo movement, discomfort, awkwardness	Views on masculinity and traditional gender roles and norms	Impact of sexual orientation, patient/ family/ partner attitude	Impact of sexual orientation, patient/ family/ partner attitude	Lack of male role models on the floor and in academia	Role strain and gender based rejection occur here
3. Prior experience of the learner: before PHN	Yes	Builds on pervious nursing knowledge or from personal experience	Builds on pervious nursing knowledge or from personal experience	Builds on pervious nursing knowledge or from personal experience	Builds on pervious nursing knowledge or from personal experience	Hearing previous students' experiences	Expectation to be rejected or feel out of place
4. Readiness to learn PHN	Yes	Core curriculum	Individual intellectual capacity	Core curriculum	Lack of confidence	Core curriculum	Lack of confidence due to gender

		and testable content		and testable content		and testable content	norms and role strain
5. Orientation to learning for PHN	Yes	Core curriculum and testable content	Individual learning style	Variation in teaching and orientation style of instructors and professors	Pre-clinical comfort level determines how much orientation is needed	Variation in teaching and orientation style of instructors and professors	Variation results from attitudes and beliefs of male nursing students' capability relative to female students' capability
6. Motivation to learn PHN	Yes	Core curriculum and testable content	Core curriculum and testable content	Core curriculum and testable content	Core curriculum and testable content	Core curriculum and testable content	Discouraged from a societal level due to social and gender norms

Appendix 18: Ethics Certificate from the University of Ottawa

12/11/2019

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-09-19-4947
Titre du projet / Project Title	A Mixed Methods Study of Ontario Male Nursing Students' Perception of their Practicum of Perinatal Health Nursing
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
Statut du projet / Project Status	Approuvé / Approved
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Équipe de recherche / Research Team

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Conditions spéciales ou commentaires / Special conditions or comments