British South Asian male nurses’ views on the barriers and enablers to entering and progressing in nursing careers

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Abstract

*I don’t think I’ve had any contact with a senior Asian male nurse in my entire career…… I’ve been nursing for 36 years now* (NI 1).

Aim: To ascertain British South Asian male nurses’ views on the barriers and enablers to entering and progressing in nursing education and careers.

Background: There is a shortage of men from Black, Asian and Minority Ethnic groups in the National Health Service nursing workforce. There is a dearth of evidence on the views of British south Asian men on this subject.

Methods: A qualitative interpretative intersectional approach was used to carry out one to one interviews (n=5) with British South Asian male nurses using a semi-structured topic guide. Interviews took place between July 2018 and February 2019, across England. A Framework Analysis approach was used to analyse the interview transcripts.

Results: The main themes emerging as barriers were: poor pay and conditions, negative immediate, extended family, community views and a lack of knowledge and awareness of the nursing profession.

The main themes emerging as enablers were: personal circumstances (including role models) and ethnicity (including the role of religion and masculinity).
Conclusion: Findings suggest that the intersection between ethnicity and gender presents as an important enabler, as well as inhibitor, for British South Asian men. Nursing careers and salient barriers exist at a systemic level and include institutional racism.

Implications for Nursing Management:

- Review policies and practice on unconscious bias and institutional racism in the recruitment, retention and progression of British South Asian men.
- Provide continuous professional development including mentoring support to help career progression for these men.
- Develop culturally specific interventions to reduce the stigma associated with the nursing profession in the British South Asian community.
- Consider places of worship as venues for delivery of these interventions when promoting nursing.

Keywords: Gender and ethnicity, intersectionalism, barriers, enablers, NHS, nursing workforce, institutional racism, unconscious bias.

Background

The National Health Service (NHS) is the leading employer of nurses in England (NHS England, 2016; The Kings Fund, 2017). Despite this one of the main challenges for the NHS has been shortfalls in attracting a nursing workforce that represents the super diversity of the United Kingdom (UK) population it serves (Buchan & Seccombe, 2013; Health Education England, 2014). Underrepresented groups include young people (Watson et al., 2005), those without qualifications (Kaehne, Maden, Thomas, Brown, & Roe, 2014), low skilled, part-time and temporary workers (Ross, 2013), those on low incomes and/or working age benefits, older adults (Robinson, Zass-ogilvie, & Hudson, 2012), those with disabilities (Connor, 2008), those with literacy, numeracy or learning difficulties, some Black and Asian minority ethnic (BAME) groups (Adams, Nursaw, & Smith, 2017; Naqvi, Razaq, & Piper, 2017) and men (Evans, 2004; Rajacich, Kane, Williston, & Cameron, 2013; Whitford et al., 2018).
Evidence suggests that diversifying the nursing workforce contributes to improved health outcomes for patients (Kline, 2013; O’Neill, 2016; Wray, Aspland, Gibson, Stimpson, & Watson, 2009). In recent years there has been a policy priority to increase the UK educated or trained NHS healthcare workforce (Baker, 2017; Naqvi, 2017; Naqvi, Razaq & Piper, 2017) because as well as addressing nursing (and allied healthcare) shortfalls (Health Education England, 2014; Munn, 2018) recruiting a healthcare workforce from the diverse communities it serves contributes towards providing culturally competent healthcare services (Vydelingum, 2006; Harris et al., 2013; O’Neill, 2016) leading to improvements in quality of care for patients (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003; Cohen, Gabriel, & Terrell, 2002), increased patient satisfaction (Loftin, Newman, Gilden, Bond, & Dumas, 2013) and cost management (Hunt, 2015; O’Neill, 2016).

With respect to ethnic diversity BAME groups are underrepresented in the NHS nursing workforce across various healthcare sectors (Health Education England, 2014; Naqvi et al., 2017). Ethnicity is a contested and complex construct encompassing various shared characteristics including biology, culture, language and religion (Chaturvedi, 2001; Salway, Ellison, Higginbottom, & Allmark, 2009). There is a substantial literature discussing explanations for the underrepresentation of BAME groups in the nursing workforce. Barriers include a lack of BAME role models within nursing education (Gilchrist & Rector, 2007; Loftin, Newman, Dumas, Gilden, & Bond, 2012; Yoder, 1996); lack of cultural competency in nursing education (Amaro, Abriam-Yago, & Yoder, 2006; Johnson, 2012; Yoder, 2001); and institutional racism within recruitment, retention and progression policies within the nursing workforce (Allan, Larsen, Bryan, & Smith, 2004; Chambers & Alexis, 2004; Likupe & Archibong, 2013; Likupe, Baxter, Jogi, & Archibong, 2014).

With respect to gender the numbers of men registered as NHS nurses has increased from 10.63% in 2004 to 11.5% in 2016 (Nursing and Midwifery Council, 2016) but despite making up 50% of the total UK population (ONS, 2011) men remain underrepresented in the NHS nursing workforce (Clifton, Higman, Stephenson, Navarro, & Welyczko, 2018; Evans, 2004). These patterns are similar to those across the world with a few notable exceptions such as Spain, Italy, Tanzania, Israel and Jordan where men are more visible in the nursing workforce (Abu Al Rub, 2007; Achora, 2016; Punshon et al., 2019).
Possible explanations in the literature for barriers leading to the underrepresentation of men in the nursing workforce have been categorised as the perceived low status of the nursing profession including disincentives of long working hours (Khokhar, 2017; Mackintosh, 1997) and low pay (Kluczyńska, 2017; Pham, 2013); and gender dynamics within nursing such as the perceived feminisation of the nursing profession (Genua, 2005; Klein, 2009); the fear of allegations due to touching of female patients (Harding, 2008); gender discrimination when working in a female dominated environment (Folami, 2017; Rajacich et al., 2013; Shen-Miller & Smiler, 2015; Zamanzadeh, Valizadeh, Negarandeh, Monadi, & Azadi, 2013) and a lack of male role models (Meadus, 2000; Twomey & Meadus, 2016).

Whilst there have been some notable UK studies exploring the underrepresentation of South Asians (Indians, Pakistanis and Bangladeshis) in NHS nursing (Darr, Atkin, Johnson, & Archibong, 2008; Dyson, Culley, Norrie, & Genders, 2008; Health Education England, 2014; Iganski, Mason, Humphreys, & Watkins, 2001) there is less available evidence on the experiences of British South Asian (BSA) male nurses. This is significant, as BSA male nurses contribute to the UK educated or trained nursing workforce. Generally, there is very little available evidence intersecting ethnicity and gender (Crenshaw, 1991) to understand the barriers and enablers for men entering and progressing in nursing careers. The small amount of significant literature has considered the circumstances of BAME men in the United States (Dorsey, 2005; Price-Glynn & Rakovski, 2012; Wingfield, 2009); Arabs in Israel (Keshet & Popper-Giveon, 2016) and immigrants in Norway (Karlsen, 2012). All of these studies point to the racialising of the ‘glass elevator’, or being afforded preferential treatment in career progression in comparison to women. In other words ethnic minority men do not experience the patriarchal advantages reported for their White male counterparts when working in female dominated professions. We do not know whether this is the case for BSA male nurses.

Therefore a knowledge gap exists regarding how ethnicity (masculinity, religion and culture) and gender intersect in the experience of nursing for BSA men in the UK. There has been a lack of consideration of how gendered constructions of masculinity

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1 The term British South Asian refers to those people of South Asian ethnicity, born or socialised in the United Kingdom (UK)(Ali, Kalra and Sayyid, 2006). It is most closely aligned with the ethnic group definition used in the 2011 census (Office of National Statistics 2011) where Asian/Asian British refers to Pakistani, Indian and Bangladeshi (not including Chinese or any other Asian background).
may be different across different ethnic groups and how this may impact on nursing education and careers.

Theoretical approaches analysing the disadvantage faced by minority ethnic groups within nursing and the workplace have included critical race theory (Ackerman-Barger & Hummel, 2014); every day racism (Mapedzahama, Rudge, West, & Perron, 2012); gender based analysis (Choiniere, Macdonnell, & Shamonda, 2010); and unconscious bias (Williamson, 2018) and microaggressions (Solorzano, Ceja, & Yosso, 2000). More recently intersectionality has been used in healthcare research and also provides a useful theoretical framework to understand the intersecting factors influencing the experience of South Asian men and nursing.

To the best of our knowledge, this is the first study that has used an intersectional approach to ascertain BSA male nurses’ views on the barriers and enablers to entering and progressing in nursing education and NHS careers. Recruiting more BSA men can contribute towards improving the diversity of the NHS workforce (Ali et al., 2018; Anthony, 2004; Kirk, 2011) and meeting some of the shortfalls in the nursing workforce. This is particularly significant because BSAs make up the largest ethnic minority group in the UK at 7.5% (including Indians 2.5%, Pakistanis 2%, Bangladeshis 0.7% and other Asian groups 2.3%) of the total population (63.26 million) (Office for National Statistics, 2012), have a younger age profile (9% of 15-29 year olds) (Runnymede Trust, 2015) and have higher levels of demographic growth (Health Education England, 2014) when compared to all other ethnic groups. Population projections have calculated this group as having a combined annual growth rate at over 10% (Coleman, 2010) and therefore addressing barriers and understanding enablers for BSA men (and the BSA group generally) have the potential to make a significant contribution to the future NHS nursing workforce.

The Study

Aim

To ascertain BSA male nurses’ views on the barriers and enablers to entering and progressing in nursing education and careers.

Methods
The investigator conducted one to one interviews with BSA male nurses (n=5) using a semi-structured topic guide. Interviews lasted approximately 45 minutes to 1 hour long and took place in settings chosen by participants including participants’ homes and community centres between July 2018 and February 2019, across England.

**Participants**

Purposive sampling was used to recruit participants who were educated, trained and employed as nurses in the England (Etikan, Musa, & Alkassim, 2016; Rajacich et al., 2013). A newsletter was circulated to recruitment departments at NHS Trusts in England, community centres and places of worship. The individual participant characteristics for each interview are found in table 1 below

**Data analysis**

Interviews were audio recorded and transcribed verbatim by the investigator (Farmer, Robinson, Elliott, & Eyles, 2006; Moorley & Cathala, 2019). The secondary investigator checked the audio recordings against transcripts to ensure the accuracy of transcription. Participants were given codes so that they could remain anonymous. The transcripts were kept on password protected USB sticks and computers. The data was analysed using a framework approach which involved a detailed familiarisation with the data, identification of key themes to form a coding frame, indexing the material according to the coding frame, and finally interpreting the findings in the context of other research in the area and policy and practice considerations (Spencer, Ritchie, Jane, & Dillon, 2003). Overall, the framework analysis approach relies on a thematic, comparative organisation of narratives, which allowed the research team to agree when saturation had been achieved and apply an intersectional lens when analysing findings. The approach incorporated issues of reflexivity, reliability and validity (Fusch & Ness, 2015). To minimise researcher bias during analysis the secondary investigator developed the coding frame which was discussed and refined in an iterative process in meetings with authors. Themes were identified deductively guided by the semi structured discussion guides and inductively as they emerged from the data. Themes and sub-themes were also discussed with the authors redefined until a consensus was achieved (Thiele, Pope, Singleton, & Stanistreet, 2018). This paper follows the
Ethics

Ethical approval was obtained from the University of Bedfordshire Ethics Committee. All data collected was anonymised and no personal, or individually identifiable, information was shared. Consent forms explaining all participatory implications were used as well as participant information sheets. The data gathering process was further reviewed in order to assure compliance with recent national General Data Protection Regulation (GDPR) guidance.

Findings

Barriers

Barriers are the social and personal factors that can hinder BSA men entering and progressing in nursing education and careers and have been categorised as personal, as well as contextual variables that enhance or constrain personal agency (Lent, Hackett, & Brown, 2000). A number of barriers were identified including poor pay and conditions, negative immediate and extended family and community views, and the general lack of knowledge and awareness of the nursing profession. These are presented in more detail below.

Poor pay and conditions

The consensus among participants was that nurses generally (regardless of ethnicity or gender) were underpaid and their salaries did not reflect the important role, long working hours and responsibilities which involved high levels of stress. Some participants also argued that they experienced discrimination based on their ethnicity and gender demonstrated by poor progression and associated salary increases. Participants described the lack of BSA nurses in senior nursing and management positions in the NHS.

I don’t think I’ve had any contact with a senior Asian male nurse in my entire career........ I’ve been nursing for 36 years now (NI1).
.... the next time it was advertised there was a much more junior English nurse who only worked part-time and she has currently got that job but I actually withdrew from the interview process because it was evident no matter how bad she could have been that she would have got it (NI1).

Negative immediate, extended family, community views

There was a consensus among participants that the negative views of the nursing profession from the immediate and extended family and the South Asian community were a barrier to BSA men entering the nursing profession. Often the opposition was from male relatives who saw nursing as ‘woman’s work’. In other words cultural constructions of masculinity were not aligned with nursing.

If we look at modern South Asian masculinity it’s about fast cars, big houses, masculine symbolic things and masculine roughness, masculine drunkenness (NI 4).

Participants explained that these views were also heavily influenced by media representation of nursing being a predominantly white female profession.

…Mary Seacole who was a famous black nurse, we don’t hear very much of that…being white and angelic and so forth and that’s what the perception of a nurse was (NI 3).

Participants explained that central to South Asian masculinity is the ability to ‘provide’ for the immediate and often extended family and the general perception of low salaries led to nursing being perceived as a low status job and this was a barrier to choosing nursing. They went on to argue that BSA men are encouraged to take on higher paid (and status) professions jobs such as doctors.

It’s relatively obvious to me and that’s that, if you are South Asian and you are a male, you will be a doctor or bust (NI4). The low status of nursing was also associated with the caring role within nursing and the association with ideas of ‘serving’ others and the narrative extract below illustrates.
I think a lot of Asians view of nursing is that you are providing care is something you do as a servant whereas medicine is perceived very differently (NI1).

*Lack of knowledge and awareness of the nursing profession*

There was a consensus that the BSA community (like the general public) did not have enough awareness of what the nursing role entailed. Participants felt this was a barrier for BSA men in considering the nursing role from an informed position.

I think people think that it’s just about physical healthcare, cleaning, washing and dressing people. (NI2).

…not at all, there is no awareness out there at all (NI5).

*Enablers*

Enablers are societal and personal resources that influence or contribute towards prospective BSA men entering and progressing in nursing education and careers (Lent et al., 2000). A number of enablers were identified and these included: personal circumstance; role models; ethnicity (including ethnicity and masculinity) and positive perceptions of the profession such as nursing being a noble profession. These are presented in more detail below using samples of narrative extracts from interviews.

*Personal circumstances (including role models)*

Participants highlighted personal motivations for becoming a nurse which focussed on caring for self/others at a young age, having a spouse, relative or friend who was a nurse and provided a source of encouragement and support to join the profession.

…a friend just turned around and said to me why don’t you try nursing and yea I fell into nursing… She was a nurse, she started her nurse training (NI 3).
Ethnicity (including religion and masculinity)

Some of the BSA male nurses agreed that their South Asian masculinities (especially in relation to their religion) were conducive to the qualities and attributes required for being a good nurse. They felt that BSA men did demonstrate key qualities needed for nursing such as commitment, care and compassion in their attitude toward family members. As such their masculinities could be seen as being a potential enabler, however, some felt that South Asian masculinity was not necessarily an enabler for them. However, participants also explained that South Asian religions (Islam, Sikhism and Hinduism) reinforce the idea of caring for others and therefore religion was an enabler to choosing a nursing career but that cultural interpretations of BSA masculinity superseded religious interpretations and sanctions of caring for others. They also pointed out that the focus of BSA role as carers was predominantly for immediate and extended family.

…with the ethos of Sikhism when you do nursing or something like that it’s doing seva and that’s how we do it and seva is volunteering your services to other people to care for them and think you could almost brandish it under that label and say as a nurse this is what I’m doing (NI 3).

Discussion

In common with other studies our research findings identified a number of barriers, some of which relate to ethnicity, some of which relate to gender. Our research also identified particular enablers relating to the intersection of ethnicity and gender. What follows is a discussion of how findings from this study align with, or differ from, previous research.

As reported in previous studies (Gilchrist & Rector, 2007; Loftin et al., 2012; Yoder, 1996) BSA male nurses suggested that the lack of BAME role models was a barrier. Similar to other studies, institutional racism and unconscious bias emerged as factors participants perceived as contributing to the underrepresentation of BAME people in senior posts within the NHS and nursing workforce (Kline, 2014; Likupe et al., 2014; NHSE, 2017; Priest et al., 2015). Participants spoke explicitly about the difficulties for BAME people achieving senior positions with associated increases on
the nursing pay scale. Participant’s views on the lack of opportunities for continued
career development and successes aligned with previous research on racism and its
effects in the NHS which outlines that BAME nurses experience humiliation and low
morale as a result of thwarted aspirations (Mistry & Latoo, 2009).

The perceived low status of the nursing profession (Khokhar, 2017; Kluczyńska,
2017; Mackintosh, 1997; Pham, 2013) has previously been reported as a barrier for
men in nursing. This study found that there was a consensus amongst BSA nurses
that that the public did not have any clear ideas of what the nursing role entails. They
felt the role was minimised to domestic duties, personal care and following orders
from doctors in any information that was made available (Buerhaus, Donelan,
Norman, & Dittus, 2005). Parental views were a barrier to BSA men entering the
nursing profession. BSA nurses reported that the men in their family, especially, did
not approve of such a career, as they felt it was ‘women’s work’ (Jordal & Heggen,
2015; Rambur, Palumbo, McIntosh, Cohen, & Naud, 2011).

Furthermore, if we explore the intersection of gender and ethnicity within the
dynamics of the nursing profession for BSA men, this study identifies a number of
barriers in line with the current evidence base. The reported gender discrimination
for men when working in a female dominated environment (Folami, 2017; Rajacich et
al., 2013; Shen-Miller & Smiler, 2015; Zamanzadeh et al., 2013) is coupled with
racial discrimination as the BSA male nurses felt they were the victims of prejudice
twice over as they were discriminated against once for belonging to a minority ethnic
group and then again for being a man. This phenomenon of minority ethnic men
facing disadvantage in female dominated work environments has been reported
upon previously (Dorsey, 2005; Wingfield, 2009). They felt they were victims of
gendered racism within the profession, (Solanke, 2009; Van Herk, Smith, & Andrew,
2011).

This perception demonstrates a doubling up of the existing evidence on lack of
representation being seen as a barrier for men in nursing (Clow, Ricciardelli, &
Bartfay, 2015; Ellis, Meeker, & Hyde, 2006; Stanley, 2012) as well as a barrier for
BSA people and nursing (Ali et al., 2018; Darr et al., 2008; Dyson et al., 2008). This
lack of perceived representation and lack of voice within the workforce could leave
BSA men feeling twice excluded from the nursing profession, on the basis of gender

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and ethnicity. This would explain BSA nurses perceiving a ‘glass ceiling’ with regard to their career progress as opposed to a ‘glass elevator’ which other White men might experience in their nursing career.

There are a number of international studies that acknowledge the potential advantages that some men experience when they do join the nursing workforce. The particular circumstance of men being in the minority in the nursing profession, yet experiencing accelerated career progression (Evans, 2004); higher average earnings (Barrett-Landau, 2014; Punshon et al., 2019) and more equal treatment from male medical practitioners (Ellis et al., 2006) evidences patriarchal advantage within nursing. However the findings of this study do not concur with these previous studies. This discrepancy may be due to the specific geographic nature and cultural aspects of living in the UK.

These findings suggest that within the intersection of their gender and ethnicity, BSA male nurses presented enablers for them entering and progressing in nursing careers. In particular they reported their masculinities were conducive to the qualities required for good nursing. Characteristics such as being caring, having compassion and being committed were common to their constructions of masculinities as well as the nursing profession. This is particularly significant as research has shown that patients of South Asian background often prefer gender matched healthcare practitioners (Bhatt, 2015; Janssen & Lagro-Janssen, 2012; Vandan, Wong, & Fong, 2019).

The role of religion provides an interesting enabler as BSA nurses felt there was a clear moral purpose to their work. They spoke about their own religious backgrounds and how it aligned with the nursing profession. From the concept of ‘seva’ in the Sikhism through to the obligation to help others in Islamic tradition, a common thread around religious values and nursing emerged within the views of BSA male nurses. This finding is particularly interesting as the majority of the literature in this area points to religion being construed as a barrier for South Asians entering the nursing profession (Ali et al., 2018; Daly, Swindlehurst, & Johal, 2003; Hollup, 2014). Typically, nursing has been intrinsically linked with the Christian religion in its evolution as a profession (Buck, 2015; Clementson, 2008; Kelly, Watson, Watson, Needham, & Driscoll, 2017; Lundmark, 2007). This alignment of the historical
development of nursing as a profession with the religious values of Christianity has come at the cost of excluding other world religions such as Sikhism, Islam and Hinduism. The discourse of nursing has held Christianity and femininity at its centre, inadvertently creating a perceived mismatch between religions such as Islam and nursing. Evidence of this can be found in the Indian subcontinent where until recently it was widespread practice for only Christian women to be employed as nurses as opposed to Hindus, Sikhs or Muslims.

Nurses often reported them getting to know an individual who encouraged them to go into nursing. This individual was often a nurse, student nurse or someone working within healthcare. This specific phenomenon of joining a profession whilst knowing someone from that profession has been reported previously. When researching underrepresentation of BAME people within the fire service, (Singh, 2002) argues this phenomenon to be the critical factor in encouraging underrepresented groups into the profession. As mentioned above (Bagilhole & Cross, 2006) also point to the existence of role models within a field being an explanatory factor for why some men choose to enter traditionally female dominated professions.

Conclusion

This paper has explored the barriers and enablers for BSA men entering and progressing in the nursing education and careers, through an analysis of the views and perceptions of those BSA men that did become nurses. The findings from this study suggest that the barriers and enablers for BSA men are many and complex.

The findings from this study suggest that the barriers for BSA men entering and progressing in nursing outweigh the patriarchal advantage that other men may experience (Dorsey, 2005; Karlsen, 2012; Popper-Giveon, Keshet, & Liberman, 2015; Wingfield, 2009). Some of these barriers are specific to the intersectional experience of BSA men such as being BAME and men in nursing. The evidence base would suggest that their gender would afford them a patriarchal advantage but alongside this another set of literature evidences that BAME people face specific disadvantages in nursing. These disadvantages manifest themselves in the institutional practice within nursing education and employment, and British White
male nurses may not face them in the way that participants have reported in this study. This is a concerning finding as it points to a long standing tradition of prejudice and discrimination within nursing in the UK and beyond, may it be termed microaggressions, unconscious bias, or institutional racism (Bhopal, 2016; EHRC, 2019; Likupe, 2015; Mapedzahama et al., 2012; Priest et al., 2015; Sporek, 2015).

However, it is critical to note that these findings point to a number of enablers within the intersectional experience of BSA men and nursing. Contrary to current understanding of ‘traditional South Asian masculinity’ (Everitt-Penhale & Ratele, 2015; Hann et al., 2018; Kalra, 2009), it may be that BSA men’s constructions of masculinity could be seen as an enabler for them being well suited to the nursing profession. As masculinities are constructed differently across different ethnicities (Swami, 2016) BSA masculinity may include aspects such as caring, demonstrating commitment and contributing to one’s community which could be seen as aligning with key qualities needed of a good nurse. In addition, the role of BSA religions like Islam, Sikhism and Hinduism may well be considered a potential enabler for BSA men entering the nursing profession. These are significant findings, which point to the specific intersectional experience of BSA men as opposed to British White men and provide a new and positive perspective on the subject.

Implications for Nursing Management

This study provides a useful insight into the views of an underrepresented group within the nursing workforce. Policy makers and those involved in managing and diversifying the nursing workforce can take note of the identified barriers and enablers for BSA men in NHS nursing in England.

Policies and practice on unconscious bias and institutional racism in the recruitment, retention and progression on BSA men may be reviewed because some of the barriers identified by this study are external to the BSA community and embedded within nursing education and employment institutions. A perceived ‘glass ceiling’ was mentioned by the participants and therefore nurse managers and those involved in human resources and organisational development could monitor carefully and provide tailored mentoring and support for marginalised and underrepresented groups within their workforce, such as BSA nurses. This support could include continuous professional development including mentoring support.
Culturally specific interventions to reduce the stigma associated with the nursing profession in the British South Asian community could be developed because the findings from this study suggest that a number of barriers exist for them from within their communities (such as negative family views and lack of awareness of what the nursing role entails). Therefore those involved in nurse recruitment may pay particular consideration to engaging with communities as well as individuals when disseminating information on nursing as a career. These engagements may be part of ethnically targeted interventions which may be designed collaboratively with schools/colleges, Universities, NHS trusts, prospective students and parents and delivered through BSA social networks and community media.

Places of worship could be considered as venues for delivery of culturally specific interventions when promoting nursing as a career because of the finding in this study that religious beliefs may be an enabler of BAME to consider nursing, places of worship may be a good place to engage with the community and hold a career fair. These interventions may place emphasis on the values common to South Asian religions and the nursing profession because a number of enablers were identified including ethnicity, religion and masculinity. The role of South Asian religions like Islam, Sikhism and Hinduism may be a potential enabler for these men entering the global nursing profession. Emphasising values and beliefs common in these religions and the nursing profession may be a useful reference point for discussions. In addition, constructions of masculinity may be utilised as an enabler for these men being well suited to the nursing profession, when developing marketing material for nurse recruitment. Findings provide a new and positive perspective on the subject for those policy makers involved in developing and diversifying the global nursing workforce.

Limitations

Due to the small number of BSA men working in NHS nursing, this study was not able to recruit a large sample. This group was particularly difficult to identify and access. The sample was sufficient to reach saturation but may not be ‘representative’ of BSA male nurse views, which limits the ‘transferability’ of the findings. Secondly, sharing the transcripts from the interviews with participants and receiving feedback could have added further depth to the findings. Future research
may seek to recruit larger sample sizes and confirm transcripts with participants in order to seek further ‘validity’.

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<tr>
<td>NI4</td>
<td>NHS nurse</td>
<td>Nursing workforce (adult/corporate)</td>
<td>BSA (Indian heritage)</td>
<td>Sikh</td>
</tr>
<tr>
<td>NI5</td>
<td>NHS nurse</td>
<td>Nursing workforce (mental health)</td>
<td>BSA (Indian heritage)</td>
<td>Sikh</td>
</tr>
</tbody>
</table>