

## **“YES, THE GUYS CAN DO IT!”: MIGRANT MALE CARE WORKERS IN CANADIAN AND SWEDISH NURSING HOMES**

**Abstract.** *Canada and Sweden are seeing growing numbers of migrant male care workers in long-term care settings, yet research exploring their everyday experiences within this context is scarce. We draw on interview data of migrant men to compare how they come to be in nursing home care work, negotiate their social role, and reconcile and challenge norms about masculinity. The study finds that migrant men work to find a balance and manage tensions related to working in a women-coded field. They attempt to maintain their masculinity without losing their caring approach in both their work and social interactions.*

**Keywords:** *migrant, masculinity, long-term care, care work, nursing homes*

### **Introduction**

In this article, we focus on migrant men's entrance into, motivations for, and experiences of paid care work in Canadian and Swedish nursing homes. Which general similarities emerge in these men's descriptions of the benefits and challenges they face in the everyday life of care? This question guided us while analysing interviews from two research projects in order to make visible the common experience of being employed in a women-dominated and feminine-coded occupation.

As Braedley (2006) notes, social inequalities of race, gender and class have always been central for who provides care. However, the normative picture of the care worker as a white working-class woman is in transition (Storm, Braedley and Chivers, 2017; Sörensdotter, 2008), although care is still primarily defined as women's work and it is often assumed that women are natural carers. The global ageing population, the working conditions, combined with the availability of other employment options (Hussein and Christensen, 2017; Seeberg, 2012) have contributed to shortages in the native-born supply of care workers. According to Armstrong (2017), these

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factors together have led to growing international demand for migrant people to provide care, a trend observed in Canada and Sweden (also see Novek, 2013; Giertz and Jönson, 2018). At the same time, the deteriorating conditions in low-income countries have prompted migrations with the resulting migrant populations becoming an important recruitment base for care work. Care work is increasingly framed in both the informal and formal care sector as an area for migrants to find gainful employment in a job market that often excludes or marginalises them, and underdevalues their competence and skills (Locke, 2017; Seeberg, 2012; Williams, 2010). This social change has been analysed in relation to the “global care chain” concept introduced by Hochschild (2000). The concept illustrates “a series of personal links between people across the globe based on the paid or unpaid work of caring” (Hochschild, 2000: 131): persons from poorer countries migrate to high-income countries to work in care-related occupations (Hochschild, 2000; Williams, 2010). The multiple studies applying this concept reveal the conditions and relations of care women migrants face; yet, as Locke (2017) among others stress, few studies explore migrant men’s position in relation to global care chains. In particular, migrant men’s experiences of paid care work is understudied but is growing in feminist care research (Hrženjak, 2013; Gallo and Scrizini, 2016; Storm, Braedley and Chivers, 2017; Storm, 2018).

The existing literature on migrant men’s experiences of care work can be located in a broader stream of research on “men in women-dominated occupations” (Storm, 2018). This field emerged during the early 1990s and generally focused on men employed in nursing, childcare, teaching and social work. A core theme in these studies was investigating how men negotiate and reconcile masculinity in a women-coded context. One main finding was that men seldom face the same obstacles as women found in men-dominated occupations (Cross and Bagihole, 2002)). Williams (1989) established many men in these jobs come to be appreciated by women, are given a high status within the work team, and are encouraged to advance in the organisation, rather than hitting the ‘glass-ceiling’ that many women encounter in their career. Williams (1992: 256) introduced the “glass-escalator” concept to conceptualise how men in female-dominated occupations are pushed up the organisational hierarchy, in contrast to the glass ceiling women can hit in occupations that men dominate. This earlier body of research relied on quite a structural view of gender, constructing men as superior to women without considering the interplay of different social positions like class, race and sexuality.

During the late 1990s, theories emerged on men and masculinity within the field of critical studies. Pioneering work by Connell (1995), among others, drew attention to how masculinity should not only be understood in

relation to femininity, but also be analysed with respect to other forms of masculinities. For instance, one major threat challenging a masculine position may arise when men act too closely to femininity (Connell, 1995). These theories inspired researchers, especially in nursing (Evans, 2004), to investigate how men negotiate and reconcile their masculinities in a feminine-coded workplace (also see Jordal and Hegge, 2015; Meadus and Twomey, 2011). In Lupton's (2000) study of men in a women-dominated occupation, two main approaches to reconciling masculinity were found. The first entailed re-constructing masculinity, making the work more congruent with their own notions of masculinity; the second was to embody a different form of masculinity, characterised by less power and control and less need to distance themselves from female workers. Widding-Isaksen (2002) established that male nurses were often overrepresented in areas associated with social and cultural norms of masculinity, such as emergency care and management positions. In harmony with Evans (2002), Inoue, Chapman and Wynaden (2006) reported that male nurses can experience intimate patient care as challenging due to patients' gender. Providing intimate care to female patients can evoke a fear of sexual assault, while providing intimate care to male patients can evoke taboos concerning homosexuality (Inoue et al., 2006).

Later studies also challenged William's (1992) concept of the glass-escalator as being a universal experience for all men in women-dominated occupations. For example, Price-Glynn and Rakovski (2010) found in their study of nurse assistants that men are likely to experience stigma and have fewer advantages when doing low-paid women's work. This is consistent with Wingfield's (2009) study of black men in nursing where, instead of having advantages due to gender, these men encountered obstacles based on stereotypes and prejudices against black masculinity.

Men employed in long-term care are studied less than male nurses and student nurses, pre-school teachers, and social workers. Among research on men in care work, Andersson (2012) showed that male managers and care workers in the Swedish home care sector experience gender-related advantages and dilemmas. Female workers appreciated the men's physical strength, but clients rejected their help, resulting in a greater workload for their female colleagues (Andersson, 2012). Storm et al. (2017) studied masculinity in two Canadian nursing homes, also finding that men legitimised their presence in the workplace with their bodily strength and ability to handle aggressive clients. Similar to Andersson's (2012) findings, some female and male residents rejected help from men, and sometimes families rejected male care providers for their relatives.

Storm (2018) found that migrant men must prove their ability to provide care in order to be accepted by the residents/homecare clients, a

finding echoing Sörensdotter (2008). Regardless of gender, migrant carers are shown to be in a more vulnerable position than their native-born colleagues (Behtoui et al., 2017; Khatutsky et al., 2010). For example, in Jönson and Giertz's (2013) study of staff in Swedish elderly and disability care, migrant men reported higher workloads and a greater risk of receiving criticism from care recipients than both migrant women and their Swedish-born male counterparts.

In this paper, we aim to contribute to the small but expanding body of related literature by drawing on data from Canada and Sweden to compare how migrant men come to be in nursing home care work, how they negotiate their social role while performing low-status, body-centred women's work, and how they reconcile and challenge the norms about masculinity, highlighting the particular strategies they use to manage and/or mitigate tensions. This comparative study juxtaposes the issue in a particular context with a broader perspective in order to capture migrant men's experiences across two countries. Two topic areas – racism and language barriers – are common experiences among both non-white male and female workers (Novek, 2013; Storm, 2018), and we do not consider these issues here.

## Methodological Approach

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This study draws on data from an international research project<sup>1</sup> and a smaller connected study. Ethical approval was obtained through the York University Office of Research Ethics. For the larger project, within a feminist political economy framework, rapid, site-switching team-based ethnography was used (Armstrong and Lowndes, 2018; Baines and Cunningham, 2013). Feminist political economy was the right fit for this inquiry given its emphasis on social justice, consideration of gender, and focus on care as a relationship (Armstrong and Braedley, 2013). In rapid ethnography, background documents are collected, and observations and interviews are conducted over a short period of time by a team of researchers (Armstrong and Lowndes, 2018; Baines and Cunningham, 2013). In addition to weeklong observations over shifts by researcher pairs, a total of 530 semi-structured interviews were conducted with management, staff, residents, volunteers,

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<sup>1</sup> *"Reimagining Long-term Residential Care: An International Study of Promising Practices"* was a major collaborative initiative funded by the Social Sciences and Humanities Research Council (accessible at <https://carleton.ca/carework/research-projects/current-year/reimagining-long-term-residential-care/>). The second project *"Healthy Ageing in Residential Places"* was funded in Canada by the Canadian Institutes of Health Research and in Sweden by the Swedish Research Council for Health, Working Life and Welfare (accessible at <https://carleton.ca/carework/research-projects/current-year/healthy-ageing-in-residential-places/>). Dr. Pat Armstrong was Principal Investigator on both projects, which studied 27 sites across six countries (Canada, USA, UK, Germany, Sweden and Norway).

students, and family members. For the smaller project, the lead author conducted 12 interviews with migrant male care workers in Swedish nursing homes, focusing on their experiences.

We included the following four sites because men born outside Canada had been interviewed in those locations, and at least one of the authors was involved in the related site visit: Manitoba in Canada (1), Ontario in Canada (2) and Stockholm in Sweden (1). The 12 participants in the smaller study were working in various Stockholm nursing homes. All nursing homes provided 24-hour nursing care and were government regulated.

Interviews included in this study were limited to male care workers not born in the respective countries in which they were living and working during the period under study (2012–2015). A total of 24 interviews were included: a) Manitoba – 1 registered nurse (RN), 1 licensed practical nurse (LPN) and 1 care aide/unit clerk student; Ontario – 2 registered practical nurses (RPN-same designation as LPN) and 7 care aides; Sweden – 1 care aide plus 8 nursing assistants and 4 care aides from the smaller study. Participants gave their written informed consent prior to involvement, and all interviews were audio recorded and transcribed verbatim. Quotes from the Swedish interviews were translated by the lead author.

### *Analysis*

The analysis was in keeping with the traditions of feminist political economy, which foregrounds the significance of care work as being gendered. First, both authors read the transcriptions and during the second read began the process of coding data illustrating migrant men's experiences of coming into and working in the area of long-term care. As we read the material, we made note of interesting ideas and "potential coding schemes" based on the data set (Braun and Clarke, 2006: 79). We collaborated on the relevant data items and initial patterns we each could see in the data set (Braun and Clarke, 2006) and started to loosely group the coded items into categories. During this stage, coded sections of the interviews were sorted and transcripts were reread to ensure all data items were included.

The thematic analysis was an iterative process, going back and forth between the transcripts, coded items and existing literature (Braun and Clarke, 2006). Some themes were collapsed in the next phase because the coded material was so closely connected to and fit within broader themes. The research team members were regularly consulted to ensure the accuracy of our analysis and findings and they also read and provided feedback on earlier versions of this paper. The results are presented below under the core themes: a) *migrant men coming into care work*; b) *masculinity in care work*; and c) *the challenges faced by male care workers*.

## Results

### *Migrant men coming into care work*

Participants had migrated for various reasons and in different circumstances from countries including Afghanistan, Cameroon, China, Ethiopia, Ghana, Haiti, Hong Kong, Indonesia, Iraq, Kenya, the Philippines, Somalia, Sri Lanka, Peru, Poland and Yemen. Some, especially the men working in the Canadian nursing homes, had come with their families and been in the country for most of their lives, while others had migrated more recently, some after leaving their families in their home countries. Others, especially the men employed in the Swedish nursing homes, had migrated as adult refugees. None of the Swedish participants had lived in the country for a long time. One man had worked in Sweden for 1 year and was waiting for permanent residency status.

Some participants had left their homelands to start a new life in these comparatively wealthier countries with the understanding they would have better life opportunities. A man from Sri Lanka explained, “We had heard beautiful things about Canada, so my family is here. My mom is here. So, there I go. When I came here, I have a 5-year-old daughter so now I have four” (care aide, Ontario). For others, the migration was forced in order to avoid war and oppression, as a man from Cameroon described, “I was a refugee. At university, I was a political activist in my last year, and my father said, ‘It is time for you to leave the country’” (care aide, Stockholm). These men may have deemed it more important to migrate to a country with a generous migration policy.

Regardless of the reasons behind the migration, many participants had not been in paid care work before entering the new country. They had varying work experience, including in a textile factory, gas station, retail, cleaning, farming, and one had been a florist. Their educational backgrounds were also often outside the healthcare field and included data technology, economics, art, civil engineering, dentistry and teaching. Three participants arrived in the new country with healthcare training and work-related experience from their homeland. However, this education and work experience was either not recognised or attributed with a lower status in Canada. For example, one care aide had been a social worker in Sri Lanka, and an RPN had been trained as an RN and registered psychiatric nurse in Kenya. A practising RN had received higher graduate level education in the Philippines that was not recognised.

In Sweden, the men talked about coming to the new country without having a sense of which jobs to apply for and that care work was an area recommended for migrant employment.

*At the beginning, you have no information on how you should study and how to choose an area for the future. No one tells you about this. It is only this area they recommend to apply and search for care work, and to work as a nurse assistant. We who come to Sweden also want to work, and we have family members outside Sweden. We do not live alone; we must help our family and find a job as soon as possible. (nurse assistant, Sweden)*

Another man reported, "In my situation...I think it is easier to find these kinds of jobs" (care aide, Sweden). Yet another care aide in Sweden explained, "It is because we are migrants. It is not easy for us to find job at a bank or somewhere else. The only work we can get is easier jobs like home care, newspaper delivering or food markets". The men entered care work as one of their only options available in view of the limited labour market for migrant men and also partly because they are pushed into certain, lower-status work areas such as care. Further, in Sweden care education is helpful but not a requirement to work as a care aide so they can start making an income immediately. There is also demand for care workers in this sector; namely, jobs are available. Training is required to become a nurse assistant, but in Sweden financial assistance and as such incentive is given to apply for such education. "We got an offer from the school, those who want to work with children or those who want to be educated as assistant nurses. So, you get some support too, study funds from [name of funding body] ... therefore I chose it, to work in the care sector" (nurse assistant, Sweden).

The participants in Canada did not report being directed into care work upon entry. Although certification is required to work as a care aide in Canada, most courses are 10 months to 1 year in length. This is a relatively short time for employment training compared to many other professions and, similar to Sweden, jobs are available upon certification. Training to become an RN is longer, more expensive and more difficult to get into. Some participants become trained as care aides with the intention of continuing their education later. For example, a student we spoke with informed us that he wants to be an RN but took the care aide course in view of the long waiting list for nursing, and from this he wishes to gain experience and see what the medical field looks like. Two men employed in Swedish nursing homes said they will stay in care work only until they can secure their preferred type of work. One man from Yemen reported that he needs to improve his language skills to meet the Swedish requirements before he can practise as a dentist, his former occupation. However, many of the men in both countries stated they prefer to remain in care work, even if some had been sceptical at the beginning.

In both countries, participants also described their entrance into

long-term care as a job choice because they knew someone who was doing this type of work. One participant's wife was an RN, while another had a brother in care work and yet another had a sister who was a care aide. "I had a friend who worked in care, and he told me about what he was doing. This seemed to be valuable, so I first worked as a personal assistant to a client. Thereafter, I started with in the nurse assistant education. I did my training here and was given employment" (nurse assistant, Sweden).

In addition, some participants in the two countries said they entered the area of long-term care because they had cared for an elderly relative and this experience had drawn them to caring for older people. "I took care of my grandmother when I was 14 years old, for 3 years. So I like taking care of older persons" (nurse assistant, Sweden). A care aide from Hong Kong explained, "[M]y father was not feeling well, so I ended up staying [in Canada] and he was in long-term care. I was here every day. I was here with him [for] breakfast, lunch, dinner, whenever" (care aide, Ontario).

Most men described how they either do not have nursing homes, or very few, in their countries of origin and taking care of their elderly relatives at home had given them experience that could be used in their paid work. "[W]e don't have care home[s] back home. I was born and raised in the Philippines. We always taking care of our extended family, our elderly" (RN, Manitoba). A man from Ethiopia echoed this, "The tradition in my country is to take care of the older, they live together with the family. The whole family takes care of those who are older" (nurse assistant, Sweden). Interviewees from Afghanistan, Africa and Iraq expressed similar sentiments. There are few, if any, nursing homes and poor welfare systems, and families care for their elderly relatives in their home through to their death.

*The Swedes, they want other jobs where you can earn respect, like doctor or engineer. They do not want to be associated with care work ... Migrants want to help people, regardless of whether it is an occupation or not. It is about respect.* (nurse assistant, Sweden)

*They are family for me ... I feel like I'm giving care to my mother, to my father, to my uncle, to my aunt, to my family and I will see myself in that position too one day ... That's why when I do it I do it with my heart whatever I do for them.* (care aide, Ontario)

Instead of looking at their job as being low-level, the migrant men saw their care work with pride, bringing their cultural values into the workplace, and caring for residents as they had done with their elderly relatives at home. It is on this basis that the men carve out their presence in the everyday life of care in the nursing home, as we explain next.

### *Masculinity in care work*

Care work is perceived as women's work in most cultures (Armstrong and Braedley, 2013). Men may struggle to have their career choice accepted by their family and community back home since some cultures do not perceive care work as suitable for a man. Participants spoke about care work not being provided by men in their home countries. A man from Kenya explained,

*I come from a culture where some work ... if you are a man, you should not work ... it is a female job ... immediately I understood what the job was when I started working. It's more than that, among my friends here ... it's a little more feminine which I understand, but it's also qualified work, so you need also qualified staff. Yes, and I enjoy it. I have found my way to enjoy it. I go there and I'm really proud. (nurse assistant, Sweden)*

A man from Indonesia also said this type of work is not done by men in his country, but he also considered himself fortunate to have an accepting family and paternal role model. "I am lucky because I lived in a democratic family. My dad did the same tasks as the girls, [like] dishes and washing. I also did that in Indonesia, and that's not the norm in my culture. Most of the men do not do domestic work" (nurse assistant, Sweden). Some men told us how they had to handle notions of care work, most typically arising from friends and family, as a de-masculinised, feminine career choice suited to gay men.

The participants saw it as challenging to be a man while trying to fit into a women-dominated workplace. A male care aide reported feeling more on the outside of his co-worker groups.

*[T]hey [women] would like to come together. Male, probably I cannot say it's isolated but it's a little different I think ... Because female staff, you know, they always come together ... I am here. You are a little bit over there. (care aide, Ontario)*

When asked if a difference exists between male and female workers, another respondent in the same care home said,

*Yes. It's different. Especially the females ... they're different behaviour, different attitude too. There's one female [care aide] who is like the boss ... When all males are working, very quiet. We're very quiet...No talking, talking. We just work and work. If you need me, I'll help you. But when there's like a boss female it's terrible. (care aide, Ontario)*

In this instance, the care aide is referring to another care aide who he perceives as enforcing dominance over male co-workers. This was echoed by two men in Sweden who had lamented that some female co-workers had tried to decide how to perform the work – or place an extra workload on the men – something that did not happen when they had worked with other men. In Sweden, one nurse assistant reported, “The [males] are more relaxed. It is cool, you do not have to talk all the time. You can take a short break, take a cup of coffee, and ... be silent for 5 minutes. It is okay. However, with women, you have to talk all the time”. A care aide in Sweden stated, “I feel comfortable talking to [my colleagues] ... about different things ... Women just talk about the house and work but, with men, you can talk about anything”.

The participants described the need for more men in this area of work. “We need both women and men. We need more men. Women dominate in this occupation, but we have many older men living in nursing homes. Some of them have special needs that only a guy can handle” (nurse assistant, Sweden). Although two men working in Swedish nursing homes expressed the view that too many men may not work given the need to seek out female workers if/when residents reject their care, the majority described wishing to have more colleagues for both comradery and to better meet the individual needs of residents, particularly men.

There was also a perceived expectation that men are stronger and hence can do heavier work. “You have some expectations. We should be able to lift heavy stuff. ‘Yes, the guys can do it!’... it speaks to me because I am a man and I should do certain tasks if they are heavy or to change a bulb” (nurse assistant, Sweden). A care aide in Ontario used the analogy of being at war, needing to bring order and safety to the daily chaos. The men also wanted to help their co-workers in this sense. If their physical strength could be of assistance, they were happy to help.

*What I observe if you're a man care aide you can do everything because ... the man has the force, the strength. Because the women getting old. Their strength I think is decreasing too. And they need help. They always ask the men to work ... I understand it because ... they cannot do things, lifting especially. (care aide, Ontario)*

In another Ontario home, an RPN explained that men were placed on nightshift in during times of very low staffing levels to help protect the female employees.

*They expect you to be stronger ... Especially at night, they expect you to be like more vigilant for the night. And I think an incident happened in*

*the past. That's why the manager decide to always put a man with whoever working like a woman. And we did have some difficult patients, a psychiatric problem, who we did have to get a man to deal with.*

A care aide lamented,

*They don't understand. Just me, a man in the morning team, this is a problem ... I need protection because it is very, very problem to be man working here. Two, three man is good, but alone ... Sometimes you give care but you don't feel good, you know.*

The male care workers' physical strength was considered an asset by the home and other employees, but the men also felt like they themselves sometimes needed support and protection.

### *The challenges faced by migrant male care workers*

The participants described residents as not wanting care provided by men as one of the biggest challenges. Male residents sometimes also refused care given by men:

*It is a problem, you know. Men and women not the same. Like I said that job has belonged to women long time. Men started working in that field not too long ago. How many men [care aides] do you see here? How many women do you see? You see. More women than men, right? ... oh, it's not easy ... to let men walk in ... some men, they resent what any men do. (care aide, Ontario)*

Another care aide in a different Ontario care home reported, "I always look after this gentleman, but he can't see. He has a habit of ... asking 'Are you a boy or a girl?' I say, 'A boy, so don't touch me'".

More often, they indicated that some women refused care from a man, even though there were only a few men in each home. "[S]ome female residents still don't want a man to do care. When I was part-time, I went upstairs too. But that time some people say they don't want a male. Whoever work there is a female" (care aide, Ontario). Similarly, in Sweden a nurse assistant stated, "It happens that some of the women residents do not want a man to help them". We also heard, "[T]here are residents [who] don't like men and there's female residents that like men [and] don't like women" (care aide, Ontario). He added,

*[S]ometimes the ladies like more men to do care. They think the man is softer...Soft because we are talking to them. I don't know how ladies deal with ladies but when we talk to the ladies they are happy. Maybe some old ladies they are happy to talk to the men [care aides] ... Sometimes they say 'I love you' or 'You're my boyfriend'. We make them happy. Whatever they say is okay. If they are happy, they are alright.*

In contrast, we heard that men had a particular way of gaining residents' trust and willingness to engage in care simply by being a man. For example, a nurse assistant explained that some female residents think, "I am like a young doctor who is asking you if you can take your clothes off", gaining their cooperation during care work.

The men described different strategies for managing rejection based on gender. "[I]f they refuse, we send in women. The same thing with older men who do not want a woman to help them, but this does not occur so often. However, I respect them. I help another resident and send in women who can help her" (nurse assistant, Sweden). A care aide in Sweden noted similarly, "It is no problem. We can split up the work with each other. She can help the woman. I can take another resident, so we can share". They also arrange for female workers from other units to come and provide care if necessary. Another strategy was, where possible, to switch the residents' schedules.

*It is common on my ward, the residents are all clear in their heads, and they do not want to be naked in front of a man they do not know. If there are no women ... ok, how do we solve the situation? It is your day to shower. Maybe you can shower tomorrow, we can shower someone else today, and we must be flexible ... Sometimes I try to joke, 'I can dress like a woman and shower you'. However, we are all good staff who help each other, so there is always a solution. (nurse assistant, Sweden)*

As seen in the above quote, laughter is another approach relied on to engage and help the residents relax. The participants stressed the importance of getting to know each resident and then tailoring their care approach accordingly. "You should make yourself available to learn who this guy is, who she is, okay?" (care aide, Ontario).

## Conclusion

The men in our study moved to Canada or Sweden for various reasons and in different life circumstances. Regardless of their migration motives, we found the nursing home work gave these men employment opportunities with better working conditions compared to their home countries and

other occupations available to migrant men in their new countries (Storm, 2018). In line with Locke (2017) and Seeberg (2012), nursing home work can provide gainful employment in a restricted labour market that otherwise excludes and devalues migrant workers' competencies and skills. However, all of the men who had previous health-related experience and education from their home countries had to accept lower-status positions: degrees are often not recognised as being sufficient according to national standards (see Novek, 2013). Downgrading in a social status sense was a reality for this group, even among those men with no previous education or related work experiences; they often had to take part-time and casual work, and in Sweden there is little to no hope of full-time employment in this or other occupations (Storm, 2018b), making it very difficult to earn enough money to support themselves and their families.

Although this process of exclusion is a reality for both migrant men and women, the growing body of research highlights the unique challenges men face when engaging in low-status work dominated by women. Seeberg (2012) found that female migrants from poorer countries could experience upward social mobility in their new country. In contrast, men might feel downgraded by doing women's work (Scrinzi, 2010). Downgrading due to gender is reflected in various ways by most migrant men when they discuss their working experiences (Storm, 2018; Sörensdotter, 2008). As Connell (1995) notes, one factor that may contribute to a subordinated masculine position is acting too closely to femininity by doing a job typically viewed as women's work. Also in contrast to men, stereotypical norms around migrant women's characteristics often highlight them as family-oriented with natural caring skills (Scrinzi, 2010). The connection between migrant men and caring skills is much weaker – and migrant masculinities are often marked by more negative expectations like aggressive, patriarchal behaviour (Wingfield, 2009). This is shown in Wingfield's (2009) study of black men in nursing where she found they had to handle prejudices based on negative stereotypes of black masculinity. This general scepticism of migrant men's caring approach can perpetuate their exclusion from care work since both employers and care receivers prefer women (Dyer et al., 2008; Hussein and Christenson, 2016). In our study, the men drew on past experiences of caring for elderly relatives by treating the residents "as family" in their approach to care, and were careful to prioritise dignity and respect by switching residents who had refused their care, learning about each resident and tailoring their interactions and care to individual needs.

Although Hrženjak (2013) stresses that migrant men often use their cultural background as an excuse for seeking work in care, this pattern was not seen in our study. Instead, their cultural experiences were used as an argument for commencing care work. Even though only a few of the men had

previous social and health care education, most had extensive experience of engaging in informal care work with older family members as part of an inter-generational obligation out of respect and due to a lack of alternatives. This in turn might have contributed to the more gender-neutral approach to care in their paid work- and reduced the stigma attached to this option for these particular men.

A further finding in our study is that most of the men enjoyed and were proud of their work. The participants repeatedly reported taking pride in doing a good job and ensuring that the residents, who they often referred to as family, were well taken care of. They used some common (e.g. switching residents with female colleagues) and some unique strategies (e.g. assuming the role of a doctor) to manage and negotiate the tensions they faced due to their gendered position. A common theme in our study is the focus on masculine-coded skills such as physical strength and the ability to handle aggressive residents as a masculine resource, a finding echoed by others (Andersson, 2012; Storm et al., 2017; Williams, 1992). As Lupton (2000) notes, this might be a strategy men use to bring their work more in line with their own notions of masculinity. The recurring emphasis on physical strength must be understood in the nursing home context, mainly focusing on what Widding Isaksen (2002) described as dirty body work – coded by working class femininity (Seeberg, 2012). Several studies of men in nursing highlight that a common strategy is to reconcile a masculine identity by distancing themselves from dirty bodywork by choosing more high-status jobs such as emergency care (Ekstand, 2005; Evans, 2004; Williams, 1989). This distancing from dirty bodywork was not possible for the men in our study, which may have led to a certain emphasis on men's physical strength as a resource.

A few of the men in our study lamented having felt subordinated by some of their female co-workers and perceived there were few opportunities to change their situation. Instead, they remained silent and on "the outside". This finding resonates with William's (1992) glass-escalator metaphor whereby men's status and advancement in female-dominated occupations are less likely in women-coded, working-class occupations (Price-Glynn and Rakovski, 2010).

Finally, as noted in studies of men in nursing (Evans, 2002; Inoue, 2006), both female and male patients reported the refusal of help from men, citing gender as an issue. Similarly, we found male and female residents, albeit only a few in each home, had rejected care by male workers. Confirming Storm et al. (2017) and Sörensdotter (2008), we also found that migrant men, compared to other care workers, can encounter different challenges and must work to be recognised as good and competent carers. The men relied on particular strategies to win over residents and family members and gain their

trust, often over a period of time. They used laughter to engage with residents: putting a smile on the residents' faces was deemed important because it signified warmth and connection, while also enhancing the residents' quality of life. Another strategy was to conceive of the relationship as a professional interaction, for example by engaging like a doctor and patient. Finally, men reiterated the importance of patience, compassion, and getting to know the residents as integral to tailoring their care approaches.

Migrant men are increasingly employed in nursing home care work in wealthier countries like Canada and Sweden. Our study is one of the first to capture their experiences of entering a new country and finding their ways into employment in long-term care, while also shedding light on how they navigate care work within a female-dominated work area. Migrant men often bring culturally cultivated skills and sometimes health-related education (albeit not recognised on the same level in the new countries), which helps them in their day-to-day approaches to eldercare. Although all describe heavy workloads and the fact that the work is difficult, they love and take pride in their jobs. Specific challenges migrant men face include fitting in with their female co-workers, gaining the trust of the residents and relatives, and balancing the stereotypical thoughts and expectations of masculinity with their approaches to care. Migrant men employ unique gendered strategies to negotiate the tensions within their everyday life of nursing home work.

### *Study Limitations*

We relied on one category "migrant men" instead of looking at specific groups and individuals within these groups, which may mean that different experiences were overlooked in this study. Future research should explore these areas to gain deeper insights into the unique racialised social positions of men and women and their interplay in their everyday work experiences.

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