OpenCare

Opening careers for males in CARE

OpenCARE – EU report template

DELIVERABLE 2.3

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Executive Summary

This deliverable explores men's participation and experiences in long-term and social care across five European countries (France, Italy, Portugal, Romania, and Cyprus). Led by the OpenCARE consortium, the study examines gender dynamics in caregiving and challenges the idea of care work as a "female vocation." It contributes to the European Care Strategy (2022) and the Gender Equality Strategy (2020–2025) by addressing workforce shortages, promoting inclusion, and advancing equality in the care sector.

SCOPE AND METHODS OF OUR RESEARCH

The study combined qualitative methods, including semi-structured interviews and focus groups, to collect data from three key stakeholder groups:

- Male carers, to explore motivations, experiences, and perceived challenges;
- Care providers/employers**,** to assess institutional practices and recruitment barriers;
- Care receivers**,** to understand perceptions, comfort levels, and attitudes toward male carers.

A total of 136 participants took part across the five countries. Data were thematically coded to identify both shared and country-specific trends.

KEY FINDINGS OF THE RESEARCH

The findings highlight common themes and country-specific nuances but reveal an overall pattern of underrepresentation and persistent gender bias in long-term care.

1) **Motivations and identity of the male carers**

Men often choose care work for personal or altruistic reasons, challenging traditional masculine norms but facing social misunderstanding.

2) **Stereotypes and task distribution in the workplace**

Male carers are often assigned physical or technical roles, reinforcing gendered views and limiting recognition of their emotional skills.

3) **Male carer's integration and perception by colleagues and care receivers**

Most men feel accepted after trust is built, though some resistance remains, especially in intimate care situations.

4) **The employers' perspectives**

Employers value gender diversity but lack strategies to recruit and support men. Institutional cultures remain largely feminized.

5) **The systemic and cultural barriers identified**

Low pay, limited progression, and cultural expectations discourage men from entering or staying in care work.

6) **The care receivers' perspectives**

Beneficiaries mainly value empathy and competence over gender, and positive experiences reduce initial bias.

POLICY RELEVANCE OF OUR RESEARCH

The findings support the goals of the European Care Strategy and the EU Gender Equality Strategy (2020–2025). They call for action to reduce gender segregation in care by creating pathways for men to enter the profession, improving recruitment and training systems, and promoting care as a professional, gender-neutral field. The study also recommends awareness campaigns to destigmatize male carers, more inclusive workplace cultures, and the integration of gender perspectives into national and regional care strategies.

RECOMMENDATIONS AND FUTURE ACTIONS

Building on these findings, the OpenCARE consortium proposes several actionable recommendations to foster inclusion and equality in care professions:

Visibility of their stories: Encourage male carers to share their stories publicly through testimonials, short videos, or local awareness events to inspire other men to join the sector.

Encourage peer learning spaces and workshop on gender: Propose sessions for carers of all genders to reflect on challenges, emotional labor, and professional identity.

Promoting more inclusive recruitment strategies: Create gender-sensitive « campaigns » that focus on skills, values, and the social impact of

care work and raise awareness among the recruiters and directors of establishments.

Policy mainstreaming: Advocate for the inclusion of male participation targets or monitoring mechanisms in regional and national care workforce plans. In addition to this promote the care related careers for the younger generations.

Younger generations: Promote care careers in schools with testimonials of professionals to inspire young boys to consider and pursue careers in the care sector.

CONTRIBUTION TO THE EUROPEAN CARE STRATEGY

This deliverable contributes directly to the European Care Strategy (2022) by addressing two of its key pillars: workforce sustainability and quality of care. By promoting gender-balanced participation, it supports efforts to respond to labor shortages, improve working conditions, and strengthen the social recognition of caregiving professions. It also aligns with the EU Gender Equality Strategy (2020–2025) by challenging occupational segregation, promoting inclusive education and employment systems, and reinforcing equality in social protection and work-life balance policies.

In doing so, the OpenCARE consortium offers a practical and evidence-based contribution to a fairer and more inclusive care ecosystem, one that recognizes care as both a human right and a shared social responsibility, open to all genders.

1. Introduction

1.1 Background & Context

Over recent decades, Europe has undergone profound demographic shifts driven by increasing life expectancy, medical advances, and declining fertility rates. These trends contribute to a steadily growing population of older adults, many of whom live with chronic illness or functional impairment, generating rising demand for long-term care (LTC) services. Projections suggest that the number of EU citizens requiring care will increase from around 19.5 million in 2016 to roughly 23.6 million by 2030, and potentially to over 30 million by 2050. In parallel, between 2021 and 2031, about eight million job openings in the health and care sector are expected. Without targeted interventions to improve the appeal of care professions

and to retain the workforce, many EU member states face the risk that supply will lag behind demand.

Yet long-term care remains heavily gendered. Women constitute approximately 76 % of the EU's 49 million care workers, and 86 % of personal care workers in health services. By contrast, men make up only about 14 % of the caregiving workforce. This imbalance is more than numerical; it reflects cultural norms, institutional practices, and economic structures that limit men's participation. Low wages, limited career progression, social and cultural perceptions of care as "women's work," and stigma around men in caring roles all serve as barriers. Addressing these is essential both for workforce adequacy and for gender equality.

This project emerges against this backdrop. It aims to challenge stereotypes and stigma related to male care workers by fostering education and awareness, and to promote their inclusion through dedicated recruitment and strategies. By encouraging values of interdependence, empathy, and care to be integrated into masculine professional identities, Open Care should offer a pathway to reshape both practice and perception. Moreover, the project aligns with broader EU policies: the European Care Strategy (2022) and the EU Gender Equality Strategy (2020–2025); which call for improved working conditions in care, increased formal care service availability, recognition of care workers, and the dismantling of gendered occupational segregation.

1.2 Project Overview

OpenCARE is a multi-country initiative led by Anziani e Non solo. It proceeds through a structured research-to-policy model in order to create career opportunities for men in formal long-term care work, addressing deep-rooted prejudices and helping to fill the growing shortage of qualified staff, a crucial factor in supporting the work-life balance of all workers. It encompasses several work packages; these are the main:

Output n°2: Identifying Men's Care Fulfillment Needs and Barriers	Led by CUT. This output aims to identify the motivations, needs, and barriers experienced by male carers through qualitative research, including interviews with male caregivers, care providers, and care receivers, leading to a European comparative report and a White Paper outlining key findings and recommendations.

Output n°3: Awareness Workshops and Events to Break the Stigma	Led by APPDI. This output will build on these findings and focus on designing, testing, and implementing awareness-raising workshops across partner countries to challenge gender stereotypes in care work, promote positive male role models, and produce a final Awareness Guide based on tested materials and participant feedback.
Output n°4: Toolkit to Reduce Stigma in Care Work	Led by Aproximar. This output develops and pilots an interactive European Toolkit co-created by all partners to provide practical tools, methods, and strategies for reducing stigma and promoting gender inclusivity in care professions, culminating in a validated and translated final version for broad dissemination.
Output n°5: Dissemination	Led by Easi. This output establishes a strategy to promote, share, and ensure the sustainable use of the Open CARE project's results through targeted communication, broad dissemination, and effective exploitation actions across the partners countries.

1.3 Research Objectives

This research aims to systematically investigate the position and perception of male carers within long-term care (LTC) professions through a fourfold approach:

IDENTIFY
Identify the nature of gender-based stigma, stereotypes, and institutional barriers that affect male carers in long-term care professions (including nursing assistants, aides-soignants, qualified nurses, etc.).
UNDERSTAND

Examine how three key stakeholder groups perceive male carers in long-term care settings: • Male carers, focusing on their motivations, lived experiences and the challenges they encounter; • Care recipients, particularly older adults, in relation to their expectations, trust, acceptance and comfort when receiving care from men; • Employers, recruiters and care facility directors, with regard to their hiring practices, institutional culture and the influence of gendered norms on their perceptions of care work.
COMPARE
Compare these experiences across five EU settings: France, Italy, Portugal, Cyprus, Romania, to uncover both common patterns and country-specific dynamics (like legislation, culture, resource constraints).
PROPOSE
Propose actionable solutions: recruitment strategies, educational/training reforms, awareness-raising, policy reforms to reduce stigma, improve retention, and enhance the appeal of male participation in LTC roles.

1.4 Structure of the Report

Introduction: frame of the problem, definition of the key concepts, presentation of country-by-country contextual histories, and state of the research objectives.

Methodology: detailing of the qualitative design, the sample strategy, data collection tools (interviews, focus groups), ethical considerations, and analytical approach, including thematic analysis and cross-country comparison.

Key Findings: Exploration of the demographic profiles; experiences and challenges of male carers; perceptions of employers and care providers;

views of care recipients; country-by-country variations and examples of good practice; including some illustrative quotes.

Policy and Practical Recommendations: drawing upon findings to make recommendations for policymakers; training institutions; care organizations; civil society and media to support gender inclusion in LTC.

Conclusion: summary of the takeaways, implications for gender equality in care, and prospects for implementation through the OpenCare deliverables (toolkit, further study, policy uptake).

1.5 Definitions & Key Concepts

C

CARING MASCULINITY: Forms of masculinity that embrace caring values, such as empathy, emotional labor, nurturing, interdependence; challenging traditional gender norms which situate care and emotional support as feminine.

CARE RECIPIENTS: Individuals who receive care services, whether formal or informal; in this study especially older adults (65+), and persons with disability or dependency.

D

DEPENDENCY: the state of needing help for basic daily living tasks due to age, illness, or disability.

OLD-AGE DEPENDENCY RATIO: number of older persons (often 65+) relative to the working-age population (often 15-64), an indicator of potential care demand.

E

EMPLOYERS / CARE PROVIDERS / RECRUITERS: Organization's, facility directors, HR staff, coordinators, etc., who hire or manage care workers and set institutional practices and policies.

G

GENDER-BASED BARRIERS: System-level obstacles (economic, legal, cultural, institutional) which limit or discourage the participation of men in LTC (like low wages, part-time or precarious contracts, lack of male role models, cultural norms).

I

INFORMAL CARE / INFORMAL CARERS: Care provided outside of formal labor markets: by family members, friends, volunteers, or migrant domestic workers; usually unpaid or poorly remunerated; often marginalized in policies.

INSTITUTIONAL CARE VS COMMUNITY / HOME-BASED CARE: Institutional care: care in facilities such as nursing homes, residential care homes, or long-stay hospital units. Community/home-based care: care delivered in clients' homes or community settings, or day centers; tends to allow more autonomy, less institutionalization.

L

LONG-TERM CARE (LTC): Formal and informal services supporting individuals who, due to aging, disability, chronic illness or cognitive impairment, need assistance with activities of daily living, instrumental activities of daily living, or require supervision over a prolonged period. Includes residential facilities, home care, day-care, rehabilitation, etc.

M

MALE CARERS / MALE CARE WORKERS: Men (paid or formal) working in LTC or medico-social roles (nurses, care assistants), or informal carers (family / community) who provide care services.

MEDICO-SOCIAL SECTOR: A domain of service provision that integrates medical or nursing care with social support services (such as daily living assistance, autonomy, social inclusion). Distinct from purely hospital-based acute care or strictly social welfare.

S

STEREOTYPES: Widely shared but oversimplified beliefs or images about the traits, roles, or behaviors appropriate for men or women, for example, care being 'female' work, emotional labor being less masculine.

STIGMA: Social disapproval, negative attitudes or discrimination directed at individuals because of perceived deviation from gender norms, here especially men doing work socially viewed as feminine or inappropriate.

1.6 A brief history and context on how each country works with older adult care

France

France's medico-social sector has evolved gradually over the 20th and early 21st centuries, combining public policy, social welfare, and health care reforms.
A major reform in 2002 (*Law No. 2002-2 of 2 January 2002*) aimed to "medicalize" retirement homes, giving more structure to the care of older people who are dependent. This reform created or reinforced *EHPADs* (*Établissements d'Hébergement pour Personnes Âgées Dépendantes*, Residential Establishments for Dependent Older People), which combine accommodation, daily living support, and medical care.

In addition to *EHPADs*, there are *USLDs* (*Unités de Soins de Longue Durée*, Long-Term Care Units) in hospitals, and *résidences autonomie* (Independent Living Residences) for persons who are more autonomous but still require social services.
Over time, the role of local authorities, *Centres Communaux d'Action Sociale* (Municipal Social Action Centres, CCAS), and personal allowance schemes such as *Allocation Personnalisée à l'Autonomie* (Personalized Autonomy Allowance) has increased, aiming to support home care and reduce reliance on institutionalisation.

Current challenges include coordinating health and social services, ensuring sustainable funding, addressing workforce shortages, and maintaining quality and oversight in « EHPADs ».

Cyprus

Cyprus is undergoing more recent reforms in its long-term care (LTC) and *medico-social* sectors; the system is less mature and more fragmented than in many Western European countries.

The universal health insurance system (*GeSY* : *General Healthcare System*), introduced in 2019, has gradually integrated some LTC-related services such

as home care and rehabilitation. Governance is divided between the Ministry of Health and the Social Welfare Services under the Ministry of Labor and Social Insurance.

Public expenditure on LTC remains among the lowest in the EU, with much care still provided informally by family members or migrant domestic workers.

Recent developments include the *National Strategy for Active Ageing (2025–2030)* and reforms under the *Recovery and Resilience Plan (2021–2026)*, which aim to expand home, community, and residential care services.

Italy

Historically, care for older people in Italy relied heavily on family support and charitable or religious institutions, with limited state involvement. This "familistic" model, typical of Southern European welfare systems, meant that most dependent older people were cared for within the household rather than in public facilities.

In 1978, the establishment of the National Health Service (Servizio Sanitario Nazionale, SSN) promoted a more integrated approach to health and social care, gradually expanding community-based and home services. Over the following decades, Home Care Services (Servizi di Assistenza Domiciliare) and Day Centres (Centri Diurni) were developed to support ageing in place, although the majority of long-term care still depends on informal family caregivers and family care workers (assistenti familiari or badanti).

Italy's long-term care (LTC) system today combines monetary benefits (most notably the Indennità di Accompagnamento, an attendance allowance for dependent older adults) with in-kind services delivered by regions and municipalities. However, provision remains highly decentralised, and marked territorial disparities persist. Northern regions tend to have stronger infrastructure and greater access to residential and community-based services than southern regions and islands.

In 2023, the government adopted a major reform, the Framework Law on Non-Self-Sufficiency (Legge Delega per la Non Autosufficienza), aimed at creating a more coordinated national system for long-term care. The reform seeks to better integrate health and social services, strengthen home-based and community care, and support family caregivers. Implementation is ongoing, representing a key step towards addressing Italy's demographic

ageing and ensuring more equitable access to older adults care across the country.

Portugal

Portugal's history of care and disability reflects a Southern European model, historically based on informal, family, and church networks. Following the Carnation Revolution in 1974, the 1976 Constitution recognized the rights of persons with disabilities and older adults to social protection.

During the 1980s and 1990s, the Portuguese government began to formalize social care provision through the creation of Instituições Particulares de Solidariedade Social (Private Institutions for Social Solidarity, IPSS), non-profit organizations that remain the backbone of the country's social and older adults care system.

Major legislative milestones include Law No. 38/2004 (Regime Jurídico da Deficiência, Legal Framework on Disability), which established rights and a protection framework for persons with disabilities, and the Ratification of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) in 2009.

The ageing population led to increased development of long-term care services under the Rede Nacional de Cuidados Continuados Integrados (National Network for Integrated Continuous Care, RNCCI), launched in 2006 to coordinate health and social support for dependent persons, particularly older adults. Portugal has since advanced toward inclusion and deinstitutionalisation, promoting home-based and community services. However, regional disparities and reliance on family and non-profit providers remain structural challenges.

Romania

Under the communist regime led by Nicolae Ceaușescu, long-term care, particularly for persons with disabilities and older people, was institutionalized in large asylums or orphanages (case de copii), often under harsh conditions with minimal oversight. Older adults who lost family support were frequently placed in state-run residential facilities with limited resources and care standards.

After the 1989 revolution, international attention and media exposure revealed inhumane conditions in many institutions, prompting a process of deinstitutionalization and systemic reform. This transition focused on

closing or transforming institutions, developing community and home care, and strengthening legal protections for people with disabilities and older persons.

Throughout the 2000s, Romania adopted several reforms aligning with EU standards, progressively shifting from institutional to community-based care. Local authorities and social assistance directorates (Direcțiile Generale de Asistență Socială și Protecția Copilului, DGASPC) became key actors in implementing social services.

The National Strategy on Long-Term Care and Active Ageing (2023-2030) now provides a comprehensive framework for integrating health and social care for older adults, expanding home-based support, and improving staff training and quality monitoring. Nonetheless, challenges remain regarding funding, workforce shortages, and ensuring consistent standards across rural and urban areas.

2. Methodology

2.1 Research Design & Approach

The study adopted an exploratory qualitative research design, which was suitable for investigating complex and underexplored social phenomena such as men's participation in long-term care (LTC).

A thematic analysis (Braun & Clarke, 2006) was applied to identify and interpret recurring patterns within the data. The analysis followed a deductive orientation, guided by Social Role Theory (Eagly, 1987).

2.2 Data Collection Methods

2.2.1 Sampling Strategy

A purposive sampling approach was employed to select participants with relevant experience and insights in long-term care (LTC) across five European countries: Cyprus (CY), France (FR), Romania (RO), Italy (IT), and Portugal (PT). The study included 145 participants: 49 male carers, 42 employers, and 45 care receivers.

Female participants were included intentionally to provide comparative gender perspectives and strengthen the analysis.

2.3 Data Collection Tools:

Two qualitative tools were used:

- **Semi-structured interviews (male carers):** Explore personal experiences, motivations, challenges, stigma, and professional development.
- **Focus groups (care recipients and care providers/employers):** Explore shared perceptions, social attitudes, and organizational practices related to gender and care.

All sessions were audio-recorded with consent, transcribed verbatim, and anonymized. Researchers also kept structured notes using standardized templates. Transcripts were coded with pseudonyms and country identifiers (e.g., CY_01) and securely stored on encrypted institutional servers.

All transcripts were translated into English before analysis, ensuring conceptual and linguistic equivalence across countries.

2.4 Data Analysis Plan

The analysis was based on deductive content analysis, aiming to interpret the data through pre-defined categories related to gender roles, stereotypes, and barriers faced by men in LTC.

Data were coded, compared across national datasets, and reviewed collaboratively by partners to ensure consistency and reliability.

Specifically, the validity of the analysis was ensured through triangulation among researchers and countries, as well as through peer debriefing sessions, during which preliminary findings were discussed and compared. This process enhanced the reliability, coherence, and credibility of the interpretation.

This analysis was not only a scientific but also a deeply human process. Through the participants' voices, the researchers engaged with social realities, stereotypes, and perceptions that often remain invisible. The reflexive stance adopted toward the data was essential, allowing the interpretation of experiences with respect, accuracy, and sensitivity.

2.5 Ethical Considerations

The study adhered to the ethical principles of informed consent, confidentiality, respect, and integrity (Christians, 2005; World Medical Association, 2008).

Consent procedures: Written and verbal consent were obtained before data collection.

Anonymity: Pseudonyms and coded identifiers were used in all transcripts and reports.

Data protection: Audio files and transcripts were stored on encrypted, password-protected servers, accessible only to authorized researchers.

Retention & deletion: Recordings were deleted six months after analysis; anonymized transcripts remained archived for project reporting.

Ethics approval: Was granted by the Cyprus National Bioethics Committee [ΕΕΒΚ ΕΠ 2025.01.135].

Participants retained the right to withdraw at any stage without penalty or consequence. The study ensured full respect for participant dignity and autonomy and adhered to the highest standards of ethical and scientific integrity.

3. Key Findings

3.1 Demographic Overview

Across all participating countries, the study included a total of 136 participants, consisting of 49 male carers, 42 care providers/employers (30 male and 12 female), and 45 care receivers (27 male and 18 female). The detailed demographic characteristics of each target group are presented below.

3.1.1 Demographics of Male Carers

The total sample included 49 male carers: 10 from Cyprus, 10 from Italy, 12 from France, 7 from Romania, and 10 from Portugal **(**Figure 1**).**

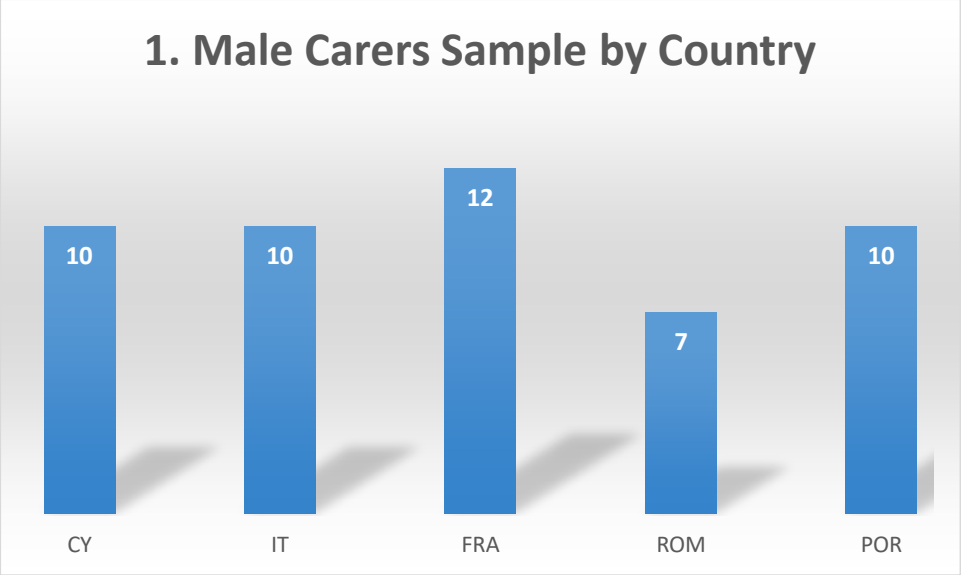

Figure 1: Male Carers Sample by Country (n = 49)

Most participants were between 21 and 40 years old, with older age groups (41–60 years) more common in Cyprus and Portugal (Figure 2 & 3)**.**

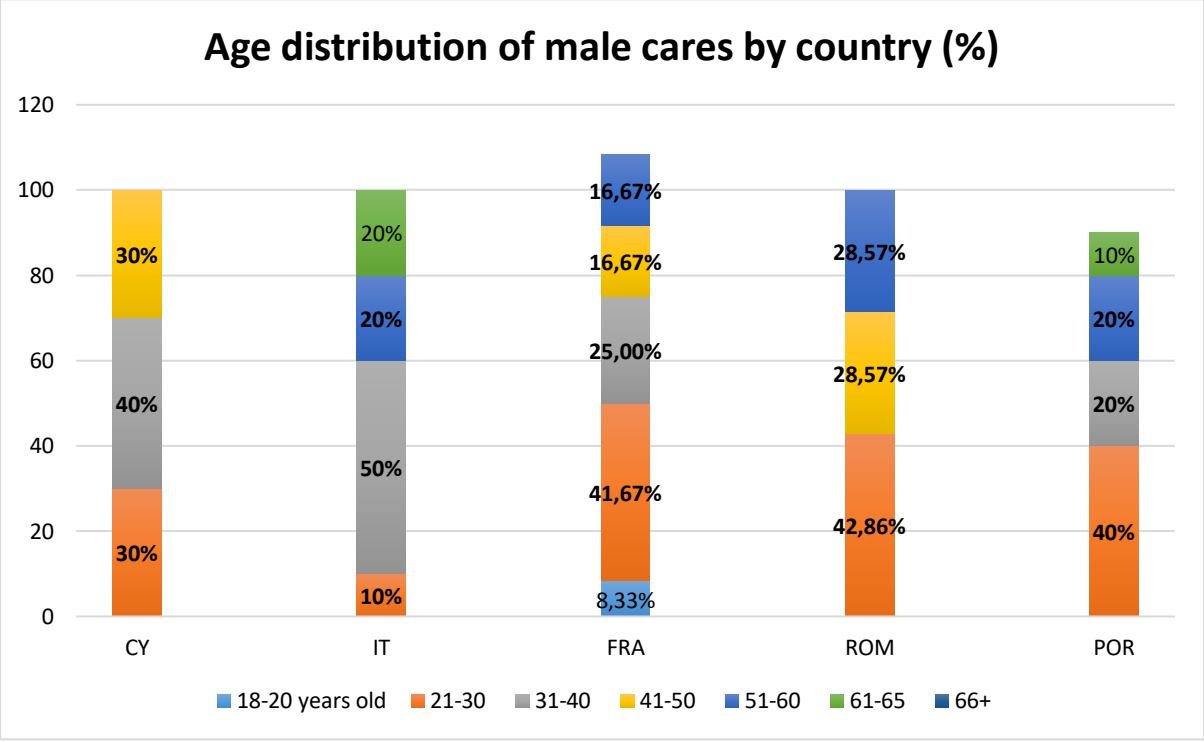

Figure 2: Age distribution of male carers by country (%)

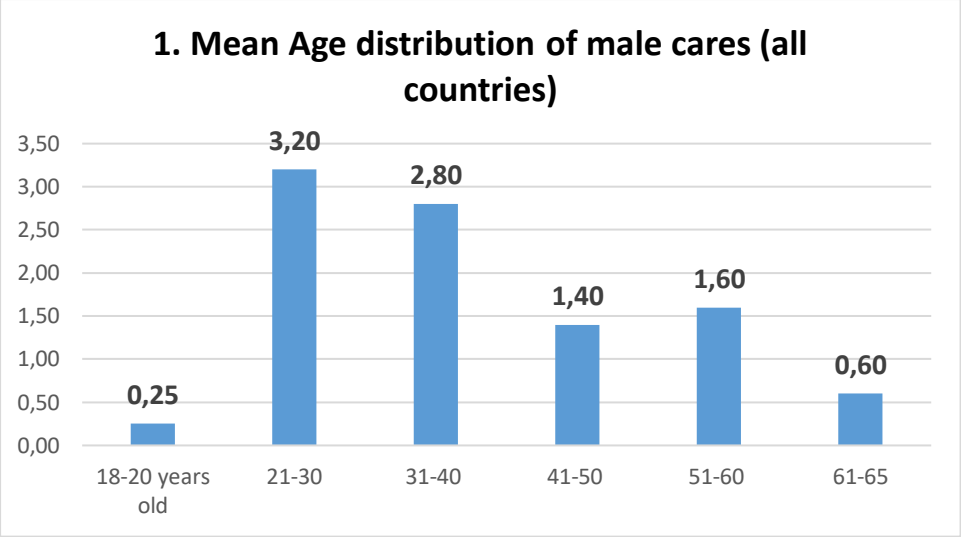

Figure 3: Mean age distribution of male carers (all countries)

The majority of male carers had completed diploma or bachelor-level studies, primarily in health-related areas (Figure 3). Educational backgrounds were comparable among countries, though France presents slightly more diversity in qualifications (Figure 3 & 4).

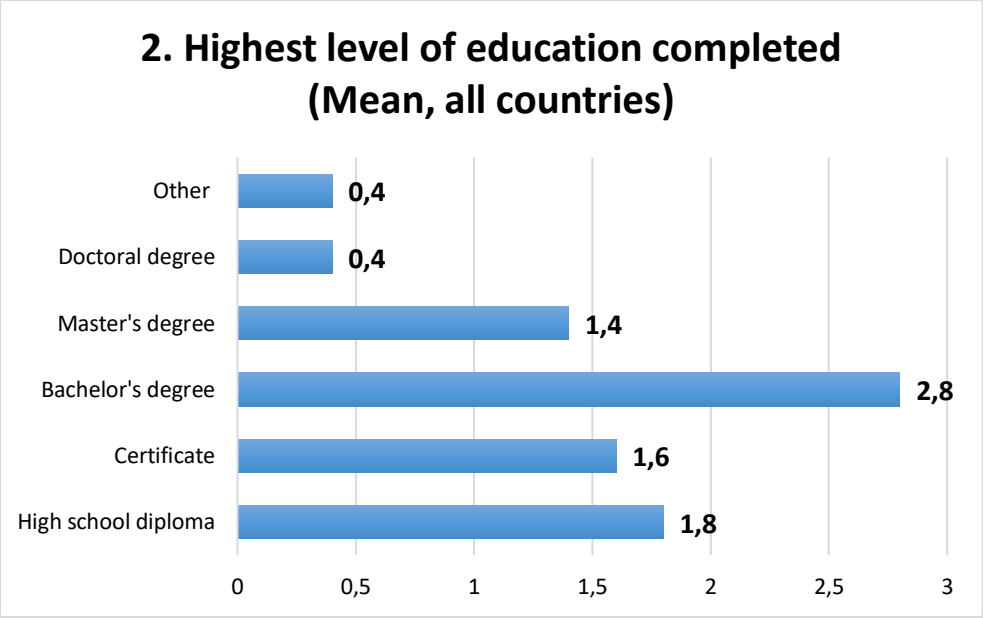

Figure 3: Highest level of education completed – mean (all countries)

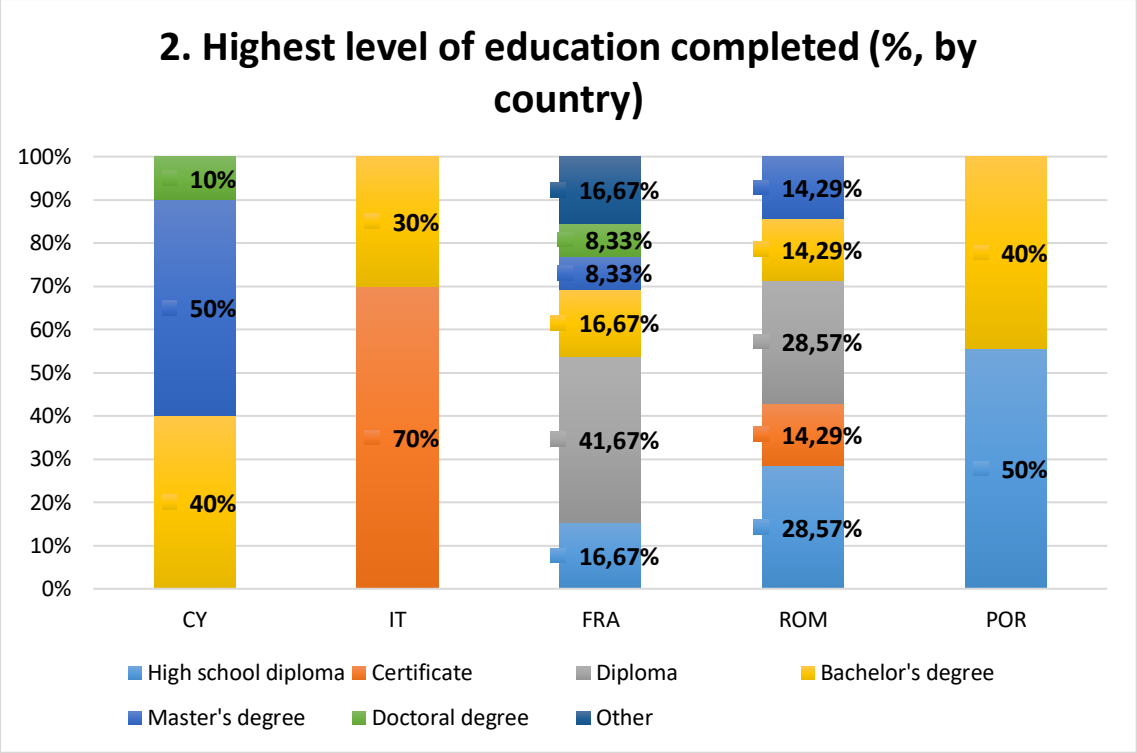

Figure 4: Highest level of education completed by country (%)

Field of Study

Participants in Cyprus, Italy, and Portugal mainly studied nursing or related healthcare subjects, while respondents in France come from more varied educational fields, including medicine, physiotherapy, and even non-health sectors such as fashion design.

Across all countries, male carers had over five years of experience in healthcare (Figure 5 & 6).

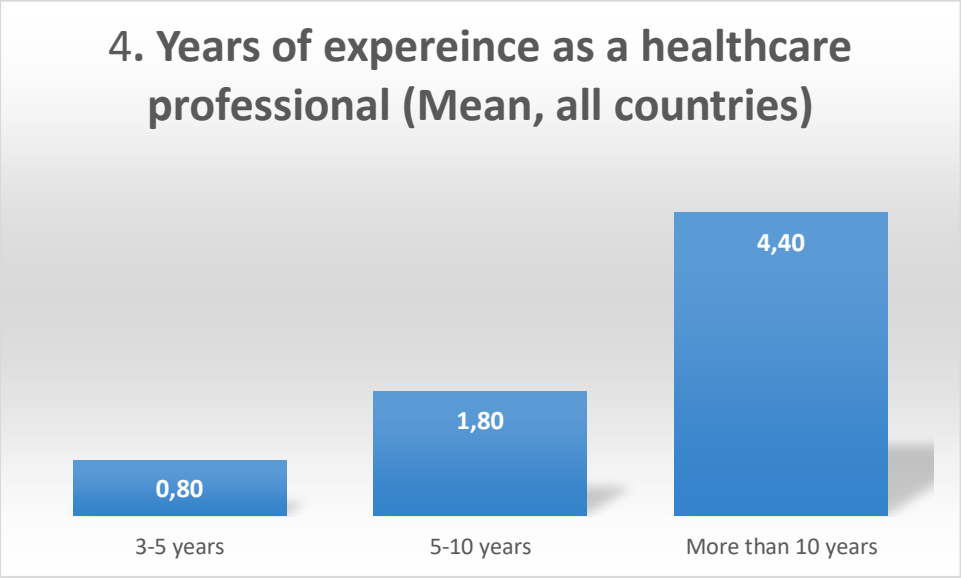

Figure 5: Years of experience as a healthcare professional (mean)

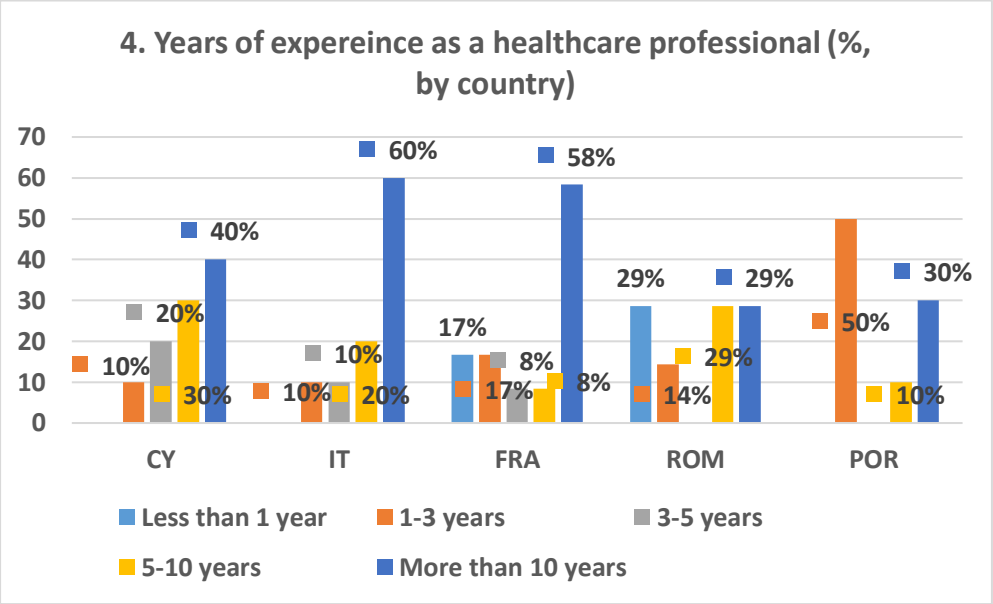

Figure 6: Years of experience as a healthcare professional (%)

Most participants were employed full-time, either in public or private healthcare institutions. Part-time and temporary contracts were also present but represent a smaller share of the workforce (Figure 7).

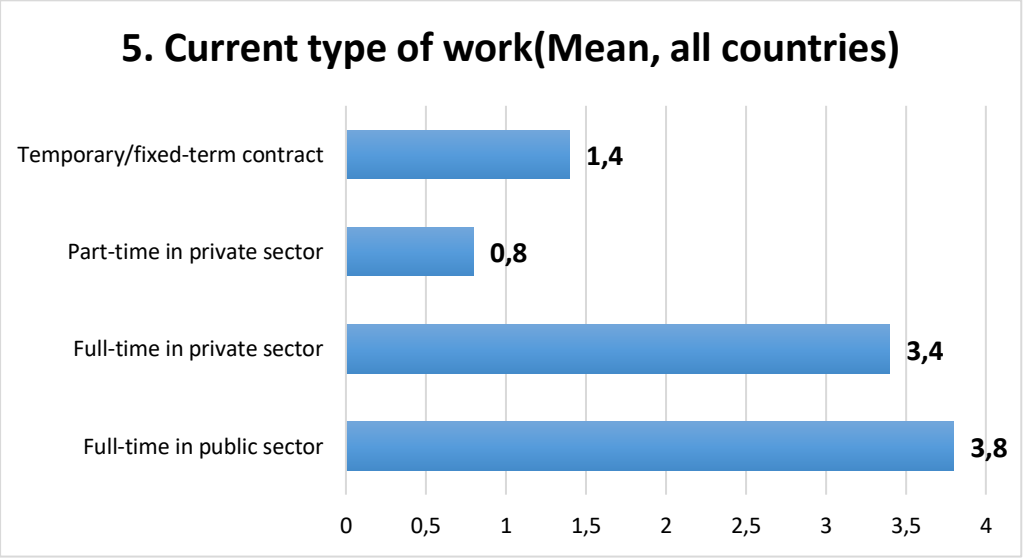

Figure 7: Current type of employment (mean, all countries)

The majority of male carers work in hospital settings, followed by those employed in residential or long-term care facilities (Figure 8). Other workplaces, such as community or home care services, are less common.

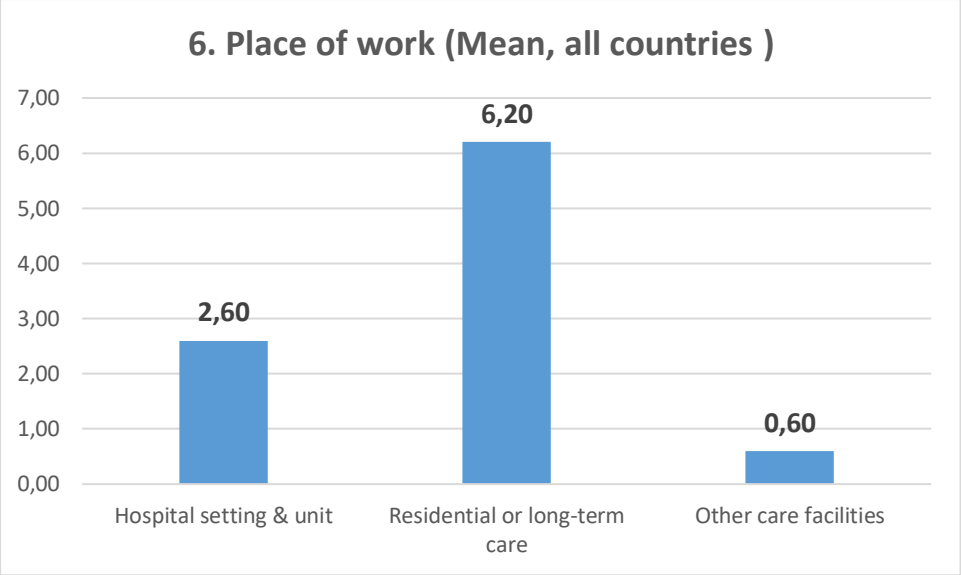

Figure 8: Place of work (mean, all countries)

Male carers find the greatest satisfaction in their 'relationships with patients', the 'emotional fulfilment' they gain from their work, and in 'feeling a sense of job security and recognition' (Figure 9). On the other hand, the main challenges identified were 'heavy workloads', 'low pay', and challenges in maintaining a healthy work–life balance, which are common across all countries (Figure 10).

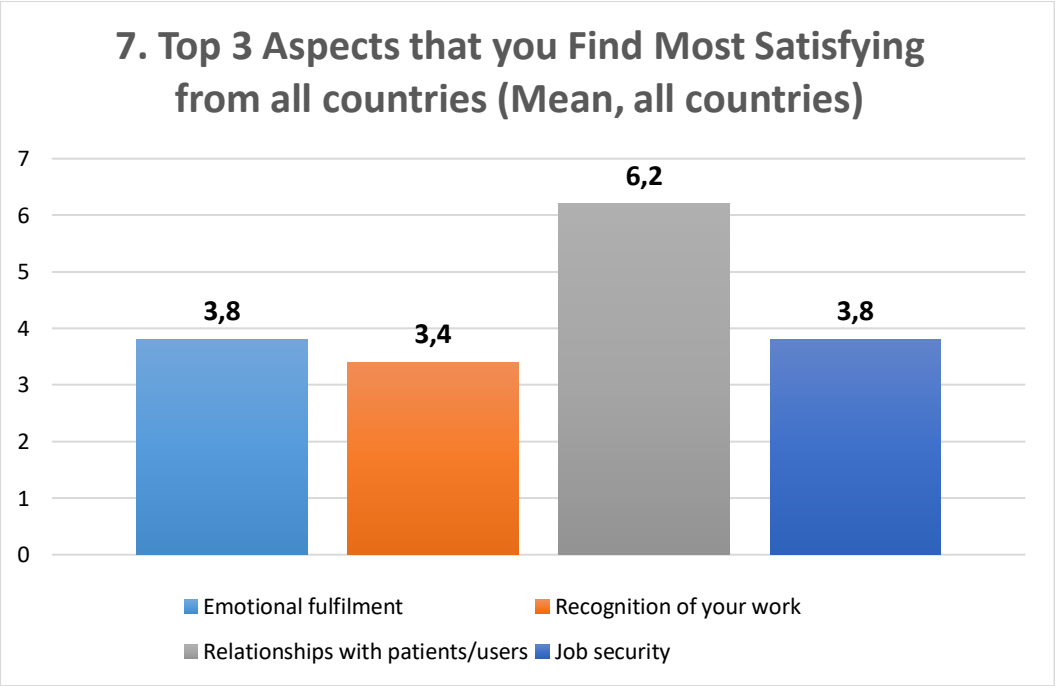

Figure 9: Aspects of work found most satisfying (mean, all countries)

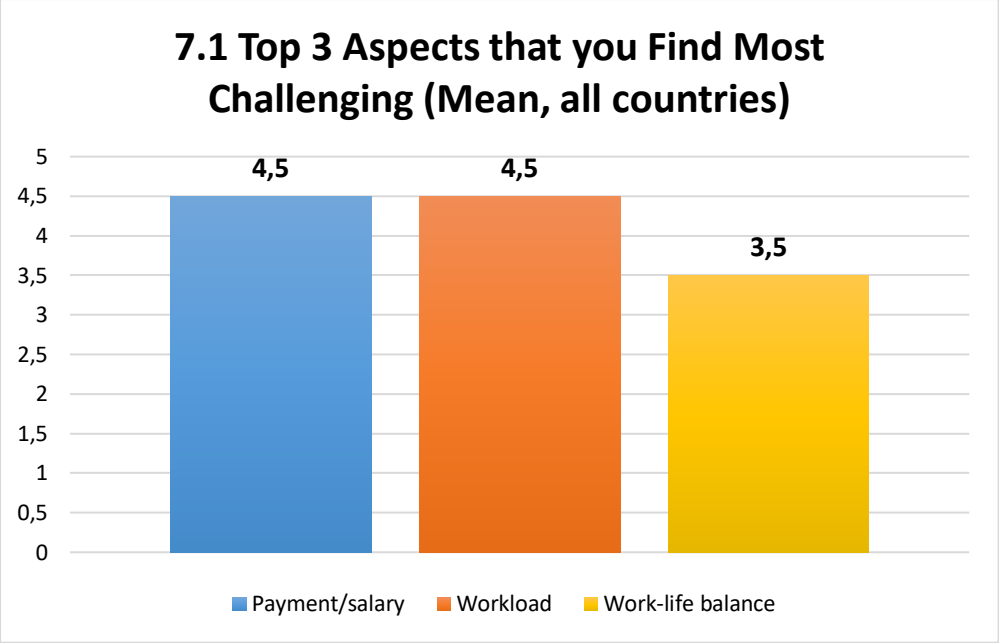

Figure 10: Aspects of work found most challenging (mean, all countries)

A considerable proportion of participants reported gender-based bias or discrimination at work, up to 80% in Cyprus and 50% in Portugal. In contrast, 80% of participants in Italy and France, 50% in Romania, reported that they had not experienced gender-based bias or discrimination at work (Figure 11). The most common situations involved 'discomfort or resistance from female patients', 'patients preferring female carers', 'assumptions that men are less suited to caregiving roles' and 'colleagues questioning men's abilities (Figure 12). These patterns appear across all countries, pointing to persistent stereotypes about men in care (Figure 13).

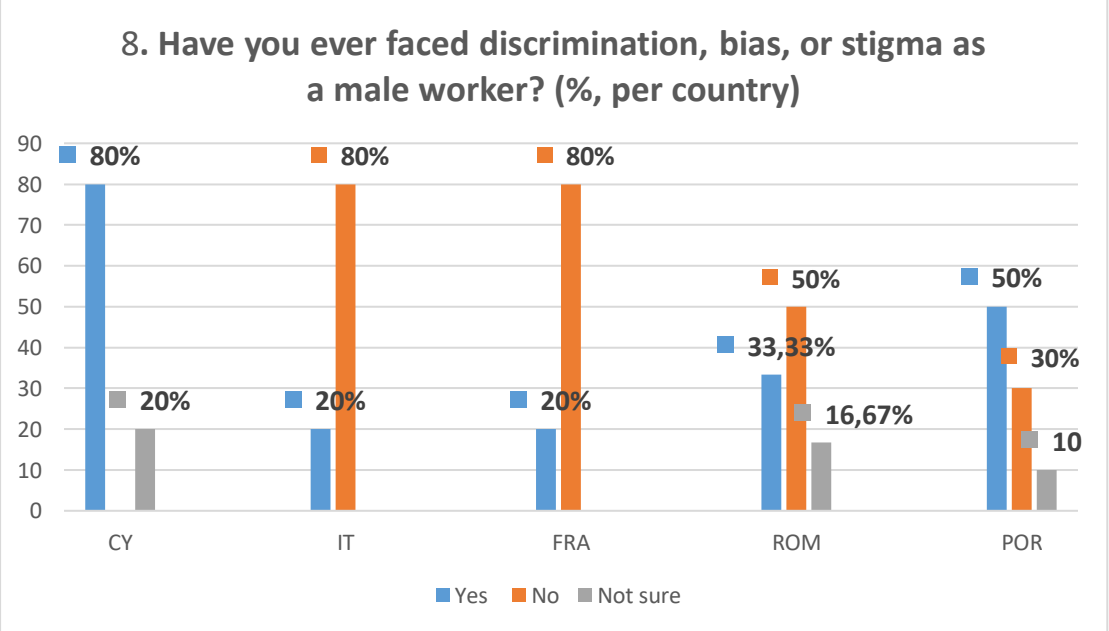

Figure 11: Experiences of discrimination, bias, or stigma (% per country)

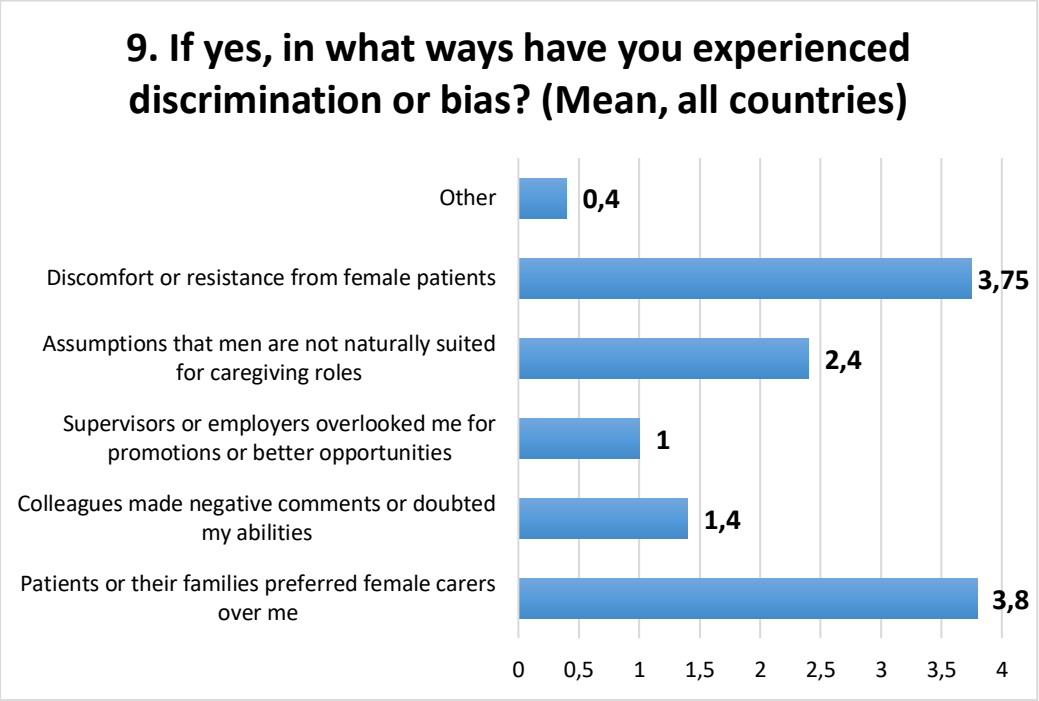

Figure 12: Forms of discrimination or bias experienced (mean, all countries)

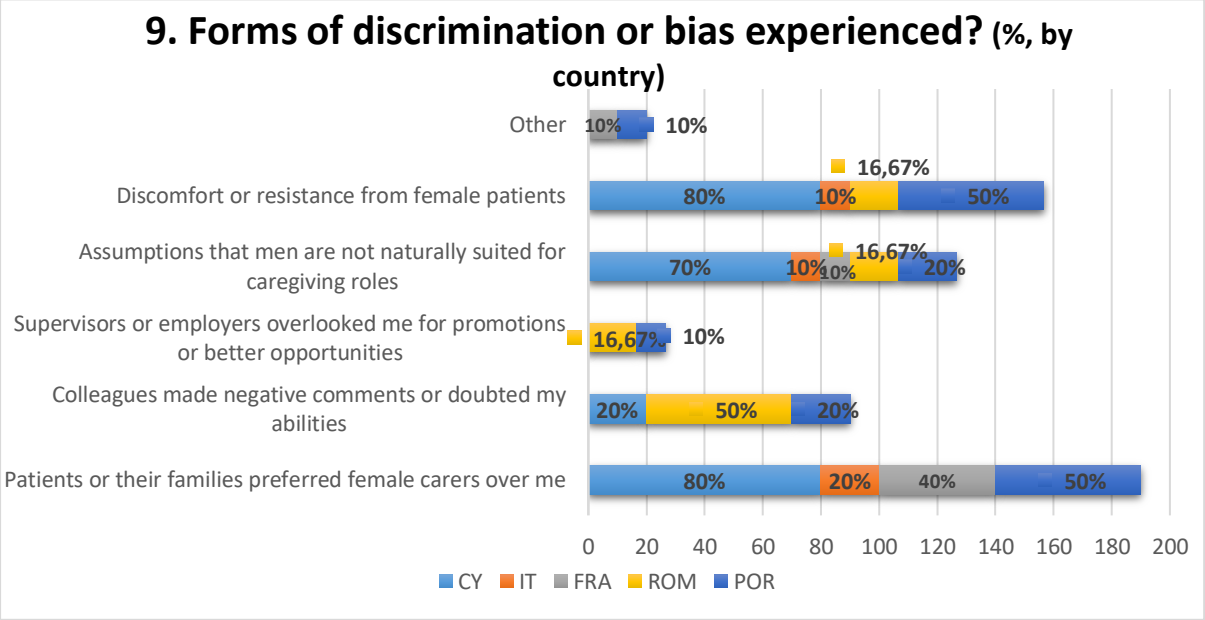

Figure 13: Forms of discrimination or bias experienced (% by country)

3.1.2 Demographics of Employers

The total sample consisted of 42 employers: 9 from Cyprus, 8 each from Italy, Romania, and Portugal, and 9 from France (Figure 16).

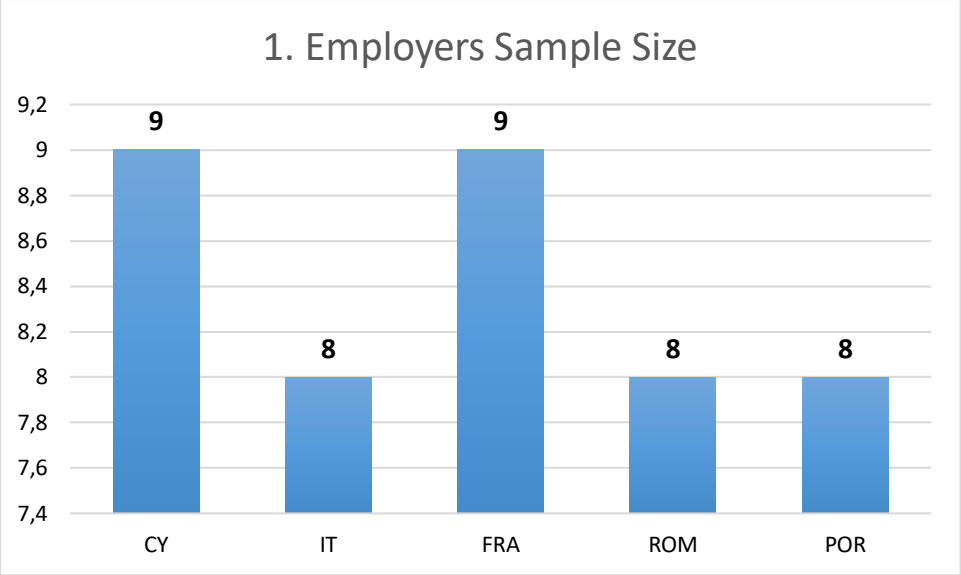

Figure 16: Employers Sample Size (n=42)

The gender distribution of employers differs by country. Men formed the majority in Cyprus, Italy, France and Portugal, while Romania, shows more women in these roles (Figure 14).

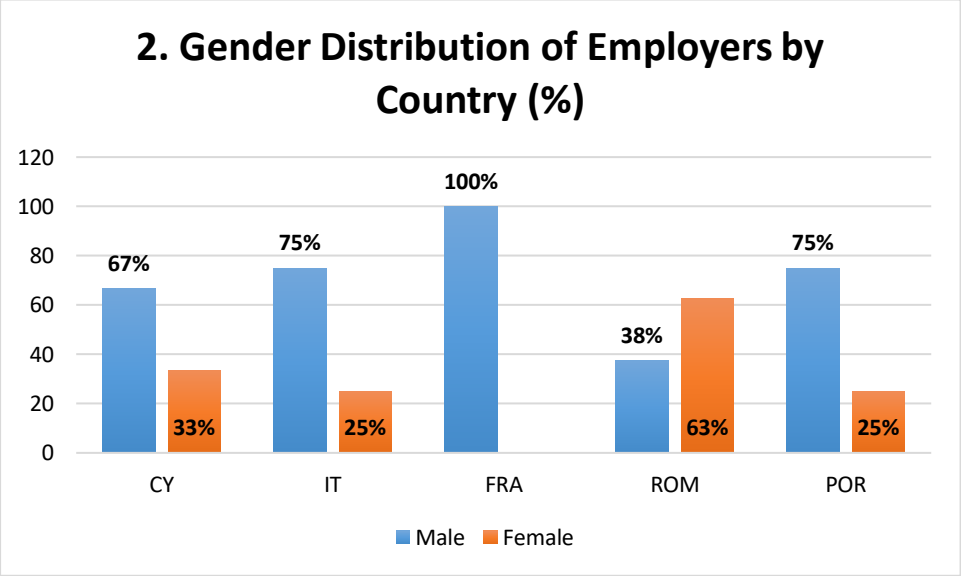

Figure 14: Gender Distribution of Employers by Country (%)

Most employers were between 41 and 60 years old and held bachelor's or master's degrees, typically in health, social work, or management disciplines (Figures 15).

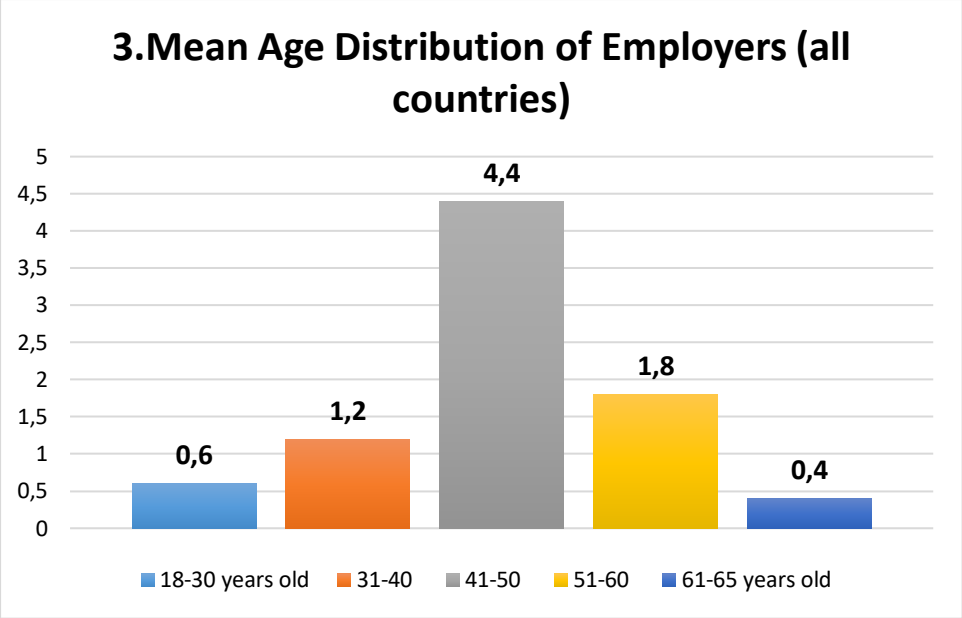

Figure 15: Mean Age Distribution of Employers (all countries)

The group of participants are highly educated, with most participants holding bachelor's or master's degrees (Figure 16). The majority holds qualifications in health- and care-related disciplines, such as nursing, social work, and gerontology. A smaller proportion have academic backgrounds in management, humanities, or law, reflecting the multidisciplinary profile of professionals in care leadership roles.

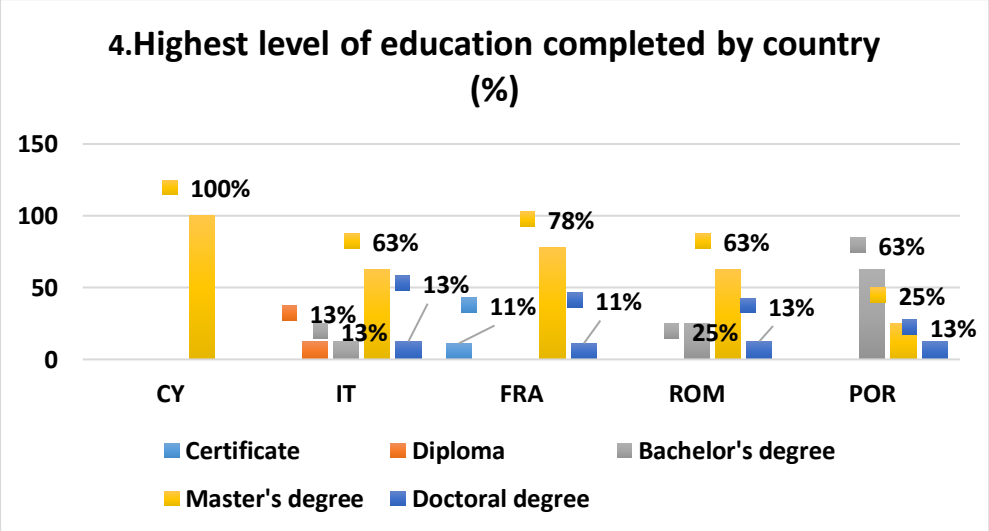

Figure 16: Highest level of education completed by country (%)

Many participants reported 10+ years in the sector, confirming substantial professional experience (Figure 17 & 18).

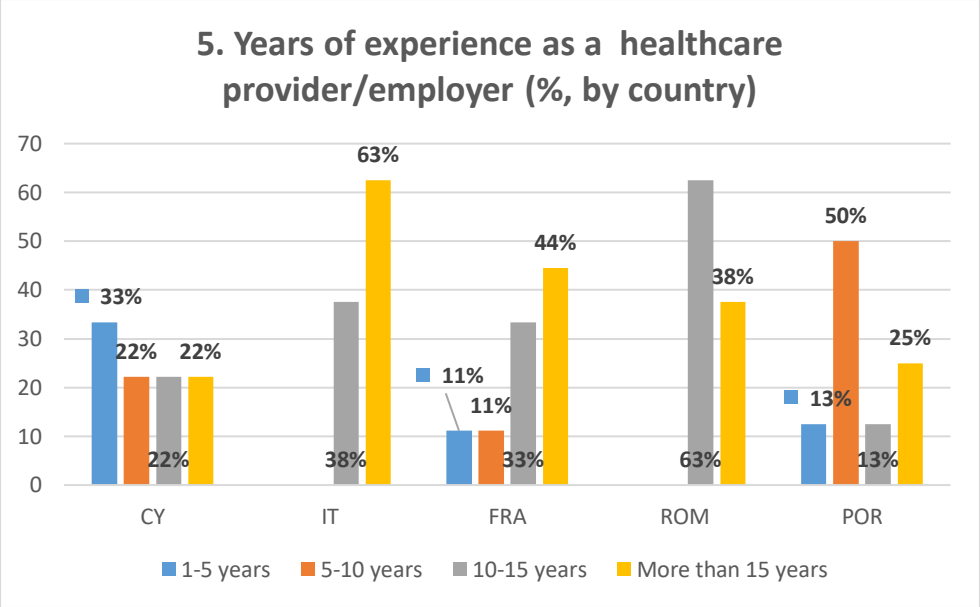

Figure 17: Years of experience as a healthcare provider/employer (%, by country)

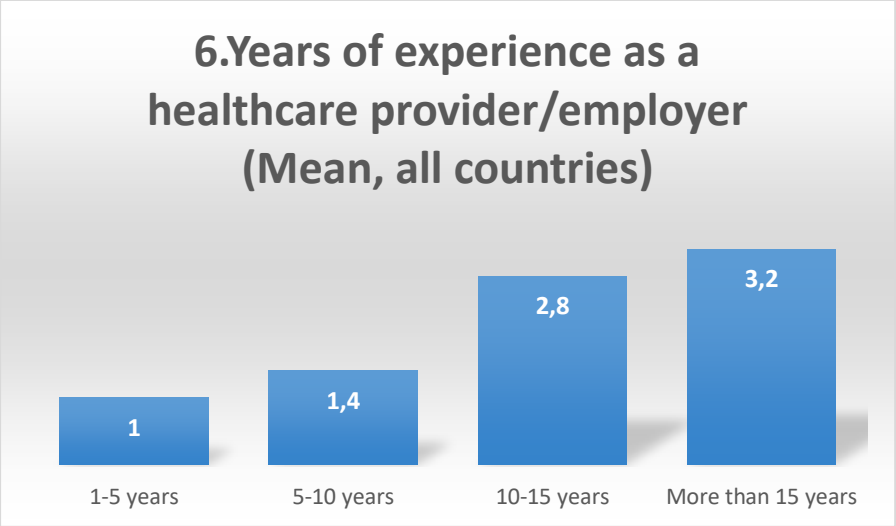

Figure 18: Years of experience as a healthcare provider/employer (mean, all countries)

Regarding the type of employment, participants reported mainly full-time positions, with most working in nursing homes or long-term care facilities. Smaller proportions were employed in hospital settings (acute care, specialized units, etc.) and rehabilitation centers (Figures 19 and 20).

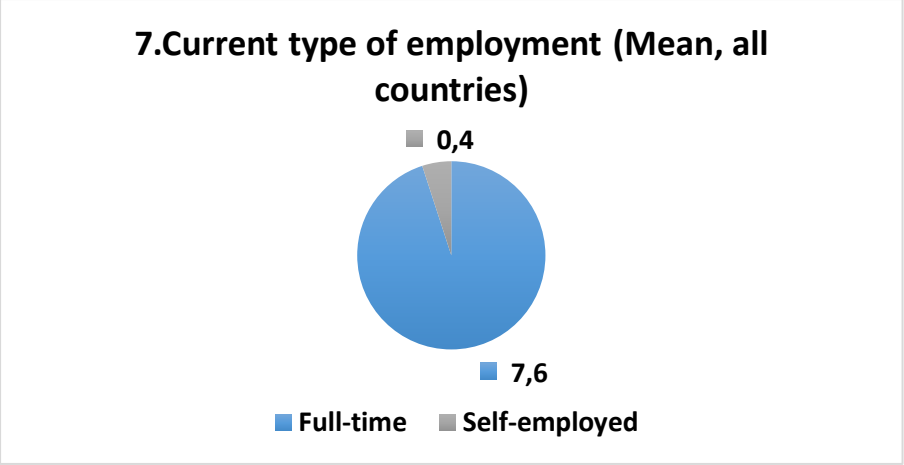

Figure 19: Current type of employment (mean, all countries)

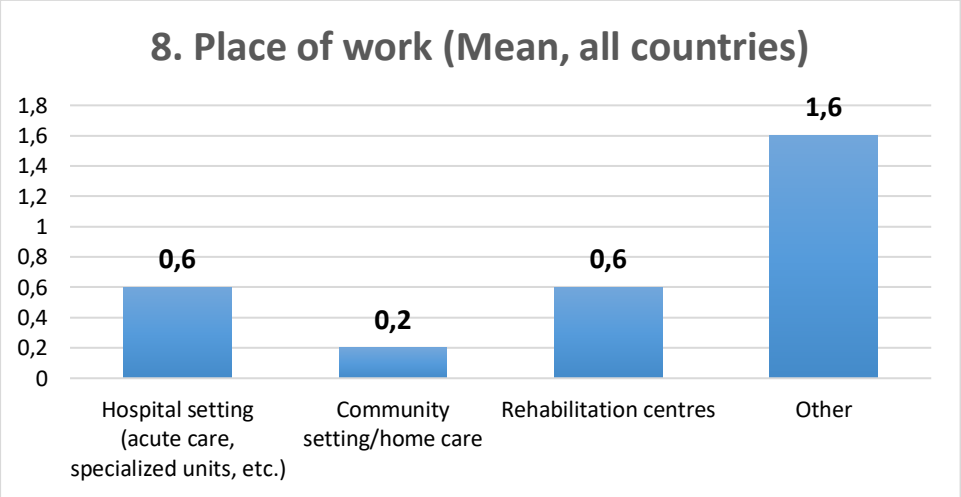

Figure 20: Place of work (mean, all countries)

Overall satisfaction among coordinators and leaders is moderately high, with mean scores ranging between 1.6 and 1.8 on a five-point scale (where lower values indicate greater satisfaction) (Figure 21).

The data show that Italy, Romania, and Portugal reported the highest satisfaction levels (mean ≈ 1.6), while Cyprus and France show slightly lower satisfaction (mean ≈ 1.8) across most aspects of their roles. Despite these small national variations, participants across all countries expressed positive experiences with their work–life balance, recognition, and support from management. However, salary, workload, and career advancement opportunities remain areas where satisfaction is comparatively lower.

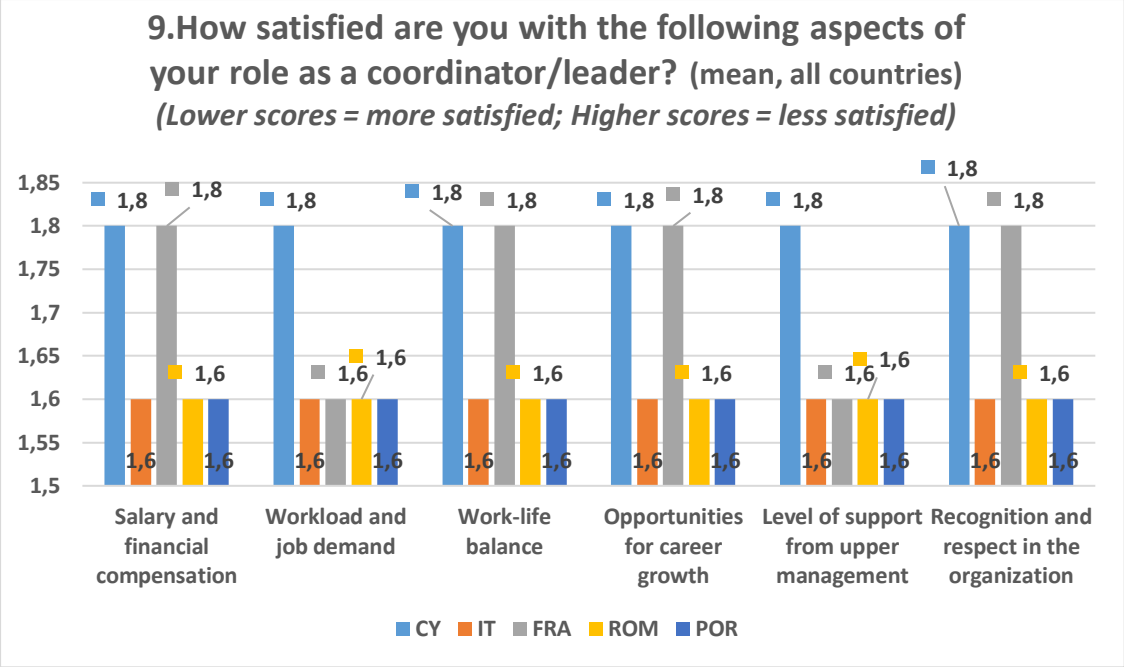

Figure 21: Mean satisfaction with key aspects of the coordinator/leader role (all countries)

3.1.3 Demographics of Care Receivers

A total of 45 care receivers participated in the study: 13 from Italy, 8 from Cyprus, 8 from France, 8 from Romania, and 8 from Portugal (Figure 26).

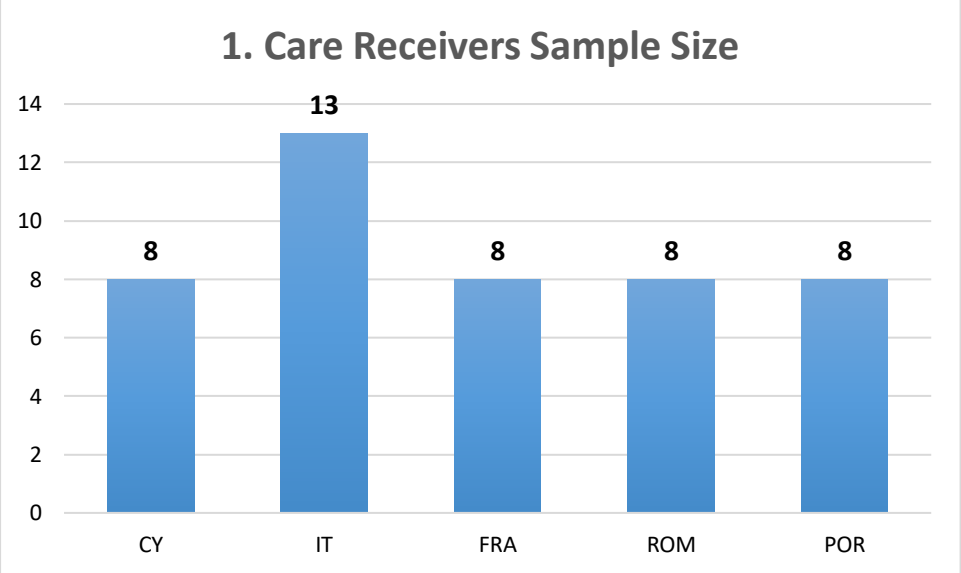

Figure 26: Care Receivers Sample Size (n=45)

The gender balance among care receivers varies across countries. Men are more frequently represented in Cyprus, Italy, Romania and Portugal, whereas women are the majority in France (Figure 27).

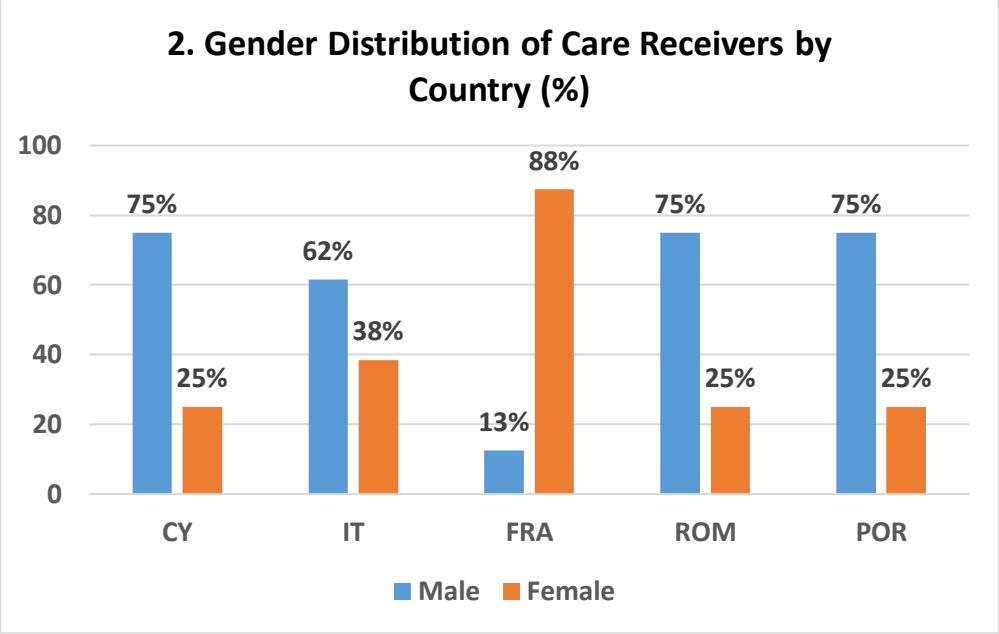

Figure 27: Gender Distribution of Care Receivers by Country (%)

Most care receivers were older adults, between 65–75 years old, followed by those aged 76 and 85 (Figure 28). Only in Cyprus 63% of the participants were over 86 (Figure 29).

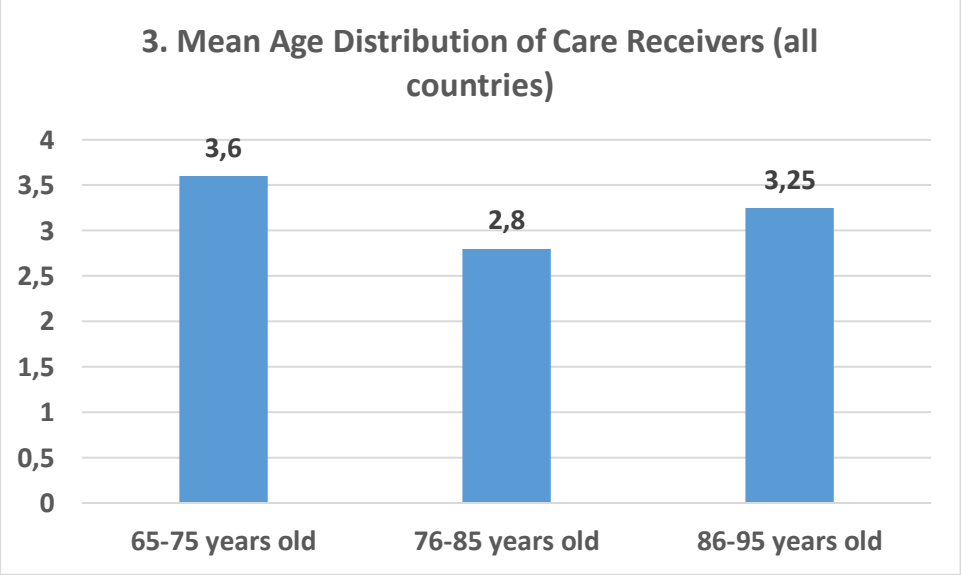

Figure 28: Mean Age Distribution of Care Receivers (all countries)

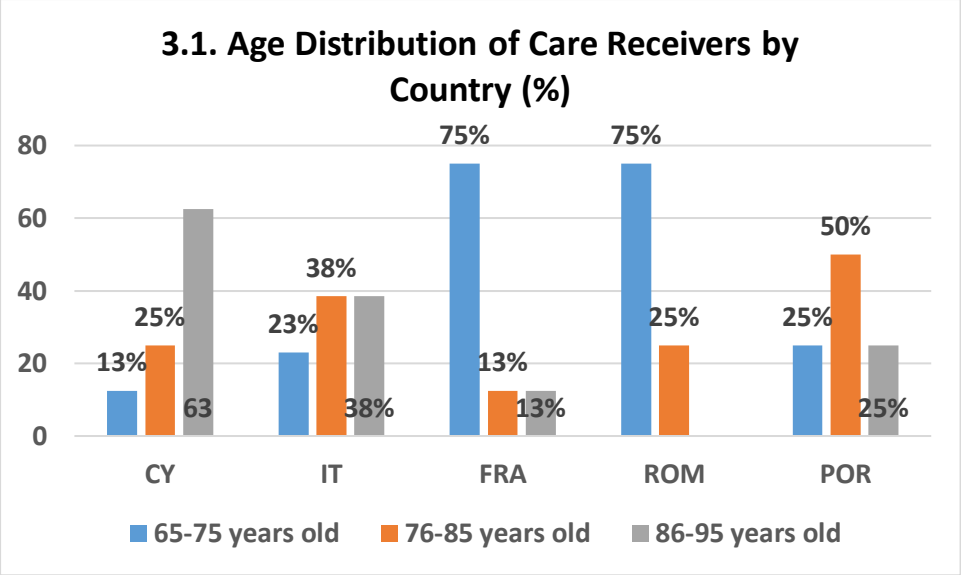

Figure 29: Age Distribution of Care Receivers by Country (%)

Education levels among care receivers was mixed. The majority completed elementary or secondary education, while a smaller proportion hold diplomas or bachelor's degrees. Very few reported having no formal education (Figure 30).

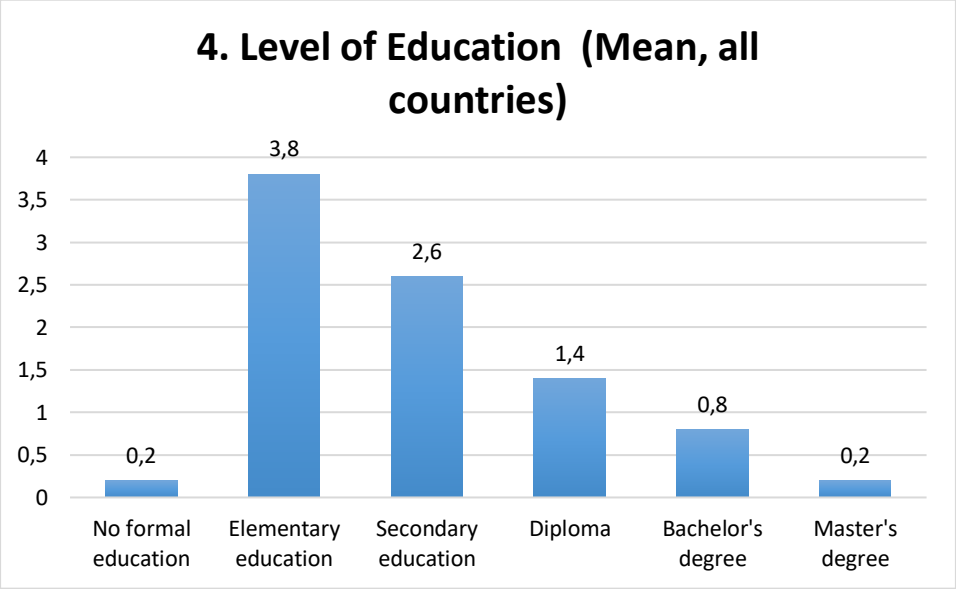

Figure 30: Level of Education (mean, all countries)

Most participants reported having received care from a male carer, with the duration of assistance typically lasting between one and three years (Figure 31 & 32).

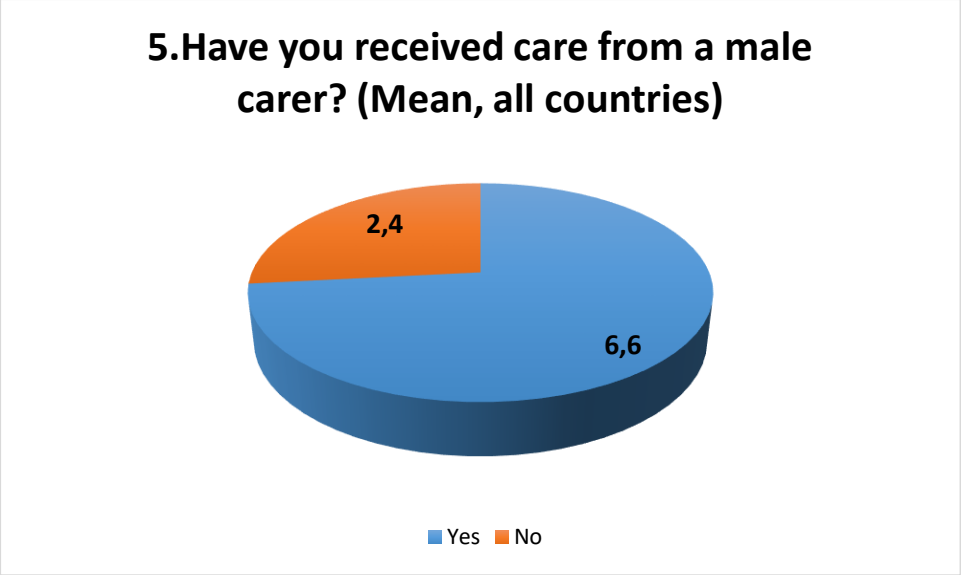

Figure 31: Experience of Receiving Care from a Male Carer (Mean, All Countries)

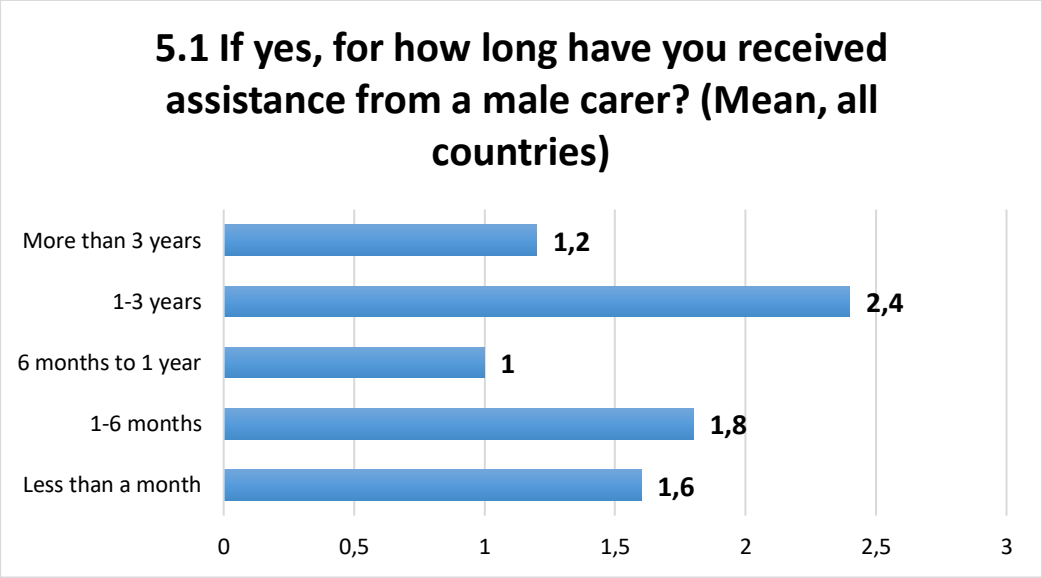

Figure 32: Duration of Care Received from a Male Carer (Mean, All Countries)

The most common types of care include basic medical care (medication, wound care, vital signs), personal care (hygiene, social support), rehabilitation and therapy services and daily living assistance (chores, cooking, cleaning, transportation). A smaller number received emotional support (Figure 33 & 34).

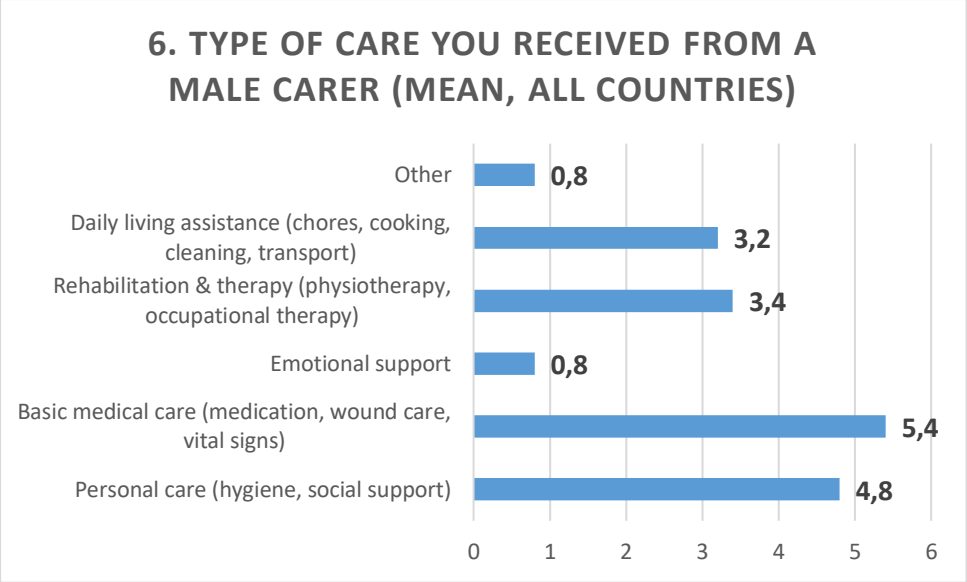

Figure 33: Type of Care Received from a Male Carer (Mean, All Countries)

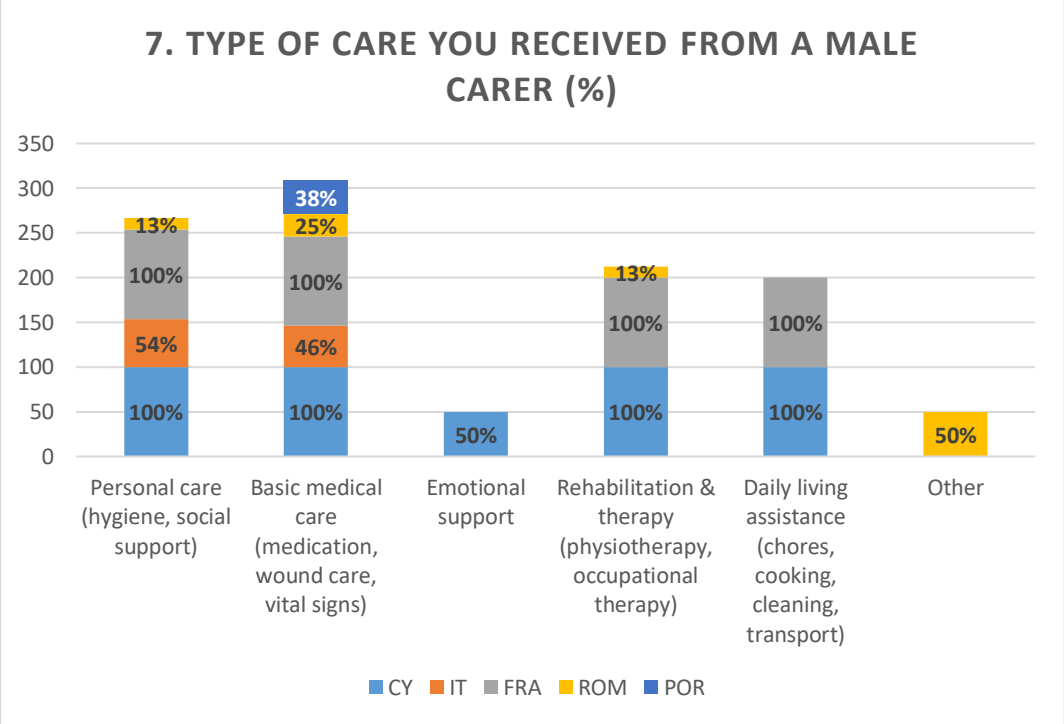

Figure 34: Type of Care Received from a Male Carer by Country (%)

Care was mainly provided in residential units, nursing homes and long-term care, followed by hospital units and community settings (Figure 35).

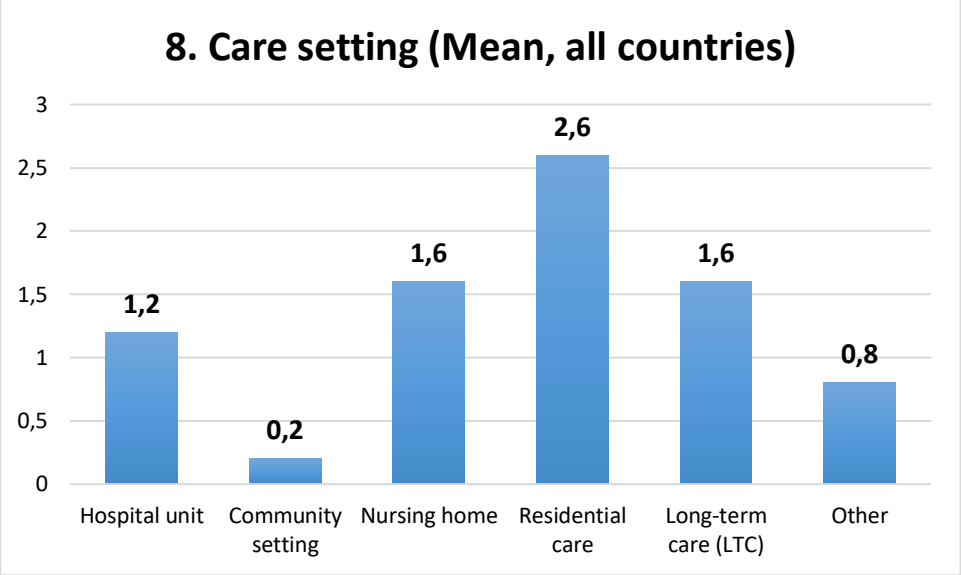

Figure 35: Care Setting of Care Receivers (Mean, All Countries)

Overall satisfaction with male carers was generally positive, across all participating countries. Care receivers reported being most satisfied with carers' physical strength and ability to assist with mobility, their professional care approach and techniques, as well as their attitude, empathy, and overall quality of care (Figures 36 and 37).

Instances of discomfort when receiving care from a male carer were rare (Figures 38 and 39). When they did occur, they were mainly related to privacy concerns, a perceived lack of empathy or emotional support, doubts about professionalism or competence, and occasional communication difficulties (Figure 40).

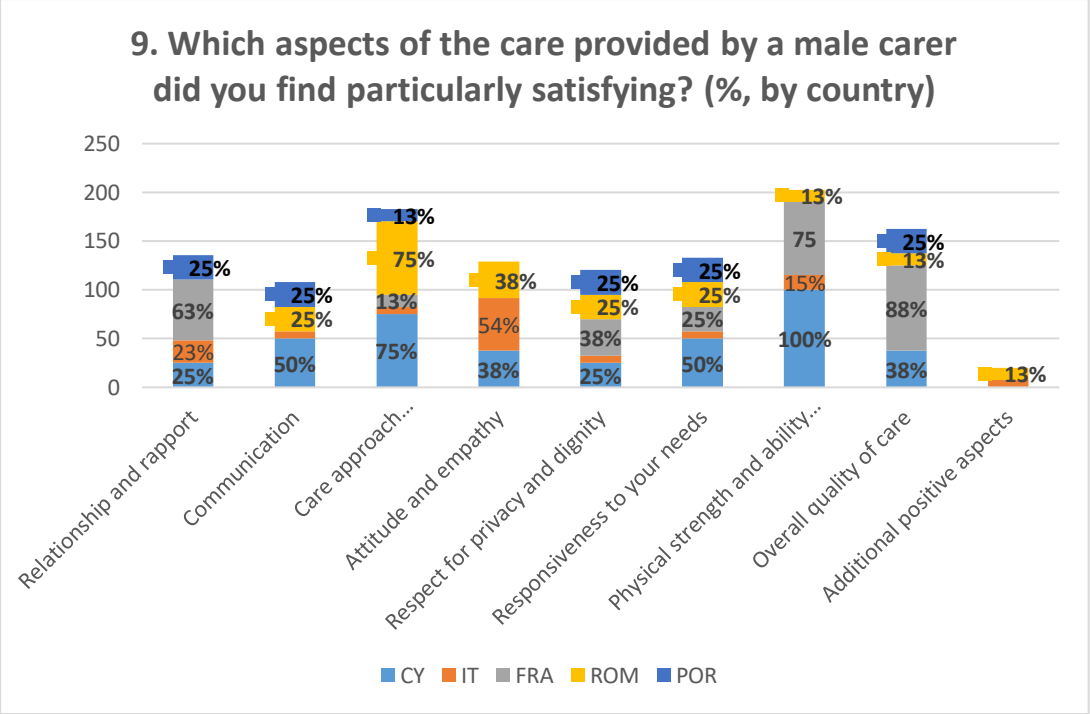

Figure 36: Satisfaction with Male Carers (%)

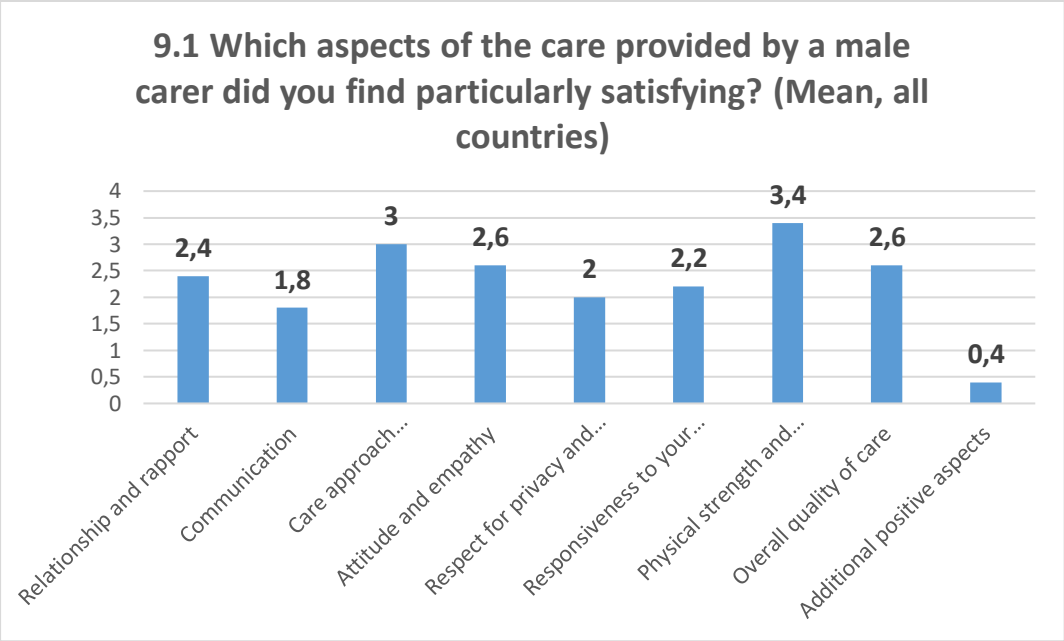

Figure 37: Satisfaction with Male Carers (mean scores)

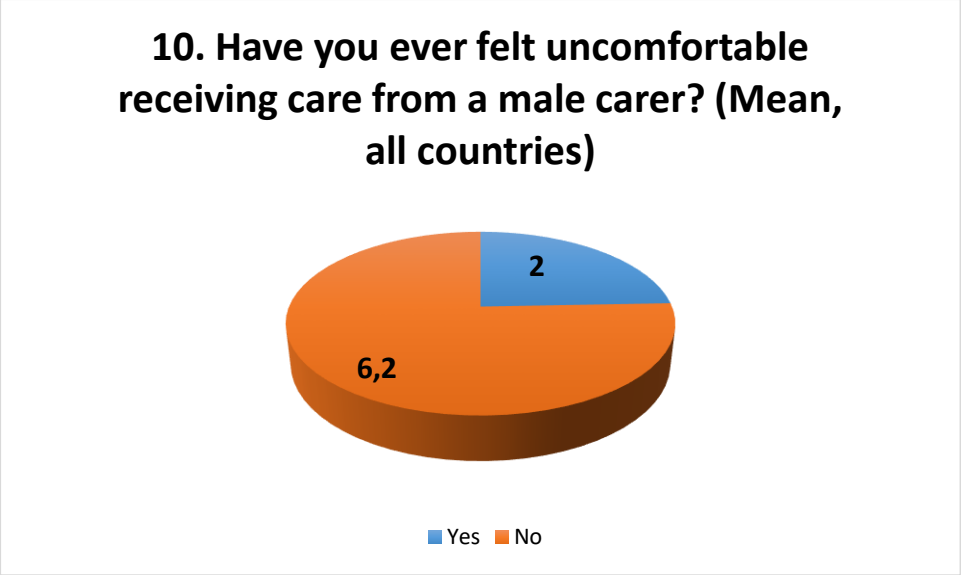

Figure 38: Discomfort When Receiving Care from a Male Carer (Mean, All Countries)

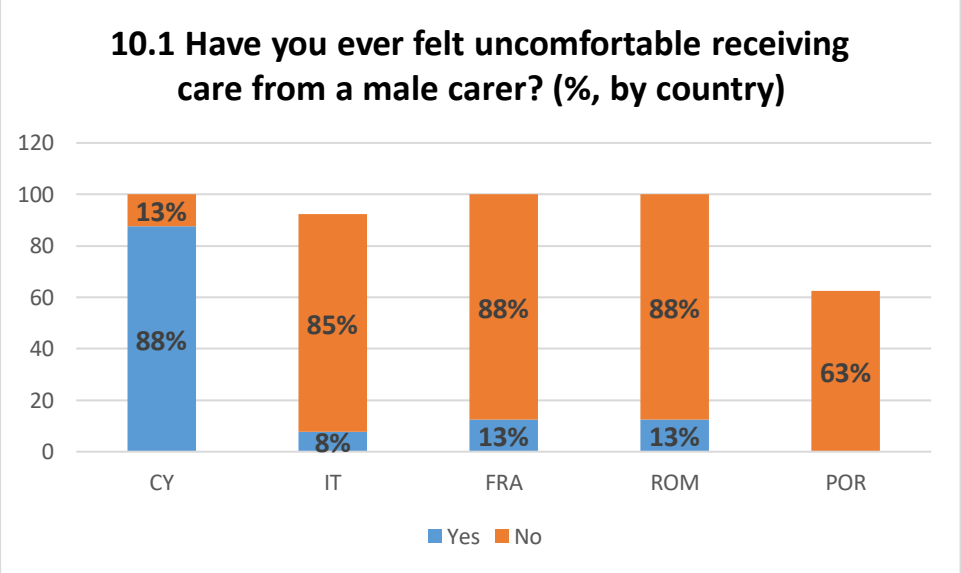

Figure 39: Discomfort When Receiving Care from a Male Carer by Country (%)

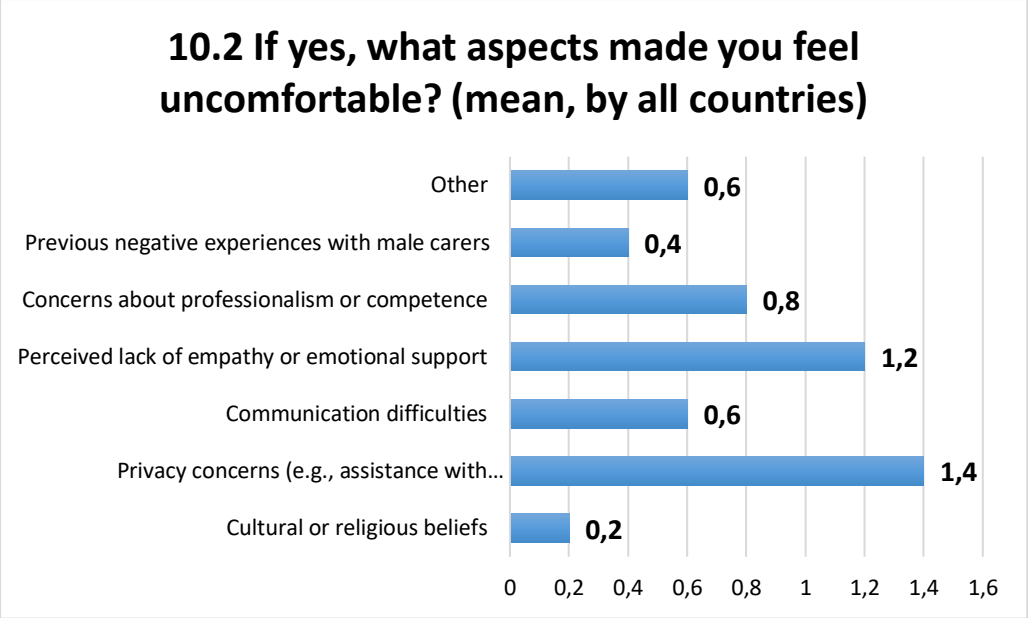

Figure 40: Reasons for Discomfort When Receiving Care from a Male Carer (Mean, All Countries)

When asked about preference, most care receivers stated no preference regarding the gender of their carer, while a smaller group expressed preference for female carers. Very few specifically preferred male carers (Figure 41).

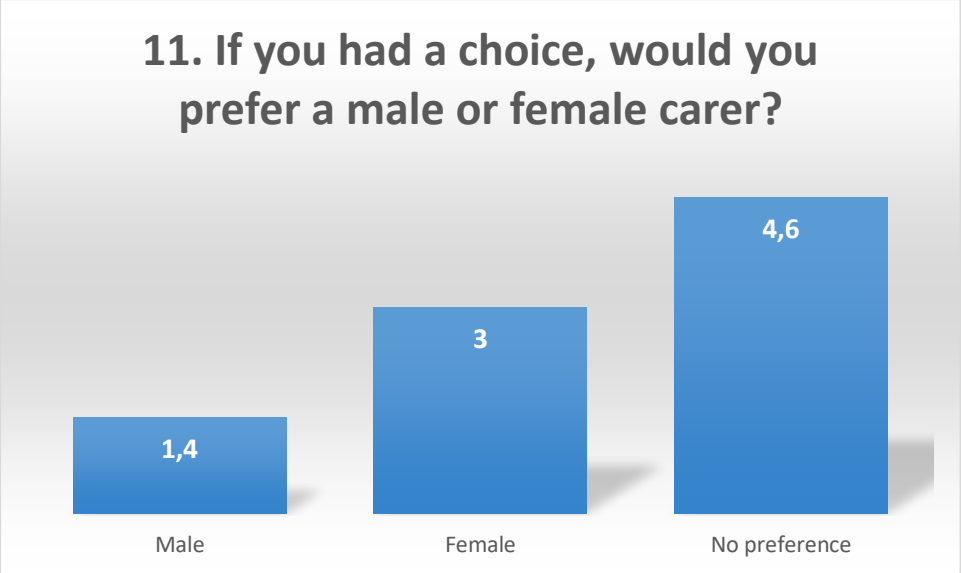

Figure 41: Figure 41. Care recipients' preference for the gender of their carer

3.2 Comparative Insights from Five European Countries

This section presents a comparative synthesis of findings from five participating countries, Portugal, Italy, France, Romania, and Cyprus examining the experiences, challenges, and perceptions surrounding male participation in the long-term care sector.

Through qualitative data collected from male carers, employers, and care recipients, the analysis explores how gender roles, cultural expectations, and organizational structures shape men's involvement in caregiving.

The key themes are organized into three main areas:

(1) Experiences and Challenges of Male Carers, highlighting motivations, barriers, and discrimination in the workplace;

(2) Perceptions of Employers and Care Providers, focusing on institutional biases, recruitment practices, and gendered dynamics within care settings; and

(3) Perspectives of Care Recipients, examining trust, comfort levels, and cultural attitudes toward being cared for by men.

Together, these findings provide a cross-country understanding of how men navigate a predominantly female profession, revealing both shared structural barriers and emerging shifts toward greater inclusivity and professional recognition across Europe.

3.2.1 Experiences and Challenges of Male Carers

3.2.1.1 Barriers to entry and career progression

Across the five countries, male carers consistently described cultural resistance and limited professional mobility as key barriers to entering and advancing in the care sector. In Romania and Portugal, men entering care work confronted traditional beliefs that caregiving was "women's work," often facing surprise or subtle disapproval from family and society. This initial skepticism acted as a psychological and social barrier that many had to overcome through persistence and demonstration of competence.

"Many say: 'That's women's work, what are you doing there?' But I believe men can help too." (P7, Romania)

"I was the only man here when I started... we need to increase the male role in this profession." (P7, Portugal)

In Italy and France, while gender resistance was less overt, male carers still faced structural barriers such as lack of career progression, low remuneration, and inadequate institutional recognition. They often described feeling "invisible" within large care systems, where career advancement was stagnant and emotional labor undervalued.

"Appreciation, progression, and even some respects have often been difficult to achieve." (P1, France)
"Physically demanding but meaningful — we are invisible and indispensable." (P2, Italy)

In Cyprus, caregiving was often chosen for pragmatic reasons, viewed as a readily available job with immediate entry opportunities. However, it remained a short-term or transitional occupation for many men due to limited professional development structures.

"It was one of those professions where you'd immediately find a job." (P1, Cyprus)

Overall, across all contexts, male carers perceived their role as professionally stagnant yet socially meaningful, remaining motivated by the relational dimension of their work rather than institutional incentives.

"For me, it's the same level... I plan to do a course to move up a level." (P5, Portugal)

3.2.1.2 Workplace discrimination and gender biases

Workplace discrimination was rarely explicit, but gendered expectations shaped men's daily experiences. In Italy and Portugal, men were often valued for their physical strength and dependability in demanding

situations. Yet this appreciation coexisted with task segregation: men handled lifting, transfers, or managing behavioral challenges, while women were assigned intimate personal care.

"Physically, as it is a physical job, men are sought after... Many residents seek out male carers because it makes them feel at ease." (P2, Italy)
"They preferred that I go, because they thought I was stronger and wouldn't let them fall." (P1, Portugal)

In Romania, these gendered divisions where more pronounced male carers were sometimes directed toward maintenance or technical roles, reinforcing assumptions that men were less suited to emotional or nurturing aspects of care.

"Men were assigned to heavier tasks, while women were in direct care." (P2, Romania)

In France, male carers described a lack of professional identity and recognition, often feeling interchangeable and undervalued within large institutions. Although men and women faced similar structural challenges, men noted that their contributions were more easily overlooked due to stereotypes that positioned them as "helpers" rather than caregivers.

"We are numbers. Within the macro context of my hospital unit, I am a number." (P1, France)

Several Portuguese participants explained that acceptance from female colleagues and families increased with time and trust. Early skepticism tended to fade once patients experienced the professionalism and empathy of male carers, suggesting that prejudice can be reduced through consistent positive interaction.

"Some families initially doubted me because I was a man, but later they trusted me completely." (P7, Portugal)

Thus, across Europe, discrimination was less about exclusion and more about role expectations, a quiet persistence of gender stereotypes that define what men "should" or "shouldn't" do in care.

3.2.1.3 Motivations and career pathways

Despite structural and social challenges, male carers across countries expressed deep personal commitment and meaning in their work. Their motivations often stemmed from personal or family experiences with illness or vulnerability, shaping empathy and a sense of moral duty. In Romania and Portugal, these experiences inspired many to pursue caregiving as a way to "give back" and support others in need.

"I saw the work of all those professionals... I said maybe I can contribute to helping others." (P1, Romania)
"Care is there, with the patients, always close to them. It is something I really like." (P6, Portugal)

In Italy, caregiving was described as physically demanding but emotionally rewarding a vocation that brought pride despite limited social status. Participants highlighted the human relationships and sense of usefulness that counterbalanced the hardships of the job.

"Physically demanding but meaningful, we are invisible and indispensable." (P2, Italy)

French participants similarly connected motivation to a sense of civic responsibility and compassion, but lamented the lack of institutional acknowledgment, which they viewed as a failure of social justice for both carers and care recipients.

"I am proud to do this work, even if it is not valued." (P5, France)

In Cyprus, motivations were largely economic and practical, but several participants noted that emotional satisfaction grew over time, transforming what began as a necessity into a source of purpose.

"It was one of those professions where you'd immediately find a job." (P1, Cyprus)

Across contexts, men entered care work for different reasons but stayed because of the emotional reward and sense of human connection. Their narratives reflect resilience and pride in performing a role that, though undervalued, they see as morally essential.

"Even if it is hard, I like what I do. I help, and that makes it worth it." (P8, Portugal)

3.2.2 Employers' & Care Providers' Perceptions

3.2.2.1 Organizational biases and recruitment challenges (hiring bias)

Across countries, employers acknowledged that recruiting men into care remains rare and often constrained by cultural expectations. In Romania and Italy, several directors admitted that male candidates were *"never considered"* or were thought unsuitable for intimate care roles. Recruitment decisions were influenced not by qualifications but by stereotypes regarding emotional competence or appropriateness.

"Male candidates were never considered; at the time I don't know the reason, I can only guess what it was." (P5, Romania)
"The door is always very closed to men, it's true." (P1, Italy)

At the same time, a number of Portuguese and French employers highlighted positive shifts toward inclusion, noting that male professionals often bring balance and stability to predominantly female teams. They emphasized the value of mixed-gender environments, both for the staff dynamic and for the quality of care.

"Having a heterogeneous work group is always an advantage, and the more diverse the group is, the better." (P2, Portugal)

"Hiring men also played a role... because it was an entirely female team with lots of conflicts among them." (P5, France)

In Cyprus, care providers reported fewer explicit barriers but acknowledged that the supply of male applicants remains low, often because men perceive care as an unattractive or underpaid profession. Employers saw this as a societal challenge rather than an institutional one, noting that greater visibility and public awareness could help shift attitudes.

"If we want more men to join, society must see caregiving as real work, not as women's duty." (P4, Cyprus)

Overall, while some organizations have become more open to hiring men, structural biases persist—both in recruitment language and in the unspoken belief that men are "exceptions" rather than integral members of care teams.

3.2.2.2 Workplace dynamics and career development opportunities (workplace culture)

Employers across the five countries generally recognized the importance of gender diversity in maintaining positive team dynamics but also admitted to persistent inequalities in daily practice. In Portugal, managers often reported strong collaboration among staff, describing male carers as *"essential allies"* in physically demanding contexts. However, this appreciation sometimes reinforced gendered divisions of labor, where men were valued for strength rather than caregiving skill.

"We always try to assign a man to each shift... so there is greater balance in certain types of tasks." (P7, Portugal)

In Italy, directors observed that male carers' presence helped reduce conflict and fostered professionalism within large, mostly female teams. Yet, they also noted that men tend to leave earlier, often moving into hospital positions with better pay and recognition, a phenomenon linked to limited career progression in long-term care.

"All the men I've had here have moved on to the hospital, but precisely to keep the same roles." (P5, Italy)

French employers described care as a profession "of endurance", where both men and women face high workloads, emotional fatigue, and low pay. They stressed the need for institutional investment in training and recognition to retain male workers, who often seek environments that value professionalism and respect.

"It is very difficult to work in this area, even if you really enjoy it. The salary is simply miserable and doesn't cover anything at all." (P3, France)

In Cyprus and Romania, opportunities for continuing training and career progression were often limited, with few formal pathways or mentoring structures in place. Male staff who advanced typically did so informally, driven by personal persistence or external encouragement rather than institutional planning. Similar experiences were described in Portugal, where one participant noted:

"I had support for everything I wanted, even going to Human Resources to be able to return to study here. Because Dr. Sandra wants me to study. She wants me to qualify here as a nurse. But the universities she suggested were very far away and for me it didn't make sense. I would have to leave Lisbon to go near Porto and it was complicated for me. I am looking at public universities, but competition is very high."

(P5, Portugal)

"We have difficulty finding qualified staff... people who can develop something different." (P2, Romania)

Across all contexts, employers recognized that while men contribute positively to teamwork and care quality, the absence of structured career pathways continues to push them away from the sector.

3.2.2.3 Gendered expectations in caregiving roles

Despite progress, gender stereotypes remain deeply embedded in employers' perceptions of caregiving roles. Most managers described women as *"naturally caring"* and men as *"stronger and calmer"*, perpetuating a symbolic division between emotional and physical labor.

"The aptitude for caregiving is inherent to women. This is a genetic issue." (P6, Italy)

Even in settings committed to equality, residents' and families' preferences often shaped how men were deployed. Employers explained that female residents, particularly older generations, might initially refuse male carers for intimate tasks, leading teams to adapt assignments based on comfort and cultural norms.

"I have women who are really very reluctant to receive care from men." (P6, Portugal)

"Some families were suspicious (about hiring a man) [...] but now he's almost their preferred caregiver." (P7, France)

In France and Portugal, several institutions actively tried to challenge these biases by highlighting men's professionalism and empathy. Managers described providing communication training, awareness campaigns, and role modelling to help normalize male presence in care.

"We directors also have an important role in demystifying this prejudice." (P2, Portugal)

"Give more visibility and voice to this type of professional (male caregivers)." (P3, France)

In Romania and Cyprus, employers linked persistent bias to broader social attitudes that view care as a continuation of women's domestic duties. Efforts to include men were often described as "symbolic" rather than systemic, reflecting a slow cultural transition rather than immediate institutional change.

"Care work is still seen as an extension of housework, and that keeps men away." (P4, Cyprus)

Overall, while employers generally express openness toward male carers, their narratives reveal a subtle reproduction of gender norms, where inclusion is accepted in principle but constrained in practice by long-standing cultural beliefs about who is "naturally suited" to care.

3.2.3 Care Recipients' Perspectives

3.2.3.1 Trust and Comfort Levels with Male Carers

Across all five countries, care recipients expressed varying levels of trust and comfort with male carers, often shaped by generational and cultural norms. In Portugal and Italy, many older women initially felt embarrassed or hesitant to receive intimate care from men, though later described positive relationships once trust was established. Male carers' professionalism, calmness, and patience were crucial in overcoming initial discomfort.

"He is a man, I feel embarrassed." (P7, Portugal)
"Some older women refuse to be treated by me, for example with personal hygiene, but otherwise there are no barriers." (P5, Portugal)
"Over time, if they realize that the person is careful, they will end up accepting it." (P4, Italy)

In France and Cyprus, trust issues were less related to gender and more to personal interaction and quality of care. Participants emphasized that what mattered was the carer's respect, attention, and skill rather than their

sex. For many, physical need overrode embarrassment, especially in long-term relationships with caregivers.

"It was a man who washed me... but I was sick, it was for my own good, so never mind." (P3, France)
"As long as they do the job well." (P5, Cyprus)

Romanian participants echoed similar sentiments, suggesting that trust develops through familiarity and empathy rather than gender. However, some still admitted a residual sense of discomfort when assisted by male staff, especially during bathing or dressing.

"If needed, it has to be." (P4, Romania)

Across all settings, these reactions highlight that discomfort tends to be situational and generational, gradually diminishing as carers prove their professionalism and sensitivity.

3.2.3.2 Perceived Differences Between Male and Female Caregivers

Most care recipients did not report substantial differences in the technical quality of care, emphasizing that both men and women could perform their duties competently. However, many still attached emotional and symbolic attributes to gender roles, often describing women as more nurturing or affectionate.

"It is the same, but women are more capable." (P2, Portugal)
"I prefer to be cared for by ladies, the more affectionate side." (P3, Italy)

In France and Cyprus, participants expressed neutral or egalitarian views, reflecting broader social normalization of men in caregiving. For these respondents, motivation and professionalism were valued above gender.

"Motivation is what counts; gender does not matter." (P3, France)
"Everyone should be able to manage well." (P4, Cyprus)

Conversely, in Romania, some participants still framed men as exceptions in care settings, describing women as "better prepared" and associating caregiving with femininity and patience.

"Female workers are already prepared for this." (P6, Romania)
"I don't know if there are male workers to work here." (P7, Romania)

Despite these differences, respondents across countries consistently highlighted respect, communication, and dedication as the true markers of good care. Gender remained relevant mainly in intimate or culturally sensitive contexts, rather than as a determinant of competence or compassion.

3.2.3.3 Cultural and Societal Influences on Preferences

Cultural norms strongly influenced comfort and expectations around male caregiving. In Southern European contexts, notably Italy and Portugal, older generations carried traditional gender norms associating care with women's domestic roles. Feelings of embarrassment or modesty were most common among older adults' women who grew up in patriarchal settings where physical assistance by men was considered inappropriate.

"An older woman is harder for me to care for than a lady of 60 or 70 years, because the older ones carry that shame from the past." (P5, Portugal)
"Women prefer to be treated by women." (P4, Italy)

In Romania, media coverage of care-related scandals (e.g., abuse cases) further shaped public perceptions, reinforcing caution toward male carers and amplifying pre-existing gender stereotypes.

"I've heard about cases of abuse by male carers on the news." (P7, Romania)

French and Cypriot participants, however, reflected a more modern perspective, viewing gender diversity as part of a changing social reality.

They emphasized that men's participation in care represents social progress and equality.

"Nowadays in the world as it is, everything is already the same, man or woman." (P6, Cyprus)

"The soul has no gender." (P2, France)

Overall, the degree of acceptance depended on both cultural background and generational openness. Younger or more educated respondents tended to value professionalism over gender, whereas older adults, especially women, still framed comfort in relation to traditional modesty and decorum.

Taken together, the findings from all five countries reveal a shared tension between tradition and transformation.
Men entering the care sector continue to face cultural barriers and limited professional recognition, yet they are gradually redefining caregiving as a human rather than gendered act.
Employers are beginning to value diversity, but systemic challenges, such as low pay, limited career progression, and the persistence of gender stereotypes , remain central obstacles to equality.

Care recipients' growing trust in male carers signals a generational shift toward inclusivity, suggesting that gender diversity in care not only enriches team dynamics but also enhances patient well-being and choice.

"Everyone should perform their role well... what matters is care, not gender." (P2, Portugal)

Across Romania, Portugal, Italy, France, and Cyprus, the integration of male carers is an evolving social and institutional process.
While gender bias still shapes perceptions and opportunities, men who enter the field often embody resilience, empathy, and a strong ethical drive to serve others.

Their experiences reflect both the persistence of old stereotypes and the emergence of new forms of professional identity, pointing toward a future where caregiving is recognized not as a "female role," but as a shared human responsibility.

"We are few, but we make a difference. I think it's time people see that." (P3, Portugal)

Across all participating countries, the findings underscore a progressive yet uneven transition toward gender inclusivity in the long-term care sector. While men continue to face structural barriers, persistent stereotypes, and limited career pathways, their presence is increasingly recognized as an asset that enriches team dynamics and broadens the quality of care. Employers and care recipients alike are gradually shifting from traditional views of caregiving as "women's work" toward an understanding of care as a shared human responsibility grounded in empathy, skill, and professionalism.

Despite national differences in labor policies and cultural attitudes, a common thread emerges: the need for systemic support to normalize men's participation in care, through improved training, awareness-raising, and equitable working conditions.

Together, these insights highlight both the challenges and the transformative potential of fostering gender balance in care , a necessary step toward more inclusive, sustainable, and person-centered long-term care systems across Europe.

3.3 Cross-country Comparison

Across the five participating countries: Portugal, Italy, France, Romania, and Cyprus, the integration of male carers in the long-term care (LTC) sector presents both shared structural barriers and country-specific dynamics shaped by culture, policy, and institutional practices.

While the care profession remains predominantly female in all contexts, the data suggest that men's participation is slowly increasing, supported

by gradual cultural change, labor shortages, and local initiatives that promote diversity in the care workforce.

A synthesis of recurring themes, country-specific highlights, and illustrative participant quotes (Table 1).

Theme / Insight	Cross-country Synthesis (Summary)	Illustrative Quotes (from dataset)
Persistent gender stereotyping	Across all five countries, traditional views continue to shape attitudes toward male carers. Although stigma has decreased in Portugal and France, in Romania and Italy care remains seen as "women's work." Cyprus also reflects generational discomfort, especially in personal care.	"We always respect the patients' wishes... a man should care for men and a woman for women." (Portugal) "Male candidates were never considered; the door is always closed to men." (Romania) "Women are more capable... it's more natural." (Care recipients – Cyprus)
Career stagnation and low remuneration	Limited career progression and low wages were consistent concerns across all countries. Male carers often described feeling undervalued and lacking institutional support for advancement, which affects retention and motivation.	"There is no fair wage for what people do." (Portugal) "What you do today is what you will do in 10–15 years; there is little career progression." (Romania) "The salary is simply miserable and doesn't cover anything at all." (France)
Intimate care discomfort and trust-building	Discomfort in receiving intimate care from male carers remains widespread among older female patients, particularly in Cyprus, Portugal, and Romania. However, familiarity and trust tend to overcome these initial barriers.	"At first, there was always some apprehension about being a man, but after the first time... they didn't want any other colleagues." (Portugal) "She said she was ashamed to be cared for by a man." (Romania) "He is a man, I feel embarrassed." (Care recipient – Cyprus)
Portugal – Inclusive training and awareness partnerships	Portugal demonstrates best practice through institutional collaboration with nursing and technical schools, promoting visibility and inclusion of male carers. Training hubs encourage gender awareness and professional identity development.	"We are a training hub... we receive many nursing interns." "Having a heterogeneous work group is always an advantage."
France – Supportive workplace policies	France shows strong organizational commitment to equality. Employers provide flexible schedules, training, and well-being initiatives, helping normalize male participation in care teams.	"We offer performance evaluations, health insurance, and an extra day off." "We try to adjust schedules to prevent absenteeism."

Italy – Emerging male role models	Italy is slowly shifting from rigid gendered divisions to greater inclusion, supported by education and mentorship. Highlighting male role models in caregiving has helped challenge stereotypes.	"We give a voice to male professionals who overcome challenges and become role models in caregiving." "Men were placed as drivers or gardeners, while women were placed in direct care roles."
Romania – Need for awareness and public trust	Romania faces strong cultural prejudice but also displays resilience among male carers striving for recognition. There is a need for structured awareness campaigns and training to change perceptions.	"Male candidates were never considered." "There are women who feel ashamed to be cared for by men… it comes from the past."
Cyprus – Emerging participation and professional identity	Cyprus reveals a younger caregiving workforce, with men entering care for practical reasons but finding personal meaning in their role. Stigma is mild but traditional preferences persist.	"It was one of those professions where you'd immediately find a job." "Women prefer female carers for intimate care, but otherwise it's the same."

Table 1: Summary of Cross-Country Findings on Gender and Caregiving

3.3.1 Portugal: Emerging Inclusivity and Professional Recognition

Portugal stands out as a progressive example of inclusion, where gender stereotypes in caregiving are seen as less pervasive today than in the past. Participants described a sector in transition: while older generations still show some discomfort toward male carers, both employers and care recipients are increasingly open to men in caregiving roles.
Organizations have begun to actively recruit and support male carers, recognizing their contribution to a balanced workforce. Employers highlighted the positive impact of gender diversity on team dynamics, noting that male carers often bring stability, patience, and conflict resolution skills.

However, low wages and limited progression opportunities remain key challenges. Despite this, Portugal demonstrates good practice in employer awareness and inclusion training, as well as in supporting continued education for male carers, including collaborations with technical schools and universities.

3.3.2 Italy: Persistent Stereotypes and Emerging Change

In Italy, the care profession remains highly gendered, with caregiving culturally linked to women's nurturing roles. Employers openly acknowledged gender bias in hiring, noting that men are often assigned to physically demanding or technical tasks rather than direct personal care.

Nevertheless, Italy also shows promising signs of progress, particularly in professional education and local leadership initiatives. Some institutions are beginning to advocate parity in care teams and provide training opportunities that include male caregivers. A few male participants reported advancement into leadership positions (e.g., technical director roles), showing that competence and persistence can overcome gender barriers.

Still, social attitudes among older care recipients continue to reflect modesty and embarrassment when cared for by men, suggesting that cultural change remains gradual.

3.3.3 France: Professional Equality and Organizational Innovation

France presents one of the most institutionally advanced environments for gender equality in care. Legal frameworks promote equal opportunity and non-discrimination, and employers widely reported a gender-neutral approach to hiring and workplace management.

However, practical barriers persist, particularly in career stagnation and professional recognition. Male carers expressed frustration over limited upward mobility and high workloads, but also described their jobs as meaningful and socially valuable.

Some organizations in France demonstrate good practice through flexible scheduling, training programs, and awareness campaigns aimed at demystifying gender roles in care. In particular, mixed-gender teams are valued for reducing interpersonal conflicts and enriching care quality.

Among service users, trust and comfort with male carers were generally high, indicating a more mature acceptance of gender diversity.

3.3.4 Romania: Cultural Barriers and Low Recognition

Romania reflects the most traditional attitudes toward male caregiving among the five countries. Male carers often described social stigma and disbelief surrounding their role, both from colleagues and the public.

Employers confirmed a lack of male representation and admitted that men are rarely considered in recruitment for personal care positions. Additionally, low pay, limited training, and societal mistrust, occasionally fueled by media stories about abuse, contribute to the difficulty of attracting men into the sector.

Nevertheless, there are emerging examples of resilience: male carers expressed strong intrinsic motivation, often describing caregiving as a calling or moral duty. A few institutions have started to include gender-awareness training, though such initiatives remain fragmented and localized.

Romania's experience underscores the need for systemic support and national campaigns to promote care as a gender-neutral and respected profession.

3.3.5 Cyprus: Pragmatic Entry and Evolving Acceptance

In Cyprus, male participation in care is limited but gradually increasing, particularly among workers entering the sector for economic reasons. For many, caregiving began as a pragmatic job choice but evolved into a profession of emotional and relational meaning.

Care recipients in Cyprus generally reported high levels of comfort and trust with male carers, showing little gender-based resistance. The focus was on professionalism and compassion rather than gender.

Employers expressed openness to hiring men, yet formal gender equality policies remain scarce.

Despite the absence of institutionalized inclusion measures, small-scale examples of good practice include mentoring of new male carers and informal peer support systems, which help them integrate smoothly into predominantly female teams.

4. Policy and Practical Recommendations

The project's research has highlighted the experiences, motivations, and challenges of male professional carers across several European countries. The elements presented in this chapter come directly from the research

conducted by all project partners. They reflect the recommendations and strategies that emerged from these analyses.

Male carers bring valuable skills to predominantly female teams, combining emotional support, practical problem-solving, and physical capacity. At the same time, they face persistent stereotypes, underrepresentation in leadership positions, and professional challenges such as emotional strain, limited recognition, and precarious pay.

This chapter therefore presents a set of insights, practical recommendations, measures, and awareness-raising strategies that can help organizations, policymakers, and educational institutions build more inclusive and effective long-term care teams.

KEY INSIGHTS FROM THE OVERALL RESEARCH

As previously stated, across the countries studied, male carers tend to enter the profession motivated by a combination of humanistic values, prior caregiving experience, and practical considerations such as stable employment or career change. While many derive deep personal satisfaction from helping others, they also encounter societal and cultural biases framing caregiving as "women's work." Initial reluctance from some care recipients regarding intimate care is common, yet professional behavior and trust-building often mitigate these concerns. Male carers are usually welcomed by colleagues and care managers, and their presence contributes to team balance, bringing a complementary set of skills. However, challenges remain: men are often allocated physically demanding or conflict-related tasks, opportunities for leadership are limited, and emotional strain is frequent. Retention is affected by career mobility, with some carers leaving for hospital roles that offer higher pay or larger teams.

These insights emphasize that male carers are both valued and vulnerable within LTC systems. Structured support, recognition, career development, and awareness initiatives are key to enabling their full participation and reducing gendered barriers.

Concrete actions to considerate:

- Ensure care teams recognize and value male carers' emotional and relational skills alongside physical contributions.
- Watch how tasks are assigned to men and women and adjust them to avoid reinforcing stereotypes
- Provide structured emotional support to manage stress and promote wellbeing.

- Facilitate mentorship and career progression pathways to encourage retention.
- Collect and monitor recruitment and retention data separately for men and women to guide actions.

Target group: Researchers, training institutions, care employers, HR managers, policy makers.

POLICY RECOMMENDATIONS

Policy measures play a key role in creating a gender-inclusive long-term care (LTC) workforce. Promoting gender equality requires strategies that cover recruitment, training, pay, and recognition. This can include adding gender and diversity awareness modules in national curricula, supporting ongoing professional development, and setting up systems to collect and monitor data.

Financial incentives or formal recognition for organizations that actively recruit and retain male carers can encourage good practices. Improving the status of carers, through minimum pay levels, extra allowances for night shifts or difficult work, and pension benefits for long-term service, helps with retention and professional dignity.

National competence frameworks and short professional certificates can formally recognize specializations such as dementia care, palliative care, or case management in career progression and pay scales. Policies should also support recognizing prior experience, help migrant carers integrate, and give carers a voice in decision-making to make reforms practical and lasting.

Concrete actions:

- Integrate gender-sensitive modules in care education and ongoing training.
- Offer financial or recognition incentives for organizations promoting gender balance.
- Implement minimum pay and benefits to strengthen retention and professional recognition.
- Develop national competence frameworks with certified skill programs for specializations.
- Recognize prior experience for carers and provide language support for migrant workers.
- Create consultation channels for carers to contribute to policy and service planning.

Target group: Policy makers, ministries of health and social affairs, social partners and trade unions, funding agencies, accreditation bodies.

PRACTICAL MEASURES (EMPLOYERS & TRAINING)

Employers and training providers can take practical steps to support male carers and promote gender balance. Recruitment should use gender-neutral language and materials to show that care roles are open to everyone. New carers should have supervised induction periods and mentorship to help them adapt and build confidence.

Training that combines hands-on placements with modules on communication, emotional regulation, and person-centered care strengthens skills and job satisfaction. Peer support and counselling help carers cope with emotional stress and avoid burnout. Flexible schedules and work-life balance measures improve retention, and retention bonuses tied to attendance or performance encourage continuity. Clear policies on harassment and misconduct, along with regular feedback, help create safe and inclusive workplaces.

Concrete actions:

- Use gender-neutral job descriptions and inclusive recruitment materials.
- Provide supervised induction and mentorship for new carers.
- Offer ongoing training on person-centered care, emotional skills, and gender awareness.
- Set up peer support, counselling, and wellbeing initiatives to prevent burnout.
- Introduce flexible schedules and retention incentives.
- Establish clear harassment and misconduct policies with regular feedback.

Target group: Care employers, HR departments, facility managers, vocational and continuing training providers, quality/HR auditors.

AWARENESS-RAISING AND COMMUNICATION ACTIONS

Changing social perceptions is key to encouraging men to work in care. Multi-channel campaigns can highlight male carers by sharing real stories, testimonials, and media features. Working with schools, career guidance

services, and vocational centers gives young men hands-on experience through demonstration days, shadowing, and career modules.

Ambassador programs train experienced male carers to speak at events, job fairs, and conferences. Community activities, such as intergenerational discussions and story circles, help normalize male participation in caregiving. Public recognition through awards, local events, or institutional branding can further boost societal acceptance. Awareness efforts should be ongoing and adapted to local culture, combining media campaigns with direct community engagement.

Concrete actions:

- Run multi-channel campaigns showing male carers' professional and emotional skills.
- Partner with school, vocational centers, and career guidance services for practical experiences.
- Train experienced male carers as ambassadors for events and career promotion.
- Organize community story circles and intergenerational dialogues on caregiving.
- Use awards and recognition events to highlight organizations promoting gender diversity.

Target group: General public, schools, career guidance centers, vocational schools, local authorities, media, NGOs, care providers.

PROMOTING GENDER EQUALITY IN LONG-TERM CARE: WHERE TO START?

Introducing gender equality in long-term care (LTC) can begin with small, practical steps that address awareness, recruitment, training, and workplace culture at the same time. Organizations can start by checking recruitment materials and job descriptions to make sure they are inclusive. Training programmes can include short modules on gender sensitivity and diversity.

Employers can also pilot mentorship and peer-support initiatives for new staff, combined with flexible schedules and wellbeing measures, to show commitment to retention. Involving local schools, vocational centers, and the media to showcase male carers helps create a wider societal impact. Tracking recruitment, task allocation, and retention data by gender allows organizations and policymakers to measure progress and adjust strategies.

By combining policy, practical support, and awareness-raising, LTC providers can gradually normalize male participation and make care careers more appealing to diverse candidates.

Based on feasibility and immediate impact, these six actions you can start with to promote gender equality in LTC:

1) Inclusive recruitment and onboarding: use gender-neutral materials and mentorship schemes to attract and support male carers.
2) Structured supervision and peer support: help prevent burnout and build professional confidence.
3) Gender and diversity training: include awareness modules in curricula and ongoing professional development.
4) Awareness campaigns and ambassador programs: normalize male participation through real stories and public visibility.
5) Flexible scheduling and wellbeing measures: support work-life balance and retention.
6) Data collection and monitoring by gender: track recruitment, retention, and task allocation to guide evidence-based actions.

The table below summarizes the recommended actions by the target group, offering a clear and practical overview of how to promote gender equality in long-term care.

Employers and Care Providers
Introduce mentorship and peer support schemes between male and female care workers to reduce isolation.
Ensure fair recruitment and promotion criteria based on skills and not gender stereotypes.
Develop internal campaigns celebrating male carers and their role in person-centred care.
Encourage flexible work arrangements that support both male and female caregivers to balance care and personal life.

Policy Makers and Institutions
Promote gender-sensitive national strategies on long-term care including men's participation as a priority.
Support the collection of gender-disaggregated data on care professions.
Fund pilot projects and innovation schemes to attract more men into the care workforce.
Integrate male carers into national ageing and care awareness campaigns.

Training Institutions and Universities
Embed gender equality and diversity training in long-term care curricula.
Create training modules addressing unconscious bias and inclusive communication in care settings.
Include testimonies from male carers and role models in educational material.
Encourage interdisciplinary learning between health, social care, and gender studies.

Civil Society and Community Organisations
Run local campaigns showing that caring is a skill and a profession for everyone, not a gendered task.
Collaborate with media and influencers to normalise men's participation in long-term care.
Support community initiatives that pair older adults with diverse caregivers for mutual learning.

Older Adults and Care Recipients
Promote intergenerational and gender-balanced care activities to foster mutual understanding.
Encourage dialogue between care recipients and professionals about expectations and stereotypes.

These recommendations clearly echo the priorities set out in the EU Gender Equality Strategy (2020–2025) and the European Care Strategy (2022). Both call for fairer, more inclusive care systems, where care work is valued, working conditions improve, and gender stereotypes no longer shape who gives or receives care.

Across Europe, the long-term care sector is facing a real crisis: there are not enough trained professionals, and many who are already in the field struggle with demanding workloads and emotional fatigue. The recommendations gathered through our research directly respond to this situation. By promoting gender balance, improving training and support, and creating workplaces where both men and women can thrive, they can help care organizations retain their employees, attract new ones, and improve the quality of life for everyone involved, carers and beneficiaries alike.

At the same time, a communication and awareness strategy can help bring this issue to the forefront of policy discussions. Making the role of carers more visible, challenging stereotypes, and showcasing the value of their work are all essential steps to ensure that decision-makers view care as a genuine priority. Ultimately, the goal is shared by all EU strategies: ensuring the highest quality of care and accompaniment for beneficiaries, delivered by professionals who are supported, respected, and proud of their work.

These recommendations can also contribute to the wider effort of making care jobs more attractive and sustainable. Actions such as peer mentoring, awareness campaigns, and partnerships between care providers, training centers and policymakers directly support the EU's vision of *"quality care for all, provided by valued professionals."*

The lessons from OpenCARE can guide future national and European actions to make the care sector more balanced and inclusive.

5. Conclusion – Key Takeaways Messages

This research highlights the important contributions male carers bring to long-term care (LTC) teams. Their presence complements predominantly female teams, adding emotional support, practical problem-solving, and physical capabilities that strengthen care delivery. At the same time, the LTC sector is facing a real crisis, with shortages of trained professionals, high staff turnover, and limited career progression. Male carers often encounter societal stereotypes, underrepresentation in leadership positions, and low pay: challenges that can impact both retention and the overall quality of care. The recommendations presented in this report, spanning policy, practical measures for employers and training, and awareness-raising strategies, are designed to address these challenges. By supporting male carers, organizations can retain experienced staff, attract new talent, and ensure that care recipients receive higher-quality support. Highlighting these issues can also help policymakers recognize that gender inclusivity in LTC is not just a matter of fairness, but essential to sustaining quality care for older adults.

The study also demonstrates clear alignment with the EU Gender Equality Strategy and the broader EU Care Strategy. Evidence-based measures, such as inclusive recruitment, structured mentorship, flexible scheduling, gender-sensitive training, awareness campaigns, and systematic monitoring of workforce data, can be implemented at both organizational and policy levels. These measures have immediate feasibility and can deliver meaningful impact, improving both workplace equality and the quality-of-care services. Even small actions, like ensuring job advertisements are gender-neutral or introducing mentorship schemes, can gradually shift workplace culture and reduce gender-based barriers.

It is important to emphasize that this report represents only the beginning of the project's work. After its delivery, translations into all partner languages will ensure broad accessibility. Following this, a white paper will be developed to consolidate the findings and promote inclusivity in LTC at the policy level. This white paper will serve as a practical guide to raise awareness among policymakers, social partners, and stakeholders about the importance of supporting male carers and creating more balanced, sustainable care teams.

A key next step is the launch of WP3: Awareness and Sensitization Workshops. These workshops are designed to mobilize and engage two main groups: care recipients and care providers/employers. Two targeted workshops will be organized for each group, using evidence-based content and materials derived from the research findings. The goal is to reduce stereotypes, stigma, and discrimination against male carers, and to foster more inclusive attitudes across the sector. At the end of WP3, a final awareness guide will be produced, summarizing lessons learned, practical tips, and suggestions for replicating these workshops in different contexts.

The objectives of WP3 are clear:

- Enable participants to recognize and understand the forms of discrimination male carers may face due to stereotypes and social stigma.
- Raise awareness of the impact and importance of addressing these issues, both for carers and for the quality of care provided.
- Engage participants emotionally, creating personal connections to the challenges faced by male carers, and motivating cultural and social change.
- Provide actionable information that can lead to behavioral changes, reducing discrimination at both individual and organizational levels.
- Promote equal opportunities and fair recognition for men and women in the care sector, reinforcing the notion that caregiving is a valued and respected profession for all.

In parallel, a toolkit will be developed to support carers, employers, and stakeholders in applying these recommendations in practice. It will be tailored to the needs identified through the research and will provide practical guidance for creating more inclusive, supportive, and effective LTC environments. This toolkit, together with dissemination events in all partner countries, will allow the project to share research results, exchange best practices, and foster learning among care providers, policymakers, and all interested stakeholders.

Ultimately, the project seeks to build a long-term cultural shift. By combining research evidence, practical measures, awareness campaigns, and policy engagement, it aims to make LTC a sector where male carers can participate fully and equally. This not only supports the workforce but also ensures that care recipients experience high-quality, compassionate, and inclusive care. The journey towards inclusivity has begun, and these first

steps lay a strong foundation for meaningful change in the European long-term care sector.

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