Open Care

Opening careers for men in long-term care

D3.1. WORKSHOP MATERIALS

Care Providers and Care Recipients

[ENGLISH]

WP3 – Awareness-raising workshops and events to break the stigma



Co-funded by the European Union

101190943

ans ANZIANI E NON SOLO società cooperativa sociale

Cyprus University of Technology

APPDI ASSOCIAÇÃO PORTUGUESA PARA A DIVERSIDADE E INCLUSÃO

aproximar COOPERATIVA DE SOLIDARIEDADE SOCIAL, CRL

Afeji Hauts-de-France

EaSI the European Association for Social Innovation

Open Care

Opening careers for males in CARE

Care Providers Workshop

Co-funded by the European Union

101190943

Co-funded by
the European Union

OpenCare seeks to challenge the barriers men face in accessing and staying in LTC roles, while actively working to make the sector more inclusive and representative.

THE PROJECT:

The overall aim of the OpenCare initiative is to address gender stereotypes by encouraging the involvement of men in formal long-term care (LTC) work.

This not only promotes gender equality but also contributes to increasing the availability of LTC services by responding to the current shortage of care staff.

Co-funded by
the European Union

1. Understanding Gender Stereotypes & Cultural Bias in Care Work

WHY IT IS IMPORTANT:

Explore how gender stereotypes and cultural biases shape long-term care: who is expected to do which tasks, how staff are perceived, how users react, and how systems are organised.

These patterns appear at different levels:

- **INDIVIDUAL**
- **ORGANISATIONAL**
- **SOCIETAL**

Co-funded by
the European Union

Gender Stereotypes



WOMEN → warmth, nurturing



MEN → strength, independence, competence

These ideas come from **social expectations**, not skills. Research shows that people assume women are “warmer” and therefore better suited to care work, even though competence is similar for all genders.

Co-funded by
the European Union

Gender Stereotypes

- **Care roles** ⇨ “warmth” ⇨ men seen as a mismatch
- **Technical/physical tasks** ⇨ “strength” ⇨ women overlooked

Stereotypes affect hiring, task allocation, and progression

When a worker’s gender does not match expectations, they may face **extra scrutiny** (e.g., men in intimate care; women in leadership).

Co-funded by
the European Union

Cultural Bias in Care

- Ideas about who is **“naturally suited”** for care.
- Shaped by tradition, upbringing, media, national norms.
- **Not connected to real competencies.**

Cultural bias influences how we view different workers and even how care recipients feel about receiving care. **These patterns differ across Europe but are structurally similar**.

- **Italy**: persistent stereotypes, emerging male role models
- **Romania**: strong barriers, low wages, weak support
- **Cyprus**: pragmatic acceptance

- **France**: gender-neutral recruitment, lingering barriers
- **Portugal**: growing inclusivity, stagnant salary and career pathways

Co-funded by
the European Union

Why these patterns persist

- Gender norms link care to women's "natural" role
- Cultural ideas of male strength/self-reliance discourage men from emotional roles
- Economic structures (low pay, low status) reinforce stereotypes
- Care work is historically undervalued because it is **feminised work**



→ Women expected to do more care (paid/unpaid)

→ Men discouraged from entering care roles

→ Workforce shortages and inequality continue

Co-funded by
the European Union

Why these patterns persist

Bias reduces diversity and can weaken care quality.

	BIAS INFLUENCE	IMPACT
WOMEN	emotional, nurturing tasks	undervaluation, low wages
MEN	physical/technical tasks	mistrust in intimate tasks, stigma
OVERALL	Restricted opportunities for both	shortages, high turnover

Co-funded by
the European Union

Why it matters?

- Mixed-gender teams **improve cooperation, user satisfaction, and retention.**
- A **culturally competent, gender-inclusive environment values skills** over stereotypes.
- Moving from “traditional gendered care” to “inclusive professional care” means **ensuring competence, empathy, and trust**—not gender—define quality.

HOW TO ADDRESS IT?

- **Awareness** – recognising implicit bias
- **Representation** – more male and female role models in all roles
- **Balanced teams** – mixed-gender teams improve care quality
- **Inclusive recruitment** – gender-neutral language and messaging
- **Training** – unconscious bias + cultural competence
- **Clear career pathways** – transparent promotion, mentoring
- **User education** – gentle conversations to address comfort/bias
- **Safe spaces** – reflection and feedback for staff

Co-funded by the European Union

ACTIVITY:

PROBLEM TREE ANALYSIS: GENDER STEREOTYPES AND CULTURAL BIAS



Reflect on **how gender stereotypes and cultural bias shape care work**.

In groups, you must identify:

- **Roots** = causes
- **Trunk** = what happens in daily work
- **Leaves** = consequences for staff & care quality
- **Fruits** = solutions & improvements

Co-funded by the European Union

ACTIVITY:

PROBLEM TREE ANALYSIS: GENDER STEREOTYPES AND CULTURAL BIAS

PLENARY:

- One major root
- Two trunk examples
- Two leaf consequences
- One or two achievable fruits (solutions)



Co-funded by
the European Union

ACTIVITY:

PROBLEM TREE ANALYSIS: GENDER STEREOTYPES AND CULTURAL BIAS

DEBRIEF:

- What patterns did you notice across groups?
- What surprised you?
- What feels most urgent to address?
- What solution is most achievable in your workplace?

Co-funded by
the European Union

2. Boundaries and care recipients' preferences

“studies have depicted the intimate and personal care situation as sensitive and challenging for care recipients as well as care providers”

Boundaries: socioemotional or physical limits set by an individual. In LTC, often it relates to “personal and intimate care (...) [that is] experienced as non-invasive, thus safeguarding integrity and self-determination”

(Lövgren et al, 2023)

Co-funded by the European Union

2. Boundaries and care recipients' preferences



Care Workers

- Communication strategies
- Relational methods
- Build trust



Care Recipients

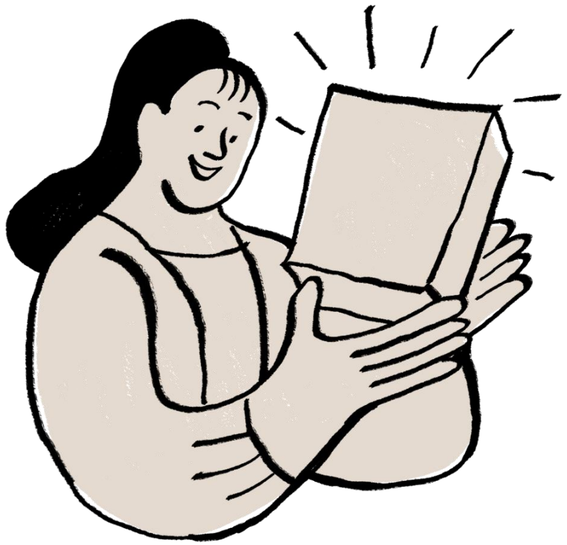
- Agency of acceptance
- Understand it as a learning journey
- Adapting to the situation

experiences that reflected the concepts of patient-centered care

Co-funded by
the European Union

2. Boundaries and care recipients' preferences

Preference



Social desirability



Resigned Agency



Co-funded by
the European Union

2. Boundaries and care recipients' preferences

Preference



May relate to caregiver gender, type of touch, timing of care, or level of physical exposure—especially during intimate hygiene, bathing, diaper changes, body care, or dressing.

- ✓ A woman receiving care prefers a female carer for personal hygiene tasks.
- ✓ A man receiving care prefers a male carer for personal hygiene tasks.
- ✓ A patient requests to be bathed in the morning rather than in the evening.

Co-funded by
the European Union

2. Boundaries and care recipients' preferences

Social desirability



Tendency of one to have a socially and culturally desirable manner, so he/she can be viewed positively by other people or seems consistent with social and cultural norms and expectations.

- ✓ A care recipient smiles and agrees to all care procedures, even if they feel uncomfortable, in order to be seen as ‘cooperative’ by the team.
- ✓ A care recipient praises the carer in front of others, despite minor dissatisfaction.

(Roustaei et al, 2015).

Co-funded by
the European Union

2. Boundaries and care recipients' preferences

Resigned Agency



Absence of power to act and seek help, option for “quiet endurance” .

- ✓ A care recipient silently endures uncomfortable repositioning in bed, believing they have no choice.
- ✓ A care recipient silently tolerates inappropriate comments during a group activity because they feel powerless to intervene.

(Loke et at, 2025).

Co-funded by the European Union

2. Boundaries and care recipients' preferences

good virtues

professional expertise

“gender was not particularly significant in patients’ preference”

(Asante et al, 2023)

quality of service provided

performance



Co-funded by
the European Union

2. Boundaries and care recipients' preferences

Trust as the foundation of ethical care:

Why trust matters in care?



"Trust is the cornerstone of meaningful care and a key determinant of residents' sense of safety."

- Trust directly impacts residents' psychological comfort and sense of safety;
- Ethical care is not only what we do, but how we do it;
- Trust is built daily, through ordinary interactions.

(CareOne – Building Trust in Senior Care)

Co-funded by the European Union

2. Boundaries and care recipients' preferences

How trust is built: everyday micro-behaviours and small actions:

- **Active listening, respect, and calm communication**
- **Explaining actions before care**
- **Respecting autonomy and intimate boundaries**
- **Reliability and consistency over time**

"Trust develops through consistent, respectful behaviours rather than isolated actions."

(CareOne, 2025)

Co-funded by the European Union

2. Boundaries and care recipients' preferences

Relational skills are core professionals skills!

"Simple relational behaviours: eye contact, tone of voice, posture, can significantly reduce anxiety and distress in care settings."

THE IMPORTANCE OF NON VERBAL COMMUNICATION

- **Eye contact at eye level and not too high above the care recipient**
- **Giving time for responses and not interrupting**
- **Smiling and open posture**

These cues reduce distress and improve cooperation in everyday life tasks

(CNIB – Communication and Relational Behaviours in Caregiving,2024)

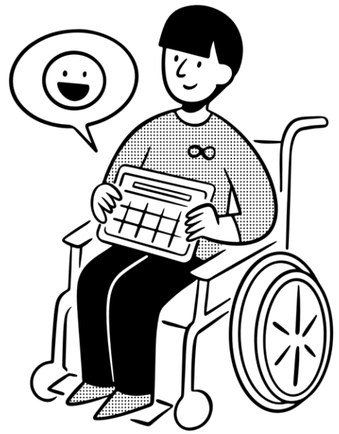
Co-funded by
the European Union

2. Boundaries and care recipients' preferences

Respecting diversity without stereotyping

- Residents experience care through personal, cultural, and emotional lenses
- Gender may influence feelings of reassurance or vulnerability
- Ethical care requires sensitivity, adaptability, and respect for individual boundaries

"Respecting dignity means recognising individual preferences and adapting care accordingly."

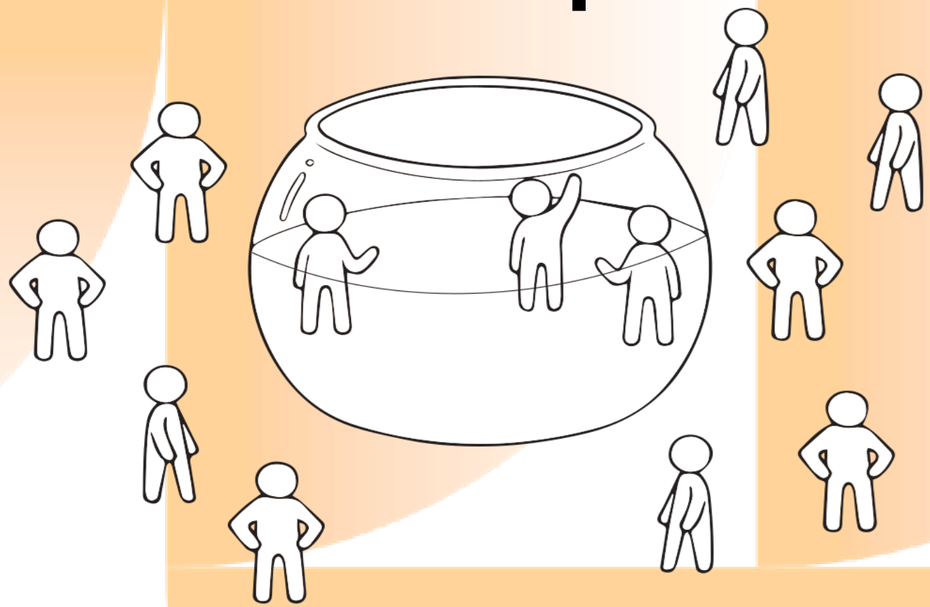


(EHESP – Ethics, Dignity, and Autonomy in Care)

Co-funded by
the European Union

ACTIVITY

Ethics, Boundaries and Respect in Care Provision.



Co-funded by the European Union

Activity– *Ethics, Boundaries and Respect in Care Provision*



Target Groups:

✓ **2 groups of Care Providers (5 p/ group)**



Material:

✓ **10 chairs**

✓ **1 table**

✓ **2 scenarios**

✓ **Paper**

✓ **Pens**

Time	Step	Activity	Description
5 min	Step 1	Introduction to the topic	Consent, preferences, boundaries, ethical dilemmas.
8 min	Step 2	Fishbowl 1 (inner circle)	Discussion of Scenario 1 – Preferences and consent.
5 min	Step 3	Reflection by the external group (Debrief 1)	Observers share: what they heard, what they felt, what dilemmas emerged.
8 min	Step 4	Fishbowl 2 (inner circle)	Discussion of Scenario 2 – Boundaries, harassment, privacy and discomfort.
5 min	Step 5	Reflection by the external group (Debrief 2)	Observers identify emotions, ethical risks and protection strategies.
6 min	Step 6	Guided synthesis + Good practices	Facilitator leads conclusions and strategies applicable to professional practice.
3 min	Step 7	Final message + verbal commitment	Each participant answers the question: “What will I change in my practice?”

Co-funded by
the European Union

Scenario 1



Maria, 81, refuses to be assisted with bathing by a male caregiver, saying, “I don’t want a man to see me like this.”

The facility has no female caregivers available; it is the weekend and there are fewer residents in the care home. Consequently, only João (male caregiver) and Pedro (head nurse) are present.

The caregiver feels that insisting may be invasive, but refusing assistance could be considered neglect of care. How should they act?

Co-funded by the European Union

Scenario 2



A male caregiver has shared a concern that has been troubling him: a resident makes daily comments about his body and personal life.

Initially, he ignored them, but the comments have become repetitive and uncomfortable, increasingly judgmental.

He fears being misinterpreted if he reports the situation to the care manager. What should he do?

Co-funded by
the European Union

Scenario 3



António, 83, lives in a continuing care facility. He has reduced mobility and a documented risk of falls. He consistently refuses help with bathing, preferring to do it himself, stating that he wants to “maintain dignity and independence.”

The staff are concerned, as there is a real risk of falls and injury. In the past week, he has fallen twice in his room but continues to refuse assistance.

When the caregiver offered help with hygiene, António responded:
“Better to fall with dignity than be washed as if I were an object.”
He also added:
“My wife was the one who used to help me; now I no longer have her. I do it myself. I don’t want any other woman, and certainly not a man.”

Co-funded by
the European Union

3. Recruitment, retention & supportive work environment



Co-funded by the European Union

Cyprus University of Technology

Open Care

3. Recruitment, retention & supportive work environment in long-term care

The long-term care (LTC) sector across Europe continues to experience significant challenges in relation to workforce recruitment, retention and sustainability

- Men represent **10–25%** of LTC staff across partner countries
- 80% of male carers report **intrinsic motivation**
- Employers describe **cultural barriers**

Care work is still widely perceived as “women’s work”, rooted in traditional gender norms that associate caregiving with femininity, emotional labour and domestic roles (European Commission, 2022; WHO, 2020).

‘We are invisible and indispensable.’
Male carer, Portugal

‘Straight away we look with suspicion at what he’s doing here.’
Employer, Romania

Co-funded by the European Union

Understanding different types of barriers

Recruitment Barriers	Barriers to recruitment are the factors, conditions, or processes that hinder an organization's ability to attract and successfully hire suitable candidates.
Retention Barriers	Retention barriers prevent an organization from keeping employees over time
Organisational Culture Barriers	These are obstacles created by the values, norms, behaviours, or unwritten rules within an organization that make it difficult for employees to perform well, feel included, or stay long-term.

Identifying barriers helps us understand what prevents a supportive work environment.

Co-funded by the European Union

Cyprus University of Technology

Recruitment, retention & supportive work environment in LTC

What we know from OpenCARE (WP2)

- Research shows that participation of men in long-term care is shaped by **interconnected factors** at:
- Individual,
- Organisational,
- Systemic level

Why focus on organisations?

Because workplace culture can either:

- reinforce exclusion and isolation, or
- create belonging, support and retention

In many LTC settings, male workers reported:

- feeling isolated in female-dominated teams
- limited access to peer support and mentoring

🗣️ ***This workshop focuses on what happens at the organisational level — where change is possible*** *(*Nerges et al., 2022).

Co-funded by
the European Union

Cyprus
University of
Technology

Open
Care

- Understand **why men remain underrepresented** in long-term care
- Recognize **barriers affecting recruitment, retention and progression**
- Reflect on how **organizational culture, team dynamics and stereotypes** shape everyday work experiences
- Identify **practical actions** to strengthen inclusivity, belonging and staff retention.

The focus is not on blame, but on learning and improvement.

Co-funded by the European Union

Cyprus University of Technology

OpenCare

Activity: World Café
"Barrier Mapping" – Collaborative Wall Exercise

What research tells us (OpenCARE-WP2):

- Care is still perceived as *"women's work"*
- Men lack visible role models in care teams
- Career pathways are often unclear or limited
- Organisational support and recognition are weak
- Fear of stigma and judgement affects belonging

What this activity asks YOU to do:

➡️ Connect these findings with **your own organisation**

➡️ Identify **real barriers you see in practice**

➡️ Explore **what can realistically change**

🗣️ *There are no right or wrong answers – only lived experience.*

Co-funded by the European Union

Cyprus University of Technology

Open Care

Activity: World Café
“Barrier Mapping” – Collaborative Wall Exercise

Why this activity?

Because barriers are often **felt before they are named**.

Purpose:

- Make invisible barriers visible
- Create shared understanding across roles
- Identify starting points for organisational change

Time: 40–50 minutes

Co-funded by the European Union

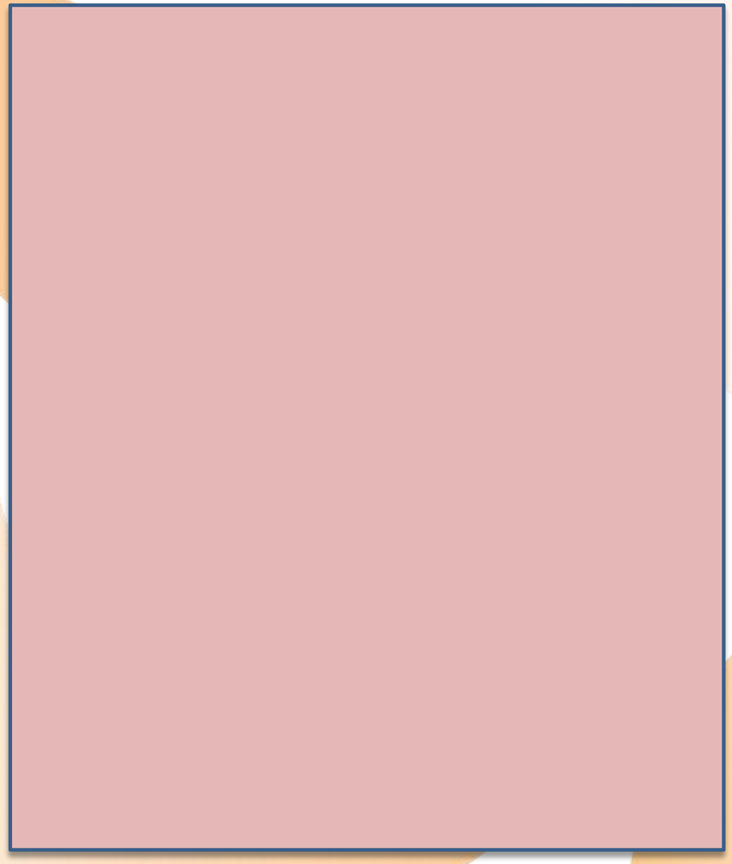
Cyprus University of Technology

Open Care

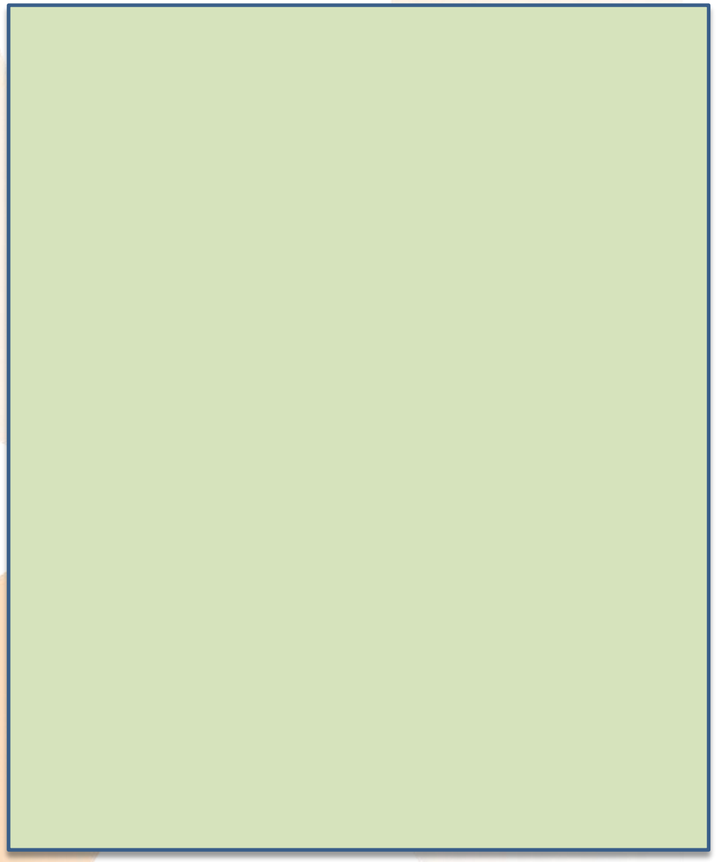
How it works

1.Place three large posters on the wall:

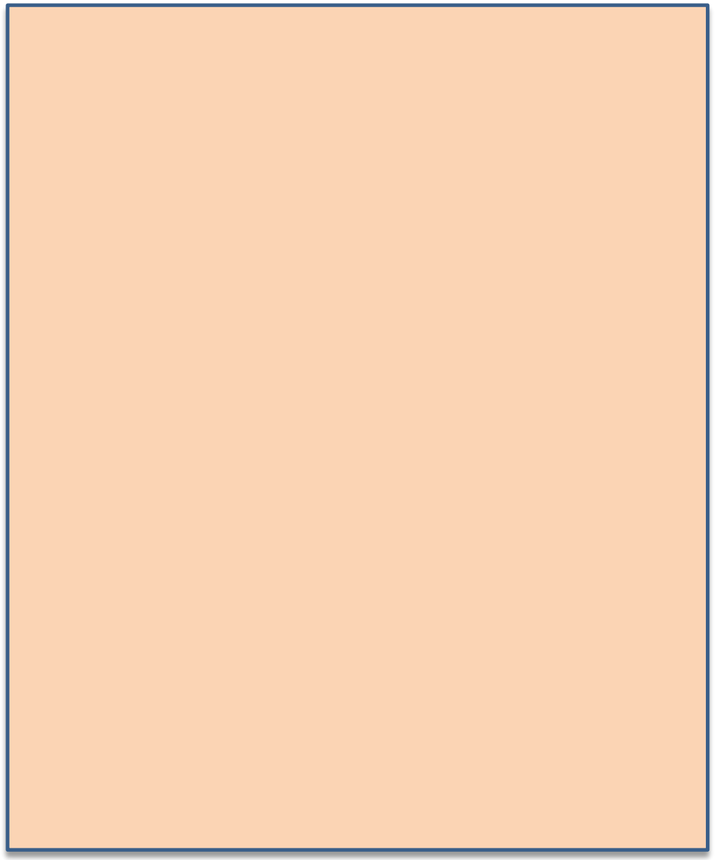
Scenario 1: Recruitment Challenges



Scenario 2: Retention & Workload Strain



Scenario 3: Supportive Work Environment & Inclusion



Co-funded by the European Union

Cyprus University of Technology

Open Care

Step 1 – Group work with scenarios

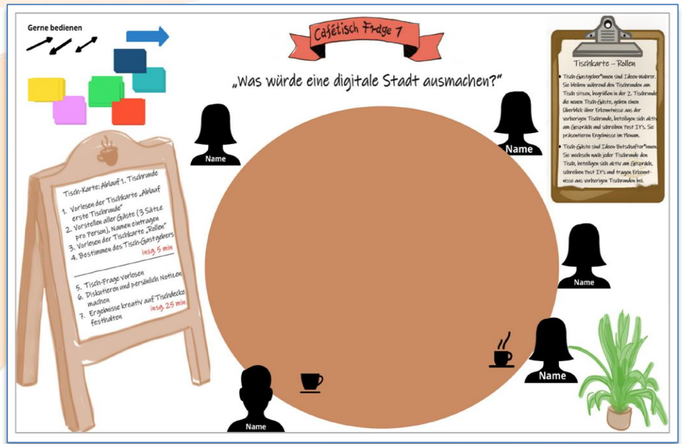
Participants are divided into three groups.
Each group works on **one scenario**:

- ❖ Recruitment Challenges
- ❖ Retention & Workload Strain
- ❖ Supportive Work Environment & Inclusion

Step 2 – Scenario-based discussion

Groups discuss their scenario using guiding questions and identify:

- ➢ Barriers
- ➢ Contributing factors (organisational / cultural / practical)
- ➢ Possible solutions or strategies



Co-funded by the European Union

Cyprus University of Technology

Open Care

Step 3 – Rotate (World Café)

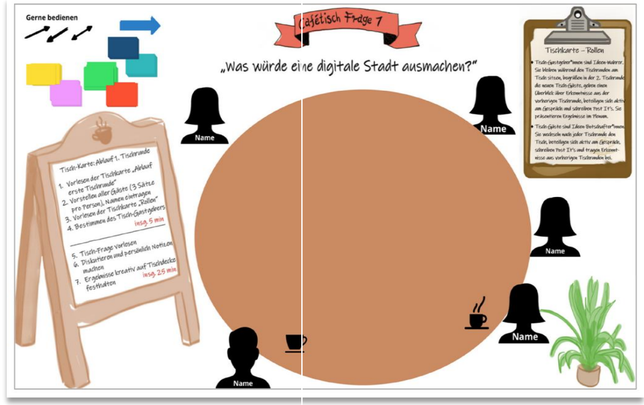
After 10–12 minutes, groups rotate to the next poster, read existing notes, and add/build on them (do not erase).

Step 4 - Visual mapping

Groups write keywords, phrases or ideas **directly on the scenario poster**.

Step 5 – Plenary sharing & clustering

The final group at each poster gives a 2-minute report-out.
The facilitator clusters common themes across scenarios



Step 6 – Collective reflection

Agree 2–3 priority actions (include at least one quick win and one medium-term change) and name an owner role.

Materials: √Posters √Sticky notes √Markers √Printed scenario cards √Timer √Dot stickers

Co-funded by the European Union

Cyprus University of Technology

Open Care

What did we notice together?

Plenary Reflection

As a group, let’s reflect:

- Which barriers appeared most often?
- Which barriers affect **recruitment**, **retention**, or **both**?
- Which barriers are **within organisational control**?
- Which barriers require **management or policy-level action**?

🗣️ *The aim is not to solve everything today, but to recognise patterns*.

Co-funded by
the European Union

Cyprus
University of
Technology

Open
Care

Closing Remarks

- What did you **take away** from these activities?
- Can you identify **one personal commitment or change** you can put in practice from next week?



Open Care

Opening careers for males in CARE

THANK YOU!

Co-funded by the European Union. Views and opinions expressed are however those of the author(s) only and do not necessarily reflect those of the European Union or the European Commission.
Neither the European Union nor the European Commission can be held responsible for them.

Co-funded by the European Union | 101190943

WP3 – Workshop for Care Providers (3H30 + 30 MIN BREAK)

Time	Content/ Activity	Brief Description	Resources
10 MIN	**INTRODUCTION**	Briefly present Open Care project, main goals and team	Projector/presentation
15 MIN	**THEORY**: Gender Stereotypes Cultural biases around care provision	***PLEASE READ FULL THEORY IN ANNEX 1:*** This section will briefly address how cultural and gender biases influence care provision, shaping who provides care, how it is valued, and how it is experienced. It will highlight persistent gendered patterns in long-term care across Europe and emphasise how trust, professional practice, and inclusive organisational strategies can help reduce bias and improve care quality.	Projector/presentation
40-45 MIN	**ACTIVITY:** Problem Tree Analysis: Gender And Cultural Bias	**PLEASE READ FULL INSTRUCTIONS IN ANNEX 1:** • Short facilitator introduction with key theory points and instructions (5 min) • Participants split into 2 small groups (4–5 people) • Group work using the "tree" exercise (flipchart or online board) to identify biases and actions (25 min) • Plenary sharing of key insights or action ideas from each group (10 min) • Facilitator summarises main biases and inclusion actions on a shared board	*In-person:* flipchart; markers; pens; sticky notes *Online:* online dashboard like Miro or Canva; shareable link for participation
15 MIN	**THEORY**: Boundaries and care recipients preferences	***PLEASE REFER TO PPT FOR FULL THEORY:*** This section explores how intimate and personal care in long-term care settings is experienced as sensitive and relational, shaped by individual boundaries, preferences, social pressures, and power dynamics, and highlights trust—built through everyday verbal and non-verbal interactions, respect for autonomy, and responsiveness to individual needs—as the foundation of ethical, person-centred care without reinforcing stereotypes.	Projector/presentation
30 MIN	***BREAK***		
40 MIN	**ACTIVITY:** Ethics, Boundaries and	***PLEASE READ FULL INSTRUCTIONS IN ANNEX 2:***	*In person*: print scenario cards

	Respect in Care Provision (Fishbowl)	• Introduction to consent, preferences, boundaries, and ethical dilemmas (5 min) • Fishbowl discussion on Scenario 1: preferences and consent (8 min) • Observer reflection on insights, emotions, and dilemmas (5 min) • Fishbowl discussion on Scenario 2: boundaries, harassment, privacy, and discomfort (8 min) • Observer reflection on emotions, risks, and protection strategies (5 min) • Facilitator-led synthesis and good practices for professional care (6 min) • Final takeaway and individual commitment to change in practice (3 min)	*Online*: presentation with scenarios
15 MIN	**THEORY**: Barriers to Recruitment, Retention & Supportive Work Environment	***PLEASE READ FULL THEORY IN ANNEX 3:*** This section highlights that workforce challenges in long-term care—driven by low status, demanding conditions, gender norms, and limited career paths—can be mitigated through supportive organisational cultures and broader structural and policy support to improve retention, wellbeing, and workforce sustainability.	Projector/presentation
40-50 MIN	**ACTIVITY:** World Café Scenarios – Mapping Barriers & Supportive Work Environment Solutions	***PLEASE READ FULL INSTRUCTIONS IN ANNEX 3:*** ●Place three posters around the room, each labeled with a scenario; ●Assign participants to a scenario/poster in groups, rotating every 10-12 minutes; ●Ask groups to write barriers, issues, or reflections directly on the poster. ●Facilitator reviews all posters and groups similar ideas into thematic clusters. ●Plenary discussion and close by collaboratively identifying 2–3 prioritised actions that participants agree could strengthen recruitment, retention and a positive work environment.	*In person: 3* posters/flipchart sheets (one per scenario), markers, sticky notes, printed scenario cards, timer, dot stickers (optional, for prioritisation) Online: virtual posters/dashboard per scenario; breakout rooms
15 MIN	**CLOSING REMARKS**	●Facilitator summarises key insights from all activities, linking theory to practice. ●Highlight recurring themes around gender, cultural bias, ethical boundaries, and workforce challenges. ●Reinforce actionable takeaways for participants: practical strategies, inclusive practices, and organisational or policy-level considerations. ●Encourage reflection on individual commitments to change or improvements in their professional practice. ●Optionally, invite a few participants to share one key insight or commitment with the group.	Projector/presentation

		●Close on a positive, motivating note, emphasising the role of each participant in creating a supportive, inclusive, and ethical care environment.	

ANNEX 1 – ACTIVITY PROBLEM TREE ANALYSIS: GENDER AND CULTURAL BIAS

Partner	**ANS and APPDI**
Theme	**Gender Stereotypes Cultural biases around care provision**
Target group	Care providers
Name of activity	**PROBLEM TREE ANALYSIS: GENDER AND CULTURAL BIAS**
OBJECTIVE(S)	• To raise awareness among care providers and employers of how gender stereotypes and cultural biases influence care provision and workforce composition in the care sector. • To promote discussion on how to recognise, challenge and reduce biased assumptions (about gender, role, career progression, patient preferences) in their hiring, assignment and support of care workers. • To generate practical ideas for more inclusive practices in recruitment, role design, career progression and user-care worker matching.

METHODS	• Guided discussion using discussion cards in groups and discuss prompts.
	• Face-to-face or online adaptation:
	  ○ Face-to-face: provide a flipchart with a Tree to map causes, daily experiences, consequences and solutions.
	  ○ Online: use breakout rooms in Zoom/Teams, virtual board such as Miro/Canva.
	• The facilitator will guide the debrief in plenary

TIME ALLOCATED	Estimated amount of time: 40-45 minutes • Introduction/instructions: 5 minutes • Group work and discussion: 25 minutes • Plenary debrief: 10+5 minutes
RESOURCES NEEDED	• Print (or digitally share) discussion cards (15-20) • Flipchart or whiteboard (or virtual board) for plenary debrief to capture key insights • If online: video conferencing platform with breakout rooms, screen share, digital slide or Miro with tree to be interacted with. Optional: projector/presentation slide to show mini-theory introduction.
THEORICAL CONTENTS*	Understanding gender stereotypes and cultural bias in care work begins with recognising how deeply social expectations shape the roles we imagine for men and women. Across Europe, cultural and gender biases continue to influence how care work is organised, valued, and experienced. These expectations affect who is seen as suitable for particular tasks, how staff are judged, and how entire care systems operate. By examining these patterns, we can better understand their impact on workplace fairness, team dynamics, and the quality of care received. Gender stereotypes often associate women with warmth and nurturing and men with strength and competence. Although these ideas are rooted in

Partner	ANS and APPDI
	tradition rather than true ability, they continue to shape how we understand “good” care, how tasks are distributed, and how colleagues are perceived. Because care roles are commonly linked to warmth, men may be viewed as a poor fit for intimate or emotional care, while women are frequently overlooked for technical or leadership roles. When someone’s gender does not match expectations for a task, they may face additional scrutiny — men in personal care and women in specialised or senior positions. These stereotypes affect recruitment, career progression, and daily interactions between care providers and users. Cultural bias reinforces these patterns by shaping beliefs about who is “naturally suited” for care. These assumptions are informed by upbringing, longstanding traditions, and media portrayals, and because they have been present for generations, they often feel normal or unquestioned. However, they are not connected to actual competencies and can limit team flexibility and individual potential. Evidence from OpenCare research shows that care continues to be seen as a “female domain,” contributing to the undervaluation of women’s work and to stigma or exclusion for men. Cross-country findings illustrate how this varies across Europe: France and Portugal show movement toward more inclusive norms, Italy and Romania continue to be strongly shaped by traditional gender expectations, and Cyprus demonstrates gradual acceptance of mixed-gender care driven largely by practical needs. These cultural biases also intersect with systemic inequalities. Long-term care systems, wage structures, and institutional frameworks often reinforce gendered divisions, creating environments where women’s contributions are undervalued and men’s participation is questioned. As a result, women may be funnelled into emotional or nurturing roles that are lower paid, while men may be limited to physical or technical tasks, leading to mistrust around intimate care. Overall, assigning tasks based on gender rather than skill restricts opportunities for everyone, contributing to burnout, workforce shortages, and high turnover. Addressing these forms of bias is essential for building fair, effective, and sustainable care environments. Challenging stereotypes leads to better teamwork, more balanced task distribution, and a stronger sense of inclusion. Coordinators and employers play a central role by recognising and addressing implicit biases in organisational practices, supporting diverse and balanced teams, and promoting equal recognition of all care workers regardless of gender or cultural background. Ultimately, competence, respect, and communication — not gender — are what matter most for delivering high-quality, dignified care.

Partner	**ANS and APPDI**
INSTRUCTIONS **	• Facilitator gives a short introduction (5 min) with key points from the theory section and instructions. • Participants are divided into 2 groups of 4-5 persons each one. Each group has 25 minutes to discuss: - Face to face: Each group a flipchart paper (or large paper sheets) with a tree (image below) with roots, trunk, leaves and fruits. The group is invited to use sticky notes or markers to write on each part of the tree according to instructions below. - Online: in breakout rooms, the groups will use Miro/Canva with the image of the tree to use sticky notes or write directly onto the tree. • After the small-group discussion, reconvene in plenary and each group shares one or two key insights or action ideas (10 min). • Facilitator captures on flipchart/board the themes both biases identified and potential actions to reduce bias/increase inclusion.
REFERENCES	Almeida-Meza, P., Di Gessa, G., Lacey, R., Xue, B., & McMunn, A. (2025). Gender inequalities in care across long-term care public spending systems in Europe: evidence from the European Health Interview Survey. International Journal of Care and Caring, 9(3), 490–503. https://doi.org/10.1332/23978821Y2025D000000133 Bennis H., Rowbourne A., Kaur G., Palmer H., Deku A., Pittaway S., Exton Smith H. Ipsos report "Gender Bias: The 'Invisible' Barrier to Equitable Healthcare", Nov 2024. https://www.ipsos.com/sites/default/files/ct/publication/documents/2024-11/Gender%20Bias_Nov2024.pdf?_gl=1*1yz7bcc*_up*MQ..*_ga*MjIzNzEzNDY4LjE3NjI4NTk4OTg.*_ga_X263VWZR69*czE3NjI4NTk4OTckbzEkZzAkdDE3NjI4NTk4OTckajYwJGwwJGgzMjM3Mjc4ODY Bezgin & Odabaşı Koç, "Investigation of Gender Stereotypes in Nurse Clinicians' Metaphors and Concepts of Patients", 2024. https://doi.org/10.1155/2024/8861439 González, I., Seo, B., & Floro, M. S. (2022). Gender Wage Gap, Gender Norms, and Long-Term Care: A Theoretical Framework. Feminist Economics, 28(3), 84–113. https://doi.org/10.1080/13545701.2022.2081353 Halper, L. R., Cowgill, C. M., & Rios, K. (2019). Gender bias in caregiving professions: The role of perceived warmth. *Journal of Applied Social Psychology*, *49*(9), 549-562. OECD (2025), Gender Equality in a Changing World: Taking Stock and Moving Forward, Gender Equality at Work, OECD Publishing, Paris. OpenCare Transnational research in Italy, Romania, Cyprus, France, Portugal, WP2 internal dataset, 2025. Sharma, K. et al. (2025). A Diversity, Equity, and Inclusion (DEI) Framework for Addressing Gender Disparities in the Nursing Profession. *Cureus*, *17*(8), e91265

Partner	**ANS and APPDI**
	Webster, C. S., Taylor, S., Thomas, C., & Weller, J. M. (2022). Social bias, discrimination and inequity in healthcare: mechanisms, implications and recommendations. BJA Education, 22(4), 131–137. https://doi.org/10.1016/j.bjae.2021.11.011 World Health Organization. (2024). Fair share for health and care: Gender and the undervaluation of health and care work (Global report). https://www.who.int/publications/i/item/9789240082854
HANDOUTS	• Flipchart/whiteboard with tree image to be interacted with; • A short slide or handout summarising the theoretical content (to be provided to participants at the end)

***Full Theory:**

Time allocated for theory: 15 minutes

Cultural and gender biases around care provision operate at multiple levels, i.e. individual, organisational, and societal. Bias refers to implicit or explicit assumptions that certain genders or cultural groups are more or less suited to caring roles, influencing how care work is distributed, valued, and rewarded. Societal gender roles assign caregiving, sensitivity and emotional expression to women, while positioning men as independent and strong, a dichotomy that limits both genders within healthcare (Bezgin et al., 2024).

Research shows (Harper et al. 2019) that gender stereotypes in caregiving are strongly tied to perceptions of warmth. People commonly infer that women are warmer and therefore more suitable for caring roles, while men are often associated with strength or practicality. Importantly, empirical studies find little difference in perceived competence between men and women; the bias is primarily about warmth and likeability. These warmth-based expectations help explain occupational imbalances in care professions and influence care recipients' initial preferences.

Across Europe, long-term care (LTC) systems remain highly gendered. According to Almeida-Meza et al. (2025), gender inequalities in care provision persist even in welfare regimes with high public LTC spending. Their analysis of the European Health Interview Survey found that women are more likely to provide unpaid or low-paid care and to combine it with paid work, while men remain under-represented in personal care roles. These inequalities reflect deep-rooted cultural expectations and are not fully offset by formal policy frameworks.

Feeling uncertain about receiving care from someone of a different gender is a normal response rooted in socialisation and prior experience. However, studies indicate that initial doubts tend to fade when recipients observe professional behaviour — kindness, competence, and respectful communication — suggesting that relationship quality and transparency matter more than the carer's gender. This creates an opportunity for care services to prioritise trust-building measures that reduce the role of gender in shaping comfort. Cultural expectations of male self-reliance often prevent men from seeking or accepting emotional support, leading to an inequitable experience of care (Bennis et al., 2024).

González et al. (2022) explain this through gender norms and economic structure. In this frame gendered expectations about care work intersect with the gender wage gap, leading to a self-

reinforcing cycle where women are socially expected (and economically incentivised) to provide care, while men are discouraged from entering low-status, low-paid care occupations.

In the WP2 transnational research findings, this pattern is visible across all five countries involved:

- Italy: persistent stereotypes linking care to women's "natural" role, though emerging examples of male leadership and role-modelling.
- Romania: strong cultural barriers and limited recognition for male carers, coupled with low wages and lack of systemic support.
- Cyprus: pragmatic entry of men into the care workforce, with moderate acceptance from users and employers.
- France: advanced institutional frameworks and gender-neutral recruitment, yet practical barriers in progression remain.
- Portugal: emerging inclusivity and recognition of the benefits of gender-diverse teams, though salary and career stagnation persist.

These differences illustrate that gender bias in care is context-dependent but structurally consistent and that masculine absence limits evolution.

Webster et al. (2022) describe how social bias and discrimination in healthcare operate through mechanisms of implicit association and role conformity. Providers and managers may unconsciously replicate biased patterns, for instance by assigning men to "technical" or "transport" tasks and women to "nurturing" roles. Such patterns reduce diversity and can compromise quality of care, as mixed teams often provide more balanced, empathetic and stable support.

Cultural expectations of masculinity discourage men from expressing discomfort, and this silence is frequently misread by healthcare professionals as resilience (Bezgin et al., 2024).

Older users, particularly in Italy, Romania, and Cyprus, often express embarrassment or discomfort at receiving intimate care from male carers, reflecting internalised cultural norms. However, OpenCare research data also shows that trust and familiarity can overcome initial discomfort, suggesting that exposure and competence gradually reshape user attitudes.

This highlights that cultural competence in healthcare requires not only "cultural tailoring" (adapting services to user backgrounds) but also the active reduction of provider bias. In fact, at the interpersonal level, bias influences care relationships and reducing bias means recognising how stereotypes (such as assumptions about gender appropriateness in intimate care) can hinder trust and communication.

Stereotypes do not exist in a vacuum: they are reinforced by institutional patterns such as undervaluation of care work, pay disparities, and occupational segregation. Global analyses show that health and care work has been systematically undervalued and that this undervaluation is a gender equality issue with consequences for who enters and stays in care professions (WHO, 2024). Almeida-Meza et al. (2025) show that countries with stronger LTC investment have narrower gender gaps, but these do not disappear unless accompanied by cultural change and equitable workplace practices. Structural interventions (such as transparent promotion systems, inclusive training, and mentoring for under-represented groups) are essential to address both conscious and unconscious bias.

At the organisational level, care providers and employers play a key role in reshaping practice. Webster et al. (2022) recommend multi-level interventions:

- reviewing job descriptions and language to remove gendered assumptions;
- diversifying teams to normalise mixed-gender care;
- providing training on unconscious bias and culturally competent communication;
- establishing safe spaces for staff reflection and feedback.

The OpenCare research findings reinforce these recommendations because male carers report motivation and moral commitment but often lack visibility, support, and recognition. Where employers promote gender equality, teams report better cooperation, user satisfaction, and retention.

A culturally competent and gender-inclusive care environment values professional skill over stereotype and recognises that caring is not inherently feminine but human, relational, and professional. Effective strategies to reduce bias include:

- Awareness and reflection, by recognising implicit assumptions.
- Representation and promotion of diverse role models and balanced teams.
- Policy alignment and integration of equality principles in recruitment, training, and advancement.
- Education by gently addressing user biases through communication and trust-building.

Ultimately, bias reduction is a continuous organisational learning process, not a one-time training. The aim is to move from "traditional gendered care" to "inclusive professional care", where competence, empathy, and trust define quality, not gender or cultural stereotypes.

****Full instructions:**

Phase 1: Introduction (5 minutes)

The facilitator opens the session with a brief introduction, lasting no more than five minutes. This introduction should:

- Outline the aims and purpose of the activity to reflect on how gender stereotypes and cultural bias shape care work.
- Explain that the idea is to look at the causes (the roots), the visible expressions in daily practice (the trunk), the effects on workers and residents (the leaves), and finally the solutions (the fruits)
- Provide a few simple theoretical references drawn from the theory section. These should be concise and illustrative, offering a basic conceptual anchor without influencing or "framing" participants' thinking too strongly.
- Explain the flow of the activity, including how the group discussions will take place and how the flipchart/online board will be used.

Phase 2: Group division and discussion: 2 groups of 4-5 people (25 minutes)

Participants are then divided into 2 groups of 4–5 people. Each group receives a flipchart (in person)/access to an online board (online) with a tree on it (Annex 1).

Face to face: participants will write on sticky notes or with markers directly on the flipchart.

Online: Using a Miro/Canva board so all participants can work together online.

In groups, the participants must start mapping:

- **Roots** = causes
- **Trunk** = what happens in daily work

- **Leaves** = consequences for staff & care quality
- **Fruits** = solutions & improvements

The facilitator must provide some guidelines/prompts for the discussion:

Starting from the roots, the underlying causes. These are not things we usually talk about openly, but they shape our behavior and expectations.

Think about social norms, upbringing, professional traditions, staffing structures, or policies that may reinforce stereotypes.

ROOTS:

- What cultural ideas influence our assumptions about men and women in care?
- What messages did we learn from families, school, religion, media?
- What organisational norms reinforce these stereotypes?
- What structural or policy factors play a role

TRUNK:

The trunk represents what we see happening in the workplace. This is where stereotypes become visible in behavior or decisions. These are not meant to blame individuals; this is about understanding systems and patterns.

- How do these beliefs show up in daily practice?
- Who gets assigned which tasks?
- How do staff, families, and residents respond to male or female carers?
- How might these norms affect decision-making and teamwork?

LEAVES:

The leaves show the effects, the outcomes we can easily observe. How do these patterns impact individuals, teams, and the quality of care? Try to think about consequences not only for workers, but also for residents and the organisation.

Impacts on:

- On workload & burnout
- On team dynamics
- On career progression & job satisfaction
- On recruitment & retention
- On quality of care for residents

FRUITS:

Now that we see the root causes, the workplace expressions, and the consequences, it's time to co-create solutions. These are the fruits - practical actions that help us build a fairer, stronger, more inclusive care environment.

Solutions should respond directly to what appears in your tree:

- Fair task distribution
- Gender-inclusive recruitment
- Training on stereotype awareness
- Role modelling & mentoring
- Clear communication with residents

- Policies that support equity

Phase 3: Plenary discussion (10 minutes)

After the group discussions, everyone reconvenes in a plenary session lasting approximately 10 minutes.

Each group has around 5 minutes to share: one major root; two trunk examples; two leaf consequences; one or two achievable fruits (solutions).

The facilitator listens actively and keeps track of the main themes (including both the biases identified and the possible actions to reduce bias and enhance inclusion) on a flipchart or whiteboard.

Phase 4: Conclusion (5 minutes)

Debrief questions:

- What patterns did you notice across groups?
- What surprised you?
- What feels most urgent to address?
- What solution is most achievable in your workplace?

To close the session, the facilitator summarises the main outcomes and can distribute or present the theoretical materials. This final step offers participants a more detailed conceptual framework, helping them situate their own reflections and discussions within a broader theoretical context:

This exercise shows that gender stereotypes and cultural biases do not operate at just one level, they grow from cultural roots into workplace behaviours and systemic outcomes. But the 'fruits' show that solutions are possible when we understand the whole system.

Today's analysis helps us see where change is possible, both personally and organisationally. Bias is not about blame. It's about understanding how our environments shape us, and how we can reshape them to strengthen care and teamwork.

Annex 1.2: Problem Tree



ANNEX 2 – ETHICS, BOUNDARIES AND RESPECT IN CARE PROVISION

Partner	**APROXIMAR**
Theme	**1.2. Boundaries and care recipients preferences**
Target group	**Care Providers**
Name of activity	Ethics, Boundaries and Respect in Care Provision
OBJECTIVE(S)	• Reflect on professional and ethical boundaries in care provision. • Understand and respect care recipients' preferences, including caregiver gender, touch, communication, and privacy. • Identify situations that may violate the emotional, physical, or cultural boundaries of care recipients. • Recognise behaviours that may constitute harassment or invasion of privacy, even if unintentional. • Develop communication strategies to negotiate preferences with respect, empathy, and professional safety.
METHODS	Fishbowl Discussion – Structured Conversation Circle What it is: A participatory method where a group discusses a topic in the centre (inner circle) while others observe (outer circle). Afterwards, they swap roles, ensuring everyone participates actively.
TIME ALLOCATED	40 minutes
RESOURCES NEEDED	Room with chairs arranged in a circle Printed scenario sheets Flipchart or poster board Markers Timer
THEORICAL CONTENTS*	Providing care to older adults involves physical, emotional, and relational closeness. Respecting the individual preferences of care recipients is essential to ensure dignity, autonomy, and well-being. Preferences may relate to caregiver gender, type of touch, timing of care, or level of physical exposure—especially during intimate hygiene, bathing, diaper changes, body care, or dressing. Harassment and discomfort can also be experienced by carers, particularly **male carers**, who are often subject to mistrust, offensive, or sexualised comments. Studies (Webster et al., 2022) show that harassment towards male carers is underestimated and poorly recognised. Therefore, ethical care requires protection of both the care recipient and the professional.

INSTRUCTIONS*	**Step 1 – Explain the session objectives** • Inform participants that the session focuses on reflecting on boundaries, preferences, and mutual respect in care. • Explain that real situations involving ethics, consent, privacy, dignity, and harassment will be discussed. • Emphasise that there are no right or wrong answers, only different perspectives. **Step 2 – Create a safe and respectful environment** • All opinions will be respected. • Participants may choose not to share personal experiences. • Reiterate that what is shared in the activity should remain confidential. **Activity Organisation with Care Providers (Fishbowl)** **Step 1 – Form two groups** • Divide participants into two equally sized groups. • Group A: inner circle, initiates discussion as debaters. • Group B: outer circle, observes. **Step 2 – Explain the roles of each group** • Inner circle: discusses the presented scenario, sharing opinions, experiences, questions, or strategies. • Outer circle: observes the discussion without intervening, noting aspects such as emotions, ethical dilemmas, moments of discomfort, communication styles, signs of respect or boundary violations. **Step 3 – Explain role rotation** • After the first round of discussion and reflection, groups swap roles: those debating become observers and vice versa. **Step 4 – Establish ground rules** • Listen without interrupting. • Respect all opinions, even if different. • Avoid value judgments about shared experiences. • Maintain confidentiality regarding personal examples. • Avoid offensive, prejudiced, or disrespectful language.

REFERENCES	Elmfield Residential Care. (2024). The relationship between care workers and residents. Retrieved from https://elmfieldhouse.com/the-relationship-between-care-workers-and-residents/ Asante, A. O., Korsah, K. A., & Amoako, C. (2023). Does the gender of nurses matter to patients? A qualitative analysis of gender preferences of patients. SAGE Open Medicine, 11, 1–12. https://doi.org/10.1177/20503121231182514 CareOne. (2025). Building trust in senior care: It starts with one moment. Retrieved from https://www.care-one.com/blog/building-trust-in-senior-care/ Webster, C. S., Taylor, S., Thomas, C., & Weller, J. M. (2022). Social bias, discrimination and inequity in healthcare: Mechanisms, implications and recommendations. BJA Education, 22(4), 131–137. https://academic.oup.com/bjaed/article/22/4/131/6534491 Cuevas, A. G., O'Brien, K., & Saha, S. (2017). What is the key to culturally competent care: Reducing bias or cultural tailoring? Psychology & Health, 32(4), 493–507. https://pubmed.ncbi.nlm.nih.gov/27607544/
HANDOUTS	**SCENARIOS** **Scenario 1** Maria, 81, refuses to be assisted with bathing by a male carer, saying, "I don't want a man to see me like this." The facility has no female carers available; it is the weekend and there are fewer residents in the care home. Consequently, only João (male carer) and Pedro (head nurse) are present. The carer feels that insisting may be invasive, but refusing assistance could be considered neglect. How should they act? **Scenario 2** A male carer has shared a concern that has been troubling him: a resident makes daily comments about his body and personal life. Initially, he ignored them, but the comments have become repetitive, uncomfortable, and increasingly judgemental. He fears being misinterpreted if he reports the situation to the care manager. What should he do? **Scenario 3** António, 83, lives in a continuing care facility. He has reduced mobility and a documented risk of falls. He consistently refuses help with bathing, preferring to do it himself, stating that he wants to "maintain dignity and independence." The staff are concerned, as there is a real risk of falls and injury. In the past week, he has fallen twice in his room but continues to refuse assistance. When the caregiver offered help with hygiene, António responded: "Better to fall with dignity than be washed as if I were an object." He also added:

	“My wife used to help me; now I no longer have her. I do it myself. I don’t want any other woman, and certainly not a man.”

****Full instructions:**

Time	Activity	Description
5 min	Introduction to the topic	Consent, preferences, boundaries, ethical dilemmas.
8 min	Fishbowl 1 (inner circle)	Discussion of Scenario 1 – Preferences and consent.
5 min	Reflection by the external group (Debrief 1)	Observers share: what they heard, what they felt, what dilemmas emerged.
8 min	Fishbowl 2 (inner circle)	Discussion of Scenario 2 – Boundaries, harassment, privacy and discomfort.
5 min	Reflection by the external group (Debrief 2)	Observers identify emotions, ethical risks and protection strategies.
6 min	Guided synthesis + Good practices	Facilitator leads conclusions and strategies applicable to professional practice.
3 min	Final message + verbal commitment	Each participant answers the question: “What will I change in my practice?”

After each Fishbowl moment, the facilitator invites the external group (observers) to share reflections on attitudes, perceived emotions, ethical risks, communication challenges and appropriate strategies.

Questions to deepen reflection:

- What in this situation could cause discomfort for the care recipient?
- How can we respect the care recipient's preferences without compromising the quality of care?
- How can we balance the care recipient’s autonomy with professional safety?
- How can we communicate with empathy when there is refusal of care?
- How can we distinguish between a legitimate preference and discriminatory behaviour?
- How can we protect the dignity of both the care recipient and the caregiver?

ANNEX 2.1. Scenarios:

Scenario 1

Maria, 81, refuses to be assisted with bathing by a male caregiver, saying, “I don’t want a man to see me like this.” The facility has no female caregivers available; it is the weekend and there are fewer residents in the care home. Consequently, only João (male caregiver) and Pedro (head nurse) are present. The caregiver feels that insisting may be invasive, but refusing assistance could be considered neglect of care. How should they act?

Scenario 2

A male caregiver has shared a concern that has been troubling him: a resident makes daily comments about his body and personal life. Initially, he ignored them, but the comments have become repetitive and uncomfortable, increasingly judgmental. He fears being misinterpreted if he reports the situation to the care manager. What should he do?

Scenario 3

António, 83, lives in a continuing care facility. He has reduced mobility and a documented risk of falls. He consistently refuses help with bathing, preferring to do it himself, stating that he wants to “maintain dignity and independence.”

The staff are concerned, as there is a real risk of falls and injury. In the past week, he has fallen twice in his room but continues to refuse assistance.

When the caregiver offered help with hygiene, António responded:
“Better to fall with dignity than be washed as if I were an object.”
He also added:
“My wife was the one who used to help me; now I no longer have her. I do it myself. I don’t want any other woman, and certainly not a man.”

ANNEX 3: Barriers to Recruitment, Retention & Supportive Work Environment

Partner	CUT
Theme	Barriers to Recruitment, Retention & Supportive Work Environment
Target group	Care provider
Name of activity	World Café Scenarios – Mapping Barriers & Supportive Work Environment Solutions
OBJECTIVE(S)	• To identify organizational barriers that affect recruitment and retention in LTC settings. • To explore elements that define a supportive work environment for carers. • To generate practical solutions through collaborative discussion. • To strengthen leadership insight regarding gender-inclusion and workforce sustainability.
METHODS	This activity is based on: • World Café group rotation • Scenario-Based Reflection • Brainstorming barriers & solutions • Thematic clustering + plenary reporting Face-to-face version: • Participants use markers to write barriers, observations and ideas directly onto the scenario posters.
TIME ALLOCATED	40–50 minutes
RESOURCES NEEDED	• Flipcharts / butcher paper • Markers for writing directly on posters • Printed Scenario Cards (included below) • Timer

THEORETICAL CONTENTS*	The activity is grounded in research on gender stereotypes, organisational barriers, and workforce sustainability in the care sector. Findings from OpenCARE WP2 highlight that men in long-term care often encounter challenges that influence both recruitment and retention, including: · Gender stereotypes portraying care as "women's work" · Lack of male role models and peer visibility within the profession · Limited opportunities for career progression and professional development · Weak organisational support, recognition and leadership responsiveness · Social stigma, discomfort and fear of judgment from colleagues or care recipients Organisational culture plays a crucial role in either reinforcing or challenging these barriers. Environments that lack inclusivity, acknowledgment, psychological safety and gender-sensitive policies tend to contribute to burnout, disengagement and early exit from the profession, particularly among men entering care roles. This activity supports employers and managers in reflecting on these findings, connecting them with real workplace experiences, and identifying practical areas for action and improvement toward a more supportive, inclusive and retention-friendly work environment.
INSTRUCTIONS*	Place three posters around the room, each containing one scenario: • Scenario 1 – Recruitment Challenges • Scenario 2 – Retention & Workload Strain • Scenario 3 – Supportive Work Environment & Inclusion Provide participants with markers and ask them to write directly on the posters any barriers, issues or reflections related to their assigned scenario. Each group discusses their scenario and adds key points, noting both challenges and possible solutions onto the poster.

	The facilitator reviews the posters and groups similar ideas into thematic clusters. A short plenary discussion follows using guiding questions: • Which barriers were most commonly mentioned? • Which challenges can be addressed within the organisation? • Which require management or policy-level change?
REFERENCES	OpenCARE Project – WP2 Research Findings World Health Organization (2020). Gender and Health Workforce European Commission (2022). Gender stereotypes in care professions OECD. (2020, June 22). Who Cares? *Attracting and retaining care workers for the elderly* (OECD Health Policy Studies). OECD Publishing. https://doi.org/10.1787/92c0ef68-en Nerges, J. et al. (2022). Male nurses' perceptions of the facilitators and barriers to recruitment, retention, and job satisfaction. *Nurse Leader, 20*(1), 31-36.
HANDOUTS	A short handout presenting examples of recruitment, retention and organisational culture barriers A brief summary of OpenCARE WP2 findings on men in long-term care

***Full Theory:**

The long-term care (LTC) sector faces persistent challenges in recruiting and retaining a stable workforce, a trend observed across Europe and globally. High turnover rates, difficulties attracting new staff, and emotional demands of the role have led to workforce shortages, reduced quality of care and increased pressure on existing staff (OECD, 2020; WHO, 2020). These challenges are closely intertwined with organisational culture, working conditions, and perceptions of care work, which shape whether individuals join the sector, whether they remain long term, and how supported they feel in their roles. Creating a supportive work environment is therefore recognised as a critical factor for building a resilient and sustainable care workforce.

Recruitment into LTC roles is often hindered by low professional status, demanding workloads, limited career progression pathways and negative social perceptions of care work**.** Care is frequently associated with low pay, high stress and emotional labour, which reduces its attractiveness compared to other sectors. Additionally, traditional gender norms continue to frame caregiving as feminine work, discouraging men from entering the field and contributing to a gender-skewed workforce (European Commission, 2022). Research indicates that potential workers evaluate not only salary and role expectations, but also whether an organisation demonstrates respect, recognition and opportunities to grow professionally (OECD, 2020).

Retention is closely tied to the experience workers have after recruitment. Evidence shows that even when individuals enter care roles, many leave within the first year due to burnout, lack of support, inadequate staffing levels, limited supervision, and insufficient emotional or professional guidance (WHO, 2020). Workers who feel unsupported or undervalued are more likely to experience compassion fatigue, emotional exhaustion and a diminished sense of belonging, all of which increase turnover intentions. Conversely, supportive workplaces characterised by teamwork, recognition, open communication and mentorship significantly increase job satisfaction and retention.

Organisational culture is a decisive determinant of whether staff feel motivated and able to stay. A work environment where staff experience psychological safety, appreciation, role clarity, and access to training fosters personal development and strengthens commitment to the workplace (Nerges et al., 2022). Supportive leadership, peer encouragement, and opportunities for continuous learning are key elements that contribute to a positive environment and reduce staff departure. Organisations that actively encourage inclusive practices, non-hierarchical communication, shared decision-making and reflective dialogue tend to report better emotional wellbeing among employees.

Structural conditions also play a critical role. Long-term care remains one of the most undervalued sectors within healthcare, often characterised by low remuneration, limited public visibility and insufficient policy investment (OECD, 2020). Without supportive national frameworks that address workload pressures, staffing ratios and career progression, organisational efforts can only partially mitigate systemic strain. Policies promoting professional recognition, gender diversity, and formal training pathways can strengthen workforce attractiveness and stability at a broader level (European Commission, 2022; WHO, 2020).

Within this context, participatory workshops such as scenario-based World Café activities offer an effective approach for identifying local challenges and co-creating practical solutions. By collaboratively examining real workplace situations, participants can connect theory to practice, reflect on cultural patterns, and generate tangible strategies to strengthen recruitment, retention and supportive work environments. This method encourages organisations to move beyond abstract discussion toward collective responsibility, actionable change and a shared vision for workforce wellbeing**.**

Ultimately, addressing workforce instability in LTC requires integrated interventions at the organisational, cultural and policy level. Creating supportive workplaces that prioritise recognition, mentorship, emotional safety and development opportunities can enhance satisfaction, reduce turnover and attract new talent. Investing in supportive environments is therefore not only beneficial for staff wellbeing but is fundamental to delivering high-quality, sustainable long-term care.

****Full instructions:**

Estimated time: 40–50 minutes

Materials: 3 posters/flipchart sheets (one per scenario), markers, sticky notes, printed scenario cards, timer, dot stickers (optional, for prioritisation)

Ground rules: speak from experience, respect confidentiality, focus on systems and practical improvements (not individuals)

World Café rotation: groups spend ~10–12 minutes at each scenario; final group at each poster reports back

Place **three posters/tables around the room**, each with one scenario:

1. **Scenario 1 – Recruitment Challenges**
2. **Scenario 2 – Retention & Workload Strain**
3. **Scenario 3 – Supportive Work Environment & Inclusion**

Divide participants into **three groups** and assign each group to one scenario/table.

Scenario Card 1: Recruitment Challenges

A new vacancy was opened for a care assistant role. Only a few candidates applied — all of them female. When men were informed, several expressed concern about stigma, career prospects and unclear role expectations.

Discussion prompts:
• What barriers to recruitment appear here?
• How could messaging or job design be more inclusive?
• What supportive strategies could attract male applicants?

Scenario Card 2: Retention & Workload Stress

Two newly hired carers left within 6 months, due to burnout and limited mentorship. They reported feeling unsupported and unclear about progression.

Discussion prompts:
• Which factors contributed to turnover?
• What support structures could have helped them stay?
• How does organisational culture influence retention?

Scenario Card 3: Supportive Work Environment

A male carer feels isolated in an all-female team. He hesitates to share workload pressures fearing judgement. The manager is unaware of the situation.

Discussion prompts:
• What does a supportive culture look like?
• Which practices encourage belonging and safety to speak up?
• How can leaders ensure inclusion & psychological safety?

Provide markers and ask each group to write directly on the poster:

- Barriers identified within the scenario
- Contributing factors (organisational/cultural/practical)
- Ideas or strategies that could address the challenge

Encourage groups to discuss collaboratively and add as many points as possible on the poster (keywords, short phrases, solution ideas).

On each poster, capture:

• Key barriers identified within the scenario

• Contributing factors (organisational / cultural / practical)

• Ideas or strategies to address the challenge

Plus, a facilitator reminder to use keywords/short phrases and build on previous groups' notes (because of rotation).

Tag each barrier/idea with a category code to support clustering in plenary (C = Culture, P = Policy/HR, L = Leadership/Management, T = Training, W = Workload/Staffing, R = Role design/Recruitment messaging).

When group work is complete, all gather in plenary session.

Final group at each poster presents the key themes (~2 minutes each)

Facilitator clusters themes across scenarios and highlights overlaps/differences

Then the plenary guiding prompts (kept similar, but formatted clearly):

- Key barriers they identified
- How these barriers affect recruitment, retention or workplace support
- Solutions or improvement ideas generated by the group

A facilitated discussion follows using guiding prompts:

- *Which ideas were common across groups?*
- *Which solutions are realistic and could be implemented soon?*
- *Which issues require management-level or policy-level change?*
- *What would make the workplace more supportive and retention-friendly?*

Close by collaboratively identifying **2–3 prioritised actions** that participants agree could strengthen recruitment, retention and a positive work environment.

Open Care

Opening careers for males in CARE

Care Recipients Workshop

Co-funded by the European Union

101190943

Co-funded by
the European Union

OpenCare seeks to challenge the barriers men face in accessing and staying in LTC roles, while actively working to make the sector more inclusive and representative.

THE PROJECT:

The overall aim of the OpenCare initiative is to address gender stereotypes by encouraging the involvement of men in formal long-term care (LTC) work.

This not only promotes gender equality but also contributes to increasing the availability of LTC services by responding to the current shortage of care staff.

Co-funded by
the European Union

1. Understanding Gender Stereotypes & Cultural Bias in Care

WHY IT IS IMPORTANT:

All of us carry ideas from our families, culture, and past experiences. These ideas can shape how we think about care - **often without us realising it.**

Across many societies, care has long been associated with women, and this belief has become deeply rooted over time.

Co-funded by
the European Union

Gender Stereotypes



WOMEN → warmth, nurturing



MEN → strength, independence, competence

These ideas come from **social expectations**, not skills. Research shows that people assume women are “warmer” and therefore better suited to care work, even though competence is similar for all genders.
In reality, good care depends on **training, personality, and respect**, not gender.

Co-funded by
the European Union

Open Care

Feeling Comfortable With Care

It is completely normal **to feel uncertain at first**, especially when receiving personal or intimate care from someone of a different gender.

Across the research, people said that these **feelings usually fade once they see the carer behaving professionally, respectfully, and kindly.**

People generally **become comfortable** when:



- Communication is clear
- Respect is shown
- They feel safe and listened to

Co-funded by
the European Union

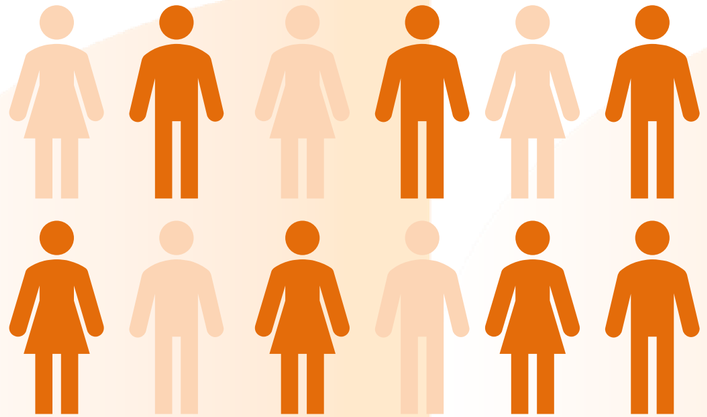
Open Care

Why Men and Women Both Belong in Care

Studies show that both men and women bring valuable strengths into care work.

HAVING MIXED TEAMS LEADS TO:

- Better teamwork
- A wider range of skills
- More choice for you as a care recipient



Co-funded by
the European Union

Cultural Ideas About Care
(and How They’re Changing)

Cultural biases - ideas we absorb without noticing - shape **what we expect from care.** These **biases influence who we think “should” provide certain types of care.**

- In **Italy and Portugal**, traditional norms associating care with women still carry a lot of weight.
- In **Romania**, cultural barriers are strong and recognition of men in the sector is low.
- In **France**, policies are more neutral, but difficulties in career opportunities remain.
- In **Cyprus**, the presence of men is accepted in a pragmatic way.
- In **Portugal**, there is growing appreciation for more diverse care teams.

Co-funded by
the European Union

What Really Matters to Care Recipients

Across studies, recipients consistently emphasised **three core values**:

- Respect
- Good communication
- Competence and attention to the person

Some stereotypes persist, such as the idea that women are “naturally better” at care or that men are the “exceptions.”

Co-funded by
the European Union

Why it matters for you?

Understanding these cultural patterns helps ensure your voice is central.

You deserve:

- High-quality care
- A sense of safety and dignity
- Choices that fit your preferences
- A respectful relationship based on trust



Co-funded by
the European Union

ACTIVITY:

BREAKING MYTHS TOGETHER - MEN IN CARE



Identify and reflect on common stereotypes or “myths” about male carers working in long-term care.

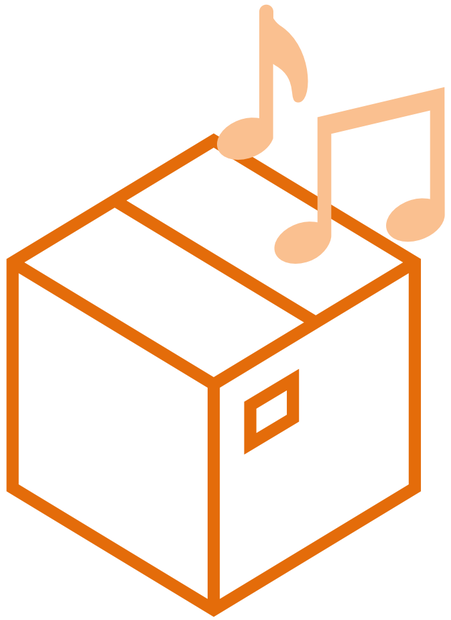
Co-funded by the European Union

ACTIVITY:

BREAKING MYTHS TOGETHER - MEN IN CARE

Debrief and reflection:

What did you think were the key insights and themes?



Co-funded by
the European Union

Ice breaking activity:
THE COMPLIMENT TOTEM

WHO: for Care recipients, supervised by the facilitators- the participants of the game should be an even number

WHEN: This activity opens up the workshops to promote trust among the care recipients and facilitators in the care facility. This game can also be played independently, outside of the workshops provided.

OBJECTIVES:

- Enhance interpersonal comfort, value each person's strengths, encourage a positive outlook among residents and carers.
- Strengthen cohesion, trust and positive attitudes between residents and carers through collective reflection.

Co-funded by
the European Union

Ice breaking activity:
THE COMPLIMENT TOTEM

1. Each person receives a symbolic animal and a positive quality from others.

2. These symbols remind us of our strengths : kindness, courage, patience, humor.

3. It’s a fun, creative way to say: “I see the good in you.”

4. When we feel recognized, trust grows naturally.



Co-funded by
the European Union

2. Boundaries and care recipients' preferences

How stereotypes shape expectations in care

Stereotypes → **influence how care workers are perceived**



✓Often linked to gender and cultural norms;
✓Shape expectations about behaviour, roles and trust;
✓Can affect comfort during care interactions.

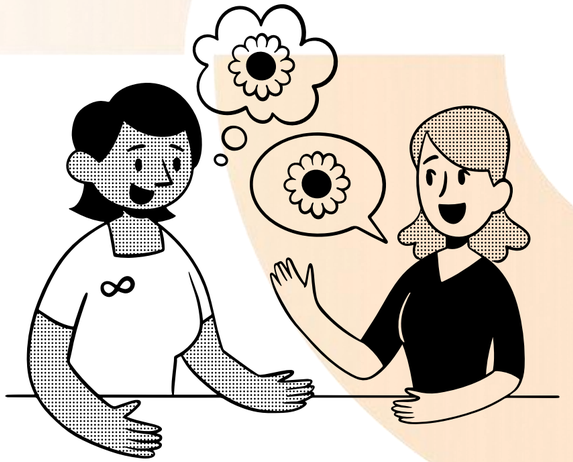
(Teresa-Morales et al., 2022; Yilmaz et al., 2023)

Co-funded by
the European Union

2. Boundaries and care recipients' preferences

Talking, listening, connecting – beyond roles and stereotypes

- Care is built through **open communication**: *talking, listening, and understanding each other.*
- Residents and carers **connect as people**, not just as roles defined by gender or profession.
- Sharing stories and everyday moments helps to **build trust, comfort, and emotional security.**
- Respecting boundaries and preferences — **without reinforcing stereotypes** — makes care more personal, dignified, and inclusive.
- When there is a genuine connection, care environments feel **safer, more respectful, and more welcoming.**



(Asante et al. 2023)

Co-funded by
the European Union

2. Boundaries and care recipients' preferences

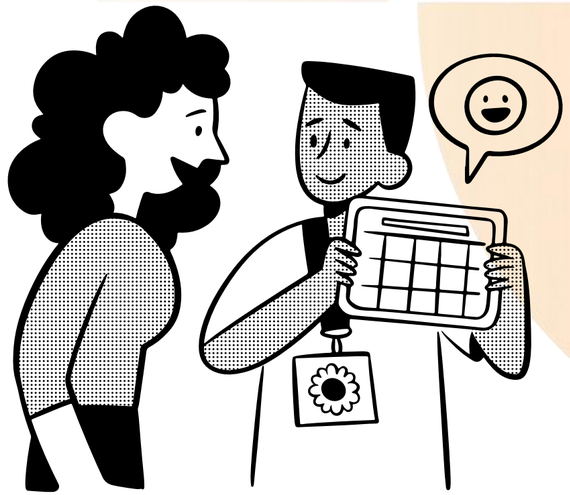
How preferences affect care delivery

Gender preferences can shape care allocation

Some care workers face greater scrutiny or exclusion

Skills may be overlooked due to assumptions

Care quality can be affected unintentionally



(Finnegan, 2019; Teresa-Morales et al., 2022)

Co-funded by the European Union

2. Boundaries and care recipients' preferences

What care recipients can expect from care workers

PROFESSIONALISM	→	Respectful and professional behaviour
CLARITY	→	Clear explanations and reassurance
PRIVACY	→	Protection of privacy and dignity
VOICE	→	Right to ask questions or express discomfort



(Asante et al., 2023; Kitole et al., 2025)

Co-funded by
the European Union

2. Boundaries and care recipients' preferences

How care recipients can help maintain boundaries

COMMUNICATION	Communicate preferences and concerns clearly
CLARITY	Ask questions if something feels unclear
CONSENT	Give or withhold consent when appropriate
RESPECT	Respect the professional role of care workers
FEEDBACK	Report discomfort using agreed channels

(Asante et al., 2023; Kitole et al., 2025)

Co-funded by
the European Union

Activity 2:

What Is Comfortable for Me? – Preferences, Boundaries and Mutual Respect



Co-funded by the European Union

Activity 2 – What Is Comfortable for Me? – Preferences, Boundaries and Mutual Respect



- ✓ **Target Groups:**
- ✓ **1 groups of Care Recipients**



- ✓ **Material:**
- ✓ **10 chairs**
- ✓ **1 table**
- ✓ **11x10 cards**
- ✓ **10 cards base**

https://www.canva.com/design/DAG5mVXLO98/bxv3acCfrEsbod2jA0C24A/edit?utm_content=DAG5mVXLO98&utm_campaign=designshare&utm_medium=link2&utm_source=sharebutton

Time	Step	Activity	Description
5 min	Step 1	Introduction	Explain the purpose of the activity: exploring comfort, boundaries, preferences, consent, and respect in care. Introduce the cards and categories (Comfortable / Depends / Uncomfortable).
30 min	Step 2	Group work on cards	Participants work together as a group to discuss each card one at a time. For each card: facilitator reads the situation aloud, participants decide as a group whether it is Comfortable, Depends, or Uncomfortable, and share reasoning and reflections. Encourage discussion about: feelings, ethical issues, communication strategies, respect for preferences, and maintaining dignity. (Repeat the same process for all cards.)
5 min	Step 3	Guided synthesis + Closing	Facilitator summarises key points, highlights good practices, and reinforces respect for boundaries, autonomy, and consent. Participants are invited to share one action they will apply in their practice.

Open Care

Opening careers for males in CARE

THANK YOU!

Co-funded by the European Union. Views and opinions expressed are however those of the author(s) only and do not necessarily reflect those of the European Union or the European Commission.
Neither the European Union nor the European Commission can be held responsible for them.

Co-funded by the European Union | 101190943

Open Care

Opening careers for males in CARE

Care Recipients Workshop

Session 2

Co-funded by the European Union

101190943

Co-funded by
the European Union

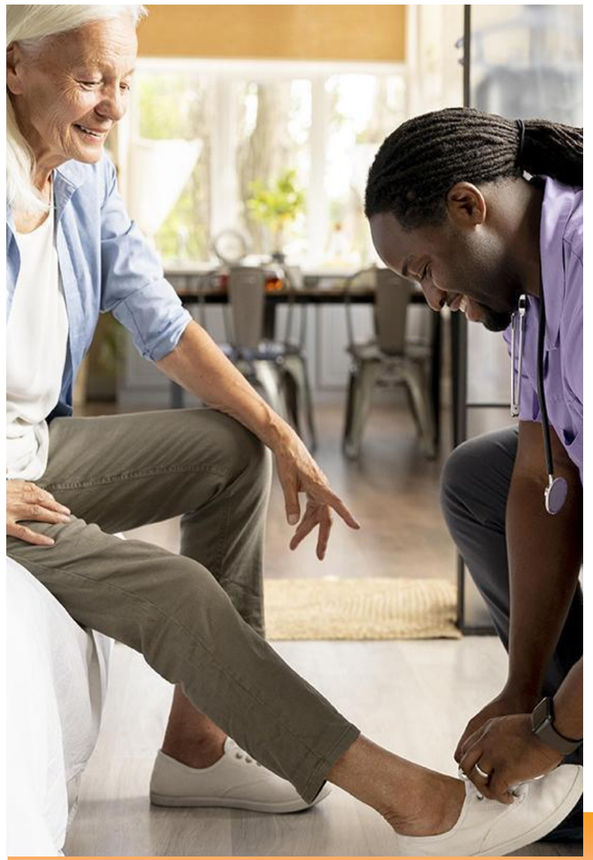
LAST SESSION WE LEARNED THAT:

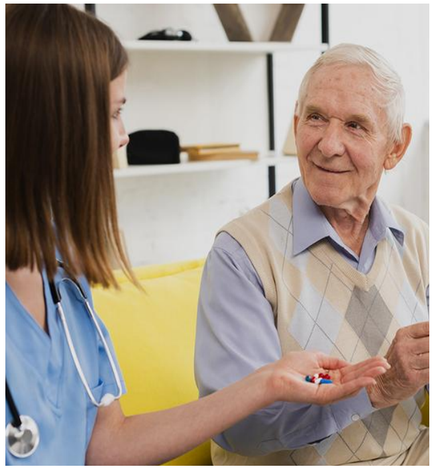
- **Care is not inherently "women's work"** – Gender stereotypes shape perceptions of caregivers and who enters the profession, but these can be challenged.
- **Biases affect experiences** – Cultural and gender biases influence both care recipients' and carers' experiences and expectations.
- **Preferences matter** – Every care recipient has the right to express who, how, and when they receive care; these preferences should be respected.
- **Mutual respect is essential –** Trust, safety, and dignity are fostered when both carers and care recipients communicate and respect boundaries.
- **Awareness supports change –** Recognising myths, stereotypes, and personal preferences helps create more inclusive, equitable, and positive care environments.
- **Active participation is valuable** – Sharing experiences and reflections contributes to better understanding and improved care practices.

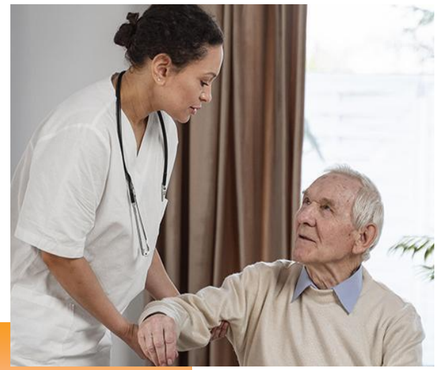
Co-funded by
the European Union

3. Positive Work Environment

do you remember?







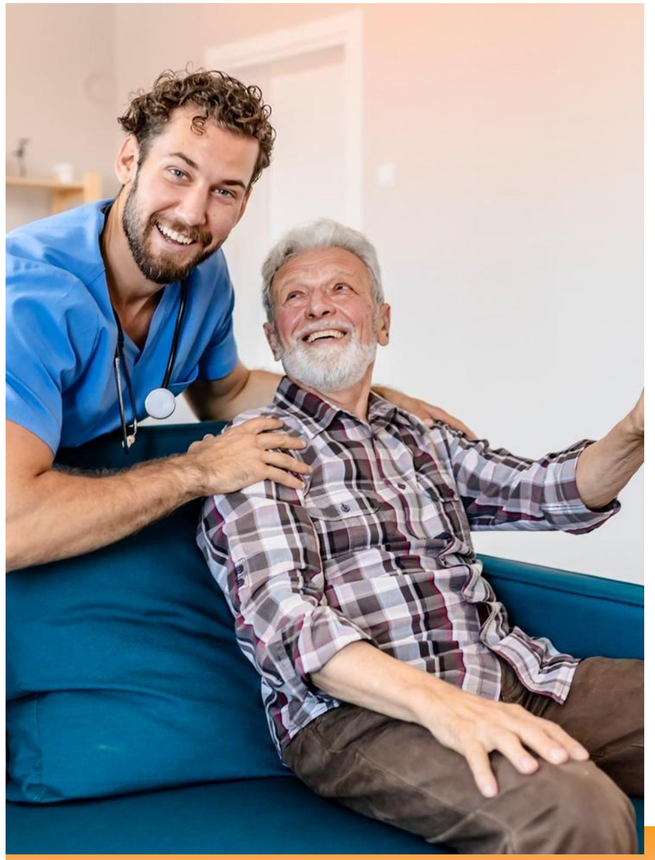
- In many care settings, men are the only male worker on their team - Male carers represent 10-20% of the long-term care workforce across Europe.
- Often very visible - every action is noticed and scrutinized more than colleagues'. Successes may be attributed to being male rather than skill.
- Often treated differently - Expected to handle physical tasks, aggressive patients, heavy lifting.

(Kanter, 1997)

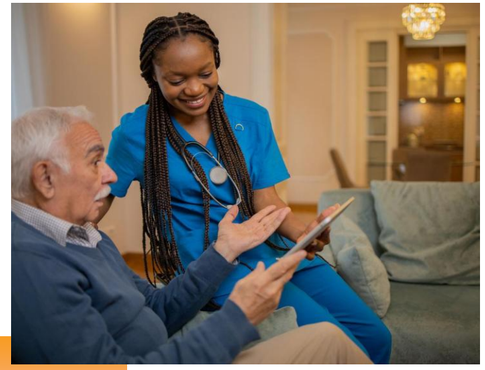
Co-funded by
the European Union

3. Positive Work Environment

do you remember?







- In daily care routines, men actively show gentleness through soft voices and calm touches to ease older adults' worries about a man's presence.
- They navigate suspicion around intimate tasks like bathing, repeatedly proving they're safe and professional, not a threat.
- This ongoing identity balancing exhausts them emotionally, layered on top of feeding, mobility aid, and companionship duties.

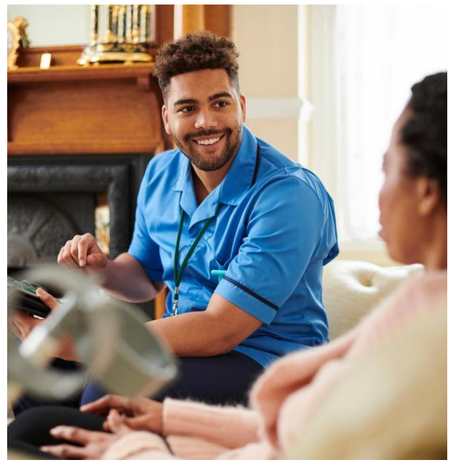
(Simpson, 2004)

Co-funded by
the European Union

3. Positive Work Environment

do you remember?







- In care for older adults, men clash with stereotypes: caregiving needs nurturing warmth, but society expects men to be bold decision-makers.
- This leads care receivers or families to view them as less naturally empathetic, questioning their fit for comforting chats or vulnerability.
- Men counter by extra-demonstrating care skills, facing lowered trust that burdens their role beyond physical and routine support.

(Eagly & Karau, 2002)

Co-funded by
the European Union

What drives carers away from the sector

The OpenCARE report highlights care as a sector with low pay, high workload, and few structured advancement pathways across all partner countries.

Entry into care

Men enter long-term care sector with hopes for meaningful work

Low pay reality

Confronted with low wages, high workload, and few advancement pathways

Migration to other careers

Better pay and recognition drive men away from long-term care

Co-funded by
the European Union

What keeps carers engaged

recognition

When men's efforts get acknowledged, it boosts their confidence right away. Feeling a sense of belonging gives them deeper purpose in their role.

belonging

Feeling a sense of belonging gives them deeper purpose in their role. To cultivate a sense of belonging in caregiving, it's important to nurture a community where everyone’s contributions are valued and seen as essential.

emotional validation

Emotional validation reinforces their identity as capable carers, countering stereotypes. It involves acknowledging their feelings and experiences, creating a safe space where they can express themselves without judgment.

meaning-making

Caregiving responsibilities not just as a duty, but as an integral part of their identity and legacy, seeing the impact of their work on the lives of those they care for.

Ribeiro, O., & Paul, C. (2008). Older male carers and the positive aspects of care. Ageing & Society, 28(2), 165-183.

Co-funded by
the European Union

What can we do to support care workers?

Positive reinforcement and clear communication work:

- Rethink perceptions related to gender
- Small gestures and feedbacks matter
- Show trust in their professionalism, once trust is established
- Share needs clearly (don't avoid them)
- Express appreciation & feedback



Benefits for everyone:

- **Ensures enough skilled carers for the future**
- **Improves care quality & stable teams**
- **Reduces burnout → More choice for**



Co-funded by the European Union

Open Care

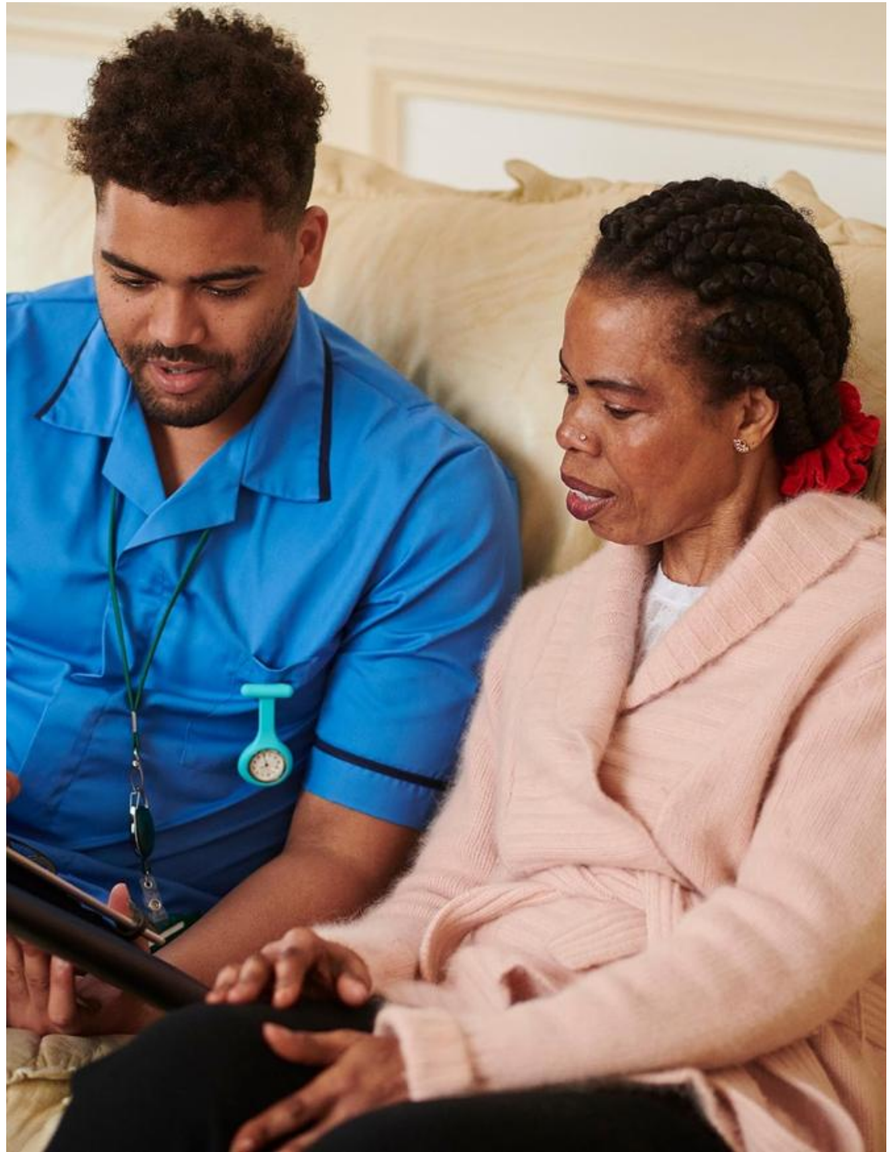
Voices & Connections

Group activity

Co-funded by
the European Union

Why we use real voices

- Theory gives us a frame, but not the whole picture
- Lived experiences reveal contradictions, emotions, and grey zones
- No single story represents all male carers
- When we listen to many voices together, shared patterns and needs become visible



Co-funded by
the European Union

How it works

1. Sorting (20 min)

Sort 18-20 quote cards into:

- Experiences (daily realities)
- Beliefs (assumptions about men)
- Structures (systems/training)
- Then identify sub-patterns within each category and create labels
- No "right answers"

2. Connecting the dots (25 min):

Draw lines to connect related quotes:

- Identify "hub quotes" with most connections
- Color-code connections (red=barrier, green=support, yellow=complex) - OPTIONAL
- Observe web patterns emerge

Co-funded by
the European Union

How it works

3. Gallery walk (5 min)

Gallery walk to see other groups' mappings.

- What did you notice across the different groups?
- Stand up and do a gallery walk even if you're not done.

4. Reflection & debrief (5 min)

- Let’s discuss what we discovered!

Co-funded by
the European Union

A good environment for male carers is a good environment for all carers.

Co-funded by
the European Union

Cyprus
University of
Technology

Open
Care

Closing Remarks

- What did you **take away** from these activities?
- Can you identify **one personal commitment or change** you can put in practice from next week?



Open Care

Opening careers for males in CARE

THANK YOU!

Co-funded by the European Union. Views and opinions expressed are however those of the author(s) only and do not necessarily reflect those of the European Union or the European Commission.
Neither the European Union nor the European Commission can be held responsible for them.

Co-funded by the European Union | 101190943

WP3 – Workshop for Care Recipients

Session 1: ~1H30 + 30 MIN BREAK

Time	Content/ Activity	Brief Description	Resources
5 MIN	**INTRODUCTION**	Briefly present Open Care project, main goals and team	Projector/presentation
15 MIN	**THEORY**: Gender Stereotypes Cultural biases around care provision	***PLEASE READ FULL THEORY IN ANNEX 1:*** Cultural and gender biases have historically framed care as 'women's work,' influencing who enters and stays in caregiving roles, how caregivers are perceived, and the experiences of care recipients, but these stereotypes can be challenged through inclusive practices, structural supports, and professional competence.	Projector/presentation
40-45 MIN	**ACTIVITY:** Breaking myths together - Men in care	**PLEASE READ FULL INSTRUCTIONS IN ANNEX 1:** **Activity Introduction (5 min)** • Briefly introduce the purpose of the activity and key theory points. **Myth Box Activity (25 min)** • Participants receive printed or digital "Myth Box" cards (15–20 statements). • In face-to-face sessions: use a box or small bag to collect participants' written responses. • Optionally, play rhythmic music or traditional tunes in the background. • Online: use breakout rooms and shared tools (Miro, Mentimeter, Kahoot) to submit responses. **Final Reflection (10 min)** • Facilitator collects and discusses key insights, summarising main reflections. • Use flipchart, whiteboard, or virtual board to note themes.	Printed (or digital) Myths Box cards (15–20 statements). In person: a box or a small bag to collect the sentences; a music player (stereo, computer, or phone) with rhythmic music or traditional tunes; Flipchart or whiteboard (or virtual board) to collect key reflections during the final reflection. *If online*: video conferencing platform with breakout rooms and shared slides or tools (Miro/Mentimeter/Kahoot).
30 MIN	***BREAK***		

15 MIN	**THEORY**: Boundaries and care recipients' preferences	***PLEASE READ FULL THEORY IN PPT:*** Respecting each person's preferences for who, how, and when they receive care, and communicating these respectfully, fosters trust, safety, and dignity for both care recipients and carers.	Projector/presentation
40 MIN	**ACTIVITY:** What Is Comfortable for Me? – Preferences, Boundaries and Mutual Respect	***PLEASE READ FULL INSTRUCTIONS IN ANNEX 2:*** Step 1 – Explain Purpose (5 min) • Introduce the activity: participants will discuss situations where they feel comfortable or uncomfortable receiving care. Step 2 – Using the Cards (15 min) • Distribute cards with different care situations. • Participants may briefly explain their choices if they wish. Step 3 – Facilitate Reflection (15 min) • Ask participants to describe how they would feel in each situation. • Discuss factors that influence comfort: tone of voice, caregiver gender, type of touch, prior explanation, privacy, empathy. Step 4 – Reinforce Final Message (5 min) • Highlight that everyone has the right to preferences, while also respecting carers. • Emphasise mutual respect: for both the person giving care and the person receiving it.	In person: Cards with care situations; Tables or boards to sort cards; Optional: flipchart or virtual board for noting reflections *Online*: online cards with scenarios; Canva or Miro
15 MIN	**CLOSING REMARKS**	• Highlight main points from the activities: myths about men in care, personal comfort and boundaries, and how care can feel respectful, safe, and dignified. • **Reinforce the importance of preferences and respect:** Everyone has the right to express their care preferences. Respecting carers and communicating openly helps build trust and a positive care experience. • Invite participants to share one thing they learned or one preference they want caregivers to know about them. • Thank participants for contributing to a supportive, inclusive, and respectful care environment. • Remind them that their feedback, choices, and preferences help improve care for themselves and others.	Projector/presentation

Session 2: ~1H30 + 30 MIN BREAK

Time	Content/ Activity	Brief Description	Resources
10 MIN	**INTRODUCTION**	Briefly Recap previous session with main concepts and takeaways	Projector/presentation
15 MIN	**THEORY**: Barriers to Recruitment, Retention & Supportive Work Environment	***PLEASE READ FULL THEORY IN ANNEX 3:*** Although long-term care is traditionally seen as 'women's work,' male carers face hyper-visibility, stereotyping, boundary challenges, and misrecognition, but equitable recognition, inclusion, emotional support, and organizational backing can help them thrive professionally and personally.	Projector/presentation
30 MIN	***BREAK***		
60-75 MIN	**ACTIVITY:** Voices & Connections	***PLEASE READ FULL INSTRUCTIONS IN ANNEX 3:*** **Round 1 – Semi-Structured Sorting (20 min)** • Groups receive all quote cards • Sort cards into 3 initial categories: **Experiences / Beliefs / Structures** • Identify sub-patterns within each category and create labels • Emphasise: no "right answers," encourage organic discovery **Round 2 – Connecting the Dots (25 min)** • Draw lines connecting related quotes • Identify "hub quotes" with most connections • Optionally color-code connections: **red = barrier, green = support, yellow = complex** • Observe emerging web patterns **Round 3 – Gallery Walk (5 min)** • Groups walk around to view other groups' mappings • Facilitate discussion of observations and "aha" moments **Round 4 – Personal Reflection & Closing (5 min)** • Structured discussion on patterns discovered • Connect individual insights to systemic themes • Reveal country origins of quotes to highlight cross-European patterns	*In person:* Quote cards (18-20 printed quotes, one per card) Category label cards (blank, 10-12 cards per group) Thick markers (2-3 per group) Large tables or floor space (one per group of 3-4) Flip chart paper & markers Stickers (optional; for marking key patterns) *Online*: Miro board (pre-populated with digital quote cards) Zoom/Teams with breakout room functionality Digital timer (visible to all) Poll function (for closing reflection)
15 MIN	**CLOSING REMARKS**	• Facilitator summarises key insights from all activities, linking theory to practice.	Projector/presentation

		• Highlight recurring themes around gender, cultural bias, ethical boundaries, and workforce challenges. • Reinforce actionable takeaways for participants: practical strategies, inclusive practices, and organisational or policy-level considerations. • Encourage reflection on individual commitments to change or improvements in their professional practice. • Optionally, invite a few participants to share one key insight or commitment with the group. • Close on a positive, motivating note, emphasising the role of each participant in creating a supportive, inclusive, and ethical care environment.	

ANNEX 1 – ACTIVITY PROBLEM TREE ANALYSIS: GENDER AND CULTURAL BIAS

Partner	Anziani e non solo and APPDI
Theme	**Gender Stereotypes and Cultural biases around care provision**
Target group	Care recipient
Name of activity	Breaking myths together - Men in care
OBJECTIVE(S)	- Encourage older people to reflect on how gender stereotypes can influence the choice, perception and effectiveness of male OSS workers. - Recognise and discuss any personal or collective prejudices towards male workers in long-term care. - Promote openness and trust in the care relationship with workers of all genders.
METHODS	1. Guided discussion using Myths Box cards in a group of at least 10 people, supported by prompts for reflection. 2. Face-to-face or online adaptation: • Face-to-face: give a box with sentences to the group, while music plays, the box is passed from one person to another. When the music stops, the person holding the box draws a slip, reads the sentence aloud, and shares their opinion by choosing True, False, or It depends. • Online: use breakout rooms in Zoom/Teams; virtual cards on shared slides, Miro, Mentimeter, or Kahoot. The facilitator will guide the final discussion to summarize key insights and reflections.
TIME ALLOCATED	Estimated total time: 40 minutes • Activity introduction: 5 minutes • Myth box activity: 25 minutes • Final reflection: 10 minutes
RESOURCES NEEDED	• Printed (or digital) Myths Box cards (15–20 statements). • If face-to-face a box or a small bag to collect the sentences. • If face-to-face a music player (stereo, computer, or phone) with rhythmic music or traditional tunes • Flipchart or whiteboard (or virtual board) to collect key reflections during the final reflection. • If online: video conferencing platform with breakout rooms and shared slides or tools (Miro/Mentimeter/Kahoot).

	• Optional: short presentation or slide for the mini-theory introduction (suggested online)
THEORICAL CONTENTS*	Understanding how we see men and women in care begins with recognising that we all carry ideas shaped by our families, cultures, and past experiences. Sometimes these ideas help us feel comfortable, but at other times they may quietly limit us. By exploring these influences, we can better understand how they affect the way we think about care and the people who provide it. Many of us grew up with the **belief that women are naturally more caring, while men are stronger or more practical.** These assumptions are common, but they don't reflect the full picture. People's abilities in care depend on their personality, training, and professionalism—not their gender. Everyone brings different strengths, and these differences enrich the care environment. It's also normal for people to feel uncertain at first when receiving care, especially if the carer is of a different gender. These feelings are valid. However, experience shows that comfort usually grows with good communication, respect, and the chance to get to know the carer's approach. Over time, trust comes from the quality of the interaction rather than the gender of the person providing support. Having both men and women in care roles is beneficial for everyone. Mixed teams bring a wider range of strengths, better teamwork, and more choice for individuals receiving care. This variety allows people to find carers whose personality and style suit them best, which can make care more comfortable and effective. Feedback from older people across countries in the OpenCare Project showed a consistent pattern: any initial doubts about a carer's gender often disappeared once they saw that the carer was kind, capable, and respectful. What mattered most was the quality of care—communication, trust, and professional behaviour—rather than gender. Cultural ideas about care also differ across Europe, and these traditions continue to evolve. Families and communities influence expectations, but today more men are joining the care profession, and more women are taking on leadership roles. These changes highlight that good care is not defined by gender but by the values and skills the carer brings.

	Ultimately, this matters because good care is built on trust. Everyone deserves to feel safe, respected, and heard. You have the right to express your preferences and to receive high-quality care that centres your needs. Understanding how beliefs about gender influence care helps ensure that your voice remains at the heart of the process.
INSTRUCTIONS*	• The facilitator gives a short introduction (about 5 minutes), summarising key points from the theory section and explaining the instructions for the activity. • Participants sit in a circle and pass around a box or bag containing slips of paper with "myth" sentences about male caregivers in LTC. While music plays, the box is passed from one person to another. When the music stops, the person holding the box draws a slip, reads the sentence aloud, and shares their opinion by choosing True, False, or It depends. The facilitator briefly asks for their reasoning and then opens the reflection to the whole group. (25 minutes) • After all sentences have been discussed (or at the end of the session), the group reflects together on what emerged from the activity. • The facilitator notes on a flipchart or board the key themes discussed — including identified biases and possible actions to reduce stereotypes and promote inclusion. The activity can also be done online by having participants respond to each statement individually (e.g., clicking "Agree", "Disagree", or "It depends") and then discussing the collective results together.
REFERENCES	Almeida-Meza, P., Di Gessa, G., Lacey, R., Xue, B., & McMunn, A. (2025). Gender inequalities in care across long-term care public spending systems in Europe: evidence from the European Health Interview Survey. *International Journal of Care and Caring*, 9(3), 490-503. Retrieved Nov 20, 2025, from https://doi.org/10.1332/23978821Y2025D000000133 Carlsson M. (2020). Self-reported competence in female and male nursing students in the light of theories of hegemonic masculinity and femininity. Journal of advanced nursing, 76(1), 191–198. https://doi.org/10.1111/jan.14220 Christensen M. Men in nursing: the early years. J Nurs Educ Pract. 2017;7(5): 94. https://doi.org/10.5430/jnep.v7n5p94.

	Halper, L. R., Cowgill, C. M., & Rios, K. (2019). Gender bias in caregiving professions: The role of perceived warmth. *Journal of Applied Social Psychology*, *49*(9), 549-562. Hanlon, Niall (2012): Masculinities, Care and Equality: Identity and Nurture in Men's Lives. Hampshire: Palgrave Macmillan Jordan, Ana (2020). Masculinizing Care? Gender, Ethics of Care, and Fathers' Rights Groups. University of Lincoln. Journal contribution. https://hdl.handle.net/10779/lincoln.24371380.v3 Keogh, B., & O'Lynn, C. (2007). Male nurses' experiences of gender barriers: Irish and American perspectives. Nurse educator, 32(6), 256–259. https://doi.org/10.1097/01.NNE.0000299478.64809.82. Martínez-Morato, S., Feijoo-Cid, M., Galbany-Estragués, P., Fernández-Cano, M. I., & Arreciado Marañón, A. (2021). Emotion management and stereotypes about emotions among male nurses: a qualitative study. BMC nursing, 20(1), 114. https://doi.org/10.1186/s12912-021-00641-z OECD (2025), Gender Equality in a Changing World: Taking Stock and Moving Forward, Gender Equality at Work, OECD Publishing, Paris. Sharma, K. et al. (2025). A Diversity, Equity, and Inclusion (DEI) Framework for Addressing Gender Disparities in the Nursing Profession. *Cureus*, *17*(8), e91265 Webster, C. S., Taylor, S., Thomas, C., & Weller, J. M. (2022). Social bias, discrimination and inequity in healthcare: mechanisms, implications and recommendations. BJA Education, 22(4), 131–137. https://doi.org/10.1016/j.bjae.2021.11.011 World Health Organization. (2024). Fair share for health and care: Gender and the undervaluation of health and care work (Global report). https://www.who.int/publications/i/item/9789240082854
HANDOUTS	Include handouts (if any, i.e.: case study, scenarios…)

<u>*Full Theory:</u>

Theory: time allocated 15 min

In many cultures, the task of caring for others has traditionally been entrusted to women. Over time, norms and expectations associating care with femininity have become entrenched: a stereotype has been created according to which women are "naturally suited" to caregiving,

while men are more suited to activities considered productive or “economic” (Carlsson, 2020; Almeida-Meza, 2025). Research on public attitudes toward caregiving professions shows that gendered expectations about *warmth* strongly shape how people evaluate caregivers. Halper et al. (2019) found that female caregivers are routinely perceived as warmer and more likeable, which increases perceived hire ability and job suitability in caregiving roles. Importantly, perceived *competence* did not systematically differ by gender in their studies - the preference was driven by warmth stereotypes rather than objective beliefs about ability. This helps explain why men are under-represented in some caring roles: not because they are seen as less capable, but because common beliefs associate care work with feminine warmth.

However, these ideas do not stem from biological differences: they are the result of history and culture (Jordan, 2020). As a result, the long-term care sector has also become an almost “feminine” field, and men who work in it may feel challenged or perceived as “exceptions” (Christiansen, 2017; Martinez-Morató, 2021;).

Some research shows that male carers are attributed different qualities: women are associated with affection, sensitivity and intuition, while men are linked to characteristics such as rationality or physical strength (Hanlon, 2012). This lead, for example, to men being asked more often to deal with aggressive patients or tasks that require strength, while they are sometimes excluded from caring for women for reasons of modesty, decisions that are often made not by the patients themselves, but by female staff (Keogh & O'Lynn, 2007).

Literature shows that stereotypes and workplace culture deter men from entering and staying in caring professions, and they outline interventions: inclusive recruitment messaging, mentorship programs, bias training, transparent career pathways, flexible work policies, and monitoring/evaluation of gender equity indicators. For this, literature suggests emphasis on dismantling implicit stereotypes (both among the public and within organisations) and building structural supports so that gender is not a barrier to entry, progression, or retention (Sharma et al. 2025).

These are examples of cultural biases: conscious or unconscious prejudices that lead us to judge people or situations before we really know them (Webster et al., 2022). Biases influence our ideas about care and who “should” or “should not” perform certain tasks. Recognising them is the first step towards overcoming them and making care more equitable and inclusive.

As part of the OpenCARE project research, a series of studies were conducted in Italy, Romania, France, Portugal and Cyprus, which show that prejudices against male carers exist but are changing.

- In Italy and Portugal, traditional norms associating care with women still carry a lot of weight.
- In Romania, cultural barriers are strong and recognition of men in the sector is low.
- In France, policies are more neutral, but difficulties in career opportunities remain.
- In Cyprus, the presence of men is accepted in a pragmatic way.
- In Portugal, there is growing appreciation for more diverse care teams.

These differences show that biases are cultural and vary from country to country, but follow a common pattern: the idea that care is “women's work” continues to influence both career choices and the perceptions of those receiving care.

Specifically, the older people interviewed said they initially felt uncomfortable when receiving intimate help (e.g. with bathing or dressing) from a male carer. However, almost all of them explained that their discomfort diminished when they saw that the carer was professional, respectful and patient.

For most participants, what really matters is:

- respect
- good communication
- competence and attention to the person.

However, some prejudices remain, such as:

- the idea that women are more suited to caregiving;
- the belief that caregiving is a female role;
- the perception of male carers as unusual or exceptional.

These are cultural biases that stem from the education and norms we grew up with. People trained in more traditional contexts tend to feel more embarrassed or distrustful, while those who have experienced more recent social changes see the presence of men in care as something normal and often positive. Overcoming cultural biases means increasing choice, improving the quality of care and fostering more respectful and trusting relationships.

For care, the 2015 OECD Gender Equality in a Changing World report frames the issue as both an economic and social policy priority: reducing occupational stereotypes and enabling career pathways in care (for all genders) supports better service quality and gives care users more meaningful choice. The OECD report reinforces that solutions require data, policy alignment, and organisational change.

**Full instructions:

Activity: time allocated 25 min
Myths Box
The **Myths Box** activity is designed to help participants identify and reflect on common stereotypes or “myths” about male carers working in long-term care.
Face-to-face: Ask participants to sit in a circle. Prepare a stereo, computer, or phone with a playlist of rhythmic music, you may include traditional songs if you wish. Give one participant a box or small bag containing slips of paper with different sentences written on them.
Start the music and have participants pass the box around the circle. When the music stops at a random moment, the person holding the box draws a slip, reads the sentence aloud, and shares their reflection, beginning by choosing True / False / It depends. After each response, the facilitator can encourage a group discussion to deepen the reflection. To help distinguish between stereotypes, it’s recommended to include positive and neutral sentences along with potentially stereotypical ones.

Online: Digitally create for each question a continuum ranging from ‘absolutely not’ to ‘absolutely yes’ and ask each participant to answer each question on the continuum so you can then see the average of the answers and the variability of the answers given by the participants and based on this data start the conversation and reflect on the pros and cons of each option.

The facilitator should then encourage the participant to explain their reasoning and invite others to share their opinions. It is important to be aware that this step should be handled sensitively, in fact light humor can be used to ease tension, however the focus should remain on reflection and understanding different perspectives.

Continue the process until several sentences have been discussed or the allocated time is over.

Final reflection: time allocated 5 min
The facilitator can conclude with a brief summary using a whiteboard, highlighting key insights and recurring themes that emerged during the discussion.

List of sentences:

Stereotype or common belief (to discuss: True / False / Depends)

1. Men are less gentle than women when providing care.
2. Older women feel uncomfortable being helped by a man.
3. Women are naturally better at caring for others.
4. Men are too strong or rough for personal care tasks.
5. A man cannot show enough empathy or tenderness.
6. Most care workers are women because they have “a gift for caring.”
7. Male carers are less patient than female ones.
8. Some tasks in care (like bathing or dressing) should be done only by women.
9. Men who work in care are unusual or “different.”

Positive or neutral

1. Both men and women can be equally good caregivers.
2. Trust and respect are more important than the carers’s gender.
3. Male carers can bring a sense of calm and security.
4. Some older people feel more comfortable with a male carers.
5. What matters most is experience, not gender.
6. Having both male and female carers gives people more choice.
7. Men can also be gentle, caring, and patient.
8. Being cared for by a man is fine once you get to know him.
9. Everyone deserves to be valued for what they do, not who they are.

Facilitator prompts for facilitating the reflection

- What makes you think this way?
- Can you think of an example from your experience?
- Would you feel the same if the carers were someone you already know and trust?
- Does anyone have a different opinion? Why?
- How common do you think this belief is in our society or workplace?
- What might change if we had more male carers in long-term care?
- What could help challenge or change this stereotype?

ANNEX 2 – ETHICS, BOUNDARIES AND RESPECT IN CARE PROVISION

Partner	**APROXIMAR**
Theme	**1.2. Boundaries and care recipients preferences**
Target group	**Care Recipients**
Name of activity	What Is Comfortable for Me? – Preferences, Boundaries and Mutual Respect
OBJECTIVE(S)	Identify situations of comfort, discomfort, and respect during care. Reflect on personal boundaries, consent, and caregiver choice. Promote the understanding that respect goes both ways — for the care recipient and the carer. Raise awareness of behaviours that may constitute harassment (e.g., touch, comments, insistence).
METHODS	**Sorting Cards** Participants receive cards with care-related situations. Each decides whether they consider the situation: 🟢 Comfortable 🟡 Depends 🔴 Uncomfortable Then, they explain how they would feel.
TIME ALLOCATED	40 minutes
RESOURCES NEEDED	• Situation cards with text and images • Board/poster with 3 columns (comfortable, depends, uncomfortable) • Tape or magnet • Markers
THEORICAL CONTENTS*	Everyone has the right to decide who, how, and when they receive help. Some people prefer female carers, others have no preference. There are no right or wrong answers — only what is comfortable for each individual. Speaking with respect and explaining preferences helps build trust, safety, and dignity for both the recipient and the carer.

INSTRUCTIONS*	**Step 1 – Explain the purpose of the activity** • Explain that participants will discuss situations where they feel comfortable or uncomfortable receiving care. • Reinforce that everyone has the right to preferences and that all answers are valid. **Step 2 – Explain how to use the cards** • The facilitator distributes cards with different care situations. • Each participant places the card in the category they consider appropriate: 🟢 Comfortable | 🟡 Depends | 🔴 Uncomfortable • Participants may explain their choice if they wish. **Step 3 – Facilitate reflection** • Ask participants to explain simply how they would feel in each situation. • Identify what makes a situation more comfortable or uncomfortable: tone of voice, caregiver gender, type of touch, prior explanation, privacy, empathy. **Step 4 – Reinforce final message** • Explain that everyone has the right to preferences, but it is also important to respect carers. • Reinforce that respect must exist on both sides: the one giving care and the one receiving care.
REFERENCES	Include sources used to create the activity (if any)
HANDOUTS	**Card 1** Image – canva Facilitator guidance – Consent, clear communication, respect for the body Card text – "When the caregiver explains what they are going to do before touching me." **Card 2** Image – canva Facilitator guidance – Privacy, dignity, physical boundaries Card text – "When the caregiver gives me privacy, such as closing the door or covering my body during care." **Card 3** Image – canva Facilitator guidance – Personal preferences, caregiver gender, consent Card text –

"When I can choose whether I prefer a male or female caregiver for certain types of care."

Card 4
Image – canva
Facilitator guidance – Physical boundaries, unsolicited touch, emotional safety
Card text –
"When the caregiver touches me without asking or explaining first."

Card 5
Image – canva
Facilitator guidance – Active listening, empathy, respectful communication
Card text –
"When the caregiver respects my time, listens to me and does not rush the care."

Card 6
Image – canva
Facilitator guidance – Autonomy, partial assistance, dignity
Card text –
"When I can do some things on my own, and the caregiver only helps with what I can no longer do."

Card 7
Image – canva
Facilitator guidance – Verbal harassment, inappropriate comments, dignity
Card text –
"When the caregiver makes comments about my body or appearance that make me feel uncomfortable."

Card 8
Image – canva
Facilitator guidance – Ethical boundaries, mutual respect, preventing harassment
Card text –
"When I make intimate, personal or body-related comments about the caregiver."

Card 9
Image – canva
Facilitator guidance – Emotional comfort, empathy, respectful supportive touch
Card text –
"When the caregiver holds my hand or to comfort me when/if I am feeling sad or anxious."

Card 10
Image – canva
Facilitator guidance – Autonomy, refusal, consent, care ethics

	Card text – "When I say I do not want help with bathing, but the caregiver insists anyway." **Card 11** Image – canva Facilitator guidance – Personal preferences, assertive communication, respect and consent Card text – "When the caregiver asks how I prefer to be treated or supported."

***Full Theory:**

Insert text (1 page - 1.5 pages)

****Full instructions:**

Time	Activity	Description
5 min	**Introduction to the activity**	**Facilitator explains that the group will review all 11 cards together, discussing each one and reflecting on preferences, boundaries, and comfort levels. Instructions for marking Confortable / Depends / Uncomfortable are clarified.**
3 min	**Card 1**	**The group reads Card 1 aloud and discusses: what feelings, boundaries, or ethical considerations are involved. Participants indicate their reactions (Comfortable / Depends / Uncomfortable).**
3 min	**Card 2**	**Same process as Card 1 – group discussion and reflection.**
3 min	**Card 3**	**Group discusses preferences and autonomy issues for this card.**
3 min	**Card 4**	**Discussion focuses on boundaries, consent, and respectful touch.**
3 min	**Card 5**	**Group reflects on communication, listening, and pacing of care.**
3 min	**Card 6**	**Discussion about autonomy, partial support, and dignity.**
3 min	**Card 7**	**Group explores situations where comments or behaviour may be uncomfortable; discussion about respectful communication.**
3 min	**Card 8**	**Discussion focuses on limits and respect for the caregiver; ethical considerations.**
3 min	**Card 9**	**Group reflects on emotional comfort and empathetic gestures.**
3 min	**Card 10**	**Discussion about autonomy, refusal of care, and professional boundaries.**
3 min	**Card 11**	**Group discusses preferences, consent, and strategies for asking how the person prefers to be treated.**

Time	Activity	Description
2 min	**Guided synthesis + conclusion**	**Facilitator summarises key reflections, highlighting good practices, respecting preferences and boundaries, and ensuring empathy in care.**

Step 1 – Explain the purpose of the activity

Explain that we are going to talk about situations in which each person feels comfortable or uncomfortable when receiving care.

Emphasise that everyone has the right to have preferences and that all responses are valid.

Step 2 – Explain how to use the cards

The facilitator distributes cards with different care situations.

Each participant places the card in the category they consider appropriate:
Comfortable, Uncomfortable, or Depends on the situation.

Each person may, if they wish, explain their choice.

Step 3 – Guide the reflection

Ask each participant to explain, in simple terms, how they would feel in that situation.

Identify what makes a situation more comfortable or uncomfortable:
tone of voice, caregiver's gender, type of touch, prior explanation, privacy, empathy.

Step 4 – Reinforce the final message

Explain that everyone has the right to preferences, but it is also important to respect the caregivers.

Emphasise that respect must exist on both sides: those who provide care and those who receive it.

ANNEX 3: Barriers to Recruitment, Retention & Supportive Work Environment

Partner	**EASI**
Theme	**Recruitment, retention & supportive work environment**
Target group	Care receivers
Name of activity	**Voices & Connections**
OBJECTIVE(S)	• Raise awareness of the specific challenges and experiences faced by male carers across European contexts • Identify systemic patterns that either support or undermine male carers' ability to thrive in care work • Connect lived experiences to research-based factors (recognition, belonging, emotional validation, meaning-making) that create supportive environments
METHODS	• Interactive sorting exercise • Systems mapping • Guided discovery • Small group collaboration (3-4 participants per group) • Gallery walk Format flexibility: • In-person (preferred) • Online adaptation: Use Miro board with digital cards, color-coded connections, and breakout rooms (see online modifications in full instructions)
TIME ALLOCATED	**60-75 minutes** (face-to-face) **40 minutes** (online, condensed version)
RESOURCES NEEDED	**Physical materials (face-to-face):** • Quote cards (18-20 printed quotes, one per card) • Category label cards (blank, 10-12 cards per group) • Thick markers (2-3 per group) • Large tables or floor space (one per group of 3-4) • Flip chart paper & markers • Stickers (optional; for marking key patterns) **Digital tools (online):** • Miro board (pre-populated with digital quote cards) • Zoom/Teams with breakout room functionality • Digital timer (visible to all) • Poll function (for closing reflection)
THEORICAL CONTENTS*	Male carers in long-term care face unique challenges rooted in gender role incongruity - the mismatch between societal expectations of masculinity and the relational, emotional nature of care work. Research across European contexts reveals that male carers experience: 1. **Hyper-visibility and scrutiny** due to minority status (token effect) 2. **Stereotyping** as physically strong but emotionally limited 3. **Boundary challenges** in intimate care situations

	4. **Misrecognition** (assumed to be doctors, not carers) 5. **Unequal task distribution** (assigned aggressive patients and physical labor) 6. **Invalidation** of emotional experiences (harassment not taken seriously) However, research by Ribeiro & Paul (2008) identifies **four protective factors** that support male carers' retention and wellbeing: • **Recognition** → improves confidence (being valued for care skills, not just strength) • **Belonging** → enhances purpose (genuine inclusion in team culture) • **Emotional validation** → strengthens identity (legitimizing emotional labor and vulnerability) • **Meaning-making** → connected to supportive structures (training, supervision, professional development) When these factors are present, male carers report fulfillment and career satisfaction despite challenges. When absent, they experience isolation, burnout, and early exit from the profession. **Key concepts:** • **Token status:** Being in a visible minority increases performance pressure and stereotyping • **Role incongruity:** Conflict between gender identity and occupational expectations • **Benevolent bias:** Positive stereotypes (calmness, strength) that still limit and burden This activity uses authentic quotes from male carers in France, Romania, Italy, Portugal and Cyprus to make these theoretical concepts tangible and actionable.
INSTRUCTIONS*	**PREPARATION:** • Print and cut quote cards (18-20 quotes) • Set up tables/stations (one per group of 3-4) • Prepare materials bundles for each group **ROUND 1 - SEMI-STRUCTURED SORTING (20 min):** • Groups receive all quote cards • Sort into 3 initial categories: EXPERIENCES / BELIEFS / STRUCTURES • Then identify sub-patterns within each category and create labels • No "right answers" - encourage organic discovery **ROUND 2 - CONNECTING THE DOTS (25 min):** • Draw lines to connect related quotes • Identify "hub quotes" with most connections • Color-code connections (red=barrier, green=support, yellow=complex) - OPTIONAL • Observe web patterns emerge

	ROUND 3 – GALLERY WALK (5 min): • Gallery walk to see other groups' mappings • Facilitate "aha" moments **ROUND 4 – PERSONAL REFLECTION & CLOSING (5 min):** • Structured discussion on patterns discovered • Connect individual insights to systemic themes • Reveal country origins of quotes (cross-European patterns)
REFERENCES	Eagly, A. H., & Karau, S. J. (2002). Role congruity theory of prejudice toward female leaders. Psychological review, 109(3), 573. EU Care Strategy (2022). Council Recommendation on access to affordable high-quality long-term care. Moss, K. R. (1977). Men and Women of the Corporation. OpenCARE qualitative research (2025). Ribeiro, O., & Paul, C. (2008). Older male carers and the positive aspects of care. Ageing & Society, 28(2), 165-183. Simpson, R. (2004). Masculinity at work: The experiences of men in female dominated occupations. Work, employment and society, 18(2), 349-368. Williams, C. L. (1992). The glass escalator: Hidden advantages for men in the "female" professions. Social problems, 39(3), 253-267.
HANDOUTS	Canva file

*Full Theory:

The Gender Paradox in Care Work

Long-term care has historically been constructed as "women's work," rooted in essentialist assumptions that women possess innate nurturing capacities. This gendered construction creates challenges for men who enter care professions.

Theoretical framework: token theory and role incongruity

Rosabeth Moss Kanter's theory of tokenism (1977) explains that when individuals comprise less than 15% of a workforce, they experience heightened visibility, performance pressure, and stereotyping. Male carers across Europe typically represent a low percentage of the care workforce, placing them firmly in token status. This visibility creates a paradox: male carers are simultaneously hyper-visible (every action scrutinized) and invisible (their care labor unrecognized or delegitimized).

Role incongruity theory (Eagly & Karau, 2002) further explains that when an individual's social identity (male) conflicts with role expectations (carer = feminine), prejudice and discrimination emerge. This manifests in several ways for male carers:

1. Stereotyping and task segregation - Male carers are frequently channeled toward tasks aligned with traditional masculinity - physical labor, managing aggressive patients, technical tasks - while their capacity for emotional labor and intimate care is questioned. Research shows this "strength stigma" both values and burdens male carers, as they become the default for physically demanding work regardless of individual capacity or fairness.

2. Boundary policing - The intersection of masculinity, intimacy, and care creates heightened suspicion around male carers' motivations and appropriateness, particularly in intimate care situations. Some care recipients refuse male carers for intimate care; while respecting

autonomy is important, this creates professional limitations not faced by female colleagues. Male carers report navigating these boundaries by performing gentleness, maintaining hyper-awareness of propriety, and accepting restrictions on their practice.

3. Misrecognition and professional legitimacy - The assumption that men in care settings must be doctors rather than carers reveals deep cultural resistance to men in subordinate, service-oriented roles. This misrecognition both elevates (glass escalator effect) and delegitimizes (not seen as "real carers") male care workers simultaneously.

Protective factors: What supports male carers?

Despite these challenges, many male carers report deep fulfillment and career satisfaction. Ribeiro and Paul's (2008) and related research highlight protective factors such as:

- **Recognition** involves being valued specifically for care competencies - empathy, relational skills, attention to detail - rather than only physical attributes. When male carers receive recognition for the full scope of their care work, their professional confidence strengthens.
- **Belonging** goes beyond superficial inclusion to authentic team integration where male carers are not perpetually marked as "different" but experience genuine collegial relationships. This includes being included in informal social interactions, having their input valued equally, and not being treated as novelties.
- **Emotional validation** means that male carers' emotional experiences - difficulty with death and loss, impact of aggression, stress from boundary navigation - are taken seriously and supported through supervision, peer support, and organizational structures. This validation helps male carers integrate their care identity with their gender identity rather than experiencing these as contradictory.
- **Meaning-making** encompasses the organizational structures that help all carers process the existential and emotional weight of care work: quality supervision, reflective practice opportunities, ongoing professional development, and psychological support. Male carers report particularly acute gaps in these supports, suggesting organizations assume men need less emotional scaffolding - a dangerous assumption.

Cross-European patterns

While cultural contexts vary - Mediterranean countries may have more traditional gender role expectations, Nordic countries more gender egalitarian frameworks - the fundamental patterns identified above appear across European care systems. Male carers in France, Romania, Italy, Portugal and Cyprus report remarkably similar experiences of hyper-visibility, strength stereotyping, boundary challenges, and validation gaps alongside deep vocational satisfaction.

This suggests that gender dynamics in care work operate at a structural level that transcends national culture. Interventions must therefore address not only individual attitudes but organizational policies, professional training frameworks, and broader cultural narratives about gender and care.

Implications for practice

Creating supportive environments for male carers requires multi-level intervention:

- **Individual level:** Care recipients and families can examine their own gender assumptions, distinguish between legitimate preferences and stereotyping, and recognize care competence regardless of carer gender.
- **Team level:** Fair task distribution, active inclusion in team culture, recognition of emotional labor, and zero-tolerance for harassment against any team member regardless of gender.
- **Organizational level:** Gender-inclusive training that addresses male-specific challenges, supervision that validates emotional experiences, career development opportunities, visible representation of male carers in materials and leadership.

- **Societal level:** Public discourse that challenges gender essentialism in care, media representation of diverse carers, policy frameworks that recognize care work as skilled labor rather than "natural" feminine behavior.

The goal is not preferential treatment but equity: ensuring male carers have equal access to the recognition, belonging, validation, and support structures that enable all care workers to thrive.

**Full instructions:

PRE-SESSION PREPARATION (before)

Step 1: Prepare Quote Cards

- Print HANDOUT 1 (18-20 quotes) on cardstock
- Cut into individual cards (one quote per card)
- Optional: The cards have a symbol indicating the country which the quote belongs to (but don't reveal this system until the end)
- Shuffle cards so they're not grouped by country

Step 2: Set Up Stations

- Arrange tables/floor spaces for groups of 3-4 participants
- Each station needs:
    - One complete set of quote cards (face down initially)
    - 3 category label cards marked "EXPERIENCES" / "BELIEFS" / "STRUCTURES"
    - 8-10 blank category label cards
    - Markers (2-3 thick markers)
    - Stickers (20-30)

SESSION FLOW

OPENING (5 minutes)

Facilitator introduction: *"Today we're exploring the experiences of male carers across Europe. You'll work with real quotes from care workers in five countries. Your task is to discover patterns in these experiences."*

Set the frame: *" These quotes reflect experiences, not blame; the aim is understanding and improving care environments for everyone. There are no right or wrong answers in the sorting. What matters is what YOU notice, what connections YOU see."*

Group formation:

- Divide participants into groups of 3-4
- Mix roles or backgrounds if possible
- Assign groups to stations

ROUND 1: SEMI-STRUCTURED SORTING (20 minutes)

Facilitator instruction: *"At your table, you'll find quote cards and three category labels: EXPERIENCES, BELIEFS, and STRUCTURES.*

- EXPERIENCES = What happens to male carers in their daily work

- BELIEFS = What people think or assume about men in care

- STRUCTURES = Systems, policies, training, organizational support

Your first task: Read each quote and sort it into one of these three piles. If a quote could fit in multiple piles, choose the one that feels strongest, or discuss with your group why it's complicated. You have 10 minutes."

Facilitator actions during this phase:

- Circulate between groups
- Listen to reasoning (don't correct)
- If groups get stuck: "What is this quote mainly about? The person's experience, what people believe, or how the system works?"
- If quotes seem to fit nowhere: "Set those aside for now - we'll come back to them"
- Time check at 5 minutes: "You're halfway through"

Find Sub-Patterns (10 minutes)

Facilitator instruction: *"Now look at each of your three piles. Within each pile, do you notice quotes that go together? Maybe some experiences are similar, or some beliefs are related. Create smaller groups within each pile and give them labels using the blank cards. You're discovering the patterns."*

Example to share if groups look confused: *"For instance, in your BELIEFS pile, you might notice some quotes are about assumptions about men's strength, while others are about assumptions about men's emotional capacity. Those could be two sub-groups."*

Facilitator actions during this phase:

- Watch what categories emerge naturally
- Note common patterns across groups (you'll reference these later)
- If a group finishes early: "Can you find any connections BETWEEN your categories?"
- Time check at 5 minutes: "Start finalizing your category labels"

Transition to Round 2: *"Look at what you've created - categories and sub-categories. Now we're going to explore how these experiences are connected to each other."*

ROUND 2: CONNECTING THE DOTS (20 minutes)

Make connections (10 minutes)

Facilitator instruction: *"Now you're going to draw lines to show connections between quotes - even across different categories. Draw and connect two quotes that relate to each other.*

Ask yourselves: - Do these quotes show cause and effect? - Do they describe the same issue from different angles? - Do they contradict each other in interesting ways?

Keep adding connections. Your table will start to look like a web. That's exactly what we want."

Facilitator actions during this phase:

- Demonstrate if needed: Hold up two cards and draw, show how to connect
- Encourage bold connections: "Don't overthink it - if you see a relationship, connect it"
- Validate different connection types: "Yes, contradiction IS a connection"

- If groups are tentative: "Try connecting just three quotes first, then keep going"
- Ask provocative questions: "What would happen if you addressed THIS hub quote - would it affect all these connected experiences?"
- Take photos of each group's web (for documentation)

Color-Code Connections – OPTIONAL (5 minutes)

Facilitator instruction: *"Now add color meaning to your connections. You have three colors of drawn lines:*

RED = This connection shows something that makes the work HARDER GREEN = This connection shows something that HELPS or supports
YELLOW = This connection is COMPLEX or contradictory"

Facilitator actions during this phase:

- Groups work quickly - this is visual enhancement
- Note which groups have mostly red vs. more green
- This will be powerful in debrief: "Notice how much red we're seeing - that tells us something"

Transition to Round 3: *"You've discovered patterns and made them visible. Now I want to show you what research tells us about what male carers need to thrive."*

ROUND 3: GALLERY WALK (5 minutes)

Facilitator instruction: *"Take 3 minutes to walk around and see how other groups mapped their work to the framework. Notice similarities and differences."*

Facilitator actions during this phase:

- Participants move freely between tables
- No formal presentations - just observation
- Prepare to debrief patterns: "What did you notice?"

Brief debrief (2 minutes): *"What did you notice across the different groups?"*

Listen for:

- Similar patterns emerged
- Same quotes identified as hubs
- Particular factors seem most absent

Facilitator synthesis: *"You discovered what researchers also discovered. The patterns you found aren't random - they're systematic. And that means we can systematically address them."*

ROUND 4: PERSONAL REFLECTION & CLOSING (5 minutes)

Facilitator closing:

"You came in with your own experiences and perspectives. You discovered patterns. You connected the dots. You mapped those patterns to research. That's the work of change.

Remember: the four factors - recognition, belonging, validation, meaning-making - aren't just for male carers. They're what ALL carers need. A good environment for male carers is a good environment for everyone.

Thank you for your engagement"

Take final photo of connections.

FACILITATION TROUBLESHOOTING GUIDE

Challenge: "These quotes seem similar, I can't tell the difference" → Response: "You're right, there are themes that repeat. That tells us something - these aren't isolated experiences. Put similar quotes together and ask: what's the shared pattern?"

Challenge: "This quote could fit in multiple categories" → Response: "Absolutely. Complex experiences don't fit in neat boxes. Choose what feels primary, or physically place it between categories. The ambiguity is data."

Challenge: "We can't agree on where this goes" → Response: "Your disagreement is valuable. It means you're seeing different dimensions. Can you both be right? What does your disagreement reveal?"

Challenge: Group finishes sorting very quickly (seems superficial) → Response: "I see you've created broad categories. Now go deeper - within each pile, what sub-patterns do you notice? Can you create 2-3 subcategories?"

Challenge: Group is stuck/overwhelmed → Response: "Let's simplify. Pick five quotes that stand out to you. Start there. You don't have to sort everything at once."

Challenge: "How do we know if we're doing this right?" → Response: "There's no answer key. What matters is what YOU notice and what sense YOU make of it. Trust your analysis."

Challenge: Participant says "But women have it worse" → Response: "You're right that women face profound challenges in care work. AND male carers face specific challenges too. We're not ranking suffering - we're understanding different experiences so we can support everyone better."

Challenge: "This seems like political correctness" → Response: "These are direct quotes from real carers describing real barriers. What do you make of their experiences? Do they deserve to be taken seriously?"

Challenge: Low energy/engagement → Response:

- Add movement: "Stand up and do a gallery walk even if you're not done"
- Make it personal: "Has anyone here witnessed or experienced something like these quotes?"
- Connect to purpose: "Why does this matter to you?"

Challenge: Time running short → Response:

- Skip gallery walk
- Reduce number of groups sharing (have 2-3 share, others add sticky notes)

Challenge: One person dominating group → Response: "I'm going to ask everyone to write their thoughts silently for 2 minutes before discussing. Everyone's voice matters."

Challenge: Silence/reluctance to share in closing → Response: "Write your commitment first, then we'll share. You can also pass if you prefer - but your commitment card still goes up."

ONLINE ADAPTATION (40 minutes)

Platform: Miro or Mural + Zoom/Teams

Pre-session setup:

- Create Miro board with:

- Digital quote cards (can be moved)
- Three sections labeled EXPERIENCES/BELIEFS/STRUCTURES
- Arrows or connector lines legend

Modified flow:

ROUND 1 - SEMI-STRUCTURED SORTING (15 min): Breakout rooms of 3-4, sort digital cards on Miro

ROUND 2 - CONNECTING THE DOTS (15 min): Use arrow tool to connect quotes and do the mapping

ROUND 3 – GALLERY WALK (5 min): Invite participants to browse all other maps.

ROUND 4 - PERSONAL REFLECTION & CLOSING (5 min): Participants type insights in chat or in the shared whiteboard.

Facilitator tip for online: Assign a "tech helper" in each breakout room if possible.

HANDOUT 1: QUOTE CARDS FOR SORTING

(Print these on cardstock, one quote per card, cut out individually. Recommended size: A6/postcard.)

https://www.canva.com/design/DAG6pXhf-60/5EjMwAiHw6dRe1nx19bFjw/edit?utm_content=DAG6pXhf-60&utm_campaign=designshare&utm_medium=link2&utm_source=sharebutton

--

📊 **EXPERIENCES (what happens to male carers)**

💭 **BELIEFS (what people think about men in care)**

🏗️ **STRUCTURES (systems, policies, training, support)**

FRANCE

“Because I’m a man, I feel I need to show I’m gentle so people relax.”

“Being in the minority makes everything you do more visible.”

“At first, some families don’t expect a man to be doing this work.”

“Some patients refuse men; I respect that and we adapt.”

“They ask me to handle difficult or aggressive patients. I’m often the one who lifts or transfers heavier people.”

“People assume I’m a doctor.”

“A resident said I was ‘the cake’ when I brought breakfast”

ROMANIA

“I feel that what I do now brings peace to my soul… I feel fulfilled.”

“If you don’t go into this for the people, then it’s not worth it.”

“Men are often seen as clumsier, heavier-handed… but I am very aware of my responsibility.”

“I don’t shy away from anything that a woman does and that I could also do.”

“Women are seen as better carers — more empathetic, more preferred.”

“Many beneficiaries called me ‘uncle,’ even if they were older than me.”

ITALY

“Older women sometimes feel embarrassed when I help with intimate care.”

“If a woman is harassed, everyone reacts. If it happens to a man, nobody takes it seriously.”

“If something goes wrong, criticism comes faster because I stand out.”

“Many residents feel more comfortable with male carers and open up to us.”

“They often say I’m like a grandson.”

“Men are sought after for physical strength, but it becomes a burden when you are always the one doing it.”

CYPRUS

“I come from a country where men have to be men and are not suited to certain services.”

“We men do things calmly… we pay attention to the smallest details.”

“They complain regardless of whether I am a man or a woman.”

“In 15 years, I have never had any psychological training on how to approach users.”

“We carry with us atavistic preconceptions: historically, men were seen as stretcher bearers, not as caregivers.”

PORTUGAL

“Men (male caregivers) feel ashamed. I don’t – I like it.”

“We have more physical strength; we came specifically to help female colleagues with this physical effort.”

“Caregiving is undervalued… all care regarding the patients first goes through us, but the salary doesn’t match.”

“With elderly women, it’s really about shame… it comes from the past and we cannot change that in their minds.”

“When a man is taking care of a man, I think he feels more at ease.”

“In the care home, we are there every day interacting with them and, whether we like it or not, we always end up creating a bond.”

“What you do today is what you will do in 10–15 years; there is little career progression.”

“There are no conditions whatsoever for these professionals to feel valued.”