

Immigrant Healthcare Assistants in Norwegian Elderly Care: Roles and Experiences in the Land of Equality

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Immigrant Healthcare Assistants in Norwegian Elderly Care: Roles and Experiences in the Land of Equality.

Vyda Mamley Hervie



Dedication

Dedicated to my lovely daughter Ingeborg, without whom this dissertation would have not been completed. Thanks for the inspiration and providing mamma with the writing space with the hope that one day, mamma will be like Doctor McStuffins. I hope that when you grow up and pick this dissertation off of the shelves, you will still carry that big heart-warming smile and be proud of mamma, even though you will better understand what this kind of 'doctor' means. Love you, Nerkie.

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In writing about the experiences of immigrant healthcare assistants, I too had experiences. However, unlike the experiences of participants, which are related to reminiscences in elderly care, my own experiences remind me of my attempt at climbing Lurfjelltind, the 1284 meters-tall mountain in Bodø. Though embarked upon with determination, my encounter with loose rocks and steep stretches of the mountain left me frustrated and with an urge to give up. However, with words of encouragement and unfailing hope, I found myself at the top of the summit with a fantastic view and feeling of fulfilment. One person who understood my doubts and fears before the start of this mountain climbing experience, yet still motivated me to try was my Norwegian ‘mother’: Liv Johansen. And when returned home with the incredible feeling of fulfilment, she said to me, ‘*Men du klarte det Vyda!*’ (i.e. ‘You made it, Vyda!’). Liv gave me all the credit without realizing that her encouragement was a major part of my achievement climbing that mountain. Similarly, there have been many people who have walked closely with me during the past three years, throughout this PhD project. These people have supported me, placed opportunities before me and motivated me to open useful doors that I felt were impossible to open. Nevertheless, only my name appears on the cover of this dissertation.

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if I become half the person and supervisor that Marie Louise Seeberg is, this will be on the list of my greatest achievements in life.

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though it was likely that you did not grasp how much more progress needed to be made to complete this dissertation. To Nicholas, Jemima, Andreas and Khetura: thanks for the lovely company during each trip to Bodø.

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Finally, to all the participants in this study, a very big thank-you for sharing your experiences with me. Now I can tell the experiences of immigrant healthcare assistants in Norwegian elderly care, with fascinating details to make this a crucial step in getting additional insights and knowledge out there.

Abstract

This dissertation draws attention to ‘unskilled’ immigrant health care assistants in Norwegian elderly care. Their everyday experiences and reflections on their role in the workplace are explored through an ethnographic approach. Fieldwork was conducted in institutional settings as well as in the private homes of elderly people. The study focuses on practices as they unfold at the intersection of two policy fields: healthcare policies aimed at meeting the needs of elderly people, and integration policies aimed at incorporating immigrants into the labour market.

The analysis draws on theoretical approaches to work and occupation (Abbott 1998; Hughes 1971, 1994), complexity theory (Heylighen et al. 2007, Kernick 2002) and intersectionality (Collins 1998, Crenshaw 1991). Concepts of dirt (Douglas 1966) and dirty work (Hughes 1956, Dahle 2018, and others) enable an in-depth analysis of participants’ narrated experiences.

The analysis of participants’ experiences brings out the following key themes: the experience of cultural dilemmas at work, limited career mobility, experiences of being disregarded, structural discrimination, and the need for adequate training. Participants’ reflections on their experiences are influenced by what they see as a corresponding lack of recognition of the elderly in society, and particularly by a political discourse where older people at the receiving end of care services are attributed a low value.

‘Unskilled’ immigrant health care assistants are part of an established and bureaucratically regulated working environment, where they must find their place in the hierarchy (Seeberg 2012, Vike 2017). In this light, the study reveals a systematic lack of priority of the needs and rights of the ‘unskilled’ immigrant health care assistants, deriving from a lacking recognition of their work and its importance to Norwegian elderly care. The structural invisibility of this occupational group directly affects their working conditions and may indirectly also affect the quality of services provided to the elderly.

Sammendrag

Denne avhandlingen retter søkelyset mot innvandrere som arbeider som 'ufaglært' pleiepersonell i eldreomsorgen i Norge. Gjennom en etnografisk studie utforskes deres erfaringer og rolleforståelser som ansatte i både institusjonsbaserte og hjemmebaserte tjenester. Studien fokuserer på praksis i skjæringspunktet mellom to politiske felt: helsepolitikk som skal sikre kvalitet i eldreomsorgen, og integreringspolitikk som skal bidra til inkludering av innvandrere i arbeidsmarkedet.

De teoretiske perspektivene er hentet fra tilnærminger til arbeid og yrker (Abbott 1998; Hughes 1971, 1994), kompleksitetsteori (Heylighen et al. 2007, Kernick 2002) og teorier om interseksjonalitet (Collins 1998, Crenshaw 1991). For å oppnå en mer dyptgående analyse av deltakernes erfaringer slik de ble fortalt, brukes også Douglas' (1966) begrep «dirt» eller urenhet og det beslektede begrepet «dirty work» (Hughes 1956, Dahle 2018 o.a.).

Analysen av deltakernes erfaringer frambringer et knippe sentrale temaer: kulturelle dilemmaer i arbeidet, begrenset karrieremobilitet, en opplevelse av manglende anerkjennelse for arbeidet, strukturell diskriminering, og oversette behov for adekvat opplæring. Deltakernes opplevelser rammes inn av det de ser som en tilsvarende manglende anerkjennelse av eldres posisjon i samfunnet generelt og spesielt av en politisk diskurs der eldre som mottar omsorgstjenester tilskrives lav verdi.

'Ufaglært' pleiepersonell inngår i et etablert og byråkratisk regulert arbeidsmiljø, der de må finne sin plass i hierarkiet (Seeberg 2012, Vike 2017). Slik sett indikerer studien en systematisk mangel på prioritering av og fokus på hvordan denne langt på vei usynliggjorte yrkesgruppen dekker viktige arbeidsoppgaver i norsk eldreomsorg. Dette får direkte konsekvenser for arbeidsvilkårene til de 'ufaglærte' innvandrerne, og kan indirekte også gå ut over kvaliteten på tjenestene slik de utspiller seg i de eldres hverdager.

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Chapter 1: Background to the study

In January 2013, I was on my way to the Nordic Africa Institute (in Sweden) as part of a scholarship I received in connection with my Master's programme at the University of Nordland. Upon arrival at Gardemoen airport, I called a friend in Oslo to say hello. I knew that he had ambitions to advance in his field of study and move upwards in his career. So I asked the question, 'My brother¹, how is your application going?'. To my surprise, he laughed out loud and said, 'Vyda, you must be a joker! Who will clean the buttocks of their folks in the "²*gamle huset*" if they allow me to go higher?' At that instant, we both laughed and talked about other issues before hanging up. But as I sat on the plane to Sweden, my friend's reply kept ringing in my ears, and I began to wonder why he felt that way. As a social work student, one of my desires was to work in institutions of elderly care. But did my friend's experience indicate that working in elderly care in Norway implies downward social mobility for immigrant healthcare workers? My friend somehow believed that certain specific roles, such as 'cleaning the buttocks' of the elderly, belong to immigrants and that it is difficult (though not impossible) to negotiate for higher positions.

While reflecting on this chat, my attention was drawn to another friend—a healthcare assistant in Bergen. Also a student, my friend would sometimes share practical experiences about her work with me. I once asked about her future ambitions in the care sector. Her reply was, 'No way, I'm not going back there'. I later discovered that she thinks her ethnic background might be an impediment to obtaining a higher position. Similar to this experience, one of my coursemates in the Master's of Social Work programme had worked in elderly care for over 6 years in Bodø. Even though I did not formally explore her experiences in care work, my casual chats with her revealed that, in addition to language barriers, she struggled with cultural values that made her think that most families had neglected their elderly in care homes. Inasmuch as this friend seemed quite happy with her job, she had plans to work in a different sector after completing school.

Whilst in Sweden, I quickly integrated into the immigrant community. One of my 'sisters' there was providing care to a disabled old man as a special assistant—to satisfy my curiosity,

¹ 'Sister' or 'brother' is a term for immigrants from my home country of Ghana and other African countries who see themselves as one people acting in a familial manner in a foreign country.

² Gamle huset in this context means elderly home.

I asked about her career prospects in elderly care. Interestingly, her plan was to quit as soon as possible. In her words,³ *'krom ha foɔ ahi na ebe ye saa ejuma fu nu? Sika ni su nye'* ('How many Swedish citizens will do this filthy job that I do? Besides, the money is not good').

In that moment, I paused, trying to make connections with the other experiences. An idea to do a PhD study on the role and experiences of immigrant healthcare assistants employed in elderly care in Norway sparked in my mind. I further discussed my idea with Professor Johans Tveit Sandvin (my supervisor for my master's thesis) and after a couple of discussions, I felt motivated to explore this topic. Thus, the starting point for this study was through my encounter with immigrant healthcare assistants in Norway and Sweden.

Elderly care policy field

Based on UN and OECD data for projected populations, scholars suggest increasing trends in population ageing among western democracies (Bloom et al., 2010; Christensen, 2003; Rechel et al., 2013). At a time of technological advancement in health coupled with the need for economically efficient healthcare, caution has been signalled about the potential to exaggerate the consequences of population ageing, thus adding to the agendas of some governments to consider consequences of demographic realities as myths (Jacobsen, 2015). However, regardless of how information about population ageing is interpreted, the recognition that ageing has multidimensional implications is important. In spite of the advantage of a high life expectancy rate, population ageing implies that 'the numbers of older people with cancer, fractured hips, strokes, and dementia will increase' (Rechel et al., 2013, p. 1320). In the debate on Norway as an ageing society, I argue that two dimensions are implicit or fundamental.

The first dimension, as per one of the major Norwegian policy documents, known as Care Plan 2020 means that quality care for the elderly, in both medical and social facets is essential for elderly care. In line with the policy objective to achieve quality elderly care, the state has launched a Competence Action Plan (CAP), which according to Halvorsen (2016) is 'based on the need for more workers with higher level of healthcare expertise' (p. 12). On this basis, it is important to note that quality and not quantity alone is expected.

³ This quote is written in Twi, the language spoken among the Akans in Ghana.

The second dimension as per the focus of this study concerns workforce challenges. An ageing population translates into an ageing workforce, and this implies that workforce challenge is of significant concern (Bloom et al., 2010; Christensen, 2003; Jacobsen, 2015; Rechel et al., 2013). Population ageing is tied to a range of policy and social issues. Arguably, a variety of approaches ranging from political, social, economic, cultural, and educational and others beyond the scope of this study can account for debates on how states can address challenges associated with population ageing. In an analysis of 19 democracies including Norway, Willensky (2002) argued that by focusing on policies or the political aspect of an economy, it is possible to know how national arrangements shape and affect the well-being of its population. The major message conveyed by Willensky (ibid) is that the state, as the highest decision-making body in democratic societies, legitimizes decisions in the form of policies, which are implemented in the interest of both the population and the government. Going by this, I argue that workforce challenges following the increasing elderly population in Norway should be viewed from a policy perspective. One of such policies is concerned with a productive workforce provided through mechanisms such as Active Labour Market Programs (ALMP). Norwegian experts in labour market initiatives—such as Brochmann and Hagelund (2011), Dahl and Drøpping (2001), Dahl and Lorentzen (2005), and Halvorsen and Stjernø (2008)—have shown that in Norway, a productive workforce is important for stimulating economic aspects of society and as a measure to encourage labour market inclusion. Among other factors, high unemployment rates among immigrants in Norway make them a target group for the supply of labour resources through Active Labour Market Programs (Bratsberg, Raaum, and Røed, 2016; Thorud et al., 2014). Moreover, evidence suggests that immigrants are overly represented in ‘low-skilled occupations’ (Thorud et al., ibid: p. 65). Taking these observations as my point of departure, I argue that the experiences of this composition of workforce in Norwegian elderly care should be an important element for policy makers.

In order to better understand the challenges concerning Norwegian elderly care and the needs of the healthcare workforce, I focus on direct care providers—specifically low-skilled care providers, where the role of immigrants has been under studied. For the purposes of this study, direct healthcare assistants refer to the front-line workers caring for the aged in Norway. In the literature, the activities of these front-line care workers include a range of services for helping the elderly with various activities of daily living (Bourgeault et al., 2008; Cangiano et al., 2009; Osterman, 2017; Walsh and O’Shea, 2009). The OECD Health Policy

Project on long-term care for older people (OECD, 2005) aptly captured activities of daily living as including ‘bathing, dressing, eating, getting in and out of bed or a chair, moving around and using the bathroom, often in combination with rehabilitation and basic medical services’ (p. 17). This is in agreement with the tasks I observed.

In Norway, ‘care services’ are not age-specific but needs-based, allocated to care dependent persons of all ages as well as the disabled (Norwegian Directorate of Health, 2012; Seeberg, 2017). Still, participants in this study provide care only for the elderly. In Norway, their work is incorporated into the health sector and they are called *pleieassistent* or ‘healthcare assistants’, while in countries such as UK, people doing very similar tasks are called ‘care assistants’ or even ‘social care workers’.

According to Statistics Norway, the majority of the elderly population receive care in nursing homes or in their own homes (Seniors in Norway, 2010). To reiterate this, a study on the ‘Use of Care Services among elderly Norwegians’ stated that ‘whilst nine out of ten residents in institution(s) are over 67 years old, six out of ten home service recipients are over 67 years old’ (my own translation) (Kjelvik and Mundal, 2013, p. 43). As such, the study will examine how care is provided by immigrant healthcare assistants in institutional settings, such as nursing homes, and in private homes. I chose these settings to cover the primary avenues for providing care in Norway.

The study was conducted in two stages. The first stage consists of an ethnographic exploration of the experiences of the immigrant care assistants in Norway. The second stage is an exploration of Norwegian policy practices within which the experiences of the immigrant healthcare assistants are situated. By combining these two stages, the study was lifted from the accounts of the immigrant healthcare assistants (micro) through an exploration of how policy developments (macro) influence these experiences. (It was beyond the scope of this study to include a meso-level analysis.)

Framed within a hermeneutic inquiry to research, theoretical perspectives drawn from the work of Hughes (1971, 1994) and Abbott (1988) on work and occupations, Heylighen et al., (2007) and Kernick’s (2002) analysis of complexity theory, as well as Crenshaw (1991) and Collins (1998) perspectives on intersectionality served as the main analytical guide.

From presumed problems to researchable questions: Finding a focus

The main focus of my project proposal was to explore the roles and experiences of immigrant healthcare assistants in Norwegian elderly care. Several months into the thesis, my analysis of

the empirical data revealed a need to expand my focus, leading me to literature from the fields of social policy, occupations and work, professional jurisdiction and intersectionality. While reading this literature in relation to my empirical data, more questions began to arise. In the course of going back and forth between my empirical data and the literature, it emerged that the experiences of the immigrant healthcare assistants are best understood in light of policy developments in Norway. Most of the participants' responses relate to dilemmas that are inherent in Norway's policy measures and practices. The study thus takes elderly care as a field where Norwegian policies meet and constitute a frame for my question: What are the roles and experiences of immigrant healthcare assistants providing care for the elderly in Norway?

I have explored this question through the following sub-questions:

- What are the challenges of the Norwegian elderly care system at the interface between policies of immigrant integration and policies of elderly care?
- What can policy makers, researchers and the wider society learn from the immigrant healthcare assistants' perception of their roles and experiences when providing care for the elderly Norwegian?

Indeed, the challenges associated with the rapid growth of an ageing population are not unique to Norway. Studies have shown that in Western societies, immigrant healthcare workers shape the future of elderly care and impact the quality of care for the elderly, as Western societies are increasingly dependent on such workers to meet the care needs of their ageing population (Bourgeault et al., 2010; Cangiano, 2014; Cangiano and Shutes, 2010; Howe, 2009; Martin et al., 2009; Moriarty, 2010; Shutes, 2012; Walsh and O'Shea, 2009, 2010).

In an effort to explore similar concerns within the context of Norway, I found it necessary to relate my discussion to the literature. Thus, in the following section, I chart the trajectory of research on immigrant healthcare assistants in elderly care and discuss how the present study contributes to the existing research agenda.

Previous studies

The rationale for this section is to acknowledge influential work focused specifically on immigrant healthcare assistants in elderly care. I have taken a hermeneutic approach to the literature review, following Boell and Dubravka (2014), who describe this as an 'interpretive approach for studying literature in which the reader engages in an ever-expanding and

deepening understanding of the relevant body of literature’ (p. 259). The authors further argue that, ‘hermeneutic does not assume that correct or ultimate understanding can be achieved, but instead, it (sic) is interested in the process of developing understanding’ (ibid).

The focus of hermeneutics in developing understanding is what I find attractive. Thus, in my reading of the literature, my aim was to understand how the role of immigrant healthcare assistants has been documented across a range of studies—and, further, how my study contributes to the research agenda on immigrant healthcare assistants in ageing societies.

I have organized this review in two parts. The first part focuses on accounts from international studies and the second looks at perspectives from the Nordic region, with an emphasis on Norway.

International migration of care labour

The increasing demand of care labour as a response to global care deficits in Western countries is well-documented (Bourgeault et al., 2008; Cangiano et al., 2009; Walsh and O’Shea, 2009). Previous research has shown that this demand has led to a situation where there has been both a formal and informal flow of immigrants from economically poor countries to so-called economically rich countries (ibid). Within elderly care, the increasing demand for care labour has led to calls for governments, especially those of welfare states, to provide a solution to the care deficit. In response, most welfare states have embraced a policy where informal care workers—who are mostly women—are responsible for providing these services. Hochschild’s (2000) ‘global care chain’ is helpful for understanding how women have become key agents in supplying the demand in these care shortages: ‘An older daughter from a poor family [cares] for her siblings while her mother works as a nanny caring for the children of a migrating nanny who, in turn, cares for the child of a family in a rich country’ (p. 131).

This global care chain reflects a growing trend in women migrating to perform care and social reproductive work whilst delegating their own care responsibilities to other members of their households. Scholars such as Yeates (2014, 2009) have further developed the concept of global care chains by pointing out that women who migrate to perform care work are usually from disadvantaged backgrounds, providing services to meet the needs of people who occupy more powerful positions. In providing these services, the care needs of the care workers are often neglected or ignored. In effect, these chains not only link the global north and south, but they also create a confluence of policy and social issues (Fudge, 2011); further, I argue that by

designating care labour to women or people from disadvantaged backgrounds, there is a potential for inequality, discrimination and vulnerability which is significant for social policy. In other words, the marketization of care labour in the global North, and the policy transformations that regulate such labour, is critical to policy debates.

In the following section, I contextualize this discussion within research on immigrant healthcare assistants in long-term care.

Immigrant healthcare assistants in long-term care: international studies

In the context of international studies, the literature that formed the core scholarship on immigrant healthcare assistants in long-term care was drawn from Canada (Bourgeault et al., 2010), Ireland (Walsh and O'Shea, 2009), the UK (Cangiano et al., 2009), and the US (Martin et al., 2009). These studies were selected due to their extensive nature and relevance to my topic, with the idea that these countries are representative of the countries studied in this body of work (in social care and healthcare).

Bourgeault et al. (2010), who focused on the Canadian context, explored policies regulating the entry, employment and integration of foreign care workers. They also explored the structure of and demand for home and long-term care for the elderly in Canada through an examination of statistical evidence on the roles that native and foreign-born workers play in the provision of Canadian elderly care. They concluded that 'there is clearly a need for immigrant care workers in Canada but that some key issues need to be addressed to better meet their needs and the needs of the older adult care recipients of their care' (p. 8). The authors described the extent to which requirements such as English or French language proficiency and Canadian cultural competency create challenges for immigrant care workers. For the authors, the 'relative invisibility of the conditions of older adult care can be seen as being mirrored in the invisibility of the work and living conditions of their immigrant care workers' (Bourgeault et al., 2010, p. 8). In terms of their care provision, the immigrant care workers were described as having 'good carer' qualities, which entail attributes such as 'being passionate, patient, compassionate, capable of understanding and responding to the needs of his/her patients, and committed to his/her job' (p. 116). However, the authors also pointed out that, because of the immigrants' background, language, racial and cultural differences, elderly care takes place in complex settings.

Thus, the extent to which policy debates consider the needs of the immigrant care workforce shapes the present and future role of foreign-born workers in the provision of healthcare services for the aged in Canada.

In Ireland, immigrant carers were seen to be a key feature of short-, medium- and long-term elderly care (Walsh and O'Shea, 2009). With a focus on immigrant nurses and care assistants, Walsh and O'Shea (*ibid*) noted that the 'strongest determinant of the demand for foreign national care workers is the difficulty in hiring and retaining Irish carers, especially registered nurses' (p. viii). This difficulty was primarily linked to negative perceptions of elderly care, underfunding of the sector and lack of career pathways. The survey from this study reported that the 'caring relationship between migrant carers and older people is complex and multifaceted' (*ibid*). The 'degenerative and debilitating conditions' of older adults imply that care work is both physically and emotionally demanding, extending beyond simple service provision. The positive aspects of migrant care work were expressed predominantly in terms of emotional attachment, friendship and the desire to make a difference. Exploitive and discriminatory conditions, for example concerning employment and immigrant regulations, and issues around racism emerged as significant challenges for the immigrant carers. For the older people, 'problems in language proficiency were a central issue' (Walsh and O'Shea, 2009, p. ix). '[P]oor knowledge in Irish culture' was also highlighted as a challenge, as it 'undermin[ed] the sense of shared cultural experience for older persons. Similar religious beliefs, however, facilitated a greater acceptance of migrant carers by older people' (*ibid*). Evidence from this study indicates that although quality was not compromised, issues such as poor rates of remuneration ultimately led to poorer quality of care. The shift of elderly care to migrant workers, coupled with underfunding, led employers to support the need for education and training to enable migrants to deliver 'appropriate person-centered care' (Walsh and O'Shea, 2009, p. ix).

With a combination of postal and online survey and individual interviews, Cangiano and Shutes (2010) argued that, in the UK, 'underfunding of social care and interrelated workforce shortages are largely responsible for the extensive reliance on migrant workers among social care providers, and raise concerns for workforce inequalities and for the quality of care' (p. 39). Overall, employers highlighted migrants' respectful attitude towards the elderly, and their willingness to work all shifts and learn new skills, as positive aspects of migrant workers' care provision. However, challenges related to English language proficiency and the requirement for additional job training (*ibid*, p. 50–51) contributed to complex caring

relationships between immigrants and older people. As such, the authors argue that a key priority must be ‘to ensure that the pay, conditions and status of care work, as well as the opportunities for career development, make the sector more attractive to all workers’ (p. 54).

Similar to the Canadian, Irish and UK contexts, Martin et al. (2009) found that in the U.S., the ‘aging population is generating an increasing demand for [long-term] care and...there is a more robust growth in the workforce of direct care providers—home health aides and lower-skilled providers’ (p. 1). By analysing census and web survey data, in addition to conducting fieldwork in Phoenix, Arizona and the Washington DC/Baltimore metropolitan area, the authors found that employers turn to immigrant workers due to difficulty hiring and retaining US-born workers in frontline long-term care. While foreign-born workers’ respect and commitment to caring for the elderly, in addition to their willingness to work in this sector, were seen as advantages by employers, their ‘poor English ability’ represented the biggest challenge (p. 66). As a policy initiative, Martin et al. (2009) recommended an increase in the ‘capacity of domestic training institutions which, being understaffed and underfunded, are turning applicants away’ (p. 76).

In Australia, Howe’s (2009) review of immigrants working in long-term care revealed that immigrants are overrepresented in the long-term workforce, yet they are neither marginalized nor a solution to workforce shortages. In accounting for this, Howe (ibid) argued that the situation in Australia is different from other countries, as ‘skills-based immigration policies largely preclude the entry of low-skill care workers’ (p. 388). Such stringent policies imply that since there is virtually ‘no inflow of migrant care workers as such, the LTC workforce has to be drawn from the local population that includes a large number of long-standing migrants and a smaller number of more recent migrants’ (ibid).

Similarly, Hugo (2007) argued that the Australian long-term care sector has characteristically had a substantial number of unskilled and semi-skilled jobs in addition to managerial and professional jobs, suggesting that the workforce challenge is ‘not pressing as in other OECD countries although the real “crunch” is likely to come somewhat later—in the 2020s’ (ibid, p. 181). However, Hugo also found that this sector faces barriers to recruiting new and younger carers in both skilled and unskilled positions; this has led to major concerns regarding future long-term carers, as the country’s workforce will likely slow due to the growing numbers of disabled elderly people in Australia.

An interesting development in the Australian context was highlighted by a study on the underrepresentation of immigrants in the healthcare workforce. Using nursing as an example,

Omeri and Atkins (2002) showed that immigrant nurses in Australia experienced marginalization; further, there was evidence of a hierarchical structure where immigrant nurses ‘were denied participation beyond the lower employment ranks and were undermined in their professional roles’ (p. 503). Conducting open-ended interviews with immigrant nurses in New South Wales, Omeri and Atkins (2002) found that for nurses with an immigrant background, ‘professional negation, experienced in lack of support; otherness, experienced in cultural separateness; silencing, experienced in language and communication difficulties’ (p. 495) were still problematic.

Similar to the immigrant nurses’ perceptions of marginalization in Australia, it has been reported that in the UK, ‘immigrants, especially women, often are relegated to performing the denigrated dirty care work that the local population refuses to do’ (Olwig, 2018, p. 44). In her study on female immigration and the ambivalence of ‘dirty’ care work, which focused on Caribbean nurses in Britain, Olwig (2018) provided evidence of a division in labour within the prevailingly hierarchical field of British nursing. Her study demonstrated that, after the abolishment of the slave trade and the presumed end to hierarchies based on race, new forms of hierarchies emerged through the importance placed on education—and knowledge, in particular—within British culture and society. With an upbringing grounded in ‘strong respect for persons with special knowledge or skills, such as teachers and nurses’... ‘Caribbean women found it quite reasonable to respect a nursing hierarchy based on superior knowledge, command of skills and understanding of proper patient relations’ (Olwig, 2018, p. 54). The Caribbean nurses felt that ‘[i]t was therefore only logical that they, as students, would begin at the bottom of the hierarchy’ (ibid). They did expect occupational mobility, however, and to ‘progress from performing the strenuous physical work focusing on cleanliness and bodily care toward the higher ranks increasingly removed from this heavy-duty work’ (p. 55). While they were able to ultimately reject their low status and the racist image accorded them—capitalizing instead on a cultural background that had taught them to be resilient in the face of harsh conditions—the barriers to, and unavailability of, opportunities for occupational advancement left them ‘sorely disappointed, if not angry’ (ibid).

Olwig concluded that ‘work becomes especially regarded as dirty when it becomes tied to a particular segment of the population which has low status within a social hierarchy’ (p. 60). This argument is important for my own work, as it contributes to an understanding of the segmented and unequal long-term workforce. Additionally, this adds to knowledge from this study about how occupational mobility for ‘unskilled’ low status care workers impacts on the

morale for practitioners of work described as ‘dirty’. In the Nordic region, there are a number of studies focused on important initiatives for elderly care, as presented below.

Nordic region-oriented work with an emphasis on Norway

Within the context of the Nordic states, the centrality of elderly care has been captured in terms of how welfare policies seek to emphasize quality care as a social right (Dahl and Rasmussen, 2012, Eriksen and Dahl, 2005, Henriksson & Wrede 2008, 2012), and to establish a balance between the diversification of family formations and care responsibilities and the state (Daatland and Herlofson, 2003), and between demographic changes and market/economic outcomes (Christensen, 2012; Vabø, 2005). These processes entail restructuring with different outcomes. Notable within the Nordic research agenda is the potential of immigrant care workers to shed light on how welfare state policies restructure efforts to meet long-term care needs.

For instance, in Finland, Näre (2013b) demonstrated that immigrants are overly represented as auxiliary workers in Finnish elderly care. Using both qualitative and quantitative data, Näre (ibid) observed that even among skilled professionals, foreign nationals are overly represented in elderly care jobs as the sector is unattractive to Finnish-born workers. Thus, in practice, immigrants are recognized as ideal employees in Finnish elderly care. Paradoxically, however, employers treat immigrant care workers as ‘inferior’, believing they are ‘lacking skills and qualifications’ and so are not as efficient as their Finnish peers (Näre, 2013, p. 77). ‘In sum, if a nurse is foreign-born it is likely that s/he will work in elder care and it is very unlikely s/he will work as a ward nurse, but rather as a practical or assistant nurse’ (ibid, p. 78). At the micro-level, the effect of such suspicion and misrecognition was conceptualized by Näre as a form of ‘otherness’ that impacts the self-esteem of foreign-born workers. And, according to Näre, a macro-level effect of this kind of *a priori* structural issue is the reification of the division of labour in Finnish elderly care.

In Sweden, Gavanas (2013) found that, particularly in Stockholm, competition among private care providers has led to the marketization of immigrant care and domestic workers with ‘ethnic’ profiles and characteristics which were considered to be more similar to Swedish people than ‘foreigners’ from other regions (p. 66). In practice, elderly customers perceived immigrant workers to be ‘extra cheap’ and flexible as they often combine elderly care work with other forms of unpaid informal domestic services. In exploring what she termed as ‘Elderly care puzzles in Stockholm’, Gavanas argued that, issues of trust and continuity are

important to the elderly service users and when combined with issues of affordability and access, immigrant workers become a significant preference/choice. As a result, Swedish elderly care is following the trend toward a 'glocalized' international division of labour where immigrants remain 'extra cheap' domestic and care workers.

Jönson and Giertz (2013), also in Sweden, used a database (Nordcare) to investigate whether workplace situations in elderly and disability care is more problematic for immigrants than natives. The authors emphasized that, in Sweden, 'migrant care workers as a category did not stand out as disadvantaged in general' (p. 820). The difference, however, was that immigrant care workers 'reported having a heavy workload and being less appreciated by their workmates' (ibid). This finding, according to the authors, is indicative of subordination hence the need to explore experiences of possible discrimination. Focusing their analysis on male care workers, Jönson and Giertz (ibid) observed that foreign male care workers experience 'precarious situations', such as high rates of sick leave, wishing to quit and feeling insufficient to meet the needs of the care users (p. 816).

In Denmark, Carneiro et al. (2008) used statistical data to explore the health and sickness absences of immigrants working in elderly care. Their overall finding was that although immigrants have worse health conditions than Danes, immigrant care workers have lower rates of sick leave than their Danish colleagues do. In linking this quantitative analysis with previous 'qualitative studies, Carneiro et al. (2010) pointed to 'other factors' (p. 49) that contribute to this paradox: for example, the fact that 'immigrants do not take sickness absence because they are careful about their present work situation' (ibid). Indeed, as one manager in elderly care stated, 'I don't think it is because they are sick less often, but, as I said before, I think they take care of their job, once they have gotten one' (Carneiro et al., 2010, p. 49). Carneiro et al. (ibid) also referred to another qualitative study, which showed that having a job and an income were strong determinants of satisfaction, pride and feelings of self-worth for immigrants; as a result, immigrants do not like taking sick leave. This finding is in keeping with the general public opinion, as presented by the Danish media and Danish Chamber of Commerce, that immigrants are a 'particularly stable and reliable workforce' who are 'motivated, willing to learn and service minded' (p. 44).

In Norway, the literature on elderly care workers posits care workers with immigrant backgrounds as a valuable resource in the particular context of workforce challenges (Dahle and Seeberg, 2013; Isaksen, 2010; Munkejord, 2017; Seeberg, 2012). At the same time, the literature has raised questions about migrant care workers' social access and rights (Dahle and

Seeberg, 2013) and their care provision for elderly citizens (Christensen and Guldvik, 2014; Dahle and Seeberg, 2013; Isaksen, 2010; Seeberg, 2012), as well as the political dynamics behind a reliance on elderly care workers (Vike, 2017).

Bringing the topic of global care work, gender and migration in Nordic societies into focus, Isaksen (2010) argued that the employment of immigrant care workers is a single solution to a double problem: One, a looming labour shortage alongside a growing demand for care, and the other, a need for cheap labour.

One of the more elaborated analyses of the role of immigrant care workers in elderly care is that offered by Christensen and Guldvik (2014). Though theirs was a comparative study between Norway and the UK, the authors suggest that forces favouring mobility across Europe, such as demographic challenges and economic globalization, are systematically linked to immigrant care workers' growing importance as resources in the context of workforce challenges. Bringing attention to what they call 'a new type of migrant' (ibid), the authors pointed out that immigrants are not necessarily 'victims of North–South problem' (p. 5) but 'individuals who actively construct their lives within the options and conditions they are given at any time' (p. 4). On the one hand, care work is a 'life project' to these care workers, as they are ensuring their own survival as well as the survival of the elderly people they care for. On the other, however, are the challenges immigrant care workers face as they provide services within devalued, flexible and marginalized sectors of the labour market.

Christensen and Guldvik (ibid) thus provide insights into the significance of immigrant care workers, with a critical stance on macro-level factors in the form of policy measures. These policy measures, according to the authors, are reflected upon differently, from individual perspectives, when immigrants consider their country of destination. As a result, it is essential to understand immigrant care workers as active agents when confronting macro-level measures, such as immigration policies.

In the discussion of Christensen and Guldvik (2014), the endorsement that care work permitted close relationship between care workers and care recipients and the relative confidence with which care workers devise strategies to negotiate negative aspects of care giving is worth considering. For me, such coping mechanisms may influence decisions to allow 'unskilled' care workers to offset negative aspects of their employment in long-term care.

Munkejord (2016) situated her analysis of immigrant care workers in Norwegian long-term care within the rural care setting of Finnmark, in Northern Norway. With a focus on what she calls ‘skilled migrant workers’, Munkejord (ibid) found immigrant care workers to be motivated and valued employees who provide care with ‘feelings of mastery’... and an ‘ability to create safety and confidence in their relationships with the users’ (Munkejord, 2016, p. 244). Contrary to notions that Finnmark, as a rural area in the periphery of Norway, is ‘old-fashioned and introverted’ (p. 243), Munkejord suggests that, in general, ‘places in small northern communities may show a particular openness and an ability to include new migrant workers’ (ibid). Indeed, the relatively small population and rural nature of Finnmark and the ‘awareness that many rural places “need people”...may have a positive impact on the attitudes of the immigrants’ (ibid).

Thus, Christensen and Guldvik (2014) and Munkejord (2016) both focused on the role of immigrant care workers within the sphere of Norway’s elderly care. In particular, they placed the role within the global frame of ageing populations, where care workers of immigrant backgrounds are recruited as resources with social, economic and political relevance.

This latter is echoed in the literature on global care labour in Nordic societies, where studies on the gendered nature of immigrant workers point to the allocation of women’s unpaid work in the hands of female immigrants (Dahle and Seeberg, 2013; Isaksen, 2010; Seeberg, 2012). Immigrant care workers thus provide the necessary labour to supplement care deficits. This care deficit, as Isaksen (2010) stated, is ‘not only related to women’s integration into paid employment and to demographic changes, but also to changes in the labour market itself’ (p. 143). With evidence of a hierarchical structure and new divisions that position immigrants below their skills and qualifications, Dahle and Seeberg (2013) caution that the reliance on immigrant workers should not obscure the new constellations and challenges that will be brought forward. For instance, while it is acknowledged that paid care work means improved social mobility for immigrant women (Seeberg, 2012), their care work underpins privileged access and uneven power which challenges notions of egalitarianism in Norway’s welfare regime.

Adding a public policy perspective to the existing literature is Riemsdijk’s (2008) study of the narratives of Polish immigrant nurses in Norway, in which she argues that the question of belonging and exclusion can identify interpersonal and institutional discrimination. Riemsdijk found that ‘Polish nurses exert considerable agency in improving working conditions’ (p. iii), and their experiences as immigrants in the Norwegian labour market shed light on the

processes of national and regional boundary making, the politics of inequality and the difference, and struggles for labour rights' (ibid). An important issue raised by Riemsdijk (2008) that is relevant for my study is how the experiences of immigrant care workers can illuminate labour market challenges in relation to systemic discrimination.

One of the most comprehensive contributions in the area of care assistants in Norwegian elderly care is that offered by Vike (2017), who provides a strong critique of the ways in which the decisions of policy makers overburden the frontline care workers in Norway's elderly care system. Drawing on Lipsky's theory of street level bureaucracy, Vike points out in his analysis of the value of what he calls 'utopian time' (Vike, 2013, p. 36) that in both historical and contemporary times, the lack of adequate resources by nation states to meet an ever-growing demand for services translates into practical dilemmas that must be overcome by employees who represent welfare policies. In the context of Norway, Vike (2017) claims that when combined with the mandatory requirement to implement or discharge policies on behalf of state authorities, the difference between the theoretical aspect of state policies and the enactment of those policies is substantial. Taking into account the service-intense nature of the Norwegian welfare system, what stands out is that frontline workers are 'not a marginal part of the state, but serves as the main interface between "the state" and the population' (Vike, *ibid*, p. 134–5). By recognizing the subtleties of policy goals behind concerns of inadequate resources vis-a-vis the huge caseloads under which frontline care workers discharge their duties, Vike claims that it is possible to understand the representation of frontline care workers in the ways in which service provision is played out in elderly care. He further suggests that there is a need to challenge the emerging orthodoxy of the dilemmas of frontline care workers by moving beyond the individual employee to a critical analysis of the overall health care system. On this note, Vike (2017) highlighted the need to understand the services of frontline care workers in terms of political and institutional directives.

What is missing from the Norwegian literature on immigrant healthcare assistants in elderly care are the experiences of 'unskilled' healthcare assistants with migrant backgrounds. These 'unskilled' immigrant healthcare assistants take part in workforce opportunities created by Norway's ageing population. However, due to the expanded focus on skilled healthcare assistants, the services of 'unskilled' immigrant healthcare assistants have been rendered invisible. As such, whilst it is acknowledged that for some immigrant healthcare assistants—especially the skilled or trained—work in Norwegian elderly care work has meant improved

social mobility (Munkejord, 2016; Seeberg, 2012), there is little known about the experience of ‘unskilled’ immigrant healthcare assistants in this scenario.

The current study thus supplements existing literature by situating the analysis within the specific context of ‘unskilled’ immigrant healthcare assistants in Norwegian long-term care in the following ways.

First, while existing studies have primarily focused on immigrant healthcare assistants in skilled professions such as nursing, this study approaches immigrant healthcare assistants operating as frontline workers in ‘unskilled’ positions—specifically, as healthcare assistants in elderly care.

Second, prior studies have mainly analysed data based on interviews with immigrant healthcare assistants, observations and interviews with immigrant care givers, and/or focus group discussions. In this study, I have combined observations, interviews, and focus group discussions with a comprehensive review of a range of policy documents relevant to participants’ experiences. In addition to interviewing immigrant healthcare assistants, I also interviewed managers of long-term care institutions. Moreover, participants were drawn from nursing homes and home care settings in the southern and northern parts of Norway. I designed the study in this way to capture a range of information across two geographical zones, using a comprehensive approach that was different from those used in previous studies.

With my own vantage point as an immigrant in Norway, my involvement in this study on immigrants also adds a unique perspective to the existing literature. The meaning of my own background as a Ghanaian immigrant in this study becomes important, given the insistence of acknowledging how differences in cultural competence influences care giving situations among immigrant healthcare assistants and their care recipients in previous studies (Walsh and O’Shea, 2009). Given that there are two groups (the elderly care recipients and the immigrant healthcare assistants) at the centre of the care relationship, the cultural complexities and differences should make us pause and try to understand the intricacies of cultural understanding from the perspective of healthcare assistants in order to assess the goals of policy initiatives and understand how the aims of policy initiatives are fulfilled. So far, such understanding of cultural meanings from immigrant healthcare assistants who care for the elderly has not received significant attention in the Norwegian literature. I will discuss this further in **chapter 7**.

To ground these arguments, the next chapter examines some of the trajectories of immigrant healthcare assistants in Norwegian elderly care. First, I lay out several factors that must be taken into account regarding the significance of immigrant healthcare assistants in elderly care in Norway; next, I explore the political dynamics behind immigrant labour in the Scandinavian market. The last section connects the case of immigrant healthcare assistants to specific labour market policy decisions. Though these discussions are placed in the context of Norway, reference is made to international debates and perspectives wherever possible.

Key concepts and definitions

Below is the standpoint from which I approach key words/terms in this study.

In its present incarnation, the word ‘**immigrant**’ seems to be at the centre of lively public and political debates, while simultaneously causing social tensions and political controversies. Yet it seems to me that the definition of the word remains a paradox. In databases, the word ‘immigrant’ is reduced to country of birth, nationality and length of stay in a country (Anderson and Blinder, 2015). In policy and public debates, as well as in the media, it is often the case that ‘immigrant’ is used to refer to ethnic minorities, asylum seekers, refugees or religious minorities (Baker et al., 2008; Beutin et al., 2006; Saggar and Drean, 2001). There is also evidence that suggests that when used in public opinion surveys, especially those targeted at attitudes towards minorities, ‘immigrants’ may specifically signify foreigners, asylum seekers and low-skilled workers (Anderson and Blinder, 2015). For instance, in a study on ‘The absence of race in Norway?’, Kyllingstad (2017) defined immigrants as including ‘labour migrants from EU countries, refugees and asylum seekers, and family members of previous immigrants’ (p. 323). According to Norway’s Statistics Bureau, immigrants are ‘persons born abroad of two foreign-born parents and four foreign-born grandparents’ (SSB, 2018). With such a variety of usages, **immigrants** in this study refers to persons who possess or have possessed non-Norwegian citizenship and have racialized features. This is an important distinction, as this study stemmed from the idea that it is more complex and challenging to be an immigrant healthcare assistant than a healthcare assistant with no ‘immigrant’ identity—I will explore this in greater detail below.

Another term that plays a critical role in this study is ‘**identity**’. Though the term is usually traced to the early work of psychologist Erikson in the 1950s, in everyday vocabulary and in policy and public debates, identity is discussed as a social category and/or a distinctive quality of a person (Fearon, 1999). Identity as a social category relates to the rules that define and

distinguish membership within a community and other labels and characteristics that mark the margin between natives and non-natives (ibid). Regarding the use of identity to distinguish distinctive personal characteristics, this can be a source of pride or shame, and/or can lead to the unchangeable attribute of a ‘foreigner’ (Fearon, 1999, p. 2). To paraphrase Fearon (ibid), given these dual usages, it is not surprising that even dictionaries have failed to fully capture the current meaning of the word ‘identity’. However, the effort to define ‘identity’ is not simply a technical challenge. In this study, the immigrant healthcare assistants described identity in a way that seems to surpass its normal use in everyday language or in policy debates. For the immigrant healthcare assistants in this study, **identity**—particularly immigrant identity—refers to a bond that makes them consider one another as people from different countries who have converged in a different land (in this case, Norway) and offer services which are necessary yet stigmatized. Most significantly, this bond was described in terms of a ‘brotherhood’⁴, where the immigrants care for each other, especially in situations in which they consider themselves to be disadvantaged. For me, this description of ‘identity’ is more concrete and significant and, as I will argue, reflects a better understanding of the experiences of the immigrant healthcare assistants.

Elderly clients’ refer to the aged persons who receive care services from the immigrant healthcare assistants.

Narratives were my access to participants’ experiences. I use the term ‘**experience**’ to imply unravelling narratives, which also involve the feelings of participants’ lived experiences in elderly care as they were transmitted to me through the participants’ words and other means of communication. The richness, uniqueness and ambiguities of participants’ narrated experiences imply that I use the term ‘**experience**’ in a subjective way, which means that ‘experience’, used in this way, may or may not offer general insights. My own bodily experiences of tasks and situations that I shared with participants during fieldwork contribute another layer of understanding to the narratives. In chapter 4, I expand on my approach to experiences through the lens of phenomenology.

Healthcare assistants: International research suggests that a plethora of titles are used to designate workers who are labelled as ‘unskilled’ and ‘unqualified’ healthcare assistants. For instance, in the US, such titles range from ‘unlicensed assistive personnel’, nurse’s aides and

⁴ ‘Brotherhood’ in this context is gender neutral and used to symbolize the close relationship between siblings.

orderlies; to assistants, attendants and surgical technologists (Nyberg, 1999, p. 851). Similarly, in the UK, titles for healthcare assistants include ‘clinical support worker, ward assistant, care worker, home care assistant and even ‘bed maker’ (McKenna et al., 2004, p. 452, citing Thornley, 2000). As observed by McKenna et al. (ibid), the variety of titles assigned to healthcare assistants points to the confusion and uncertainty regarding who actually makes up this workforce, their roles and competencies.

Indeed, this kind of variation and confusion was observed in the present study. Partly, the confusion arises because ‘*hjelpepleier*’ and ‘*omsorgarbeider*’, both authorized semi-skilled professionals, were reorganized into ‘*helsefagarbeider*’ in 2006 (Skjetne, 2016; Skålholt et al., 2013). Participants’ for this study are not recognized as authorized or skilled care workers, but rather are support workers categorized as healthcare assistants (*pleieassistent* or *pleiemedarbeider*) in Norway. According to an official website for information about Norwegian educational system and vocational training (utdanning.no), there are no entry requirements or mandatory training programmes for the *pleiemedarbeider*. To work as a *pleiemedarbeider*, the applicant must simply be interested in and good at working with people (ibid). Essentially, work as a *pleiemedarbeider* is unregulated and there are no educational qualifications or national standards or guidelines. Perhaps most significantly, I did not come across the title *pleieassistent* (or *pleiemedarbeider*) on the website of the Norwegian National Health Directorate and in the policy documents I reviewed in this study. The takeaway here is that the category of healthcare assistants who form the centre of this study are overlooked in policy discourse and arguably even unrecognized by, formal healthcare training.

Overview of chapters

The dissertation is organized into **12** chapters. **Chapter 1** laid the foundation with a brief introduction, background to the study, and description of the questions I set out to answer. This was followed by a discussion on previous studies related to my topic. I then aligned the significance of the current study against this background and finally discussed the standpoint from which I approached key concepts and definitions.

Chapter 2 opens with a discussion of policy developments, rooted in historical and political accounts, that concern immigrant labour. Here, I begin by exploring labour market transformations through debates on the international migration trends in care labour. I will then look at social policy transformations by examining the implication of policy

transformations in relation to elderly care—I conclude by further exploring the likely effects of these in shaping the healthcare assistant labour force.

In Chapter 3, I present and discuss the theoretical approaches to, and understandings of the research phenomenon. In these discussions, my aim is to frame the theoretical perspectives that shaped the study. I argue that these perspectives furnished the study with insights, which were useful for analysing the experiences of the immigrant healthcare assistants.

In Chapter 4, I discuss my methodological choices. The chapter is organized into two sections. I begin the first section by tracing the process of how I managed to find a ‘better’ focus through the research design, and I outline the research methods for the study. Further, in this section, I present the research plan, including a discussion of how I gained access to the research sites and other processes pertaining to my fieldwork. The study participants are also introduced.

The second section provides information on data analysis and ethical considerations, followed by further methodological considerations that explore the interaction between me, as an immigrant, and the research participants, who are also immigrants. The chapter ends with a reflexive account on my approach to writing.

Chapter 5 is the first of the six chapters in which I present my empirical data. In this chapter, I analysed how the immigrant healthcare assistants interpret their work within the private spaces of the elderly in Norway. In doing this, I explored how care is provided to the elderly, with the home (i.e. *hjemmetjeneste*) as the site of care work.

In Chapter 6, I explored the realities of participants’ experiences in relation to their perceptions about doing unskilled and low status jobs. Here, I also analysed participants’ experiences, exploring how they understand, interpret and ascribe meanings to work in Norwegian elderly care through the common questions, ‘what do you do?’ and ‘what do you actually do?’

Chapter 7 builded on Chapters 5 and 6 by delving into gender identities and negotiations among male immigrant health care assistants.

Following the discussions in chapters 5, 6 and 7, **Chapter 8** delved deeper into how cultural dilemmas impact the daily activities of immigrant healthcare assistants. I argue that the effects of some of these cultural dilemmas are taken for granted in the workplace environment.

Chapter 9 deals with the theme of communication. The chapter illustrates how the Norwegian language is made meaningful in relation to being an immigrant in low status jobs. In this analysis, I explored participants' interpretation of how communication can enhance or inhibit meaningful relationships in care situations.

Following the discussions in previous chapters, **Chapters 10** and **11** paid particular attention to the second stage of the thesis by exploring policy practices as an important domain within which the experiences of the immigrant care assistants are situated. These chapters include an exploration of the realities of participants' experiences in relation to policies, both in theory and in practice.

Chapter 12 concludes the dissertation by taking readers back to findings from the empirical chapters. The findings will be discussed in relation to my research questions and rationale for the study. Based on these discussions, I highlight the policy implications of this study and raise new questions for future studies.

Chapter 2: Immigrants in elderly care: the case of Norway.

*‘Things are known in two senses: known to us and known absolutely.
Presumably, we must start from what is known to us’ (Aristotle 1976)*

Having laid the foundation to the study in Chapter 1, in this chapter, some of the historical policy developments for integrating immigrants into the welfare states and labour market will be presented as a basis for future discussions. The following major topics will be highlighted:

- Integration of immigrants into the welfare states and labour market
- The political and economic context of an active labour policy targeting immigrants
- Political rhetoric and the reality of practice

Norway represents a model of the Scandinavian social democratic welfare regime, and the country’s welfare system is tasked with the responsibility of providing high-quality care for its elderly citizens (Christensen, 2012; Daatland 1997, 1990; Vike, 2017). As in other Western countries, new trends are emerging in Norway’s demographics: One of these is the unprecedented growth in Norway’s ageing population (Dommermuth, Klobas and Lappegård, 2015; Syse et al, 2016a, Syse et al 2016b, Tønnessen et al, 2016, UN World Population Projections, 2017). As of 2016, national statistics project the number of people aged 70 and over to represent 11% of the total population (Tønnessen et al., 2016, p.6). This means that ‘about every ninth person is aged 70 years or over’ (ibid). In addition, there is likely to be a greater increase—of about 19%—in those aged 70 years and over by 2060 (ibid). As such, it is estimated that ‘almost 1 in every 5 persons’ (ibid) will be 70 years or older by 2060. The number of people aged 70 years and older is expected to increase from 600,000 in 2016 to about 1.2 million in 2100 (Tønnessen et al., 2016, p. 5). Moreover, for the population aged 80 and above, there is likely to be a double increase from 220,000 to 440,000 between 2016 and 2100 (ibid).

The estimated growth in Norway’s aged population will presumably include people with both short-term and long-term health conditions (Holmøy, Otnes and Haugstveit, 2016; Otnes, 2014, 2010; Ramm, 2013). As reported in the Senior Citizens of Norway Policy Challenges 2010–2013, ‘Most older people are healthy, but most people who become ill are older’ (p. 26). It has been pointed out that these trends will eventually have major implications for social policy, as they put the social and healthcare needs of the elderly into question (Jacobsen, 2015; Senior Citizens of Norway Policy Challenges, 2010–2013). In ongoing

policy debates, one of the primary concerns relates to the available workforce to provide care services in Norwegian society (ibid).

Further, a policy brief on long-term care for older people reported by the Organization for Economic Cooperation and Development (OECD, 2005) has raised concerns about insufficient long-term care services in OECD countries such as Norway. It has been argued that a shortage of care workers in OECD countries would create greater challenges to the sustainability of the countries' healthcare (ibid). As a result, social policy considerations for long-term care in all OECD countries are increasingly focused around the fact that, 'for the future...when the number of very old persons in the population will increase steeply, more resources for long term care will be needed from public and private sources (OECD, 2005, p. 2). Subsequently, an OECD policy brief reported that, in a survey of 19 OECD countries, (including Norway), '[s]taff shortages and staff qualifications were the number one concern among long-term care policy makers. It is therefore important to address the issue of staff shortage now in order to avoid a further worsening of the situation in the future' (OECD 2005, p.6). In this policy brief (ibid), it was argued that 'it is unlikely that better quality care will be sustainable in the future with current staffing levels in the long-term' (p. 5). Subsequently, the report raised questions regarding how different OECD countries will meet the increasing demand for the long-term care for older people.

In many Western democracies faced with an ageing population and workforce challenges, immigrant care labour has become a way of killing two birds with one stone (Bourgeault et al., 2010; Cangiano, 2014, Cangiano and Shutes, 2010; Walsh and O'Shea, 2009). This is certainly the case in Norway, which is experiencing rapid growth in the demand for healthcare workers (Task Force Healthcare Market Survey, 2017). Compared to countries such as Denmark and Sweden, it has been argued that Norway has a significant advantage in their ability to employ more healthcare personnel. This notwithstanding, however, 'Norway has experienced a shortage of healthcare professionals to service the one million people living in rural areas' (ibid, p.17, citing World Bank, 2017). Thus far, critical attention has been paid to Norway's increasing demand for skilled or professional care workers, such as doctors and nurses. For instance, in November 2015, Health Minister Bent Høie was reported as saying that Norway would not be able to recruit enough doctors and nurses (my own translation) (Aftenposten, 2015).

In this interview, Høie expressed concern about the need for an extra 44,000 healthcare professionals to keep up with the growing demand of Norway's ageing population over the

next 25 years. He stated that Norway will need 13,000 doctors and 17,000 nurses, in addition to ‘more’ health workers in the municipalities—interestingly, Høie did not specify which kind of workers were being referred to with this last, just that ‘more’ of them were needed. In a similar vein, a previous report for the Norwegian Statistics Bureau (SSB) by Stølen (2012) estimated that there would be a need for 57,000 *helsefagarbeidere* and 28,000 nurses by 2035.

All of this shows that there has been critical attention directed toward Norway’s increasing demand for skilled health workers. However, ‘care’ (*omsorg*) is not explicitly mentioned in any of these discussions. This observation aligns with my earlier argument in Chapter 1, that certain categories of health workers—particularly those who are ‘unskilled’—go unnoticed in the larger discourse about these issues. It has, nevertheless, been observed that ‘unskilled’ healthcare workers form an important part of Norway’s health workforce, and that immigrants play a significant role in this category (Abrahamsen and Kjølvik, 2013; Jacobsen 2015). I was unable to find any specific official data on the number of ‘unskilled’ immigrant care assistants working in Norwegian elderly care; however, in a statistical analysis on the use of health and care services among the elderly, Ramm (2013) stated that:

Even with prudent presumptions about demography and improvements in the quality of the services, the demand for health personnel in Norway will increase strongly in the years to come, especially after 2020. The percentage of the total work force engaged in health and long-term care sectors may be more than doubled by 2060. Immigrants performed 13 percent of the man-years in long-term care services. The corresponding percentage in Oslo was 40 percent. ⁵Immigrants stand for about half the increase in man-years in the last years. (p. 6)

Put together, I argue that Norway’s dependence on immigrant care workers and the lack of knowledge about the experiences of ‘unskilled’ immigrant healthcare assistants in elderly care is creating an alarming gap, which must be filled. Workers in these positions fulfil direct service-oriented tasks and have the most contact with the elderly. Yet, the full extent of the roles they play and knowledge about their relationships with their elderly clients is very limited.

⁵ In this report, immigrants were defined as ‘a person born abroad with two foreign parents’ (p. 55).

As a background to Norway's immigrant workforce, I now turn to a general overview about integration of immigrants into the welfare states and labour market.

Integration of immigrants into the welfare states and labour market

The ways in which the incorporation of immigrants has been highly regulated through various welfare schemes and policies in the Nordic states, is closely related to the need for immigrant care workers. For several decades, immigrants have played a critical role in the workforce in Scandinavian countries (Brochmann and Hagelund, 2011). Using Denmark, Sweden and Norway as a point of departure, Brochmann and Hagelund (ibid) have pointed out that these countries are generally thought to have a generous welfare system. There are, however, striking differences concerning their immigration policies. For instance, Denmark is known for its strict immigration policies: a claim fuelled by the state's connection to non-liberal ideals. Sweden, however, appears opposite to Denmark, with an international reputation for having somewhat liberal immigration policies. Norway's immigration policies, in turn, appear to be somewhere between the non-liberal model of Denmark and the liberal stance of Sweden.

In spite of these differences, however, Denmark, Norway and Sweden are built on strong labour-intensive principles, which in turn raises concerns about how immigrants are engaged in the labour market of these welfare states. The nexus between a generous welfare system on the one hand and labour-intensive market principles on the other forms the basis on which immigration policies were introduced within these countries in the 1970s. In 2007, the OECD report on international migration reported an assessment of policies that integrate immigrants into the labour market. In this report, Scandinavian countries were placed at the very bottom. Contrary to this, reports by the British Council on Migration Integration Policy Index in the same year (2007), with specific reference to policies that integrate and extend rights to immigrants among 28 European countries, placed Sweden at the topmost position whilst Norway and Denmark occupied the 8th and 21st positions, respectively. In interpreting these reports, Brochmann and Hagelund (2011) argued that, 'these surveys leave the impression that the extension of rights to immigrants in the region has had marginal impact on the ability of states to swiftly include newcomers in productive work' (p. 15).

However, Brochmann and Hagelund (ibid) observed that, historically, 'rights and duties' feature as critical components of Nordic welfare states. Association with such norms were heightened in 20th century labour movement slogans such as 'do your duty, claim your rights' ('*gjør din plikt, krev din rett*') (Brochmann and Hagelund, 2012). In the wake of rising

numbers of labour immigrants from outside Europe during the early 1970s, concerns about the potential challenges of immigrants on welfare and issues of social policy were hotly debated in Norway and other Scandinavian countries (ibid).

One part of the debate centred on economic concerns. The backdrop of this argument points to the solidarity and sharing of benefits between individuals who are perceived as members of the same ethnic or national community. Thus, Benhabib (2002) talks about bounded universalism which argues that the possibility to acquire economic rights must be the result of an obligation or duty, which is backed by an immersion into a social web. This way of thinking gave rise to the concern that, in an era of global economic developments, it is implausible to proceed from the assumption that welfare can be shared with people who do not belong to a group.

From another angle, arguments have been advanced from the point of social cohesion, resting on the weakening effects of cultural diversity to the normative base of the welfare states (Goodhart, 2004). Goodhart (ibid) holds that welfare states have a strong sense of national solidarity, which is derived from its cultural homogeneity. Cultural diversity thus undermines this homogeneity, as the values and practices of culturally diverse groups—such as immigrants—are often in contrast with the ideals of their host countries. By demanding and insisting on recognition of the cultural values of diverse groups, Goodhart (ibid) argues that the cultural values that perform social cohesion in host countries become threatened, and that this is not beneficial to welfare states.

Highlighting the kinds of immigrant practices that are compatible with the policies of welfare states, Koopmans (2010) argues that host-country language acquisition is key, and that immigrants are worse off when welfare states provide generous benefits backed by multicultural policies without an increased focus on language acquisition. This in turn leads to a situation where immigrants become highly dependent on welfare: a situation which also leads to social and economic exclusion.

The above arguments suggest that the combination of a generous welfare system with easy access to benefits leads to poor participation in the labour market, which results in negative economic and social consequences for both immigrants and the welfare states.

These arguments notwithstanding, however, it has been observed that the contribution of immigrants on the labour market offers a solution to some of the challenges faced by welfare states, such as their healthcare needs (Freeman, 2006; Nannestad, 2007; Razin and Sadka,

2000). Within such debates, issues such as labour shortages among European nation states, the need for immigrant labour, brain drain, exploitation and the consequences of global labour trade are open for discussion. As stated in the EU's green paper on managing economic migration (2005),

The current situation and prospects of EU labour markets can be broadly described as a 'need' scenario. Some member states already experience substantial labour and skills shortages in certain sectors, which cannot be filled within the national labour markets. This phenomenon concerns the full range of qualifications—from unskilled workers to top academic professionals'. (p. 4)

Since Norway is not a member of the EU, it could be argued that the above statement is not directly applicable. I argue, however, that the situation in Norway fits the EU description of a 'need' scenario, one of the effects of which is reflected in political and socio-economic measures, such as labour market initiatives in Norway.

The political and economic context of an active labour policy targeting immigrants

In the past four decades, welfare systems in Western countries have witnessed shifting political and economic measures, which underscore the need to emphasize the politics of efficiency. Though the focus of this discussion is Norway, the discussion is much broader. Glazer (1990), for example, has charted trends dating back to the 1970s in the US healthcare system, where economically driven motives led to de-hospitalization. In discussing the implications of this, it has been argued that management arrangements and healthcare policies have long been structured around labour intensive and cost effective measures (Aronson and Neysmith, 1996; Brown and Smith, 1993; Glennerster and Matsaganis, 1993).

Similarly, in Norway, significant changes in socio-economic and demographic patterns have fuelled policies with an increased emphasis on the politics of efficiency. Two significant consequences of this development can be seen through economic and labour market policies and initiatives that emphasize a cost-effective workforce and the use of cheap labour, such as that provided by immigrants.

These policy measures—such as the active labour market participation programme—include a range of initiatives for increasing employment opportunities, particularly for the population of people who have challenges accessing the labour market (Brochmann and Hagelund, 2011; Halvorsen and Stjernø, 2008). The implications of these policy measures have sparked a range of debates (Bratsberg, Raaum and Røed, 2017; Dahl, 2003; Dahl and Drøpping, 2001; Dahl

and Lorentzen, 2005, 2003; Djuve et al., 2017; Langeland, Dokken and Barstad 2016; Strøm et al., 2015). On the one hand, policy makers anticipated that increased participation in the labour market could solve the need for workers. On the other hand, in spite of the significant increase in labour participation (Christensen, 2003), there remains a fundamental concern regarding meeting the workforce needs of Norwegian society, especially due to the ageing population (Høie, 2015; Ramm, 2013; Norwegian Directorate of Health, 2012; Task Force Healthcare Market Survey, 2017). Additionally, as reported in the OECD's (2005) thematic review on Norway's policies to improve work incentives: 'Major challenges for the Norwegian labour market policy are to retain people in the labour force, to support the good functioning of a flexible labour market with vocational and geographical mobility, and to increase the supply of labour' (p. 3).

In line with such observations, the Norwegian Parliament passed a legislation in June 2005 on worker protection and environment issues. Effective in January 2006, this legislation was to 'create a more inclusive working life' (OECD, 2005, p. 6). The main ambition was to have a comprehensive policy that would be flexible enough to include people who are at the margins of the labour market. Major target groups for both the active labour market policy and the new legislation included immigrants, the vocationally disabled, and other vulnerable groups (Brochmann and Hagelund, 2011; Halvorsen and Stjernø, 2008; OECD, 2005). This represents the belief among policy makers that an active workforce would also encourage groups who are socially excluded to be included in the labour market. An interesting observation, however, is a concern which relates to how to have a proper balance between the policy goal of creating possibilities for the so-called 'vulnerable' groups in the labour market and the general challenges inherent in the system (OECD, 2005, p. 6). This becomes particularly crucial following studies which indicate that after 7–10 years, some of these 'vulnerable' groups, such as immigrants, drop out of the labour market (Bratsberg, Raaum and Røed, 2016).

In the second instance, workforce challenges in the Norwegian labour market are discussed in terms of demographic development with its attendant development of decreasing trends in labour force participation (Sandvik, Bø and Horgen, 2017, 2018). One of the explanations cited for this is that, on average, the working population is growing older, and with a decreasing birth rate, the task of reaching a balance between an ageing population and an active labour market is formidable (Dommermuth, Klobas, and Lappegård, 2015; Syse et al., 2016b; Tønnessen, Leknes and Syse, 2016). With both a welfare and political commitment to

care for its elderly, Norway's ageing population has a direct effect on government expenditure for health and elderly care. In a publication entitled '*Health and Care: Use of Services Among the Elderly*', Ramm (2013) reported that long-term care cost for the elderly in Norway is high. Similarly, in an OECD (2005) report, Norway was mentioned as one of the two countries with the highest expenditure on healthcare.

Following the high cost of long-term care, initiatives that encourage cost effective measures became intensified. For instance, the Norwegian state combines a capacity building approach, which seeks to encourage home care services for the elderly and discourage institutional care, since the latter is deemed more expensive (Bjørnholt et al., 2017). Accordingly, there is also the need to cut down on both administrative and professional positions to save wages.

Practically, this translates into a situation where there are staff reductions. In principle, the need to be cost effective makes sense. Yet, the reality remains that in spite of these efforts, there is still a considerable number of elderly Norwegians in need of care assistance (Ramm, 2013). These elderly people live in institutions or their private homes, and 'those who live in institutions are in more need of care than used to be the case' (ibid). To reiterate this, a report by the Norwegian Institute of Public Health (NIPH, 2016, p. 1) observed that, 'although more elderly people than previously report good functional ability...there are also many who live for many years with chronic diseases'. Following this, it makes sense to argue that there is a category of elderly Norwegians who need someone to help them put on their diapers, take their coffee to them and support them so they can function in their daily life.

Consequently, the need to balance the emphasis on the politics of efficiency through wage cutting measures and the demand to provide for the healthcare needs of elderly Norwegians imply a need for strategic adjustments. One of these strategies is to rely on a category of the workforce who could be offered lower wages to fill otherwise professional positions. As pointed out by Isaksen (2010),

As the welfare states expanded, the provision of services has become more costly. One strategy to keep costs down has been to hire migrant workers as part of a cost-minimization strategy. The ageing population ...have been important as a driving force in developments of intersecting welfare and migration politics. (p.12)

With the opening of the Norwegian workforce market to immigrants through active labour market participation initiatives, and with the focus on cutting healthcare expenditure through cheap or less labour, it is perhaps not surprising that immigrants are becoming familiar faces

in Norwegian care work. As reported by Abrahamsen and Kjelvik (2013), there has been a doubling effect in the number of immigrants in Norway's care sector. For instance, between 2006 and 2011, the number of immigrants' man-hours in the elderly care increased from 7.6% to 12.9% (p. 56). Abrahamsen and Kjelvik (ibid) pointed out that, in general, the proportion of immigrants in care work is significantly higher than the national average. This is particularly the case in large eastern municipalities, such as Oppegård and Bærum, and in Northern municipalities, such as Bjarkøy and Vadsø.

In Oslo, it was reported that immigrants contribute 40% of the man-hours (ibid). These immigrants, as observed by Abrahamsen and Kjelvik (ibid), come from 168 different countries (ibid, p. 58). Increasingly, immigrants from these different backgrounds and countries are those who take care of the elderly Norwegians in nursing homes as well as their private homes. When related to the above discussion on the historical and policy developments for integrating immigrants into the welfare states and labour market, I observe some tensions, which are elaborated in the following sub- section on political rhetoric and the reality of practice.

Political rhetoric and the reality of practice

'Both local and national politicians are aware of the fact that many frail elderly people do not get help even for their most basic needs' (Leader of the Elderly Action group, 2009, Aftenposten, 2009, as cited by Jacobsen, 2015, p. 204).

It seems to me that the policy transformations concerning immigrant labour reflect a major tension wherein two important concerns for the welfare state meet. The first concern stems from the need to ensure decent standards of living and self-support for people living within the state's boundaries. The second is derived from the bargain of utilizing immigrant workforce (or cheap labour), chiefly among healthcare professions because of staff shortages. Taken together, I think that the linkage between these concerns provide a backdrop to some of the challenges with immigrant labour that augment the focus of this study. For instance, consistent with the state's overall philosophy regarding the provision of care for its population, a number of policies have been reformed in an attempt to provide both organizational and workforce solutions in the healthcare sector. These reforms are part of a range of healthcare policies that are also linked to elderly care. As pointed out by Seeberg

(2017), policy decisions about Norwegian healthcare are usually made at the national level, spearheaded by the Ministry of Health and Care Services.

With specific reference policy documents on elderly care, Jacobsen (2015) has argued that in Norway, the language of reforms reflect a political attempt to demonstrate efficiency. A key challenge, however, is that there are inconsistencies between the messages embedded in health policy documents, and the dominant concerns that these policies claim to address (ibid). For instance, with reference to elderly care workforce needs, Jacobsen points out that ‘important themes are strikingly absent from the public policy papers...one of them is who cares for the frail elderly’ (p. 204). In addition, the fact that the majority of caregivers are women—and that these caregivers are increasingly multi-ethnic—are topics that are absent from policy documents and unmentioned by most politicians (ibid).

An important parallel development in this context are concerns from elderly Norwegians through organized groups such as the Norwegian Pensioners Association (NPA) and the Norwegian Senior Citizens Association (NSCA).

The Elderly Action group, which is quoted at the beginning of this section, has likened elderly persons to post office parcels, sent between hospitals, nursing homes and their own homes. The implication here is that that elderly Norwegians have difficulty accessing care and although politicians are aware of this issue, it remains unaddressed.

Concerning my own study, I argue that the difficulties experienced by the elderly in accessing care raises questions about the obligation of the state to take care of the needs of its elderly citizens. When narrowed to workforce needs, it is a question of how policy debates can effectively address specific issues related to the essential and practical workforce needs in elderly care. The specific workforce at the centre of my discussion is immigrant healthcare assistants. In the next chapter, I explicitly lay out the theoretical perspectives that shaped the research focus to render the experiences of participants’ meaningful.

Chapter 3: Theoretical perspectives

In reference to how the *pleieassistent/pleiemedarbeider* has been described as lacking formal qualifications in Chapter 1, the immigrant healthcare assistants also told me about common perceptions related to their job. In the words of a participant named Dido, ‘people do not respect you because they see healthcare assistant jobs as work for people without qualification or training’. Dido’s example carries the assumption that healthcare assistants in elderly care are perceived as lacking recognized qualifications. As such, the immigrant healthcare assistants I interviewed are considered as ‘unskilled’.

In the literature, the classification of work as skilled or unskilled is rendered meaningful through scholarly perspectives that analyse work both as a feature of the division of labour in workplace environments and as a part of relationships in society. Many of these ideas are found in the fields of sociology of work and education, which draw attention to the ways in which the function of work can capture and reflect societal complexity. Scholars have analysed occupation and work from different perspectives—for example, Hughes’ (1984) research on the world of work and occupations, and Abbott’s (1988) analysis of professional jurisdiction, both of which are relevant to my own work.

The participants in this study talked about their experiences in a way that combined the complicated nature of interactions among skilled and semi-skilled occupational groups with the complexity associated with multiple social categories (e.g. gender, class/status, race/ethnicity). When faced with the question, therefore, of how theoretical perspectives could provide an increased understanding of participants’ experiences, my focus centred on theories that could help highlight how interaction with semi-skilled and skilled occupational groups enhance or impede the ability of the immigrant healthcare assistants to provide care, and explore how the social categories of being an immigrant healthcare assistant can be understood as crucially significant.

In the literature, it seems to me that this requirement can be partly met through perspectives on complexity theory and intersectionality. Like the sociology of work and occupations, these topics have also been analysed from various perspectives, but (as I discuss below) I found the work of Heylighen et al. (2007) and Kernick (2002) on complexity theory, and Crenshaw (1991, 1989) and Collins’ (2015, 1998) work on intersectionality to be most influential in shaping the focus of my discussion. First, however, I begin by discussing the work of Hughes and Abbott (mentioned above)—which, taken together, presents one of the most fully

articulated analyses of the sociology of work and occupations. I then broaden my theoretical perspectives by identifying fundamental ways in which scholars have conceptualized complexity theory. Next, I explore the evidence of intersectionality within central domains such as race, class, gender and ethnicity. Finally, I consider how sensitivity to the element of ‘dirt’ enriches participant’s experiences in Norwegian elderly care.

Work and occupations

Hughes (1958), in referring to the notion of work and occupations, argued that occupations or work is one of the fundamental means by which individuals obtain access into larger society. In an extension of this in later writings, Hughes (1971) asserted that occupations are made up of different competences and skills, and it makes practical sense that certain levels of competence are expected from various members of an occupation. Hughes argued that occupations mainly try to secure their image and position in society by pursuing a professional status. This can create certain internal dynamics within occupations, and it can be argued that one of the means through which these occupational dynamics occur is when occupational groups define their activities as different from those of other people (ibid).

In emphasizing the significance of occupational dynamics, Hughes (1971) made an analytical distinction between ‘license’ and ‘mandate’. For Hughes, license ‘consists of allowing and expecting some people to do things which other people are not allowed or expected to do’ (ibid, p. 287). Mandate, on the other hand, refers to how occupations ‘define what is proper conduct of others toward the matters concerned with their work’ (ibid). Broadly applied, the license for defining and controlling occupations is built on a self-conscious solidarity and interest, which makes the activities of a particular occupation different from those of others. Thus, ‘by virtue of gaining admission into the charmed circle of professions, they (sic) individually exercise a license to do things others do not and (sic) collectively, they presume to tell society what is good and right...indeed, they set the very terms of thinking about it’ (Hughes, 1971, p. 288).

The license does not only tell society what is ‘good and right’, but is implicit or explicit in a mandate, which, according to Hughes (1971), includes the right to sanction members of an occupational group to abide by the demands of the occupation, as established by others. In effect, when occupations demand ‘proper conduct with respect to matters concerned in their work’ (p. 287) the issue of quality assurance and expectations becomes key.

Thus, licenses and mandates complement each other and their elements are achieved through various symbolic requirements—such as educational qualifications or specialized training and skills—and the demarcation of roles and responsibilities that establish criteria for judging an occupation as the most important among other occupational groups (Hughes, 1971).

Consequently, Hughes argued, it is essential for occupations to inform the public about the specialist nature of their work by insisting that it can only be performed by the qualified or trained. When this is achieved, occupations—through professional associations—impose considerable control, enabling them to define codes of practice and emphasize dangers when their profession is practiced by the unqualified or untrained.

Hughes (1971) further asserted that by examining how occupational groups validate the importance of their occupation through claims to professional status, it is possible to have a deeper knowledge of the meaning of occupational status in society. Here, my understanding of Hughes is that through the concept of license and mandate, it is possible to analyse how occupational status can also influence the entry and location of people within the stratified system of society. Thus, by studying the importance of occupational groups, I explore how the emphasis on qualification works to shape the distinctions between the skilled, semi-skilled and ‘unskilled’ healthcare workforce within Norwegian society. In order to explore my analytical focus, I use Hughes’ concept of license and mandate to illustrate that the distinctions among occupational groups are mutually constructed to emphasize the importance of inclusion and exclusion. Through the distinction of occupational groups, some categories of workers are labelled as qualified, skilled or belonging whilst others are not. In other words, I argue that the concept of license and mandate can also be understood as a process of creating a category of ‘others’.

Occupational mobility and being disadvantaged or vulnerable are relevant topics that came up in my empirical data, particularly in relation to social policy measures and practices. As a result, one of the theoretical questions in my analysis concerns how to explore the relation between the accounts of participants to the external processes of policy programmes and practices. I have found Hughes' work to be helpful in framing this question. Essentially, Hughes (1994) argued that the system of work is dynamic and not static and as a result, any attempt to understand an occupation must refer to the system in which it operates. This includes an emphasis on the settings in which both professional and non-professional occupations occur with ‘attention to the shifting boundaries between them and the kind of cooperation required for any one of them to perform effectively’ (ibid p. 76).

In keeping with this idea, Hughes demonstrated the effects of dynamism on work systems and the possibility for occupational mobility. He clearly recognized that lack of occupational mobility ‘undermines social stability’ (1994, p. 1) but it is not clear to me how individuals attain mobility, or if there is equal opportunity for occupational mobility among all members of an occupational groups.

As we shall see, my data show that in sharing experiences in elderly care, participants referred to occupational groups above their ranks. These accounts were mostly described as a competition in relation to the preservation of occupational status and the boundary that separates the skilled and semi-skilled from the unskilled. Thus, the question for me is how to understand this competition. I turn now to Abbott’s (1988) theory of professions, which build on Hughes’ ideas above, and discuss its relevance to my study.

Professional jurisdiction

Abbott was primarily concerned with the process by which an occupation control its knowledge and skills or its peculiar services and activities through the creation of boundaries. Thus, in his *System of Professions*, Abbott (1988) introduced the concept of jurisdiction and defined it as a link between

a profession and its work, a link I shall call jurisdiction. To analyse professional development is to analyse how this link is related in work and how it is anchored in formal and informal social structure, and how the interplay of jurisdictional links between professions determine the history of individual professions. (p. 20)

Here, it seems that Abbott’s conceptualization of jurisdiction is closely related to the way in which I explore how the distinctions among the occupational groups in Norwegian elderly care are linked to policy practice. With this in mind, my understanding of Abbott is that professions are linked to work (i.e. sets of tasks) and these are further hemmed in by jurisdictional ties and the social system. An analysis of professional development is therefore an analysis of how the link between professions and their work or tasks are linked to claims of jurisdiction and how these are further linked to the internal system of work and the external structures of society. Within the system of work and the social structure, Abbott (1988) observed that professions interact and compete with each other. Thus, of significance to Abbott is the ‘interrelations of professions’ (p. 8). These interrelations are mostly grounded in perpetual control for knowledge and skills. This control is accomplished, Abbott argued, by

two means. The first is through occupations ‘commonly called crafts’ (ibid) which emphasize the use of techniques. Secondly, through the use of ‘abstract knowledge’,

[p]ractical skills grow out of an abstract system of knowledge, and control of the occupation lies in the control of the abstractions that generate practical techniques. The techniques may in fact be delegated to other workers (Abbott 1988, p. 8).

From this perspective, a critical characteristic that distinguishes professions from other occupations is the claim to an abstract body of knowledge:

Any occupation can obtain licensure...but only a knowledge system governed by abstractions can redefine its problems and tasks, defend them from interlopers, and seize new problems...abstraction enables survival in the competitive system of professions’ (Abbott 1988, p. 9).

Here, what Abbott seems to address in his conceptualization of abstract knowledge is an emphasis on how professions use exclusive knowledge about their activities to protect and promote their status in a hierarchy of professionsstatusl. In this study, I use abstract knowledge to discuss the process of limiting occupational mobility and entrenching boundaries among occupational groups in the healthcare sector. However, I use this with a different emphasis. For instance, when trying to understand the hierarchical nature of the care sector and opportunities for occupational mobility, participants involved elements such as the nature of their tasks and the lack of financial support to participate in training programmes for upgrading skills. Put differently, movement on the occupational ladder means having certain requirements concerning achieving what is commonly termed ‘skills’ and ‘knowledge’. This seems reminiscent of how Abbott discussed abstract knowledge as a system of knowledge governed by abstractions that define its problems and tasks.

However, when I explored occupational mobility from a policy perspective, the meaning of occupational mobility includes a disjunction between policy programmes (e.g. active work policies) and the influence or reality of such programmes on their target groups, such as immigrant healthcare assistants. In other words, I argue that when a policy is enacted, its achievement can have a different and real effect that needs to be acknowledged. Thus, when I discuss how participants are strategically placed along the elderly care hierarchy, I employ ‘abstract knowledge’ in way that emphasizes that the challenge is embodied in policy practice.

To return to Abbott, an essential aspect of professions is the means by which they make jurisdictional claims, settle jurisdictional disputes or defend their jurisdiction and professional integrity during an ‘attack’. This, according to Abbott, could be through public opinion, workplace settings or legal means. Of significance to this study is the workplace (or organizational) setting. Within this setting, Abbott argued, professionals claim and reconcile workplace tensions or disputes about professional boundaries through negotiations to emphasize their positions or public image.

The reality of jurisdictional relations in terms of tensions and settlement become blurred, however, especially during moments of increased workload and pressure. Under such settings, the focus is to complete the task and there is mounting pressure on both professionals and non-professionals to achieve this aim. Rigid demarcations, Abbott argued, become hard to maintain during work overload and pressure. In such situations, the form of knowledge that Abbott called ‘work-place assimilation’ (p. 65) takes place. Here, the lower ranking professionals or ‘non-professionals’, while they lack the theoretical trainings of a profession, ‘learn on the job the craft version of a given profession’s knowledge systems’ (1988, p. 65-66).

When narrowed to the context of this study, it could be argued that as an ‘unskilled’ group of workers, the immigrant healthcare assistants may acquire some of the skills of care work through the work activities of skilled professionals, such as nurses, or semi-skilled care workers, such as *helsefagarbeider*. In this way, the healthcare assistants to some extent may be able to perform certain aspects of the work of these skilled and semi-skilled professionals.

Abbott maintained that because of work place assimilation, it could be extremely challenging—if not impossible—for professions to claim full control over professional boundaries in the work environment. The implication here is that professional groups may have to use alternative settlements for workplace jurisdictional disputes. These could be through means such as explicit division of labour and subordination.

‘Subordination’ (Abbott 1988, p. 71), as an alternative settlement of disputes, is of particular interest to this study. Citing nursing as an example, Abbott argued that the vision of nursing ‘as an administrative and custodial equal with the medical profession’ (ibid) was unacceptable to the medical profession. This resulted in the subordination of nursing under medicine.

For Abbott (1988), subordinate groups present some advantages over professions with full jurisdiction in the workplace. For instance, in addition to being seen as a means of settling

complex workplace relations or divisions of labour, subordination ‘also permits the delegation of dangerously routine work’ (p.72).

Taking the system of occupations as a frame, in his final analysis, Abbott examined the sources of disruption or change in the system of professions. These include the influence of distinctions within occupations that in turn influence power relations, and the influence of organizational and societal changes in technology, which could disrupt the mandate over which professions claim control.

For Abbott, distinctions within occupations often lead to disturbances in the system of professions, as professions tend to move away from tasks that separate them from other occupations. This, Abbott observed, is the result of status ranking whereby the highest-ranking professions claim tasks in professionally ‘pure’ environments or contexts. Following this, tasks within ‘impure’ work environments or contexts are delegated to particular members of an occupation. As we can see, what Abbott addresses in his discussion on occupational ranking is similar to Hughes’ emphasis on the relational aspect of occupational groups. Abbott maintained that such division of labour reveals inter-occupational power relations by dividing work into segments, which are claimed to be professional and non-professional.

In discussing some of the social forces which influence the system of professions, Abbott made links with how the central value system of a society can legitimize claims for jurisdiction. For instance, Abbott observed that changes in values, such as contemporary reliance on science and technology and the rise of universities, reflect value shifts in wider society. Accordingly, these changes in societal values have moved inter-occupational competition to a level where there is emphasis on requirements—such as authorization or authorized professionals—for efficiency of service through explicit division of labour. These changes, according to Abbott, provide legitimate grounds to separate professionals (experts) from non-professionals in the system of work.

Related to this study, I discussed in Chapter 1 how the emphasis on organizational efficiency through modifications in the Norwegian healthcare assistant workforce poses challenges for the care assistants and for elderly care. In extending this discussion to the rise of universities, Abbott argued that universities train professionals such that they can provide authorized services in a legitimate capacity. In this regard, a potential source of inter-professional conflict in the system of work can be traced to a dimension of professional training that guarantees autonomy over separate or specialized knowledge. This observation by Abbott is salient for this study, as the distinction between skilled and semi-skilled healthcare

professionals is mostly tied to relevant education-based knowledge or qualification. Consequently, the simultaneous presence of skilled (nurses), semi-skilled (*helsefagarbeider*) and ‘unskilled’ (immigrant healthcare assistants) in Norwegian elderly care implies that there is likely to be the sort of inter-professional competition that Abbott describes. This could occur, for example, when the skilled and semi-skilled attempt to claim autonomy over their skills in relation to education, training or recognition in the form of authorization.

Abbott’s ideas were more focused on the systems of professionals as a whole and not necessarily on the details of individuals within a profession. On the one hand, this makes sense, since professionals are usually defined in terms of groups rather than individuals. Yet, on the other hand, I argue that individuals make up a group and depending on the composition of individuals in a group, it is reasonable to pay attention to the different identities of the individuals in a group.

In addition, a limiting effect in the works of Hughes and Abbott is that they were mostly discussed with a focus on nursing in a profession dominated by medical doctors. In view of this, Dahle (2003) suggested that one beneficial way to examine the work of care assistants in the division of labour in health care is to examine how nurses delegate their work to occupations below the rank of nursing. Such an approach also entails turning attention to the ways in which work is divided between nurses and occupational groups such as healthcare assistants. With such a focus, the many ideas raised by Hughes and Abbott are useful to explain how the division of labour and distinctions between the Norwegian elderly care workforces are formed and perhaps re-formed in the experiences of immigrant healthcare assistants.

Professional and unskilled?

Whilst it is tricky to establish how the Norwegian term(s) for ‘professionals’ or ‘skilled healthcare worker’ are used in policy debates and the structure of elderly care, it seems to me that ‘professional’ is used in a shallow sense. To take the perspective of Hughes and Abbott, firstly, it seems to me that the niche around which the word ‘professionals’ is carved in the elderly care setting has more to do with skilled workers or recognized skills. In other words, being a professional is equated to being skilled.

To bolster this, institutional structures use the trappings of professional knowledge or skills to control and exclude a category of occupational groups within the workplace. Indeed, professionalization could be acquired through the best efforts of educational/training

institutions. However, being a professional is not necessarily about extensive training. As a result, it could be argued that emphasis on professional requirements could be a career strategy for status.

In addition, the use of the word 'professional' seems to be a political attempt to emphasize a positive image for creating an efficient and effective workforce. However, given the presence of 'unskilled' healthcare assistants in Norwegian elderly care, the political emphasis on professionals without attention to the increasing number of 'unprofessionals' becomes contested.

In discussing occupations as a social role, Abbott and Hughes drew attention to how occupations link individuals to wider society and the significance of occupational roles in influencing the entry and location of individuals within the stratification of the society. Here, the authors demonstrated that work is an important basis for social integration. In analysing the impact of internal and external forces in the workplace environment and how these shape the boundaries between occupational groups, Hughes and Abbott underscored the interrelated nature between occupational groups and the complex dynamics of the division of labour, and how roles and responsibilities are negotiated and played out in the workplace environment. One of the analytical advantages of this insight for this study is the ability to potentially analyse the experiences of immigrant healthcare assistants and issues of workplace challenges in terms of workplace interactions. In the literature, discussions about complexity theory further illuminate this focus.

Complexity theory

In general, the word 'complex' is often used when it is difficult to sufficiently describe or manage something. According to dictionary definition, complex pertains to the 'state of having many parts' or 'features of something that make it difficult to understand' (Cambridge dictionaries online, 2015). As a trans-disciplinary perspective, complexity theory is known to have over 45 definitions (Kernick, 2006), but its common denominator suggests that systems are unpredictable. Contrary to systems theory, which views systems as closed and in equilibrium, complexity theory asserts that systems are far from being in equilibrium. Rather, it argues that systems are open and they interact with their environment through various forms of complex exchanges and interconnections (Byrne and Callaghan, 2013; Capra, 2005, 1996; Heylighen et al., 2007). It is further argued that these webs of exchanges and interconnections between systems and their environment must be considered within their specific context, and

the observer who is involved in shaping knowledge about the behaviour of the system must be given some prominence (Montuori, 2013; Montuori and Purser, 1996).

Complexity theorists also advance arguments, which suggest that there are various interconnected units within a social system. Further, these units are engaged in complex entangled relationships which imply that actions within the systems are not isolated. For instance, within elderly care, there are various units of care providers, ranging from the management of elderly care institutions through the medical doctors, nurses, therapists and low-skilled workers. The collective services within these multiple units influence work practices for the elderly client. These units may, however, have their own specific ways of work, but the point of implementing their work is where interactions between these units are played out. The action or effect of the work practice is therefore not isolated but shared between these different units of the elderly care system. This explains the inter-connectivity and entangled process within the system.

In this study, I use complexity theory as a theoretical perspective to explore how different dimensions of work within the units of elderly care enhance or impede the ability of immigrant healthcare workers to provide care. Most importantly, complexity theory is used to examine how connections between the various units influence care provided for the elderly. For instance, how do the ‘unskilled’ immigrant caregivers perceive their work in relation to decisions made by skilled workers, such as nurses, and semi-skilled workers, such as *helsefagarbeider*?

As argued by Klein (2004), researchers who use complexity theory must move away from using the dominant metaphoric research microscope that urges researchers to have a closer look at parts of a system. Rather, they must adopt the use of the kaleidoscope to examine parts of a system since ‘it creates shifting shapes and colors, resulting in new and unpredictable patterns and hues’ (p. 5). Klein’s idea is reflected in how I intend to use complexity theory to move away from the notion of obtaining guaranteed knowledge or whole truths, but rather to create new ways of making meanings from participants’ experiences in elderly care.

By default, complexity theory implies that the various units within elderly care engage in multiple relationships. The distinction within these multiple units produces power relations in a direct or indirect manner. In the beginning, I assumed that power relations primarily related to the professional hierarchy within the system. By this, I was thinking of how power is exercised due to the professional positions occupied by the healthcare workers. But during my fieldwork, it became clear to me that there was more than one power relation and these played

a major role in helping me understand the experiences of the immigrant healthcare assistants. This is to say that the issue of power relations as it pertains to the understanding of immigrant healthcare assistants turned out to be more complex than I anticipated.

Mainly, in my material complexity emerged through the intertwining of social categories such as gender, class, status and race. It is here that I find the work of Crenshaw (1991) on intersectionality useful. Crenshaw (ibid) maintains that not only are social identities such as race, gender and class implicated in shaping experiences; rather, they are simultaneously linked in producing experiences. This forms the focus of my next discussion.

Intersectionality

'At the core of an intersectional model is the understanding that individuals occupy complex and dynamic social locations, where specific identities can be more or less salient depending on the historical or situational context.' (Hankivsky & Cormier, 2009, p. 5)

Traditionally, the notion of intersectionality has been influential in informing a range of understandings within disciplines such as gender studies, feminist legal studies, women's studies and psychosocial studies (Crenshaw, 1991; Collins, 1998, 2000; Dhamoon 2011; Symington, 2004; Truth, 1851; Yuval-Davis, 2006). Perhaps this is due to the fact that intersectionality is rooted in black feminist scholarship and that the term is attributed to Crenshaw (1991), who coined it to heighten awareness of excluded populations in the U.S. Specifically, Crenshaw (ibid) drew attention to how women of colour were excluded from white feminist discourse, which equated women with whiteness, and anti-racist discourse, which equated blackness with men. Prior to Crenshaw, however, the famous speech by Truth in 1851 at the Ohio Women's Convention drew attention to an intersectional perspective to understanding the dilemmas of excluded populations. In her speech, 'Ain't I Woman?' Truth challenged the order of reason, which heavily relied on one social category such as race or gender to explain experience. She argued that race and gender constitute each other and one category (e.g. race) alone cannot fully explain the outcome of an experience without the intersection of other category or categories (e.g. gender). Contrary to the traditional concept, which analysed intersectionality from the perspective of disadvantaged black women, in this study, I sought to adopt a broader approach to other forms of disadvantages in relation to subjective classifications or stereotypes such as ethnic identity, class, gender and status. This

focus also meant that I focused on marginalization as it applies to both men and women and not only ‘women of colour’.

In the past, intersectionality was attuned to disadvantaged or excluded populations, but in recent times, the perspective applies to the ‘advantaged as well as the disadvantaged’ (Yuval-Davis 2006, p. 201). Practically, this makes good sense because, technically speaking, everyone has multiple identities that intersect in one way or another. As a perspective, the specific definition of intersectionality varies by different scholars and research context. A comprehensive discussion of these variations is beyond the context of this study. To the best of my knowledge, however, a common thread across discussions on intersectionality is concerned with how people have layered and multiple identities, which are connected to their history, the operations of power structures and social relations. Accordingly, intersectionality pays attention to the interplay of multiple categories such as ethnic background, gender, class/status, race and age and it is largely concerned with processes of domination and oppression (Collins, 1998; Cole, 2008; Diamond and Butterworth, 2008). Thus for Collins (2000), the notion of intersectionality can be used to explain ways in which micro-level social categories that describe an individual or group are connected to macro-level structures that create disadvantage or oppression. Put differently, intersectionality aims at exploring how disadvantage occurs because of multiple identities and the overlap of macro-level structures in compounding this.

As an analytical tool, intersectionality posits that the combination of different social categories should not necessarily be viewed as increasing the burden of individuals (Symington, 2004). Rather, the aim is to reveal how layered and multiple social identities produce distinctive or meaningful experiences in the lives of people (ibid). Here, my understanding is that, when used to explore the lived experiences of the immigrant healthcare assistants, intersectionality prompted me to pay attention to aspects of interwoven complexities that would not usually be considered relevant yet are meaningful in participants’ accounts. Thus, I ask, for example, if being an ‘immigrant’ in elderly care assistant job is the only category that makes a difference. Could there be other categories such as status, class or gender involved? How about power relations of other kinds?

In my data, I observed that some participants referred to their elderly clients and the family members of these elderly clients as people from a privileged society. Consequently, they felt that, as immigrants, their ethnic background, accent, complexion and the low position they

occupied in their job contributed to unpleasant attitudes towards them. As the participant I call Oplo said to me,

What do you expect? I don't think they see me as someone who is here to help their family members. These are rich people from a rich country... I think that what they mostly see and hear is that immigrants are people from poor countries. We have no education, cannot speak good Norwegian and we do cleaning jobs and this type of work in elderly care...but where is the time to have education when I need to keep working to pay the bills?'

In this example, I can see that categories such as social dimensions (*rich people from a rich country, immigrants are poor people from poor countries*), ethnic background (*immigrants, language*) and class (*education*) are interwoven. In other words, I observed that these categories were at work and became relevant in Oplo's account.

That said, drawing on intersectionality means that when I explore the lived experiences of the immigrant healthcare assistants, it is crucial to pay attention to how issues of their multiple identities, social positions and the systems of socio-economic and political structures are significantly interwoven—in particular in their narrations. Intersectionality therefore becomes a relevant theoretical perspective to enable me to explore categories such as language, ethnic identity and status in my data.

For instance, in exploring the categories of language, ethnicity and status, I scrutinize these as categories which represent different power relations, which in turn combine to make a difference in the lived experiences of being an immigrant healthcare assistant. This categorical approach is reminiscent to how Dahle and Seeberg (2013) discussed the interweaving of language and ethnic identity in their work titled, 'Does She Speak Norwegian?' With respect to Norwegian language, the authors suggest that immigrants face greater labour market challenges and reduced access to recognition or rewards due to assumptions that they are not likely to speak Norwegian very well.

Similarly, with respect to race, gender and class, Seeberg (2012b), in a different study, argued that immigrants are more likely to experience increased job competition or restrictions due to the complex forms of capital, the reality of integration policies and stereotypes about gender and minority groups. Here, Seeberg (ibid) conceptualized intersectionality to illustrate that the experiences of immigrants in the labour market are relational and reflect how, for example, constructions of gender are racialized to create experiences. Thus, while many Norwegian

women rely on immigrants to relieve them of their caregiving duties in order to take up high-paying professional jobs, immigrants become underprivileged as they take up these caregiving jobs in low-paid positions. In effect, such inequality on the labour market, Seeberg posits, makes Norwegian women privileged as they benefit from social constructions that define immigrants within low-paying positions on labour market.

In incorporating Seeberg's conceptualization into my work, I consider that, generally, men have different experiences from women and immigrants have different experiences from non-immigrants. Yet to understand the experiences of racialized non-Western immigrants who took part in this study requires another level of understanding of how social constructions of race are gendered to create particular experiences. As we shall see, my data show that the experiences of racialized immigrants are connected to the experiences of immigrants who are not racialized and the experiences of natives or Norwegians in the elderly care labour market. For instance, Norwegians are more likely to be viewed as professional care workers in semi-skilled and skilled positions such as *helsefagarbeider* and nurses than are racialized immigrants.

In addition, when related to racialized men, the social construction of their gender includes beliefs and practices that are interwoven with traditional notions that define women as caregivers. This web also includes notions of masculinity based on participants' ideas of how non-racialized men define their identity and status.

Further to the above, intersectional theorists such as Collins (1999b) have argued that the social category of gender is constructed as a social difference to maintain hierarchy in society. Far from being natural, gender is socially constructed and inextricably linked to stereotypes, beliefs, and practices associated with race. Such stereotypes, according to Collins (ibid), reinforce an image where, for example, 'black women' are degraded by being compared to 'white women' and 'white women' are degraded by describing them as weak people in need of the protection of 'white men'. In such instances, stereotypes reinforce gender inequality with strong racial and ethnic dimensions (Brown and Misra, 2003; Collins, 1999b).

At another level, it has been demonstrated that meanings given to race and ethnicity are highly gendered through dominant ideologies that subordinate women and men of colour. According to Collins (1999b), though such ideologies are sometimes obscure, the meanings become clear for members of a majority group or a dominant social category based on their position in the social structure. In this sense, power differences are entrenched in the social categories of gender and race, and these are reinforced as part of social life, ranging from

interpersonal relations to relational aspects of societal structures, such as the institution of work.

My personal observation is that the differences and tensions in conceptualizing intersectionality leads to different approaches in how to look for evidence in intersectionality in a study such as mine. Some intersectional scholars have focused on individuals (Crenshaw, 1991) while others have discussed intersectionality from the institutional vantage point (Collins, 1999; Browne and Misra, 2003; Seeberg, 2012; Weber, 2001).

In linking the two, I prefer to use the term intersectionality as a point of connection between individuals and institutions. The aim is to visualize and understand how the overlap of multiple identities influence opportunities and access for the immigrant healthcare assistants and, further, to explore how policy practices are inextricably linked to this. In this study, I observed that the identity of being an immigrant and policy practices, such as employment policies and programmes, converged at different points. For instance, some of the participants shared similar experiences in which they felt vulnerable because they were immigrants doing low-skilled care assistant jobs. In analysing this, it emerged that the intersection of policy practices—e.g. employment regulations and programmes and the institutional structures of the care sector—seems to support and maintain the vulnerability described by the immigrant healthcare assistants.

I see this as a different way of doing intersectionality; further, moving intersectionality to this level is helpful in enabling me to explore if the social identity of being an immigrant in a low-skilled position and the combination of policy practices or the political context created unique experiences for participants'. Thus, in my analysis, I explore, among other things, how the interaction of multiple social categories and the influence of socio-political realities complicated or simplified the lived experiences of the immigrant healthcare assistants.

I argue, however, that in using intersectionality, my aim is not to attend to all the complexities that surround the tensions in the discussions of intersectionality. In other words, the focus is not to necessarily argue that the immigrant healthcare assistants are more oppressed or disadvantaged or privileged than others. Rather, the focus is to explore distinctions that create disadvantage or discrimination. In the context of this study, an intersectional analysis opens up a perspective through which to explore how disadvantage occurs due to the combination of multiple identities (Symington, 2004). This is to say that because of multiple identities, some individuals and groups are pushed to the 'extreme margins and experience profound discrimination while others benefit from more privileged positions' (ibid p. 2). In my

analyses, therefore, I focus on how the distinctions of multiple identities and the operations of policy or power structures create inequalities that structure the relative positions and influence the unique experiences of the immigrant healthcare assistants. Thus, when exploring for example, the intersection of social categories and policy practices, it is crucial to pay attention to the context in which these merge, offering a deeper understanding of the experiences of participants'. In doing this, I observed that the notion of being in an occupation or doing work which is stigmatized or described as 'dirty' becomes significantly involved in how the immigrant healthcare assistants describe their experiences in elderly care. For instance, when participants spoke about how they felt vulnerable because of being an immigrant in a low-skilled position, they also talked about doing work that is dirty and heavy. How to deal with the involvement of 'dirty work' in this study is the focus of my next discussion. I call this an additional guiding perspective.

Dirty work

In my discussion on intersectionality, I mentioned that my aim is not to argue that the immigrant healthcare assistants are more oppressed or disadvantaged or privileged than non-immigrants. Rather, the focus is to explore distinctions that create disadvantage or discrimination. When related to dirty work, the question then for me was, 'How do I analyse or understand my data that shows that the notion of doing work, which is stigmatized as dirty, is substantively distinct in the experiences of the immigrant healthcare assistants?'

To find answers to my question, I used Hughes (1994) foundational analysis of 'dirty' work as a starting point to reflect on occupations or tasks which are perceived to be degrading. As a backdrop, Hughes (ibid) argued that the notion of the division of labour is not just about the distinctions between different parts of work. Rather, the essence is in how the different parts interact and how they are intricately linked to the social system. In emphasizing this, Hughes (ibid), stated that '[n]o line of work can be fully understood outside the social matrix in which it occurs or the social system of which it is part' (p. 55). For Hughes (ibid), '[t]he division of labour, in its turn, implies interaction; for it consists not in the sheer difference of one man's kind of work from the other, but in the fact that the different tasks and accomplishments are parts of a whole whose product all, in some degree, contribute to' (ibid, p. 50).

These different tasks, which according to Hughes (1994) interact with the system to form part of the whole, are of different values. Thus in his analysis, Hughes (ibid) took on the concept of 'dirty work' directly by arguing that '[a]nother feature of the kinds of work in question lies

in the peculiar ambiguities with respect to what is seen as honourable, respectable, clean and prestige-giving as against what is less honourable or respectable, and what is mean or dirty' (p. 51-52).

Here, a caveat to Hughes' argument is that all occupations have tasks that relate to aspects of dirt. In spite of the commonality of notions of dirty work in all occupations, Hughes emphasized that the value attached to certain tasks makes them symbolically dignified, whereas the value attached to other tasks makes them to be considered 'dirty'. In the system of work, Hughes discussed the notion of dignity or dirt of an occupation in terms of how tasks evolve. The rhetoric of this was described in how occupational groups ascend the occupational ladder. Using healthcare as an example, Hughes (1994) observed that:

The ranking has something to do with the relative cleanness of functions performed. The nurses, as they successfully rise to professional standing, are delegating the more lowly of their traditional tasks to aides and maids. No one is so lowly in the hospital as those who handle soiled linen; none so low in the mental hospital as the attendant, whose work combines some tasks that are not clean with potential use of force. But if there is no system in which the theme of uncleanness is so strong, likewise there is none in which it is so strongly compensated for. (p. 53)

Hughes used the term dirty work to refer to tasks perceived as degrading. He succinctly captured dirty work as physically, socially and morally degrading or tainted tasks. Hughes (ibid) pointed out that the concept of work described as dirty draws attention not only to the undesirable nature of such jobs, but also the connection such professions have to larger society. Accordingly, Hughes was also concerned about the consequences of work described as dirty on the sense of self or dignity of the persons in such work, as well as the discrediting of such work by society. The discrediting and lousy nature of dirty work, Hughes argued, leads to boundaries or creates 'silent' rules of avoidance, which divides occupational groups and members of a society. To fully grasp the theoretical significance of Hughes' (ibid) conception, I think that there is arguably the need to figure out why some occupations and tasks are considered dirty and how this can be rendered meaningful, and to explore if meanings about what constitutes dirty work cut across societies.

In relation to this study, the precise connection of Hughes' analysis of dirty work with larger society inspires me to highlight the social dimension of the concept of dirty work. Here, I find Douglas' (1966) conception of dirt relevant, since the emphasis of dirt as a dividing practice is also captured in her work. In elaborating this, Douglas explained notions of dirt in light of

purity and pollution. She conceded that there is no single definition of dirt that extends across cultures and societies. From this perspective, dirt so defined could have different meanings and connotations. Similar to the cliché that says that beauty lies in the eyes of the beholder, Douglas (ibid) contended that dirt ‘exists in the eye of the beholder’ (p. 2). Thus, for Douglas, the specific meaning of dirt reflects the underlying culture of particular societies and, as she further contends, understandings of dirt or pollution demands attention to its cultural and social interpretation.

Douglas (1966), however, pointed out that society connects cleanliness with goodness and dirt with badness. As a result, dirt is seen as a threat to cleanliness and society is often concerned with separating what is clean from what is dirty. In her words, ‘Where there is dirt, there is a system. Dirt is the by-product of a systematic ordering and classification of matter, in so far as ordering involves rejecting appropriate elements’ (p. 35). From these arguments, the seminal notion of dirt is degradation and stigmatization. Dirt is essentially ‘matter out of place’ (ibid).

My understanding of Douglas is that the description or definition of dirt can be analysed from different angles. The centrality of dirt, however, lies in the notion of contamination, hence the need to draw a boundary between what is seen as dirty and what is accepted as clean by the dominant value or culture of a society. Subsequently, perceptions of contamination imply that society or people are not particularly willing to encounter matters of dirt. Such perceptions are, however, context specific because as Douglas further explained in later writings, the material culture of societies is manifested through a scheme of symbols (Douglas (2002)). Symbols in this sense become the channel through which individuals transfer meanings from their personal cultural perspective to substantiate or understand cultural categories of other societies or cultures.

A meaningful way to understand the role of symbols is to regard them as a means of communication between an individual with significant reference to their culture in relation to the culture of others. As Douglas (2002) put it, ‘a symbol only has meaning from its relation to other symbols in a pattern. The pattern gives the meaning. Therefore no one item in the pattern can carry meaning by itself isolated from the rest’ (p. xxxi). I will return to this aspect of Douglas’ discussion in Chapter 6. However, returning to the specific discussion on dirt, similar to Hughes (1971, 1994), what emerges here is the notion of avoidance, where it is shown that dirt has potentially negative social consequences.

Largely, researchers have taken up the ideas of dirt and dirty work to explore how people or agents in tasks or occupations classified as dirty deal with its potential negative consequences.

My primary attention to such works was directed toward a study in which Perry (1978) analysed the work of garbage collectors in San Francisco. Perry argued that the work of garbage collectors was a perfect example of dirty work that is allocated to the most unskilled or lesser skilled in American society. However, contrary to notions of disgust and stigma associated with such occupations, Perry found out that his participants attached a certain degree of pride and esteem to an occupation that society describes as dirty.

Similarly, Emerson and Pollner (1976) pointed out that as a means of retaining integrity in work which is discredited, community mental health workers attempted to 'mask or embrace dirty work' (p. 253) by reframing and downplaying the negative meanings, associated with their job and instead, inserted positive narratives which presented their work as rewarding. Such developments, according to Emerson and Pollner (1976), Perry (1978) and Russell and Perry (2017) show that it is possible to construct positive self-esteem and a positive occupational identity doing work that is perceived to be tainted or dirty.

Contrary to notions that conceptualize dirty work as uplifting, however, Jervis (2001), in a study on the pollution of incontinence in U.S. nursing homes contended that 'aide work remains for the most part devalued socially, if not downright invisible. The occupation's lowliness, however, is not only the result of its association with bodily waste, but also derives from the gender, race, and class backgrounds of its workers' (p. 94). For Jervis (ibid), in cleaning incontinence, care assistants use their own body as the primary vehicle to get rid of the 'filth' or dirt of others and this negatively affects such workers. Beyond this, the exposure to incontinence in care assistant work reflects inequalities within healthcare profession and larger society, as distance from incontinence is a 'major factor in the struggle for occupational prestige' (Jervis, 2001, p. 94). As Jervis further points out, in American society, 'higher-status persons are rarely found in situations where they come into frequent contact with abhorrent substances....pollution is reserved for those lowest in the social hierarchy' (ibid). In this context, those in the lowest social hierarchy are the care assistants, and since they do not have an option to avoid direct contact with the pollution of incontinence, they are 'compelled to live with it ...however, uneasily' (Jervis, 2001, p. 95).

Similarly, in a study titled, *The Toilet: Dignity, Privacy and Care of Elderly People in Kwahu, Ghana*, Van der Geest (2002) pointed out that according to the dictates of Ghanaian culture, with the exception of children, each person's waste products are 'private' and expected to be managed by the individual. Human excrement belongs in the toilet and it is

considered a violation of cultural norms, and repugnant, to transfer the cleaning of such private waste to people who are not related by family ties or kinship.

Traditionally, Ghanaians associate old age with honour and the beautiful image of dignity and wisdom that signifies that a person has reached the full potential of a human being. For the aged, being old and dependent is fraught with feelings of defeat especially when this is connected with getting help with incontinence. Such situations involve sharing the intimacy or exposing the private parts of an elderly person's body, as the social technique of pretending 'not to see' is not always possible when providing help with defecation. This threatens the dignity of the elderly and creates awkward situations for the caregiver. The effect of loss of dignity for the elderly is minimized, however, if the caregiver is closely attached to the elderly. Thus,

A man who has not 'invested' much in the relationship with his wife during the time he was healthy and strong will probably be deserted by her, even before he becomes probably dependent. That principle of reciprocity works also for the children. They will be reluctant to provide assistance and try to shift the task on someone else (Van der Geest 2002, p. 241–2).

The cultural anomaly with shifting the cleaning of human incontinence to 'others' who are not necessarily kinsmen, according to Van der Geest (*ibid*), thus intensifies an already awkward situation which calls into question the dignity of the care recipient and care giver.

In the context of Norway, Dahle (2003) analysed the inter-professional conflict between nurses and nursing assistants. Dahle (*ibid*) found that dirty work designations could be seen as a delineating practice through which nurses are, for instance, separated from care assistants as the latter are positioned beneath nursing and considered a threat to the solidarity of healthcare work. In this context, nurses were rarely willing to get into contact with aspects of tasks that they classify as dirty; thus, in a way, they created the need for a group of 'dirty workers' in the form of healthcare assistants who are expected to perform tasks that nurses considered stigmatized. Thus, 'making basic care the exclusive preserve of nurses and delegating the more 'housewifely' tasks to nursing assistants effectively excludes the latter from caring work and, not surprisingly, they strongly oppose existing working boundaries and the redistribution of tasks' (Dahle, 2003, p. 139).

The above developments on conceptualization of dirty work suggest that consequences of occupations or tasks classified as dirty are either positive (Perry 1978; Russel, 1993) or

negative but rarely neutral (Dahle, 2018; Jervis 2001; Van der Geest, 2002). Specifically, my own experience in this study made me consider the place of dirty work in the experiences of the immigrant healthcare assistants, as in the encounter below.

Madam researcher, it is now your turn: How about you?

In line with my participatory approach to this study, which will be discussed in the next chapter, participants were informed that they could ask me questions if needed. Kailla was one participant who put this principle into practice as captured in the following excerpt.

Kailla: Since you said I can also ask you question, now it is your turn to tell me. How do you feel about the smells?

Vyda: I am not sure.

Kailla: Are you really sure? Huh? (*laughter mixed with an expression of surprise*).

By asking me this question, Kailla put me on the spot and I was taken unaware. This happened after we visited a client who was always mired in his own toilet every morning. This client had to be changed in the afternoon as well. I was informed that due to the client's medication, his excrement was a lot and could sometimes be watery or slimy. After going through surgery, this client believed that having plenty of excrement was a sign of a healthy stomach. As such, he liked to engage in conversation when he was being cleaned. This had to do with questions such as the quantity of poo, colour, texture, etc. Depending on the amount of excrement to be cleaned, I observed that participants do not enjoy talking and working at the same time. Indeed, the variety of medicines taken could have contributed to the smell of excrement and I must admit that this particular smell was not an easy one to contain.

With my pregnancy 'hidden' within my shirt (unknown to the participant), the strength of the stench from this particular visit had me vomiting instantly. This was both an embarrassing moment for me and perhaps for the client since it was my first time meeting him. I did not clearly hear what the client said, but I heard the participant saying to him that I had been sick since yesterday. I thought that this was a 'nice' way for the participant to cover up for me and perhaps save the client from embarrassment. The participant then came to me in the toilet and said that I could go out and wait for her if I did not feel so good. I needed that fresh air, but I was torn between how the client would feel and the meaning of my reaction to the participant. As a result, I decided to stay on. However, with a mouth full of saliva and a nose drenched in stench, I positioned my nose toward the window where I could gasp some fresh air.

Like Kailla, I never got used to the smells of body waste. And when it had to be done on the same person twice or more in a day, I usually looked forward to moments of fresh air. In response to Kailla's question, as is captured in the quote above, I told her that I was not sure how I felt about the smells. I think that I said this partly to prevent her from feeling bad about her work, and partly because I did not connect any direct feelings with the smells. Yet, from my experience, I could say that it was not a pleasant thing when I had to help change bed sheets filled with vomit, wash or clean false teeth, and take part in giving showers and changing diapers on the elderly clients.

This is not to denigrate the work of participants. Rather, as pointed out by Olwig (2018),

Work becomes especially regarded as dirty when it becomes tied to a particular segment of the population which has low status within the social hierarchy...If immigrants are forced to do dirty work permanently, rather than temporarily as part of a transitional development phase, and if they are stigmatized by being identified as the designated performers of dirty work, it is because they represent a social force that is needed, respected and feared. (p. 60)

As my fieldwork progressed, I observed that the image I had of the immigrant healthcare assistants as I met them in the corridors and around the common areas was in contrast with how I experienced their working life and what they actually told me. From a distance, participants in this study mostly appeared to be hearty workers filled with smiles, greeting everyone and making pleasant contact with the elderly. However, behind the curtains where their actual work took place, I observed, felt and heard about experiences that were not captured in the smiles I saw in the corridors. These experiences mostly took on a different mood when focused on meanings associated with the undesired aspect of cleaning contaminating substances; these were discussed in terms of reducing the dignity of the occupation of elderly healthcare assistants and the individual dignity of being an immigrant healthcare assistant. This awareness made me realize that it could be useful to pay attention to the sensitivity with which participants spoke about this aspect of their work.

I also began thinking that attending to the sensitivity of 'dirty work' could be a foundation to relate duties of the immigrant healthcare assistants to the division of labour in Norwegian elderly care. From this angle, I got the impression that the notion of dirty work as expressed by the immigrant healthcare assistants could provide a starting point to link Hughes' (1984) claims of occupational boundary, Abbott's (1988) analysis of jurisdiction and Crenshaw's

(1991) perspective on intersectionality with the everyday activities of immigrant healthcare assistants in elderly care.

In practice, this meant entering into the world of immigrant care assistants with a sensitivity about their reaction to handling contaminating substances, which are literally not discussed yet are a key aspect of concrete activities that are carried out in support of the elderly. How I entered this world is discussed in **Chapter 4** on research methods and methodology. Before turning to this, I will briefly touch on an additional guiding /theoretical perspective which is significant for future discussion.

Redistribution and recognition

At the latter part of my analysis, I was challenged by the question of how immigrant healthcare assistants can maintain a healthy sense of self during social relations.

Due to my approach to intersectionality, which connects the individual to institutional structures, it was essential to explore the question of attaining a healthy sense of self not only as a crucial element for the good of individuals but also as a means of understanding the rights of individual for overcoming stereotypes and stigma as part of the equal rights rhetoric.

Prominent theories have identified obstacles to attaining a healthy sense of self by considering how equality and/or inequality are (re)produced. In political and theoretical terms, the debates have been framed as a question of social (in)equality entrenched in the struggles for redistribution (Barry, 1995; Dworkin, 2018, 1981; Rawls, 1971; Young, 1990) or as a matter of redistribution and/or recognition (Fraser, 2018, 2014, 2008; Honneth, 2003; Taylor, 1997).

An extensive discussion of these debates is beyond the scope of this study and I do not endeavour to engage in the normative debates on social (in)equality. However, based on my data, I subscribe to a general understanding of social (in)equality informed by a commitment to the tenets of egalitarianism. This became significant, as the study is located within the egalitarian structure of Norway's elderly care. Thus, my focus is to utilize a framework to explore the empirical phenomenon of how the rhetoric of social (in)equality is done or practiced in Norwegian elderly care through the daily experiences of immigrant healthcare assistants.

Of the theoretical analysis on social inequality, I find Fraser's approach closest to the commitment of egalitarianism, as it is grounded on the liberal notions of equality in redistribution, recognition and representation.

Fraser (2008) argues that social justice is a matter of redistribution, recognition and representation. Neither alone is sufficient. According to Fraser (ibid), inequality in the distribution of resources may contribute to a subordinated way of life and lack of a voice for recognition, but redistribution, recognition and representation are not reducible to one another as they all involve analytically distinct social structures and relations which are in practice intricate and interrelated. Fraser thus proposed a conception of social justice which maintains that there is ‘no redistribution or recognition without representation’ (ibid, p. 282).

An important distinction in Fraser’s analysis is how she locates the struggle for ‘self-worth’ in the socio-political and cultural as well the economic structures of society. Fraser’s claim is that by paying attention to how the politics of the state are oriented to economic and cultural changes, it is possible to develop an understanding of how individuals and groups struggle to attain a healthy or liberated self-identity against the politics of denigration. Calling this a framework of recognition, Fraser, in her work on *Social justice in the age of identity politics*; considers the practical question of ‘what misrecognized people need in order to participate as peers in social life’ (Fraser, 1998, p. 5). The approach proposed by Fraser claims that the dilemmas and tensions of misrecognized individuals are intrinsically linked to the tensions between redistribution and the struggle for recognition. Discussing the issue of recognition from a status perspective, Fraser points out that individuals are entrenched in subordinate social status due to the existence of strategic and systemic social structures that deny individuals the opportunity to equally participate in social life. Fraser argues that, in practice, inequality is rooted in how the economic order of distribution is stratified along social class and how cultural injustice generates unequal status of recognition in relation to, for example, gender, race, ethnicity, and sexuality.

My understanding of Fraser (1998) is that in order for society to be ‘just’ it is necessary for both material and non-material resources to be fairly distributed. However, it is critical to conceptualize social justice by expanding and explicating it to include other dimensions and in this case, recognition. The notion of recognition here refers to ‘a remedy for injustice, not a generic human need. Thus the form(s) of recognition justice requires in any given case depend(s) on the form(s) of misrecognition to be redressed’ (ibid).

The focus on the dimension of recognition helps me to theorize about the role of power in how individuals—in this context, immigrant healthcare assistants—are treated during interactions at the micro- and macro-level which are mediated through institutional structures. For Fraser, social justice as a right for recognition refers to political structures and systems

within which the distribution of rights and responsibilities also takes place. To some extent, this can be conceived as distribution of economic resources or the procedure by which power is distributed in society. According to Fraser, recognition justice include distribution of economic resources but it is more a matter of the order and nature of social relations mediated by the formal and informal rules which determine how members of society relate to and treat each other at the micro- and macro-level. Here, Fraser refers to cultural justice, which leads to the second dimension of my discussion on social equality.

Whilst acknowledging the multiplicities and complexities of social groups and statuses in society, Fraser further draws attention to how patterns of institutionalized cultural values are systematically subordinating by demeaning and stigmatizing different cultural identities. Social inequalities in society leads to social injustice due to societal structures, which devalue certain categories of the population and the qualities associated with these members of the populace. For Fraser, recognition is about a status order where there is equal opportunity for achieving dignity and self-esteem by all. The challenge is that due to cultural injustice, such as the struggles over gender, sexuality, nationality and religion, some members of society are denied equal opportunity to obtain respect and/or recognition. For example, while it is acknowledged that immigrant healthcare assistants have cultural practices which are different from those in Norwegian society, in this light these different practices are not only demeaned but misrecognized through institutional structures that deny immigrants equal participation in society and stigmatize the status of immigrants. Significantly, the difference at stake is not about differences of variations or affirming a unique difference by standing up for one's own self as an individual. Rather, it is the sort of difference that promotes repression by militating against 'whatever is genuinely emancipating in the paradigm of recognition' (Fraser, 2014, p. 204). Put differently, not all differences merit celebration (ibid).

Here, I understand Fraser (ibid) to mean that status is about the distribution of power in society. Status differentials and its associated power become 'neutralized' or 'even' when people are on par with each other. As a means of maintaining status, 'difference' and stereotypes become institutionalized, which renders the status of misrecognized individuals—such as participants in this study—as subordinate. Accordingly, a subordinate status implies that the capacities of subordinated individuals—such as the immigrant healthcare assistants—become stifled or underdeveloped.

Finally, in terms of representation, the question concerns the political definition of belonging in terms of which members of the population are included or denied access for equal

participation during social interaction. Fraser argues that a key political injustice is expressed through misrecognition where individuals are side-lined and denied access to recognition, redistribution and representation. Critical to Fraser's analysis is the ability to initiate a debate on social inequality through the lens of economic and cultural injustices.

By highlighting recognition as a matter of rights and equal opportunities and not necessarily as an issue of a premature turn to ethical evaluation, Fraser's framework enables me to analyse the experiences of immigrant healthcare assistants as a claim for equitable distribution of material and non-material resources. The distinction is that, in both traditional and contemporary times, the claim for resources has been analysed as a matter of self-realization (Honneth, 2003; Taylor, 1997) and ethical values. When conceived in terms of self-realization and ethics, Fraser argues that the need for recognition is based on determinate assessment or judgement of what is 'worthy' and 'unworthy'. However, in an era of globalization, diversity and cultural pluralism, it is challenging to maintain a set of comprehensive principles to solve the issue of difference.

Thus, Fraser's model implies that the need for recognition must be understood as a universal claim for justice which must be enforced, regardless of the values and practices of individuals. In this sense, the claim for recognizing the immigrant care assistants must be understood as 'humanely' and 'universally' binding, without a focus on the tensions and complexities associated with comparing incomparable worldviews and the struggles accompanying the competition for status and class. How this can be fulfilled, according to Fraser (2014, 1998), depends on two further conditions.

First, politics must aim at providing equal opportunities for individuals and recognize the distinct cultural values of subordinate or unrecognized individuals. This is based on the assertion that misrecognition is harmful to individual self-image and when seen as intrinsic to institutional structures, misrecognition leads to subordination. In particular, Fraser's model focuses on aspects of demeaning patterns that devaluates the cultural values of individuals. The focus is not on all aspects of cultural devaluation to an individual identity. It is more a matter of patterns of demeaning a cultural value which leads to status subordination.

Secondly, theoretically, Fraser's model is about social violations and unequal access to social and institutional structures. The relevance of Fraser's model to this study lies in its ability to enable me to explore narratives of subordination in the experiences of the immigrant healthcare assistants as an issue of misrecognition which goes unnoticed due to displaced and distorted distribution of resources. As I will show later, participants narrated experiences that

could be understood as examples of how misrecognition in relation to being an immigrant healthcare assistant could lead to exclusion on the basis of ‘difference’, which functions as a status of subordination or inferiority. Accordingly, I argue that such an analysis becomes meaningful by acknowledging dimensions of redistribution (un)equal access in Norwegian welfare state and how this affects the workforce who works closely with the elderly in the state’s long term care.

Fraser’s model may not in itself be capable of supporting the immigrant healthcare assistants to overcome the complex challenges of status subordination in society, even one as purportedly egalitarian as Norway. However, by relying on Fraser’s model, it becomes possible to grasp the dilemmas and struggles of the immigrant healthcare assistants by paying attention to the right for recognition as a value for healthy self-realization. To show how I managed to grasp some of the dilemmas of participants’, I invite readers on a long journey with methods and methodology.

Chapter 4: A long journey: Methods and methodology

'Methodology should not be a fixed track to a fixed destination but a conversation about everything that could be made to happen'.

J. C. Jones (1992 p. 73)

When Silverman (2015) argued that no single methodology is better than any other, he also pointed out that, given the complexities of the real world, it is important to choose a methodology that is relevant to a specific research problem. The research questions for this study are about experiences. 'Experiences' in this context not only pertain to a collection of evidence or knowledge about something, but also concern something that has happened or is happening to us. The inherently complex nature of questions about experiences pose methodological challenges around determining the appropriate research approach(es) for answering them.

A range of arguments exist on how to resolve these kinds of methodological challenges. Whereas Creswell (2014) argues that methodology is primarily concerned with precision, McGrath (1995, 1981) believes that there is no absolute way of undertaking a research endeavour and the merit of a methodology is determined by its usefulness. This study ascribes to the recommendation of the latter by acknowledging that dilemmas are inevitable when choosing appropriate research strategies. I ultimately decided on a multiple-method research strategy, in order to incorporate the strengths of some methods to compensate for the weaknesses of others (Amaratunga et al., 2002; Creswell et al, 2007; Gill and Johnson, 2010).

In practice, I think of methodology as a way of connecting several interacting factors that explain how data or knowledge for a study has been or is being generated. I take the position shared by Schwandt (2007), who suggested that methodology is 'analysis of the assumptions, principles and procedures in a particular approach to inquiry' (p. 193). As such, the aim of this chapter is to discuss the methodological choices for and guiding perspectives of this study, and to trace how these were informed by realities in the field.

Hermeneutic phenomenology

As an introduction to my discussion in this chapter, I draw on an account of an experience that I captured in my journal:

The day before, participant Baaba had proudly told me about how he is able to provide services for the elderly in situations when their family members cannot be present. This included taking cancer patients for check-ups and holding their hands to assure them that all would be well.

The real world and Baaba's words came together when I had the chance to follow him and a cancer patient for a scan/check-up. After this, I spent the rest of my time with Baaba asking questions since I believed that it had been a great day; after all, this is an aspect of his work he feels proud of. Baaba however told me that it was not a great day. His experience was that the scan room environment with all the monitors showing the cancer-affected organs of the patient is extremely heavy and stressful. One of his concerns was that the patient's predicament makes him worried about his own health and he could not get over how much he identifies with the patient. Baaba also relayed that due to his stress or heaviness, he sometimes does not fully concentrate on the patient. Rather, he shifts attention to the images of the patient's organs on the screen. In the end, he feels that going through such an experience makes his heart very heavy. He used the Norwegian phrase '*det er veldig tungt for meg*' which translates to 'this weighs heavily on me'. (I discuss this in detail in Chapter 6.)

The impact of Baaba's words made me realize that I had been drawn on my own thinking when I assumed that Baaba had a great day. Yet, from his words, I think that he interpreted this experience in a completely different way than I did. Perhaps if I had known how Baaba felt or interpreted this experience, I would not have asked him the question. But how would I have known? It was not possible for me to know the meaning Baaba made from his experience with the cancer patient. I can only come to know or understand after talking with him. In this moment, I consoled myself with the knowledge that it is difficult to get the 'full' understanding of a phenomenon by just doing observation. Rather, by talking to Baaba and hearing his interpretation or meaning, I was able to understand his experience much better.

This entry in my journal preceded my decision to use phenomenology as a methodological inquiry for this study, and I have included it here to acknowledge that there were a variety of methodological approaches that could have been applied to the subject matter of my study. For instance, in studies on immigrant care labour, researchers have relied on various methodological approaches, including online surveys, text analyses and autobiographies. For my own study, I considered similar approaches to be an option. However, given that my

primary focus was to study lived experiences, and in an attempt to allow for a variety of possibilities, I sought a methodology that would enable participants to tell their story in the subjectivity of their everyday lives.

In this study, therefore, the accounts of participants were captured in unravelling stories, which involved in-depth, human feelings of their lived experiences in elderly care. The richness, uniqueness and ambiguities of these experiences meant that, in hearing and analysing their accounts, I would be trying to understand participants in a way that might not offer generalizable findings. I accepted this, as I value research that involves deeper interpretations and analysis to challenge surface accounts in order to evoke in-depth understanding of the tensions, contradictions and taken-for-granted aspects of lived experiences.

For my part, this approach further implied that I would explore the meanings of lived experiences in a way that, first, constituted the viewpoint of the immigrant healthcare assistants, and second, that of myself as the researcher. As my focus is thus mutually dependent on experience and meaning, one way to understand the experiences of the immigrant care assistants was to place the study in the context of an interpretive research methodology (Denzin and Lincoln, 2008; Silverman, 1998). However, I ultimately decided to draw on the tenets of hermeneutic phenomenology to explore my research focus, which entails ‘the study of *experience* together with its *meanings*’ (Friesen, Henriksson and Saevi, 2012, p. 1).

Characteristically, hermeneutic phenomenology differs from interpretive and other qualitative research methodologies in its philosophical underpinnings. As a result, it is perceived that hermeneutic inquiries will be explored through the philosophical orientations of scholars such as Heidegger, Husserl and Gadamer. However, similar to other research inquiries, hermeneutic phenomenology is a complex approach, with a variety of debates about how it should be enacted as a methodology. My own aim in this chapter is not to ‘wrestle’ with the various complex German philosophical arguments and texts on hermeneutics, but rather to discuss how I used hermeneutic phenomenology as a guide to explore the experiences of the immigrant healthcare assistants.

That being said, I think that it would be helpful to highlight some of the various debates on this form of inquiry, as a background to my own approach. As argued by Finlay (2012), one of the pivotal concerns in these debates pertains to criteria: indeed, as ‘the phenomenological researcher aims to go beyond surface expressions...it is this process of reading between the

lines which has generated uncertainty' (Finlay, 2012, p. 21). Characteristically, scholars contend between descriptive (i.e. Husserlian transcendental) and interpretive (i.e. Heideggerian hermeneutic) phenomenology.

Inspired by Heidegger (1962) and expanded by Gadamer (1975), hermeneutic phenomenology views context as critical, and is focused on complexity and difference and the meanings that individuals assign to a phenomenon (Finlay, 2011; Gadamer, 1975; Giorgi, 1985; Halling, 2008; Heidegger, 1962; Langdrige, 2007; Moustakas, 1994; Ricoeur, 1991; Van Manen, 1997). Levinas (1987) elaborated this point by arguing that hermeneutic phenomenology is not preoccupied with understanding the object 'but its meaning' (p. 110). Within this orientation, it is argued that reality is highly fluid since it consists of subjective experiences. This is distinctly different to a positivist stance and other approaches that assert that reality can be observed and described from an objective viewpoint (Denscombe, 2014; Heshusius, 1994; Levin, 1988; Lincoln et al., 2011; Nielsen, 1990).

Here, I also make a distinction between Husserl's (1859–1938) descriptive phenomenology and Heidegger's (1962) interpretive phenomenology. The former is deemed applicable when the focus of a research endeavour is to describe the meaning of lived experiences (Reiners, 2012). It is based on the notion that representation must rely on the actual words of people who experience the phenomenon under study. Critical to this is the question of bracketing: that is, the possibility to recognize the central role of the researcher in the inquiry. Husserl inspired phenomenologists to argue that researchers must set aside their personal prejudices about the reality of the phenomenon. Put differently, bracketing is recommended.

Reacting against or perhaps extending Husserl's ideas is the work of Heidegger (1962), who declared that encounters are intertwined with interpretations which are based on a person's background and history. In research practice, this translates into a situation where participant-generated data is merged with the experiences of the researcher and placed in context (Finally, 2012; Koch and Harrington, 1998; Walters, 1995).

In the words of Heidegger (1962), 'The meaning of phenomenological description as a method lies in interpretation' (p. 61). Concisely, hermeneutic phenomenology purports to highlight experience as an account that is interpreted. This could be associated with Heidegger's analysis of human experience, which argued that 'any interpretation that is to contribute understanding must already have understood what is to be interpreted' (p. 194).

Here, my understanding of Heidegger is that in the process of understanding the everyday existence of people, it is crucial for the interpreter or researcher to have prior understanding related to the lived experience of the interpreter. In the context of this study, this is firstly reflected in my position as an immigrant researcher involved in a study for immigrant healthcare assistants. Secondly, through my encounter with immigrant healthcare assistants in Norway and Sweden, I obtained significant knowledge about immigrant experiences in elderly care. Put together, my previous experience in cross-cultural studies and pre-existing knowledge on immigrant care workers were useful in providing additional basis for understanding the subtleties and nuances of the phenomenon under investigation. When related to the Heideggian tradition, it could be argued that my experiences and background informed me with a certain degree of sensitivity that assisted in a deeper understanding and observation of certain processes that might go unnoticed to someone without such prior understanding or experience.

Other key constructs in Heidegger's phenomenological method which I found relevant for this study relates to 'being in the world', 'thrown-ness' and the notion of tools. The starting point of Heidegger's (1962) argument is captured in the German word 'Dasein', meaning 'being in the world'. He used this notion to explain his interest in the understanding of the activities of daily life. For Heidegger (ibid), it appears that the notion of 'being in the world' is beyond how we traditionally think of this. He therefore invoked a question by arguing that, 'Do we in our time have an answer to the question of what we really mean by the word "being"? Not at all. So it is fitting that we should raise anew *the question of the meaning of Being*' (p. 20).

In what seems like a response to this question, Heidegger argued that, fundamentally, 'being in the world' is 'sorge'. According to Walters (1995), 'sorge', when translated from German to English usually means "care" (p. 493). Care is thus about being concerned and it is about caring for things and people (ibid). For Heidegger, understanding and interpretation are 'foundational modes of man's being' (Palmer, 1969, p. 42) and this is situated in lived experience. Heidegger was therefore concerned with the personal interpretations people give to the world around them. He was also of the view that experience cannot be detached from the worldview or context of those experiencing it. In this study, how the immigrant healthcare assistants interpret their experiences in elderly care to bring out the ways in which their meanings occur in context is significant. In conducting this study, I observed that these experiences were interwoven with unforgettable accounts that reveal the gathering of what the immigrant healthcare assistants have endured over time and perhaps continue to endure. The

complexities of these meanings were revealed in how participants' articulated the essence of working in elderly care. By equating Heidegger's philosophical, construct of 'being-in-the-world' with the logic of caring for people (i.e. *sorge*), which is situated in human reality, I draw on this construct ('being in the world') to explore the tensions and complexities of working in elderly care as reflected in the practices of the immigrant healthcare assistants.

Further to this, Heidegger endorsed hermeneutic phenomenology as a perspective where the ability to understand and interpret a phenomenon could be achieved through shared knowledge and experience (Drew, 1999; Reiners, 2012). This characteristic of Heidegger's hermeneutic phenomenology is a counter to Husserl's descriptive phenomenology, which rejects the incorporation of personal experiences in a research endeavour. My understanding of Heidegger is that it is not necessary for the researcher to bracket predetermined assumptions and notions. Rather, such preconceptions are necessary to enable the researcher to relate to the experiences of the research participants.

Polifroni and Welch (1999) further explained this by saying that, 'as we understand something, we are involved and as we are involved, we understand' (p. 242). In this sense, I understand both Heidegger and Polifroni and Welch (*ibid*) to imply that, in order to fully grasp the meaning of a phenomenon, it is crucial to be 'involved' or play an active role to generate such knowledge. In other words, the essence of in-depth understanding could be achieved through active involvement. In an attempt to explore the lived experiences of the immigrant healthcare assistants, I believe that my personal experiences and awareness as they relate to the study is intrinsic. This is where Heidegger's perspective becomes more critical since it acknowledges the position of the researcher throughout the process of the study.

Gadamer (1976, 1989), a student of Heidegger, used the notion of 'a fusion of horizon' to explain the process of understanding in the hermeneutic inquiry. For Gardemer, horizon includes a range of preconceptions that can be seen from a specific vantage point. He therefore urged researchers to be conscious and self-reflective, to identify their preconceptions of the phenomenon under study. Through this process, Gadamer asserted that researchers can go beyond their preconceptions to understand the phenomenon at a level that is above their own horizon or preconceptions. I understand this process—which, according to Gadamer, leads to the fusion of horizon—as the willingness to have an open viewpoint, such that other viewpoints can appeal to and perhaps influence me. As Thompson (1990) wrote, to experience Gadamer's fusion of horizon implies the ability of the researcher to 'tolerate the ambiguity of relaxing (not eliminating) one's own pre-conceptions' (p. 246).

When translated into this study, my ability to be fully immersed in the research process by being open and yet self-reflective as an immigrant enabled me to attain the fusion of horizon of understanding as implied by Gadamer. I argue that when participants shared their experiences, they often engaged with me as someone (a fellow immigrant) who can relate to these experiences. However, my own preconceptions and observational notes imply that under certain circumstances, my opinions may have differed from the opinion of participants.

To demonstrate how I arrived at an understanding through the metaphor of 'fusion of horizon', I try (below) to depict the voices or accounts of the participants in the context of elderly care and then show how the experiences of the participants and my own experiences or horizon were merged. Crucial to this is how the merger is located in historicity and cultural contexts of the research participants and myself.

I find Gadamer's analysis of fusion of horizon to be similar to Heidegger's views on shared knowledge between the researcher and participants. Crucially, Gadamer's perspective suggests that the act of understanding is in questioning, which leads to the discovery of new things. Mostly described as the hermeneutic circle, it seems to me that Gadamer (1976) equates this to the idea of dialogue through openness to questions and answers. Thus, in a conversation, Gadamer (ibid) suggests that our ability to understand lies 'in our ability to see what is questionable' (p. 13).

In practice, I understand this to mean that in exploring the experiences of research participants, it is necessary to use an approach (e.g. interview method) that is open. It is anticipated that such an approach, whilst maintaining the research focus, would allow participants to direct the course and take researchers to levels of new knowledge. In incorporating this idea into my study, I used an interview guide with open-ended questions. A core goal of this approach was to enable participants to direct the flow of conversation by taking me into the world of their experiences. In line with this, Heidegger's notion of phenomenology is productive for this study, as it helps to focus the analysis of understanding through dialogue with participant data and the researcher's understanding and experience.

Following the above is Heidegger's (1962) idea of 'thrown-ness' (p. 329). Heidegger used this notion to imply that to some extent, human beings are 'thrown' into certain conditions or situations in the world in which they have no control. For instance, people are born and grow at particular places and times and participate in certain cultures, histories, and activities, which they cannot control. For Heidegger, it is crucial to make sense of the world and our place in it within the condition we are 'thrown' into.

When exploring how the immigrant healthcare assistants interpret the meaning of their experiences, I observed that they sometimes visualize themselves to be in a low position due to their background. Perhaps this is necessarily not the case. The question for me however is how to understand this constructed or visualized position. To answer this, I find Heidegger's notion of 'thrown-ness' useful. According to Heidegger, thrown-ness also denotes a situation where frustrations in the present life are seen as something that is connected to the past. My understanding of Heidegger, here, is that this refers to a condition in which one does not choose. I see this as something that has more to do with kinship or ethnic ties. I argue that when participants visualize themselves in low-status jobs due to their ethnic background, they position or put themselves in a state of 'thrown-ness'. From the accounts of the immigrant healthcare assistants, it could be argued that some of them were 'thrown' into an elderly care job due to a lack of alternative opportunities. Further to this, my data show that challenges, which lend themselves to the multiple complexities of having an immigrant background, arise in participants' attempts to escape from their situations. Heidegger's notion of thrown-ness is thus useful to explain how the immigrant healthcare assistants talk about their position in elderly care by virtue of their background.

Finally, I find Heidegger's argument concerning the notion of tools useful. In an attempt to explain the relevance (or otherwise) of things around us, Heidegger used the concept of tools. According to him, human beings live in a world of tools. By this, he meant that things around us become meaningful or relevant based on how useful they are to us. For instance, a tree is a tool as long as it is relevant for providing shade or can be used as timber. Heidegger (1962) further described the relation between tools and their relevance through the notion of 'in order to'. Here, he argued that the final meaning of a tool is based on its importance in the daily activities or lifeworld of people. Heidegger provided a practical analysis of his world of tools by using the hammer as an example. He observed that the hammer could be a tool that is taken for granted as long as it performs its task, such as hitting a nail into a wood. It is not usual to think about the hammer in a theoretical way. However, when the hammer fails to perform, its users become obliged to think about it in a theoretical way. I think that when Heidegger talked about theoretical thoughts, he was referring to a process where we pause to make an analysis of why something is not functioning, as it should. This is to further his argument that, more often than not, the world of tools are overlooked by people. In other words, the relevance of things around us can go unnoticed or be taken for granted until they cease to function. This insight by Heidegger has useful implications for this study. For the

immigrant healthcare assistants, a major aspect of their work is their deep involvement with the elderly to enable them participate in the activities of daily life. Their daily contact with the elderly can be likened to a tool that is required to enable them function properly. However, for their qualified colleagues who are above them, as well as for family members of the elderly, the low status position of the immigrant healthcare assistants makes them seem like tools that are taken for granted. The contrast between playing an all important role, yet being ignored or taken for granted, forces its way into the consciousness and experiences of the immigrant healthcare assistants and they try to make sense of it. From this angle, Heidegger's notion of tools lends itself to this study since it provides a perspective from which to explore how the immigrant healthcare assistants make sense of their experience in these settings.

Concisely, hermeneutic phenomenology purports to highlight experience as an account that is interpreted. I understand this to mean that the description of participants experience must be seen in the context in which this is situated. For instance, when a participant points to being frustrated with their lack of cultural understanding and occupational mobility in Norwegian elderly care, such a statement becomes more significant when we understand the participant as an immigrant in a specific context.

Following this, the tenets of hermeneutic phenomenology suggests that interpretation is connected with how researchers make sense of the research data by drawing on their subjective understandings and life experiences. Finally, interpretations become valuable when filtered through a specific social, cultural and historical lens in the context that addresses the relationship between participants and the researcher.

In spite of its usefulness, there are critical dangers in ascribing to hermeneutic phenomenology. A major critique of Heidegger's hermeneutic inquiry is the extent to which the ideas drawn from hermeneutic phenomenology informs both the research methodology and interpretation or analysis (Finlay, 2012). Another related challenge is the question of how the subjectivities of the researcher and descriptions of research participants converge in the interpretation of research data (Giorgi, 2010; Heffron and Gil-Rodriguez, 2011; Larkin et al., 2006). These criticisms raise important challenges for my methodology. First, they relate to how hermeneutic phenomenology is inevitably implicated in my study (Finlay, 2012). In other words, does my study aim to entirely describe the experiences of the immigrant healthcare assistants in general (i.e. descriptive)? Or is it focused on interpreting individual experiences? Or perhaps both? Secondly, I see the critique on subjectivities and merger to be

related to how issues of validity and reflexivity may be established. Finally, it appears to me that power and structures are hard to grasp from this perspective.

Starting with the first challenge, I wish to reiterate that a key contrast between descriptive and interpretive/hermeneutic phenomenology is reflected in how a study may be seen as more descriptive or interpretive. In practice, I did not observe sharp boundaries between these when analysing my data. For instance, under certain contexts, I used my observation notes to describe how participants used non-verbal modes to emphasize aspects of their accounts. In such instances, I incorporate a strong element of interpretation to describe how participants' accounts were mediated or presented through non-verbal communication. However, at certain instances, I observed that how participants described accounts and how I interpreted it creatively blended to offer a better understanding. In view of this, I take the position which is similar (but not the same) to what Smith and Osborn (2008) refer to as Interpretative Phenomenological Analysis (IPA). This is mostly discussed as a phenomenological approach, which sees the continuum between description and interpretation to be complementary yet with a bias towards idiographic meanings in an attempt to understand individuals (*ibid*). This implies that description and interpretation are seen to be complimentary. That task of understanding participants may or may not offer general insights into the phenomena being studied and the strength, Finlay (2012) notes, is 'when something is revealed of the *extraordinary*' (p. 33).

In considering the second challenge, I treat it as question related to the extent to which my preconceptions are separated from participants' descriptions to enable readers to evaluate the quality of analysis for better understanding. In arguing for a hermeneutic approach to research, Draucker (1999) suggested that 'Heideggerian research should be evaluated not by indices of objectivity but by indices of convergence: the extent to which the perspectives of the participants, the researchers and other data sources are merged in the interpretation' (p. 361).

My understanding of Draucker is that hermeneutic inquiry is an interactive process and it is critical for me to reflect on my role in relation to the position of participants. I agree with this argument because I intend to use the study to demonstrate that in as much as I acknowledge the validity and relevance of participants accounts, an understanding was reached through the merging of participant-generated data, my interpretation of situations through field observations, my own preconceptions and selected literature on policy-related issues. Indeed, the dialogue on how this understanding was attained, Gadamer notes, could be a never-ending

cycle. This is to acknowledge that there would always be constructions and interpretations that may be different from mine. I therefore agree with Draucker (1999) that what is plausible is that a study that ascribes to the Heideggerian inquiry is able to exemplify the contribution of this methodological stance to the understanding of the research focus and findings.

Regarding the third challenge, the perspectives from intersectionality and complexity theory that served as analytical guides (as discussed in Chapter 3) provided this study with the tools to explore power relations.

Significantly, drawing on hermeneutic inquiry to understand the experiences of the immigrant healthcare assistants was useful for this study. By reflecting on these methodological implications, I show in later discussions how they enabled me to achieve a better perspective.

As mentioned earlier, my aim was to use a flexible approach that would foremost acknowledge the voice of participant's by exploring their experiences in Norwegian elderly care. I therefore found it necessary to conduct the study in the natural environment where these experiences occur. To this end, I found ethnography to be both appropriate and appealing since its approach held more meaning for me in my attempt to obtain in-depth knowledge about the experiences of participants'. This forms the discussion in the next section.

Following the ethnographic tradition

In this study, ethnography was used to explore the experiences of immigrant healthcare assistants in relation to elderly care. From my readings, it is clear that the definition of ethnography is contentious. One common denominator of the ethnographic tradition, however, is that it is interested in first-hand experiences and practices, and is committed to the everyday life of those being studied. Geertz (1973), in an attempt to tie some of the disjointed threads of ethnography together, has described it as 'the interpretive study of culture and its meaning, where culture is considered as the web of individual and collective learned behaviours, orientations and regulations formed by people' (p. 4-5). In effect, researchers using ethnography value a connection to context, and understand that emerging meanings stem from relationships in an environment. The value of these two elements is what I have found most meaningful in my study, as I maintain the view that a practical approach to understanding the experiences of the immigrant healthcare assistants is best captured within the context of their daily activities.

In methodological practice, this translates into a situation where the researcher is required to get closer to and interact with participants in an attempt to gain insights into how and why they behave and understand issues from a particular point of view (Ellen, 1984; McCall, 2000; Nurani, 2008). Thus, in the language of ethnography, meanings are attributed to the perspective of actors and any methods used must describe and capture activities within the natural setting of the actors (Bernard, 1995; Ellen, 1984). This aligns with my chosen research setting, situated within Norway's long-term care sector and the private homes of the elderly in Norway.

By focusing on meanings, the ethnographic approach also enabled me to explore how immigrant healthcare assistants interpret the meaning of their experiences by being present to observe, take part, examine and make inferences between the information provided and my own experience. To this end, using ethnography provided this study with the advantage of allowing me to be immersed in the stream of activities and practices of immigrant healthcare assistants, in order to better understand and describe their perceptions about what it means to be involved in elderly care.

It has been argued that ethnography is a flexible approach for exploring action during key unexpected moments, and this can be helpful for understanding both formal and informal ways of doing (Agar, 2006; Atkinson and Hammersely, 1994; Fine, 1997; Morrill and Rhodes, 2005; Neyland, 2007; Rosen, 1991). This became evident in my study when care assistants would sometimes receive phone calls that meant an instant change in their routines, or had to respond to emergency calls to help colleagues with other clients. In such moments, I was able to capture how participants responded to such calls and examine what this revealed about their approach to work in times of spontaneous decision-making or emergencies. In my journal, I named these 'frozen' moments and described them as situations where healthcare assistants must instantly leave their own clients and rush like the wind to attend to another client, without knowing what will happen to their own client.

I also captured in my journal how, in moments when I experienced such 'frozen' situations, the aura of tension in the atmosphere, the deep silence and the focused manner in which the healthcare assistants attended to their work made me step aside—I could not ask questions but reflected instead on the complex nature of such moment. As pointed out by Atkinson (1983), the mandate for a 'good' ethnographic practice is to acknowledge that the approach is not immune to weakness. By critically confronting research challenges through reflexive practice, it is argued that such an approach can offer good guidelines for good ethnographic practice

'rather than ruling out ethnographic data completely' (Brewer, 1994, p. 235). In the words of Ruby (1980), reflexivity ensures that researchers 'reveal their methodology and themselves as the instrument of data generation' (p. 153). Ethnography is thus about being responsive to vital elements in a communication process as they relate to the producer, process and product. In response to this call, the next section provides a reflexive account of the various procedures used to generate data for this study.

Research methods: Plan, process and techniques for fieldwork

My fieldwork consisted of two phases: In the first phase, my focus was on gaining access and establishing relationships as a means of enhancing my ability to understand the context and orientation of the immigrant healthcare assistants (Silverman, 2007). The second phase of fieldwork entailed spending considerable time directly immersed in the field, with a focus on the research topic.

First phase of fieldwork

Participant observation

Silverman (2001) defines participant observation as a data collection technique that implies an active engagement with research participants in their natural setting to understand things 'first hand' (p. 45). With this approach, researchers stand a better chance of obtaining and retaining the naturalness of the social setting and it provides an opportunity for gaining rich insight into the subject of the study. Other benefits of participant observation have been highlighted by Denscombe (2007), Gill and Johnson (1997), Guba and Lincoln (1981) and Wilkinson and Birmingham (2003). These include the ability to grasp emotional reactions, motives, concerns and unconscious behaviours in an ongoing natural environment; the potential to produce context-specific data; and the ability to understand occurrences from participants' viewpoints and build on tacit knowledge based on the views of both researcher and participants.

In spite of these benefits, potential challenges of this approach include its demanding nature in terms of personal commitment and resources, ethical issues and potential 'danger' to the researcher (Descombe, 2007, p. 224, 225). These suggest that in using participant observation, the journey of discovery can be cumbersome; however, it is critical to ensuring that findings accurately reflect how participants understand and experience the social world through the interpretation of the researchers' experiences.

In line with arguments concerning overt and covert participant observation, this study opted for an overt approach, in which the presence of the researcher and the purpose of the research were known (Grills, 1998; Van Mannen, 1988). I found this essential, ethically—and I also felt that it was important for me to have an identity that distinguished me from healthcare providers because in some cases, policy dictated that I wear a uniform similar to that of a nurse or care assistant. This was not an issue when I was with participants' clients because my presence and purpose were announced before I was allowed in. I did notice, however, that sometimes I was perceived as a new healthcare assistant by staff members who I was meeting for the first time, as well as some of the relatives of the elderly clients, and some elderly clients who were not part of the study. In such instances, I tried to explain my project when appropriate; interestingly, some of the staff members had already heard about it.

I provide a detailed description of the observation methods used in the section on my second phase of fieldwork, below.

Field sites

With consideration to practicalities and my familiarity with certain parts of Norway, nursing homes and private home care institutions in Oslo and Akershus (Southern Norway) and Troms (Northern Norway) took part in the study. This means that data for this study are limited in relation to other municipalities in Norway.

Within private home care, the study also took place in what is known in Norway as a '*bo og servicesenter*'. This translates literally into a 'living and service centre'. It is a care facility that is considered to be owned by the residents and they receive services in the same way as someone would in a private home. The residents could choose to either buy or rent their apartments. Initially, I felt that focusing the study on Oslo would allow me greater access to immigrant healthcare assistants, since my initial personal contact lived in Oslo. This strategy, however, was met with a few challenges.

How come I didn't think about this? Gaining access

The difficulties in gaining access to certain fieldwork settings have been well documented by ethnographers, such as Johnson (1975), Shaffir et. al. (1980), Winkler (1987) and Wolff (2004). These difficulties are often made worse when researchers need access to personal and sensitive data. How to gain access to the intimate and personal lives of elderly people, and to explore aspects of closed boundaries on how 'unskilled' immigrant health care assistants

interact and perform their duties to enable the elderly to maintain a certain amount of functionality in their daily lives was a major consideration in planning for this research. After spending almost a year out of a three-year project to negotiate access, Winkler (1987) urged researchers to consider early planning arrangements and the use of contacts and friends to overcome the challenge of gaining access into a research setting. Likely out of his own frustration with the process, Johnson (1975) recommended the use of ‘slight’ deception to gain access—however, owing to the ethical implications of this and my own personal conscience and integrity, I opted not to follow Johnson’s recommendation. Rather, the invitation to participate in this study was stated openly as: ‘Request to participate in a research project on the role and experiences of immigrant care workers... as part of a PhD study’.

The original strategy was to rely on personal contacts. This strategy, however, was met with two challenges in the southern part of Norway. Firstly, prior to the commencement of this project, my major contact had relocated outside Norway. I was fortunately able to quickly establish new contacts. Owing to the exploratory nature of the study, my first intention was to recruit participants through the snowball sampling technique. I found this technique to be convenient due my prior experience with the trust it builds between researchers and participants (Hervie, 2013). However, during the initial discussions with my contacts, it seemed that using the snowball sample technique would not present this study with a representation of views of immigrants from non-African countries. This is because my lead contact person was African and it became apparent that most of the suggested potential participants were also Africans.

I also observed that using the snowball technique made it difficult to get at least four or five participants who worked at the same place. Most of the immigrant healthcare assistants who were suggested as potential participants worked at different nursing and home care institutions. This meant that it would be difficult to arrange for focus group discussions and the constraints of moving between different institutions would have been logistically challenging. And finally, some of my contacts thought that it would be a challenge to observe them. As one contact (an immigrant healthcare assistant I met during the first phase of fieldwork) told me, ‘you can try but I know that the boss will say “no”...there have been bad reports about this place so she does not allow such things. But I can talk to you outside the workplace if you like’. Owing to these challenges, I dropped the idea of using the snowball technique. However, the trust afforded by my initial contacts in suggesting specific nursing homes where they thought the leaders could be more welcoming to my project was crucial.

One such suggestion led to my contact with a nursing home where a leader at one of the departments was my main contact person. However, shortly before I was scheduled to commence the study, I was informed that the institution was undergoing major organizational changes and that the leader who was spearheading the study was being transferred to another institution. I was also informed that the new leader (who I did not get to meet) was not interested in taking part in the study. There was to be a focus on re-strategizing and improving conditions at the workplace, and having a researcher present at the same time was not deemed appropriate. The alternative strategy I came up with was to contact all elderly care institutions in Oslo. I was able to get a list of nursing homes and institutions that provide services to the elderly in their private homes. With a total of 50 generated contacts, emails were simultaneously sent out on 15 October, 2014. Ten institutions acknowledged receipt of the letters and 7 expressed an interest participating. The primary reasons cited by non-participating institutions included a busy working environment and uncertainty about my being allowed into the ‘privacy’ of their elderly clients.

In the second locality of the study (in Northern Norway), gaining access was relatively easy. This may have been partly due to the impact of using a friend who worked in elderly care to negotiate access, following the lack of positive feedback from distributed letters. This notwithstanding, all participating institutions made it clear that they felt the focus of the study was of great significance to the future of elderly care in Norway, and that it was worth supporting. Indeed, although the original focus of the study was only on immigrant healthcare assistants, some leaders and heads of institutions expressed a keen interest in participating—and as a result, a separate agenda was planned to obtain the views of these leaders.

Following this part of the process, I began making contacts with the interested institutions, in order to meet the ‘faces behind the emails’ and to introduce myself and talk more about the study. I called this the first pilot stage and it is discussed in greater detail under the second point under ‘Procedures’, below.

Procedures

I spent approximately nine months (October 2014 to July 2015) in the field to generate data for this study. Roughly speaking, the first two months were used for the pilot study, while the second phase of fieldwork took place over seven months.

In scheduling observations and interviews with participants and managers, the leaders and institutional managers were provided with both verbal and written information (the latter in

English) about the study to enable them to inform the rest of staff. A brief introduction to this letter was written in Norwegian. Following this, the managers/leaders introduced interested participants to me, and the project commenced.

Knowing the field

As I was aware of the potential challenges in doing research that touches on intimacy, the pilot stage was aimed at adjusting the methodology. Initial meetings were organized with key contact persons during the early stages of the project. These meetings were intended to allow me to establish face-to-face contact and to listen to their views about my proposed methods to generate data. During the meetings, we brainstormed and discussed a range of possibilities, such as which type of elderly clients could be associated with the study, methods for informing them about the study, deciding whether family members should be informed and how participants could be recruited.

A suggestion during one such meeting was that I delete the part of my introductory letter that was written in Norwegian. This was to ensure that people do not feel 'misled'. As one manager said to me, 'maybe someone would not be happy to read all this information in Norwegian and know that she must speak English before they can take part'. This idea was understandable, though it conflicted a bit with my way of thinking. I was of the view that since Norwegian was the main language spoken in these settings, having the introduction in Norwegian would be more appropriate. On the other hand, I felt the need to respect the view of this manager since I believed she had more knowledge about and experience with people's attitudes to information posted on their notice board.

Another manager also suggested that perhaps I should take a break if there was a client with dementia on a participant's list during an observation session. This was due to the concern that it would be difficult to seek consent unless family members were involved, which could be cumbersome. At this meeting, it was suggested by another manager that perhaps I could observe but not report findings related to any patients with dementia. In the end, it was agreed that whenever I was scheduled to observe a participant, he/she would not be assigned to patients with dementia. I appreciated the concerns from the managers and it gave me a feel for how committed they are to the needs of their patients.

In another setting, the issue of how best to seek the approval of the elderly clients was brought up. The consensus was that, where appropriate, the clients would be informed at least a day before I arrived. However, and most importantly, they would also be informed on the actual

day of observation: The participant would go into a client's room (while I waited in the hallway) and inform the client that I was there for a study, and would then ask if it was okay with the client. The client's answer would determine if I was allowed in or not. I was made aware that a client who said 'yes' one day could 'say' no the next day, and that their feelings must be respected. The discussions and the contributions from these meetings were useful in understanding what was deemed appropriate and inappropriate whilst conducting a study in the nursing and private homes of the elderly in Norway. It also helped me to appreciate the practicalities of the activities of the immigrant healthcare assistants.

Ultimately, this period served a double purpose that helped me respond to the needs of the research environment in the most flexible approach.

Summary of the contact protocol

First contact was with the staff member at the nursing home or home care who replied to my introductory email. This person usually served as the key contact person. I was then able to meet the department leader and participants. At two of the participating institutions, information about the project was shared during staff meetings for all the shifts and was placed on the notice board. At another institution, information was also put on the notice board. Interested participants wrote their names down, and I contacted them through the support of my key contact person. Of particular interest was how such meetings were arranged. Even though participants had different shifts, my initial contact with them was arranged such that all of them could meet me at the same time. For some of them, this meant having a slight change in their work schedule. It was explained to me that reaching participants outside their working hours is very challenging. As such, it was necessary to keep such meetings as brief as possible (not more than an hour), especially if participants were on duty but also when they had finished their shift. These small details gave me an idea of how time played an essential role for those working in elderly care, and was also perhaps an indication of the increasing need for workers in elderly care. During my first contact with participants, I gave them information about the project, such as the aim, nature, voluntary participation and right to discontinue participation without any consequence.

The plan: First meeting with participants

In addition to the protocol of familiarity and providing information, my meeting with participants was intended to make the study more participatory. Most specifically, I found it useful in understanding their views about the whole research process, for example regarding

their participation, and the appropriateness of my methods. Another premise for this approach was due to my commitment to valuing knowledge from the level of immigrant healthcare assistants. On the one hand, I appreciated the insights gained from my primary contacts, who mainly held higher positions than the participants. On the other hand, I felt the need to honour the views of the immigrant healthcare assistants since they were the direct focus of the study and had more contact with the elderly. Given the success of these meetings, an adjusted, yet flexible, methodology was put in place for the next stages of the study.

Respondents

The main research objective was to explore experiences of immigrant healthcare assistants in Norwegian elderly care. However, in negotiating access for the study, I was sometimes invited to managerial meetings where I had to make a PowerPoint presentation of my project. In spite of some difficult questions during some of these meetings, it was obvious that my research topic was of significant interest to the institutions and this led to a positive response on the part of some managers who wanted to participate. In the end, the study benefited from the perspectives of these managers, though the immigrant healthcare assistants remained the focus. For the purpose of clarity, I use the term ‘managers’ to account liberally for anyone who held a senior position and had official oversight responsibility for the immigrant healthcare assistants. This group thus includes supervisors, team leaders and department leaders.

During fieldwork, one of the immigrant healthcare assistants called in sick for three consecutive days. On the third day this happened, the manager asked if it was ok for me to follow a Norwegian healthcare assistant. I responded affirmatively. I was assigned to a particular person but she mostly worked in proximity with two other care workers who were *helsefagarbeider* (semi-skilled). This gave me the opportunity to include an aspect of this close observation into my data.

Meet the main participants

In the following profile of participants, the managers and Norwegian care assistants will not be included as they were not the key focus of my study (although they did constitute a significant source of my data).

It is difficult to provide a profile that fits all participants in this study but at least it is possible trace some commonalities. For example, as mentioned in Chapter 2, when immigrants began

to enter Norway, many of them were incorporated into the labour market through programmes established by the state for refugees. Such programmes included free Norwegian language courses. Six of the participants who had come to Norway as refugees participated in this state language programme. For these participants, work in elderly care work was appraised as their ‘quickest’ means to enter the job market due to their relatively poor level of Norwegian language.

With the exception of one participant who had been a qualified nurse from his home country, the rest of the participants had years of experience in professions that were unrelated to care work. One other participant was however a former medical student from her home country. Some of the participants had never worked prior to having this healthcare assistant job. A few intended to continue working in long-term care, provided they had the opportunity for career progression. Others had plans to quit elderly care entirely.

Participants could be traced to various countries in Asia, South America and Africa. Their cultural capital or knowledge and educational qualifications were also varied, with some having university degrees and professional diplomas from their home countries. The complexities associated with these diverse backgrounds and nationalities, along with the varying skill sets of the participants, challenged the cliché that people with certain immigrant backgrounds are ‘naturally’ or ‘more’ caring, hence better suited for elderly care assistant jobs.

Faced with constraints to entering the labour market, some of the participants had previously worked in other low-skilled sectors, such as housekeeping jobs in hotels and cleaning buses and trains. For some participants, their interest in working with people, the personal reward of care work and the ability to practice or improve their spoken Norwegian made elderly care a better option than hotel work. Yet, for other participants, elderly care work was simply a ‘forced’ option for coping with the demands of daily life.

Like the different paths through which participants ended up in elderly care, their experiences and particular situations were also varied. As mentioned earlier, ranging from between 26 and 50 years of age, 13 immigrant healthcare assistants (five males and eight females) took part in this study.

As a prelude to future discussions on gender (Chapter 7), I have decided to present participants based on gender. This is also because though the dominant context of

participants' experiences were similar for both sexes, it emerged that for the men, tensions associated with gendered identities were an inherent part of their accounts.

Male participants

Pedro left South America having worked as an administrator in a hospital. He had experience working with kids with Down's syndrome but never with the elderly. Work in elderly care was supposed to be a transition to his dream job as an accountant, but with limited employment choices, he had worked for **14 years** as a healthcare assistant. He positioned himself very much as an expert in elderly care, and was keen to tell me about his experiences. In our conversation, Pedro tried to take charge by steering the discussion in his direction, thus compelling me to be more attentive with extra questions, especially when he veered off focus. For Pedro, work in Norwegian elderly care meant 'breaking his own cultural bond'. As he explained, 'It is a culture that expects perfection in everything...you are more or less expected to let go of your own culture and everything that defines you. And it is not just that. Everybody has huge and perfect expectations of the healthcare assistant: the family members, the managers, the bossy senior staff and some of the old people. I am supposed to measure and know the exact amount of air the patients breathe...very challenging'. Pedro attributes his ability to sustain his work in elderly care to his religious beliefs as a Catholic.

Dido is from Southeast Asia, and held a degree in nursing. He did not regard himself as a 'typical' healthcare assistant. During our conversation, he was keen on showing me that he did not come to Norway to be a healthcare assistant. Despite not identifying with his current career profile, however, Dido took pride in being relied upon in difficult circumstances where his knowledge in nursing was an advantage. With almost **five years of experience** in elderly care, Dido was convinced that it is difficult for immigrants to progress in their previous career because of national requirements, which disadvantaged foreigners. He lamented the fact he was compelled to work 'below' his skills and experience, thus undercutting his competency.

With **25 years of experience**, **Amadu** was the participant who had worked the longest in elderly care. Before migrating to Norway as a refugee from West Africa, Amadu worked as an auto mechanic, where he was also the team leader for apprentices. Per the expectations of Amadu's culture, being healthcare assistant in elderly care was never an obvious occupation for men. He had drifted into this job, however, upon a recommendation from his teacher in adult education (*voksenopplæring*). In doing work traditionally reserved for women in his

culture, Amadu had to find a new identity—this meant re-positioning his masculine identity in a female-dominated job. Despite finding this very difficult, Amadu discovered a liking for elderly care work. He described himself a very responsible man who would rather work than accept state support. This image of working hard to earn his own money to provide for his family was something Amadu attributed to his being an African man/male breadwinner. Even though it appeared that Amadu had changed his perceptions about traditional gender stereotypes, he was still defensive, and maintained that doing a woman's work was degrading to his status. He also believed that employers think of healthcare assistants as people who do not have need of social or leisure activities. The heavy workload and running around to meet daily targets, according to Amadu, could sometimes lead to illness and depression: 'I still manage to finish the tasks and I am able to cope but at the end of the day, I can feel that my head is burning and this makes me sick and sometimes depressed'.

Tsitsi is from Northern Africa and, being aware of traditional gender stereotypes, he considered it taboo for a man to be doing a traditionally female job. This was also deeply reflected in his cultural assumption that work for men is supposed to be more robust and ambitious and this means doing heavy factory work or being in leadership positions to make key decisions. Tsitsi's desire for advancement, authority and prestige, and the challenges he faced to achieve these, was reflected in the tensions in his narrative. In our conversation, Tsitsi's struggle for status and masculinity emerged as particularly strong, as he made every effort to link these to general challenges in elderly care. Having worked for almost **7 years**, Tsistis was happy to assist the elderly but this did not deny the fact he experienced an identity strain, as he saw himself to be taking on traits stereotypically associated with women, such as being warm.

Like the other male participants, **Baaba**—who had worked for **4½ years** in elderly care—appeared to be conscious of his presence in a female-dominated job. From his background in central Africa, taking a female-dominated job was an easier route into the labour market as the sector needs men to take care of heavy lifting. However, the consequence of being in a female-dominated occupation was the loss of his class status. With the hope of becoming a train driver, Baaba found it difficult to take time off to study, due to the lack of a good work contract. He believed that respect was a key element needed both for the elderly and for people like him who sacrificed to work in a sector frowned upon by many.

Female participants

Kailla was from Southeast Asia, with almost **15 years** of experience as a healthcare assistant. She had previously worked as a factory quality controller in her home country. If ever there was a light that easily sparked feelings of goodness in the heart of the elderly, I would describe **Kailla** as this light. With a variety of talents, such as being able to sing, knit, dance and crack jokes, Kailla had an infectious smile that was difficult to ignore. For Kailla, work in elderly care was more rewarding than her previous job in hotels and as a housekeeper in private homes. At the time of our conversation, Kailla had received sponsorship from her institution to start a *helsefagarbeider* course.

Zuzu is also from Southeastern Asia, with **8 years of experience** as an elderly healthcare assistant. She was a trained kindergarten assistant and had hoped to continue in that field. Language challenges, her love for working with people, and her experience taking care of her sick mother-in-law motivated her to consider elderly care work in Norway. My first impression of Zuzu was that she appeared to be quite shy, as she ignored most eye contact with me and provided very brief/monosyllabic answers to my questions during the initial stages of my observation. I realized that this was mainly due to her lack of ‘confidence or trust’ as she portrayed herself as someone who takes time to get to know people. As Zuzu managed to establish trust in me, she became more forthright and impressed me with the direct manner in which she talked about her experiences in elderly care. With a phobia of tape recorders, Zuzu told me that ‘if Norwegians are born with skis on their feet, I was also born with hard work in my hands. The work is tough but people from my country handle tougher situations than most others’. She believes that the elderly healthcare assistant job is not for everyone, and that immigrants will continually feature in the sector since it is a demanding job that is also poorly paid. Zuzu believed that the conditions of healthcare assistants will improve when political leaders start reflecting on the fact that, in the future, some of them will have need for healthcare assistants and that immigrants will inevitably be part of this workforce. Such a realization, Zuzu believes, will lead to investments in elderly care.

Shasha came to Norway from Central Africa after completing senior high school with an ambition to be a scientist. She had never worked in elderly care before, though she had worked as a shop assistant and a volunteer for kids in Norway. With almost **three years of experience** in elderly care, Shasha found the care assistant position to be a disadvantage. At the time of our conversation, she had invested in private tuition to become a *helsefagarbeider*.

In spite of this investment, Shasha did not see herself continuing to work in elderly care but rather with young people, either in rehabilitation or with a humanitarian organization for refugees.

As the only female child in her family, **Tabitha**, from Central Asia, described herself as someone with a strong personality. The latter is what made it possible for her to leave her family behind with the hope of working to save money so she could further her education in computer engineering. The story of her first year in Norway revealed how homesick she had felt. In addition to difficulties finding an office job, Tabitha became devastated upon receiving news of her father's death. However, she had been able to translate the negative moments of her earlier stay in Norway—her father's death in particular—into a positive narrative, as she described these moments as the reason behind her dedication to elderly care. With **6 years** of experience up her sleeves as a healthcare assistant, Tabitha was very keen on downplaying any attempts to cast a negative image on the healthcare assistant job. This was her first job, and she felt frustrated when she had to take a step back simply because nurses said so, not because it was necessarily in the client's interest. Her immediate plan was to take a degree in nursing but to continue working in elderly care afterwards. She thought that foreigners should be given the opportunity to rise up the hierarchy in the healthcare profession: 'It is about the work and those who have sacrificed and are willing to work. It should not be about nationalities. If a leader is good, everything will be good because they don't look at background. They focus on capabilities'.

Oplo has worked as a healthcare assistant for **over 6 years**, and gave the impression that she was undaunted by language difficulties. Arriving in Norway as a refugee from **West Africa**, Oplo said she took advantage of the free language tuition to 'master' the Norwegian language before starting work. Oplo also gave the impression that as a naturally calm person, she had the patience needed to work with the elderly, as the health conditions of the latter and the demanding nature of the work itself required extra patience. Oplo compared her current work in Norwegian elderly care to taking care of her own grandparents. She believed that it is a blessing to be old, and felt sad that Norwegian society saw the elderly as a burden. It was clear to me that Oplo was happy with elderly care work but at the same time she felt trapped, and worried about whether she would be able to take up studies to become a nurse in the future.

Reeki

Among the care assistants I interviewed, Reeki—from Eastern Africa—had the least experience in elderly care. This conversation took place when she was **one year** into her career as a healthcare assistant. Reeki, however, was educated in pedagogy and she was motivated by both her sense of adventure and her love for caring to try working in elderly care, having worked previously cleaning kindergartens in Norway. She said the elderly care job was both physically and mentally demanding, especially when it came to negotiating cultural differences. She described herself as a responsible person who liked to be precise, with a very careful approach to work to avoid making even the smallest mistake.

Tabio is from Southern Asia and has been working in elderly care for **5 years**. Tabio was quite pessimistic in our conversation, giving me a clear indication that she was not happy with her situation as an immigrant healthcare assistant. Her reliance on extra jobs/overtime pay, giving up part-time studies to focus on work and her lack of clear career prospects appeared to make her feel increasingly marginalized and powerless. A network of friends from her home country supported her, and they encouraged each other in times of challenges. This, Tabio believed, prevented her from being depressed. She also drew encouragement from her culture, which had taught her to persevere and never accept situations that seek to belittle her.

Gigi was a 2nd year medical student in Southern Asia prior to her settlement in Norway due to marriage. Disqualified from Norwegian medical school due to its language requirements and with a marriage that was on the rocks, Gigi had limited options other than to take the first offer of a job—which had been in elderly care. With **5 years of experience** in her current position, Gigi remained grateful for the opportunity to work—and even more grateful to her friend who recommended the job, as Gigi had two children to feed. Through her work, Gigi believed she filled an important gap in Norwegian society, saying that, ‘If I don’t go into their homes, most of them would just be lying down, sleep on empty stomachs and be stinky without changing their diapers/pants’.

Similar to some of the participants, Gigi had no formal training in elderly care. She believed that respect and patience are key elements needed to work in elderly care. She was very direct in telling me that the negative image of the elderly healthcare assistant job is because the ‘state is not very interested in people who can no longer pay active taxes’.

Having introduced the main study participants, I will now focus on the second phase of fieldwork.

Second phase of fieldwork

In some cases, the second phase of fieldwork began with an introduction to the direct supervisors of participants. This was usually the case when the initial contact person (e.g. the manager of the nursing home) was in a different position than the supervisor. These introductions opened avenues for me to be present at meetings where I could be further introduced to the rest of the team members in the department and, in most cases, I was asked to personally say a quick word about the study (though I was informed that this had already been done by someone else). Within this setting, the following procedures were used to generate data:

24/7 observation

Participant observation in this study is aligned with what Long, Carroll and Nugus (2005) described as '24/7'. I was involved in the daily practices of immigrant healthcare assistants around the clock, throughout the week, both day and night. In other words, I followed the activities of participants from Monday to Sunday and through the various shifts, which were usually 7:00–15:00, 15:00–22:00, and 22:00–6:00.

As argued by Silverman (2001, 2006), participant observation enables researchers to overcome the potential danger of self-reporting by providing an evaluation or assessment of the accounts of interviewees through actual practice. This proved to be useful for the study in many ways. First, by working around the clock, especially during 'unholy' hours such as the 22:00 to 6:00 am shifts, I was able to obtain a 'holistic' picture of the actual work practices of immigrant healthcare assistants through the various shifts. The contrast between words captured during interviews and what ensued during observations provided practical information to explain situations in which narrations differed from reality.

Secondly, taking part in the actual work practice of immigrant healthcare assistants provided me with the opportunity to reflect practically on the experiences of the participants. Subsequently, when participants reflected on their daily activities, this provided an opportunity for us to discuss possible explanations and understandings. For me, such reflexive moments enabled me to enter into the real world of participants, and they proved very useful for my analysis.

Following the 24/7 approach, I grouped the observations at each field site into two stages, though these were interchangeable depending on the setting. The first stage was a preliminary observation where I stood in the hallways and other casual meeting points to get an initial

understanding of the work practices of immigrant healthcare assistants, such as how they engaged in informal relations with the elderly and colleagues, and other processes in the department. In this position, I was able to take note of work coordination and get some ideas about the division of labour among the various healthcare workers. For instance, I observed that, in the hallways, nurses mainly pushed trolleys with medical equipment, physiotherapists engaged in training activities with clients, and the healthcare assistants were either feeding or helping the elderly back into their rooms.

The second stage involved a deeper insight into work practices, where I could feel, smell, touch and experience the world of participants in the closest way possible. Within this setting, I took part in changing diapers, giving showers, dressing, making beds, feeding, cleaning, attending hospital appointments, going for walks and joining in training and other activities. More importantly, I paid particular attention to the processes by which participants related and interacted with the elderly, how they performed their work, how they communicated, how they made decisions and how they reacted to situations.

At this stage of observation, deep-seated aspects of participants' experiences were brought to bear and it was possible to identify and make links between the first and second stages of observation. For instance, in the second stage, I had a closer view, so gained more knowledge about, for example, the different roles between healthcare assistants and other attending staff, including nurses, physiotherapists, ergo-therapists and departmental managers. During these moments, I was able to observe the differences in tasks, the modes of conversation and the nature of the relationships between the different roles. This provided me with a considerable level of clarity, which helped me to make sense of information during conversations, interviews and data analysis.

I realized that the more time I spent with participants, the more I understood their daily activities and in some situations, there was no need to ask questions. From this practical angle, I also had a better understanding of what Morrill and Fine (1997) discussed as 'perspectives in action' and 'perspectives of action' in ethnography. During perspective of action, the research participant takes time to explain what is going on to the researcher. Perspective in action, on the other hand, refers to ordinary talk that ensues between a researcher and a participant within the context of an activity. When researchers become acquainted with the practices of participants, some perspectives in action can be understood without the need for participant explanation (Morrill and Fine, 1997).

In the home care sector, the second stage of observation was particularly important. Here, it was interesting to observe the dynamics at play when participants had to work in what looked like a casual or informal environment. It was also interesting to observe how participants provided services in an environment where there were no supervisors, or as I wrote in my journal, 'when nobody was looking over their shoulders'. In addition to observations, taking part in casual activities provided additional opportunities to clarify some impressions from an informal angle.

Yin (1994, p.89) expressed concern about the potential of 'researcher bias' during participant observation. To reduce this bias, I engaged in prolonged observation, in order to view activities and processes over a period of time. In addition, I also created moments of discussion after the observation to obtain meanings, clarify actions and behaviours, and check the accuracy of my field notes to improve the quality of data.

Interviews

Data for this study were also generated through individual interviews with 13 immigrant healthcare assistants and 4 managers of Norwegian long-term care institutions. As mentioned in the first phase of my fieldwork, I gained direct insights from informal conversation with three Norwegian health workers.

Whereas observation provided a basis for direct insight into activities, interviews were used to maximize the breadth and depth of perspectives by giving participants the opportunity to reflect on their historical and current background experiences. I actually prefer to use the words 'conversation' or 'discussion' instead of 'interviews' since, to me, interviews depict a formal mode of data collection in an official or strict manner. Conversations/discussions on the other hand point to the 'relaxed' environment in which participants were made to feel comfortable or more at ease sharing their experiences. In conversation with participants, I was interested in their experiences, which they told me about after deep reflections, with real examples.

I am aware that structured interviewing techniques can often produce such in-depth exploration (Silverman, 2010). However, with my focus on lived experiences, I am equally aware of the likelihood of uncertainties and diversities. As a result, I was not in favour of a structured interview approach. In specific terms, I used semi-structured interviews in the form of an interview guide. Using an interview guide meant that pre-formulated questions would not be asked. Rather, a checklist of information was designed to guide the interview process

(Kvale, 2008; Silverman, 2010). For instance, I asked participants to tell me about what their work activities entailed. Based on their response, further topics were developed for our conversation. This ensured that no two interviews were the same and allowed the interviews to take on their own shape based on how participants responded to questions. During these interviews, I asked open-ended questions in a probing manner—I made sure, however, that my probing questions were non-directive.

Of particular concern to me were the ethical implications and questions around emotional and sensitive information. Based on this, the study paid particular attention to verbal and non-verbal cues. Discussions were structured such that attention was paid to interview protocols such as venue and time of interview, seating arrangement and the setting in an effort to value the knowledge of participants and minimize the potential for engaging in a hierarchical interview (Berg, Lune, and Lune, 2004). Interviews lasted between one to three hours and they were conducted in either English or Norwegian. All interviews were conducted by me, with the exception of three interviews where interpreters were present. In one of these instances, a participant opted to be interviewed in her native language (which I could not speak), as she saw it as the best medium to fully speak to the topic. In the second and third instances, my difficulty fully understanding the English of one participant and my inability to sustain an in-depth interview in Norwegian with another necessitated a bilingual interpreter.

In an effort to conduct a participatory interview, participants were encouraged to ask me questions. This activity of asking me questions led to a rich source of data, which has been captured in certain aspects of the study.

Interview to the double

I used Nicolini's (2009) technique of 'interview to the double' as an entry point into understanding the daily activities of participants. Originally developed in the 1970s by Italian occupational psychologists, interview to the double is a technique that enables interviewees to articulate and re-present their work practices (ibid). It has the functional task of asking interviewees to provide detailed information about their work to an assumed novice who is supposed to take over their job. In practical terms, interviewees are asked to narrate what they do in a typical day to the interviewer by assuming that there would be a "double who will take their place in the workplace the following day" (ibid, 197). In its original mode, interview to the double was used to acknowledge workers as 'bearers of valid and precious "know-hows"' (ibid). Nicolini (2009) described the tool as an effective way of eliciting descriptive

information by generating a process of discussion and understanding between interviewers and interviewees in a reflexive manner. In particular, this technique ‘brings to the fore critical aspects of the discursive and moral environment within which practice unfolds...it offers an insight on the criteria used by members to judge the appropriateness of the situated activity (Nicolini, 2009, p. 196).

In other words, interview to the double helps to elaborate the subtle ways in which interviewees do their work and presents them with an opportunity to reflect on and communicate about these work processes. It has the advantage of capturing participant experiences in a way that expands the possibility of enriching accounts through reflection. Nicolini, however, cautions that this technique must be used in a critical and reflexive way, and suggests that it has greater effect when used with other methods (such as observation).

In this study, interview to the double was used as a technique for two main reasons. Firstly, as a tool for representing practice, it enabled me to discover aspects of participants’ work practices that were unfamiliar to me. Secondly, it allowed me to appreciate and establish a connection between the practical sense of how participants gave accounts of their work and an understanding or justification of what actually goes on in the wider working environment.

All interviews were conducted at the workplace of participants, with the exception of three individuals who preferred to be interviewed at home.

Focus group discussion

As an approach, focus groups were used as a means of establishing dialogue amongst participants, as well as giving me insight into group patterns and behaviours. Focus group discussions were deemed appropriate for this study since the aims of the research involved exploring common attitudes, views and experiences within a context that was characterized by collaboration between the populations being studied (Silverman, 2010). Specifically, the study benefited from three focus group interviews, with the smallest group consisting of three participants and the largest group having five.

Using focus group discussions also allowed relevant issues that had not been discussed or mentioned during individual interviews to come to the surface. After spending a considerable amount of time with participants during fieldwork, I felt that I had a good understanding of their daily activities and this enabled me to ask relevant follow-up questions. Most importantly, having reflected on my experiences during observation and data from interviews,

I was able to approach the focus group discussions with a degree of openness that made it vital for new knowledge and understanding to occur.

Other useful methods

Field journal

The notes that I had taken in my field journal turned out to be central to my data analysis. In fact, in spite of the various approaches I used to generate data, none can be compared to the breadth and depth of information captured in my journal. As someone who did not have direct experience in elderly care, my journal notes were crucial in helping to deepen my understanding and to make sense of situations and events that were not familiar to me. For this reason, my journal notes comprise a major part of the data reported in this study.

The notes also provided me with a deeper means of understanding, interpreting and contextualizing data, particularly after the interviews. Most importantly, they created a deep sense of connection between the participants and me by helping me link events that occurred during observations with the accounts of participants during interviews and focus group discussions.

Additionally, my hermeneutic approach meant that I actively participated in generating data for this study. A reflexive journal was thus essential for recording and showing how my horizon or perspective was incorporated into the research experience to enhance credibility—my thought processes were neither eliminated nor ‘bracketed’. In this way, my journal notes provided the context that showed how my own understandings were interacting with the data from observations and conversation with participants.

Together, these notes provided me with a good basis for comparing the real accounts of participants, and they informed my analysis of the data in several ways. For instance, this journal entry about the home of one elderly person speaks volumes about the extra care he received from the participant:

The apartment looked very nice from the outside. However, the moment we entered, I saw the sharp contrast. It is a one-bedroom apartment with a small bed placed next to the window. It is obvious this room held more things that it could contain. The only sofa, which looked old and tattered, was filled with items like bandages, plasters and gloves.

The ceiling was filled with moisture and tinted with black spots and brown water. The kitchen was no different, and contained a very old stove with old-fashioned cooking utensils. The cover of the kitchen bench was peeling off like the hard bark of mahogany tree in my sunny country. The only thing that looked okay was the kettle. The toilet was no better: an old toilet seat with dark brown stains that cannot be removed by detergents. Later, the participant explained to me that there was a cleaner who used to clean this apartment every third week but this cleaner had been not around for some time. The fridge was almost empty and the last of the apple juice had been poured into the glass. And it was indeed the last slice of bread.

This note became particularly important later in my study not only in helping me understand the social conditions under which some of the elderly live, but also as a reflection of policy perceptions regarding the elderly Norwegian and the elderly sector in general.

Also evident was the way the living situation of the elderly can embody stress, as demonstrated in this example from my journal:

Everything moved very fast here and I wondered why. I was asked to do so many things at the same time. Can you please help clean the kitchen? Can you please take the garbage out? Is it ok for you to clean the bathroom whilst I finish dressing him up? Can you please help me hang the laundry? There was so much to do at this place and I found myself panting for breath. As the participant said to me, ‘Sometimes I go to the shop to buy a few things for him when I have time. He tells me I am the only person he can ask to do such things for him. I do not know much about his family situation but he has one particular friend he calls to help him when he needs food and other stuff. He has been to my country before when he was young and he tells me he enjoyed it very much. He cannot afford most things. I think of him like my father and I try to do everything for him as much as I can. My colleagues sometimes try to help but so far, I think I am the only person who cleans his bathroom and toilet and other places as extra. It is always messy when I have not been here after a week or so. Just like today...It makes the work more stressful. Many of these old people need so much. I am happy to be helping but sometimes I also need help so that I do not break my back...
(*sarcastic laugh*).

Breaking the cliché

In analysing the data for this study, I realized that one of the strengths of an ethnographic explorative approach is that one may be surprised by what one finds—serendipity, in other words. I call this ‘breaking the cliché’ as it points to ‘new’ or interesting knowledge. For instance, one of my preliminary observations was that photographs of the elderly, which displayed their youthful exuberance, were great sources of respect for them. By this I mean that, contrary to the cliché that immigrants are more respectful and caring towards the elderly because of their backgrounds (such as coming from more family-oriented societies), the respect that participants felt for their elderly clients was in fact derived from these photographs. These pictures depicted the elderly as resourceful people who had contributed immensely to society in their youthful years. To most of these immigrants, it was the achievements of their elderly clients—as displayed in their photographs—that deepened their respect for them. This is one of the notes I wrote:

The room was lavishly decorated and white was the dominant colour. The sofa was of quality leather and the Samsung TV attached to the wall was the latest model. A unique element was the collection of different pictures put in quality frames displayed in various parts of the rooms. I saw that most of the pictures on the wall represented the high moments in the life of the elderly client, such as weddings (their own and those of younger family members’), the birth of a new family member, and memorable holidays. Through such pictures, across a range of client rooms, I saw pilots, nurses, doctors, seamen, engineers, researchers, missionaries, lawyers and active sports men and women with several medals. Indeed, these were displays of the ‘high points of family life’ (Bourdieu, 1990: p. 19) and interestingly, this observation helped me reflect on the ways in which immigrant healthcare assistants talked about how they have developed a deep sense of respect for the elderly through their pictures. As one participant (Oplo) said to me, ‘I respect them a lot, because they have achieved a lot...When I look at their pictures, I see pilots, seamen and professors. I think that society needs to value them and give them some attention. It always feels like they have been dumped here and no one cares’.

I noticed that nothing was particularly said by participants about the living environment in the nursing homes. Perhaps this was because the variation was not so big.

Notes on interviews and focus group discussions

Some of my journal notes referred to significant moments that occurred during individual interviews and focus group discussions. For example, I had been given the opportunity to converse with a participant in the comfort of his private home. The difference I observed in my journal writing relates to the context and nature of this particular interaction: The uniqueness of this interview was that the context (the home environment) changed the nature and form of our conversation (though the topic was maintained). Though this data was peculiarly valuable, the conversation was extremely long and exhausting. I noted that the wife was particularly warm and welcoming, however:

Fresh warm tea was offered within an interval of 15–20 minutes. It was an interview that lasted over two hours. Tea was first poured into the cup of the husband (the participant) and then I was asked if I wanted more. Not only was fresh tea served but the cups were changed twice. I did not particularly like the interruptions since sometimes this meant turning the tape recorder off. At one point, the husband signalled for his wife to stay back. I was happy with this because he seemed to be making an important point here.

In my notes, I wrote something with three asterisks:

This man spoke with his wife through hand signals. Could it be because of the tape recorder? After the discussion, both he and his wife walked me to the train station. On the way, he spoke about his fantastic wife and how he is treated like a king when home. But why did he refer to his kingly treatment at home? Was it meant to say something more? Was it an indirect way of elevating himself above the position he occupies at work? Or was it just a display of his manliness?

One important feature of this interview was that I noticed that the participant was more at ease, and as he said to me, ‘this is my house and I talk about everything’. Notably, I observed that the use of participant’s private space and the lengthy nature of this conversation enabled me to generate extraordinarily in-depth data relevant to the study.

Notes from my journal also mentioned how focus group discussions helped stimulate communication. The dynamics at play during group discussions will vary, but people may often feel too intimidated by the presence of others to talk. This extract from my memoir, however, relates to a situation where a notably quiet person was exceptionally active during group discussion:

She seemed a bit jittery at the start of the interview and I asked if she could take a deep breath before I put on the tape recorder. I realized that her voice was a bit shaky and wondered if it had to do with the tape recorder. I asked if I could turn the tape recorder off but she said it was ok. Most of her answers were monosyllabic and most attempts to further probe were met with short answers and descriptions. But perhaps this should not surprise me because I observed that she is a bit of an 'introvert'. I was however caught in awe when I met the same participant during focus group discussion. Her zeal to discuss and ability to contribute to the various themes was simply impressive and opposite my experience with her during individual interview. I wonder what could have contributed to this sudden change in the presence of others. Could it be that hearing her colleagues speak to the same issue motivated her to share her experiences?

In the face of multiple questions and reactions, how to ensure that data was generated with openness became an important question. Guided by the Forskningsetiske Komiteer (National Committees for Research Ethics in Norway, 2016), it was my responsibility to work in a transparent and collaborative manner with participants. This leads to my discussion on research ethics, data analysis and the writing stages of this study, below.

Research ethics, data analysis and the writing process

Ethics

A notification of this study was submitted to the Norwegian Social Science Data Services (NSD) on 20 August 2014 and it received approval on 02 September 2014. As mentioned in previous discussions, some managers expressed interest in participating in the study. As they had not been included in the original plan, a second notification was sent to NSD, to include managers.

It was my priority to assign codes to participants and places where the study took place to ensure anonymity. Pseudonyms have been used in such a way that they do not relate to the real names of participants. This also applies to the managers who took part as well as to the names of elderly people where they appear in the text. In some cases, I used coloured pens when assigning codes to names. Here, much attention was paid to the colour I use for coding African names. In my country, and similar to other African countries, using the colour red on a person's name signifies death. I therefore avoided this as a form of symbolic respect. I mention some countries of origin in the text but these, too, have been changed so as to protect the anonymity of my participants.

In general, all the request letters discussed the purpose and nature of the project, assured participants of confidentiality and anonymity, offered participants the freedom to opt out at any time or refuse to answer certain questions and highlighted ethical concerns for the study. In as much as openness and honesty were a key focus of these letters, it came out that the description of study participants was met with challenges. The reason was mainly due to the fact that, even though the three-page request letters were written in English, the accompanying introduction letter was written in Norwegian and the study did not explicitly state that participants must be able to express themselves in English. This was not done on purpose and did not compromise the purpose of the letters since it was clarified and amended during the pilot studies.

Data coding and analysis

'Q: What is the colour of snow? A: White. To most of us, the answer "white" may seem satisfactory, but to an Eskimo, it would seem a joke: Eskimos distinguish between a wide variety of "whites"... So it is with qualitative data analysis'. (Dey, 1993, p. 1)

The analytical stance I take in this study supports what Smith and Osborn (2008) described as interpretative phenomenological analysis (IPA). This analytical approach acknowledges the need to understand 'how participants are making sense of their personal and social world' (Smith and Osborn, 2008, p.53). Simultaneously, IPA recognizes that the process of data analysis, including creating categories or codes and discovering emerging themes, is also based on the researcher's interaction with the field and participants and through critical questioning and reflections about the data.

Smith and Osborn (2008, p. 53) described IPA as a 'two-stage interpretation process or double hermeneutic' with the caveat that the process is interactive and not linear. In their words, '[o]ne is trying to get close to the participant's personal world...but one cannot do this directly or completely. Access depends on, and is complicated by, the researcher's own conceptions; indeed, these are required in order to make sense of that other personal world through a process of interpretative activity' (ibid). Indeed, while analysing the data for this study, I tried to get an understanding from the point of view of the immigrant healthcare assistants. In doing so, however, I was mindful that there were instances where certain

situations that I witnessed were different from how descriptions about those situations were presented to me.

Essentially, how to obtain meanings and understand the ‘content and complexity of those meanings’ from the point of view of research participants as well as the researcher is critical to IPA (Smith and Osborn, 2008, p. 66). As a result, IPA does not insist on treating data with ‘objectivity’ and generalization. Instead, the accounts of research participants and the emerging meanings and interpretations are analysed simultaneously with the interpretations and experience of the researcher.

As mentioned at the beginning of this chapter, the primary data for this study were generated through observation, individual interviews and focus group discussions. At the end of the study, I was astonished by the wealth of detailed data waiting to be analysed. However, since I personally did the observations and conducted the interviews, I had some good knowledge about my data when I started the analytical process. I manually transcribed and coded tape recordings from interviews and focus group discussions. As a guide, I used Smith and Osborn’s (2008) analytical sequence of IPA, which entails looking for themes in the first case, connecting the themes, continuing the analysis with other cases and writing up. These are outlined in the following discussion.

Looking for themes in the first case

Looking for themes in the first case aims at sensitizing researchers to the data; subsequently, by closely reading and taking note of ‘similarities and differences, echoes, amplifications and contradictions’ (Smith and Osborn, 2008, p. 67), new insights emerge. Here, one interview transcript is analysed and significant attention is paid to interesting aspects of the data. The first level in this process is to get a general overview of the transcript. This, according to Smith and Osborn (ibid), includes a critical evaluation of the transcript and how notes from observations are evident within it.

With this step, I was able to get an overview not just of the transcript, but also of my data, as I began recognizing contexts where I needed more information. I achieved this by first taking note of the key research questions for this project, and taking a closer look at questions that were actually discussed or raised in the study. I then related the questions to responses from participants and tried to figure out if the data generated could shed additional light on the research questions.

Smith and Osborn (2008, p. 53) introduced an important analytical guide for researchers by encouraging them to ask critical questions such as: What is the person trying to achieve here? Is something leaking out here that wasn't intended? Do I have a sense of something going on here that maybe the participants themselves are less aware of? Similarly, Silverman (2015) has argued that it is important for researchers to pursue the what, how, when, why and where questions when analysing data. In order to understand, explain and interpret responses from participants, I thus engaged with the data such that I could know why, how and what they meant by what they said.

These analytical questions enabled me to move beyond my initial overview of the data by transforming the data into something more concrete. For instance, I brought these analytical questions to bear on my interviews and focus group discussions with participants as well my interviews with managers. I then explored similarities and differences and used information from my observation notes and journal to obtain a deeper understanding of what the data was trying to say. This enabled me to identify important meanings, central concerns and themes that started to unfold in the accounts of individual participants. Here, I took notes of the initial significant and interesting aspects of the experiences of the immigrant healthcare assistants, resulting in what I called a summary of a new overview of my data.

At this stage however, I had neither established a conclusion nor arrived at findings for the study. I progressed by going back to my analytical questions and, following Silverman's advice, I tried to find out what the data was trying to say. How could I dig beneath the similarities and rivalries in my data to answer the overall research questions? This led me to the next stage where 'the initial notes are transformed into concise phrases which aim to capture the essential quality of what was found in the text' (Smith and Osborn, 2008, p. 68). This required a reflexive engagement with my material by lifting it from the level of common sense understanding to the level of theoretical thinking/connections (ibid). In their words, 'the skill at this stage is finding expressions which are high level enough to allow theoretical connections within and across cases but which are still grounded in the particularity of the specific thing said (Smith and Osborn, 2008, p.68).

To achieve such experiences, I brought my empirical findings to bear on the research questions to explore how the bits of information were interconnected. My focus here was to arrive at what Geertz (1973) referred to as 'thick description' which, as argued by Denzin (1978), 'includes information about the context of an act, and (sic) the intentions and meanings that organize action' (p. 33). At this stage, I paid profound attention to the context

in which the data were generated. Indeed, meanings depend on context and Dey (1993) has made us acutely aware that ‘we can make mistakes in attributing particular meanings to particular observers, but the biggest mistake would be to imagine that meaning can somehow be understood independently of the contexts in which it is observed’ (p. 36).

Significantly, delving deeper into the contexts in which participants shared their experiences led me to a phase in the analysis where I was able to situate my summary within specific setting to grasp the relevant meaning from this perspective. At this stage of working with my transcripts, it was comforting to realise that when situated deeply in context, new meanings were gradually opened and some preliminary understandings emerged. I felt that I had reached a milestone when I discovered certain themes, which related to:

- Prevalence of workplace tension that suggested a superiority-inferiority complex due to stigma attached to low-skilled jobs
- Structural/institutional challenges of being an immigrant healthcare assistant
- Tensions and conflict due to culturally sensitive values and attitudes
- Acknowledgement by managers of elderly care institution about the significant role of immigrant healthcare assistants in Norwegian elderly care

However, I began to discover (especially after my midway seminar) that some of my preliminary themes were at the analytical level of critical common sense understanding (Kvale and Brinkmann, 2009). The next task was therefore to place my preliminary themes within the context of the discipline of my study and lift them to a higher level of theoretical understanding. I found this—especially the latter—to be interesting yet frustrating at times. At this stage, it was clear to me that the process of analysis indeed takes time. At certain times, important meanings and themes were easily developed and at other times, these took a very long time. Within these moments, however, I became deeply immersed and gained more confidence in my analysis of the experiences of the immigrant healthcare assistants. Working with the preliminary themes at the level of relevant theoretical understanding tested both my data and theoretical perspectives. This provided the study with more distinct themes, which led to the beginning of the second stage of analysis in IPA: connecting the themes.

Connecting themes ‘involves a more analytical or theoretical ordering, as the researcher tries to make sense of the connections between themes which are emerging’ (Smith and Osborn, 2008, p. 70). The process refines the preliminary themes by looking for connections between them. At this stage, ‘some of the themes will cluster together, and some may emerge as subordinate concepts’ (ibid). This requires the development of a list or table of the emerging

themes, which are then checked against the transcripts to ensure that the connections are in line with the data generated from the study. I enacted this process by going back to my interviews and focus group discussions to check my analysis against the information provided by the participants. At the same time, I created something like a funnel, with which I could illuminate this information through my own observation data. This then led to the third stage of the IPA: continuing the analysis with other cases.

Continuing the analysis with other cases

At this level, the aim is to analyse other transcripts ‘to discern repeating patterns but also acknowledge new issues emerging’ (Smith and Osborn, 2008, p. 73). Continuing the analysis with other cases is the analytic equivalent of allowing meanings and concerns to emerge from varied perspectives by recognizing points of ‘convergence and divergence in the data’ (ibid). In other words, this shows the connection between patterns of meanings which can be found across the accounts of participants. Smith and Osborn (ibid) argued that it is critical that certain factors—such as how the depth of certain narrations illuminate the theme—and other aspects of the data are taken into account. Here, I was able to elaborate on some of the specific meanings that appeared to be significant in my analysis of the first transcript. This enabled me to make meaningful comparisons between the various transcripts and develop a meaningful account of the experiences of the immigrant healthcare assistants. I then organized these into relevant categories of major and minor themes. In effect, this process refined my data and laid the foundation upon which certain interpretations and explanations were based. This process also allowed me to check the analysis against my research questions to determine if the relationship between the themes addressed the research questions. Here, the central themes from the analysis formed the basis on which the empirical data in the subsequent chapters were discussed. Thus, in the final stage, IPA is ‘concerned with translating themes into a narrative account’ which is termed ‘writing up’ (Smith and Osborn, 2008, p.76).

Writing up

As the name implies, writing up involves a write-up, which outlines the analysis by presenting a discussion of research themes. IPA offers two strategies for doing this. In the first instance, researchers can discuss the analysis on the emerging themes and have a separate discussion which links the analysis to the wider literature. The second strategy is to discuss the linkage between the themes with the broader literature as one presents each theme or results. In my

write-up, I opted for the first strategy. Contextually, I mostly discussed the emergent thematic analysis at the micro-level and linked these to another level where I discussed the analysis at the macro-level.

In my writing, I have decided to present certain key examples from accounts that provide a better explanation for and understanding of my analytical arguments. In my discussion, I try to relate these examples to the experiences of other participants, to discuss and examine regularities, variations and singularities in the data. My aim in doing so is to illustrate how the examples represent the commonality of the experiences of the immigrant healthcare assistant. In spite of these commonalities, however, I realized that during individual interviews and observations (when I was mostly alone with participants), there were variations in experiences. For instance, whereas a participant may share detailed experiences in response to certain questions, the same participant might speak less when asked other questions. As such, information from specific participants may be highlighted in certain chapters and less in others.

In addition, because data were analysed for themes that represent the shared or common experiences of participants, in some discussions, I have used a summary term to identify these common themes. Depending on the discussion, I have used my own phrase as a summary term to represent participants' common experiences. This exercise became necessary as it emerged that, in some instances, specific words used by individual participants did not necessarily represent the words of other participants, even though they have similar experiences. Thus, when I discuss the emerging themes, the excerpts are the exact words of participants, yet some of the labels representing these themes are my own words and phrases.

When textbook knowledge meets reality

In the literature, there are plethoras of ideas on how to enter the research field. Following that, however, is the hard work of how to approach practical challenges using academic and textbook vocabulary. To a considerable extent, aspects of my methodological choices were met with challenges. And though these kinds of challenges are not uncommon in research endeavours, my own experience differed with regards to how I managed the challenges and the extent to which my reflections on them shaped my research process as in the following:

When the going gets tough

From the onset, it was clear that I wanted to develop an in-depth appreciation of the activities of the immigrant healthcare assistants by being an active participant. These are skills I have practiced before and I was aware that using them could help bridge the research-researcher gap (Hervie, 2013). In addition, it can sometimes be uncomfortable to just stand and watch without contributing. However, in the study, my experience with this differed in important ways and this decision was met with challenges.

In the early parts of my observation, I volunteered to do basic tasks from which I could observe the activities of participants. I made this offer without much consideration for my competency in carrying out the tasks. On one such occasion, I felt highly uncomfortable and cried in my heart for help. This was because I was asked to help change a massive amount of excrement/faeces from a very fragile man with what looked like multiple fresh bedsores stained with blood. Being involved in such a task was completely alien to me, yet I felt that I needed to respond to the situation in a way that would be useful to the participant and perhaps even the elderly client. I could not block out the sounds of pain from this old man and my eyes could not close to the distress of his nudity. It reminded me of my late uncle's pains when he was struggling with cancer in hospital. I wanted to step out, but I was asked to help by holding the waste bucket at a close distance to make it easier for the disposal of the waste items. In my state of involvement and avoidance, I accidentally knocked a glass of water over (which luckily did not break).

On other occasions, I felt uncomfortable when I was asked to change bed linens on my own or assist in giving clients showers, helping them with toileting and feeding, and helping to lift or adjust some of the clients to and from their beds. These were routine tasks and activities for the healthcare assistants I was observing. However, a major dilemma for me in doing these tasks was the uncertain line between being perceived as helpful by the participants and my personal discomfort in invading the intimacy of the elderly clients. Reflecting on this prompted me to make decisions regarding the level of my involvement depending on the context. These encounters were later useful in helping me understand how the immigrant healthcare assistants spoke about some of their initial experiences in the elderly care.

A second practical challenge in my fieldwork is what I call the dilemma of 'belonging' and 'isolation'. In my attempt to develop detailed perspectives for this study, I observed that my feet were sometimes placed in different directions. At certain times, I felt an intense feeling of

belonging and at other times, I experienced feelings of ‘isolation’ or not belonging. As I found this challenge to be an important part of the study, I discuss it in greater detail below.

An immigrant researching immigrants

In writing my research proposal, I reflected on the effect my immigrant background might have on the research process. This is due to the often taken for granted notion that researchers should not be personally involved in a study. It is often assumed that an ‘outsider’ is better able to observe and interpret behaviours of interest to a study. However, I would argue that, in line with this study, a strict ‘outsider’ approach to research does not work when working with immigrants. This is due to a number of factors, such as immigrant mistrust of outside researchers, the inability of ‘outside’ researchers to correctly interpret certain behaviours, and the possibility of missing certain details which do not signify issues of importance to the outsider (Fisher and Ragsdale, 2006; Greene, 2014; Kanuha, 2000; Martin, 2006; Renert et al., 2013; Unluer, 2012). This suggests that my immigrant background provided me with some relative advantages.

There were, however, some challenges. The dual nature of being an immigrant and a researcher sometimes led to moments of tension and I needed to find a balance between the two roles. As a Ghanaian, I understand the concept of ‘*anyemi*’, which, when translated, means that I am considered a “sister” or “close relation” by some of the participants. I am also familiar with most aspects of the “world of immigrants” and the hospitality with which participants received me made me feel extremely at home. This familiarity, however, placed me in an ‘insider without’ position during the study, following Collins’ (1986) use of the term to describe how individuals find themselves between the spaces of two groups. She used the example of African American scholars who, she argued, in spite of being marginalized, have the potential to use insights from their experiences to challenge, innovate and make changes. In reflecting on Collins’ work, my understanding is that being an ‘insider without’ has more to do with an individual who occupies two unclear positions between two groups. This makes the individual unstable and it is accompanied with contradictions and challenges. For instance, while these individuals can enjoy certain benefits of a group by virtue of their basic requirements, they do not necessarily enjoy all the benefits afforded to full members of the group. In other words, individuals can occupy a position where they are seen as the ‘same’ (belonging), yet different (not belonging).

To make this more explicit in this study, I use the term ‘insider without’ to explain the processes through which the research participants and I perceived each other as the same yet different, based on the situation. For instance, concerning identity, my feelings of being an insider relate to the fact that I shared a common identity as an immigrant with my participants. I recognized this through the direct manner in which participants talked with me, captured in expressions such as ‘you know what I mean’, ‘I’m sure you have had similar experiences on the bus/*tram*’, ‘do you thrive/feel ok at your job as an immigrant?’, and ‘I am saying this to you because you are one of us’.

At many points, I reflected in particular on the salient meaning of these expressions. As argued by Johnson-Bailley (1999), ‘culture-bound phrases’ do not need interpretations and the silent understanding that accompanies these can usually be understood by researchers when they share a cultural familiarity with participants (p.669). For instance, when participants would say to me that they were sharing certain aspects of their experiences with me because I am also a foreigner, and that they know that I understand what they mean, I realized that these statements capture deep meanings that are embedded in cultural familiarity. In other words, a direct translation of such statements cannot describe the cultural weight they carry. In effect, it takes an “insider” to hear such words and it takes cultural familiarity to interpret and analyse its deep-seated meanings. When participants spoke with me this way, I felt that the social distance between them and me were removed due to a shared common identity/background. I was seen, by them, as someone who has a better understanding of the nuances of their experiences.

In light of this, I believe that my background as an immigrant with over six years’ experience working in cross-cultural situations brought a unique cultural perspective to this study, from a historical and ethical perspective. This fostered closer ties, which allowed for sharing and learning in a beneficial way. Although this study required a high degree of trust on the part of the participants, I came across as someone who would not betray this trust. Nevertheless, it emerged that some participants were concerned that the details of their revelations and the results of my study would get them into trouble. This concern, however, was not unique to the immigrant healthcare assistants. As mentioned in previous discussions, some managers had a certain level of suspicion about the purpose of my study. This made me realize that claims about anonymity were not so straightforward in terms of practice. For this reason, I have endeavoured to demonstrate my appreciation for these concerns and honour participants’ trust in me by maintaining their anonymity as much as possible (cf Ethics).

I also encountered a different experience of being an ‘insider without’ due to the identity of being an immigrant. This occurred during my first visit to two of the nursing homes. At these places, when I asked to see the manager, one receptionist asked if the manager knew I would be around and suggested that I just leave my CV. Another asked if I was coming for an interview or looking for a job. My impression was that these receptionists were perhaps used to having a number of immigrants knocking at the door for jobs. In these instances, my ‘insider without’ position as someone with an immigrant identity was confirmed when these receptionists treated me like any other immigrant looking for a job.

My familiarity and identity undoubtedly facilitated my insider position, but this was not necessarily stable. I was familiar with aspects of being an immigrant, but I was not familiar with what it means to be an immigrant in elderly care. I have not worked in a nursing home before and I had no practical clue about what it means to provide elderly care services in Norway. Within this context, I consider myself as an ‘outsider’, as my position in these contexts were not similar to those of the participants. As healthcare assistants, they are experts in the field of my interest and possess experiences that I do not have. Hence the use of interview to the double technique to let participants tell me about their job in very simple terms. In this setting, I had the demeanour of someone who is interested in learning about things from the participants’ viewpoint. In one instance, for example, I had the following conversation:

Gigi: (laughing)...I think you have already seen what I do. You are doing a PhD and maybe you know so much about this work already.

Vyda: ...But I have no direct experience. I have not done this work before and I think you are the expert.

Gigi:...before giving the shower, you first have to inform them, take off their night dress, etc.

By telling the participant that she knew more than me, she began engaging with me as an outsider and started explaining things to me in very simple terms. This experience was not unique to this participant, as my ‘insider without’ status was constantly being negotiated. At certain points, issues of class, gender, sexuality and power shaped interactions between participants and me. On other occasions, I felt that participants perceived me as an expert in elderly care work just because I was working toward a PhD. How to approach such situations has been addressed in qualitative research on variations between researchers and research

participants, which presuppose power imbalance (Berg, Lune and Lune, 2004; Creswell, 2007; Taylor and Rupp, 2005). Many of these perspectives advocate a high level of partnership between researchers and participants. This was fundamental to many aspects of my study methodology and it offered the opportunity to focus on the various positions between the participants and myself.

A critical dilemma

In the course of my fieldwork, I was faced with a situation that set me thinking about what could constitute an ethically conscious decision. I assisted a participant with a partially bedridden elderly client who had requested a particular type of ham on his bread for breakfast. This client was told that his requested ham was out of stock in his fridge. Interestingly, I had observed a different participant with this same client the previous day. I helped stock the fridge with groceries for this client, and I remembered that the type of ham he requested had been included in his groceries. I did not take much notice, however, when the participant told the client that the ham was not in his fridge.

When we returned to this client the following day, he requested his special ham again. And again, he was told that it was out of stock. When the participant said, 'It will come with the new groceries', the client looked helpless and despairing, so I whispered to the participant that the ham *had* been included in the client's groceries. To my surprise, I was told that that the client can have other types of ham on his bread. My heart was broken when I saw the expression on the face of the frail elderly client. I did not know why his request was not granted and I did not get any specific reason for the denial. This happened at a stage in my fieldwork when I was trying to strengthen the rapport between the participants and myself and I did not want to appear to be interfering with their work.

However, on other occasions, I observed that this same participant denied other clients when they made requests for this same ham. By the third instant, I felt concerned: To me, this healthcare assistant did not appear to respect this basic need of her elderly client. Because of my own personal experiences with the death of a family member in hospital a day after he was denied his favourite food and drink, I was clearly viewing this denial of the needs of elderly clients through a specific lens in my interpretation of this data. It occurred to me that perhaps raising this issue with the participant or managers of the care institution might have a negative impact on my fieldwork. After having considered it carefully, I concluded that this was not a matter which called for an urgent ethical intervention.

To wear or not to wear? The researcher and the healthcare uniform

The study started in the home care, where the topic of dress code was never an issue. Dressing for work was ‘informal’, in the sense that no uniforms were involved and I felt comfortable. However, in the nursing home, I felt uncomfortable when it was suggested that I wear a uniform like the healthcare assistants. This was a matter of policy for everyone who has ‘official’ contact with the elderly, including researchers and students. Though this was not a huge challenge, I was unable to shake off the power of the uniform as a symbol of a healthcare professional even though I had a nametag stating that I was a researcher. And perhaps my gut feelings were right, as I did have encounters in which the uniform evoked some reactions. On one occasion, a family member who was visiting her parent at the nursing home asked me for details about her mother’s health, and I had to explain politely that I was conducting a study. On other occasions, some of the elderly persons and staff who were not participating in the study related to me like I was a new staff member—depending on the setting, I would offer information about my role in response. In other settings, such as when I was greeted with a ‘huge sarcastic welcome’ by other immigrant healthcare assistants at canteens, I did not find it necessary to explain that I was observing study participants unless it came it up.

Another important challenge I faced in my fieldwork was the extent to which relations in the field can shape the research data. At one of the nursing homes, for example, it emerged that my rapport with one of the nurses was simply not working.

The hostile nurse

On this day, I was with a participant for observation and I suddenly bumped into a nurse (who I had not met before) during lunch time for the elderly in a common area. Apparently, she was in charge of that shift, but had come after the early morning meeting so we had not exchanged pleasantries. I stood next to the study participant, trying to observe what he was doing, and I think he asked me to take out bread to put on the table. Suddenly the nurse called him and when he came back he said the nurse said I should wash my hands. He had said to her that my hands were already washed but she insisted I wash them again, which I did. The participant was motioned over again and this time the nurse said I should take off my earrings, which I did. The participant was then called over a third time, and this time the nurse said I needed to help and not be idle. The participant told me that he had explained to her that I am the researcher who was mentioned at the meeting and that I am not supposed to do anything

major. He further explained to me that this nurse is from Eastern Europe and has a ‘bossy’ outlook on immigrants of colour that he hates.

Later that day, the nurse came into a room where I was together with the participant and a client. I was standing watching the participant change diapers, and I did not want to be involved. After, as we were taking dirty clothes to the laundry room and heading to the next client, the nurse called the participant over again and this time, he was told to tell me that I either help or not help at all. The participant asked me to excuse him and he rushed into the bathroom. Whilst waiting for him, I could sense that tension was high. When he came out, I could tell from his eyes that there had been some tears. At this stage, I started feeling vulnerable and very uncomfortable. With such hostility and high tension, I made the spot decision to abruptly end the observation and the participant agreed.

However, I maintained a positive focus and tried to remind myself that the study was not about the nurse. I also tried to minimize the effect of this negative attitude by thinking about the support and encouragement I had received, particularly from the leader of the institution where this nurse works. After all, such encouraging support provided by managers and participants in the study was what enabled me to contribute knowledge on the immigrant healthcare assistants’ experiences through this study. Most significantly, I never, at any stage, felt intimidated or treated negatively by the elderly or the research participants and their managers who agreed to take part in this study. This prevented me from generalizing or allowing the negative, intimidating, and resistant attitude of this nurse to affect the data analysis for this study.

Documents

As mentioned in an earlier discussion, this study draws on a range of literature related to policy documents on elderly care. Thus, in saying that understanding is attained by the fusion of horizon, I extend this to include data sources. This means that, in this study, ‘holistic’ fusion is attained by merging participant-generated data, my preconceptions, and selected literature on social policy.

Some of the policy documents and white papers I read include Care Plan 2020, Strategy for Skills Policy (2017-2021) and Work, Welfare and Inclusion (2006-2007) - supplemented by websites of different government institutions responsible for the policies of elderly care and immigrant immigration. In this way, I gained a deeper insight into the history and workings of the Norwegian welfare state

The approach to writing: A reflexive account of my visible and invisible self

'In order not to authoritative, I've got to speak autobiographically'. (Hall, 1992a, p. 277)

In writing this thesis, I have surrendered to the knowledge that the entire research process has been an academic journey on different kinds of road surfaces. Some of the smooth surfaces can be compared to the asphalt roads in Norway, whereas the craggy potholes remind me of the untarred roads to lovely Somanya, my village/hometown in Ghana (West Africa).

Academic teachings seem to favour scientific canons of objectivity: a position I find to be in opposition to the methodological approach to this study, and thus difficult to adhere to. Thus, I defer to the Heideggerian notion that the focus should not so much be on producing a universal objective truth, but rather should centre on exploring differences and complexities. It is for this reason that the information presented in this study is influenced by my views, hence my decision to write in the first-person. Further to this, I ascribe to Behar's (1996) approach to 'self-revelation' when conducting an ethnographic study. In her words, 'there is no greater taboo than self-revelation' (p. 26); however, anthropological studies, which have direct bearing on individual realities, are generated through the researcher's knowledge, which are rooted in what 'I' understand though a 'we' or 'they' is being observed. Until recently, revealing the self ('I') was regarded as 'ahistorical and non-individuated' (ibid). Throughout this thesis, it can be observed that I have used 'I' instead of phrases such as 'the author or writer'. This is because I do not seek to hide the reality that this study was conducted in how 'I' explored the realities of the immigrant healthcare assistants' experiences. As such, I think that using phrases such 'the author or writer' puts distance between me and my connection with participants' perspectives and the entire research process. This was a continual struggle in my approach to writing, but ultimately I decided to write in the first-person: a style I deemed appropriate for expressing my reflections through the writing process.

Further to this, reminiscent of his (1992a) work on race and ethnicity, Hall used the term 'to speak autobiographically' (p. 277) as a way of making meaning that includes the vantage point of the writer. This importance, according to Hall, shows on the one hand that the premise of certain accounts and arguments are far-reaching and call for in-depth understanding on the part of the writer or interpreter. However, due to differences and complexities, cautionary measures must be taken so that ideas or interpretations are not presented under the assumption that the individual experiences being interpreted are homogenous.

My approach to writing includes elements of Hall's autobiographical speech (ibid). At times, and depending on the context of my discussion, this translates into the provision of autobiographical explanations and examples from my vantage point as an immigrant from Ghana to concretize some of my arguments. Following Halls' precaution, however, I provide these arguments in a circumscribed manner to avoid what Hall terms 'authoritative' (ibid). This means that I do not speak authoritatively of the 'immigrant experience' or the 'African experience'. Rather, I try to make meaning or interpretations by taking into account my own background and experience. In a way, this reiterates my hermeneutic methodology.

In an attempt to present direct information from participants, in some cases I have provided the transcribed data without making grammatical changes. I have used inverted commas (‘’) to indicate direct quotes from participants where necessary and I have shortened some information by the use of ellipses (...). While the ellipses illustrate the continuation of the participants' narrated experiences, they also show that as I move in a direction which I find productive for developing an understanding of these narrations, the dialogue continues, as there will always be interpretations and understandings that may be contrary to mine. In the next chapter, I discuss how I interpreted an aspect of my data that relates to how immigrant healthcare assistants experience work in the private settings of Norwegian elderly care.

Chapter 5: Private homes turned into public places

Domus sua cuique est tutissimum refugium. [Everyone's house is his safest refuge

(‘Every man's home is his castle.’)] -

Sir Edward Cooke (1552–1634)

Policy initiatives for the frail, elderly Norwegian continue to focus largely on home-based care. Often, this trend is supported by economic objectives, political commitments and conceptions of future elderly citizens who are predicted to be more healthy, self-sufficient and independent (Halvorsen, 2016). The focus of this chapter is to explore how care is provided to elderly Norwegians with the home (i.e. *hjemmetjeneste*, or home services) as the site of care work. My aim is to understand how participants ascribed meanings to their daily work situations in the private spaces of elderly Norwegians. In doing this, the experiences of immigrant healthcare assistants are essential, yet in framing my analysis I also discuss my own observations, perspectives and relevant literature, which contributed to the interpretation of this data. The emerging themes, which contributed to the understanding of participants' experiences, involved issues of time pressure and ambivalence.

Prior studies in Norway and a range of other countries have referenced the significance of home care for the elderly and the problematic nature of work in the setting of the home. For example, Førland and Folkestad (2016) showed that home care services in Norway are increasingly gaining users who are relatively young, with complex health needs that demand more professional care. The authors found that, whereas home service users expressed great satisfaction with the services and attitudes of employees, municipal resources do not match the number of users and their complex needs, thus creating challenging experiences in home care. Compared to other public and municipal services, Førland and Folkestad (*ibid*) reported that the reputation of Norwegian home services is somewhat below average and with more complaints, particularly from the relatives of service users.

In the Canadian context, Martin-Matthews (2007) found that work regulations and employment policies made it difficult for home care workers to address the unmet needs of their service users. Similarly, Armstrong and Armstrong (2004) in their work on women, work and caring in Canada pointed out that good care in the home environment depends on the relationship between the carers and the clients in the home environment. In the U.S., Rubinstein (1989, 1990) also explored care work in the home of service users and reported that a vital aspect of the home care experience is the socio-cultural meanings embodied in the

home environment. Overall, findings from these studies suggest that, when providing support to enable the elderly manage their daily lives in their own homes, care assistants were torn between providing care based on the individual needs of their clients and the competing values of the health care systems.

As the findings from these studies share similar themes with those derived from the present discussion, I argue that the home setting is indeed significant in elderly care.

The home as a private space

‘Home’ is a colossal subject in anthropology and the concept of home is pregnant with different meanings and connotations. For some people, the mention of ‘home’ evokes a sense of belonging that indicates a connection with past experience such as childhood memories or private space (Després, 1991; Moore, 2000; Oswald, and Wahl, 2005). Yet, for others, the home can evoke negative feelings or indifference (Després, 1991). The reasons people receive health care assistance in the privacy of their own homes may be varied, but as pointed out by Oswald, and Wahl (2005), the majority of chronically ill patients see their home as a secured place where they can be sheltered from conditions and other forms of stress that could worsen their health challenges. Oswald, and Wahl (ibid) therefore believe that older people feel a strong sense of security when care is provided for them in the comfort of their homes. Després (1991) also observed that the home is a place for familiarity, privacy and identity. ‘It relates to ideas such as a place to get away from outside pressures, a place where one can control the level of social interaction, and a place for privacy and independence’ (ibid p. 98). From this perspective, home is thus more than a building: It is simultaneously connected to privacy, intimacy, individual histories and an attachment to familiar objects and events, which are relevant to and highly valued by those occupying it (Després, 1991, Moore, 2000; Oswald, and Wahl, 2005). Perhaps it is this intimate connection with ‘home’ that led Sir Edward Cooke (1552–1634) to proclaim that a man’s house is his castle.

However, just as how illnesses can break through the strength of our immune system, the privacy of the walls that protect the sanctuary of the home also seems to break down at the onset of old age, as it demands the services of home care assistance. Having a sense of control or security over the home environment is one of the things that are in jeopardy when the intimate world of the elderly is 'invaded' through care work.

The courtesy of knocking: does it really matter?

In his discussion about the boundaries that define another man's property, Porteous (1976) argued that it is necessary to respect the boundary of another man's home, and this starts at the doorstep. According to the dictates of social norms, rituals or certain formalities surround the act of entering another's home. These include knocking at the door, waiting to be asked to enter, saying hello, etc. Being asked to enter after knocking indicates that a person has been 'permitted' or allowed entry (Porteous, 1976). Entering another person's house or property without being permitted is a violation of this social norm. At the highest level, this could be seen as a violation of the law of breaking and entering into another person's property (ibid). But what does this mean for immigrant healthcare assistants in the client's private home? I observed that in entering the homes of their clients, participants had access to keys. The common courtesy of knocking on doors or ringing bells was followed. However, immediately after the door is knocked upon, participants send out a signal by saying, 'home service' (*'hjemmetjeneste'*) and some even used the term *'hjemme sykepleier'* (which translates into 'home nurse'). My observation was that, in most instances, before the clients could say anything, their doors were opened by the healthcare assistants, who then entered into their homes to start the routine for the day. To better illustrate this, I use my experience with participant Tabitha during our visit to a client, who I have named Ole.

Judging from the pictures that decorated the room, I think that Ole was an ex-seaman. I would describe him as someone who seemed to have full control over his home. He was not very ill but, like some clients, he needed help with basic things. During one of the visits, Ole was in the bathroom and did not answer when the door was knocked. As soon as we entered, he screamed, 'Who is there?!' The participant replied, 'It is Tabitha, the home nurse. I knocked on the door'. Ole replied, 'But I did not answer. Go out and wait, I am in the toilet!'

Tabitha: 'Can't we wait inside?'

Ole: 'No, go out and wait!'

At this moment, I could see disappointed and perhaps 'anger' on Tabitha's face. But as we were going back, she said to me, 'This man is like that, he sometimes likes to command everyone. Sometimes he takes too much of your time'.

Tabitha's inability to attend to little details, such as paying attention to Ole's need for privacy before the onset of her work, was related to time constraint.

At one level, it can be argued that the immigrant healthcare assistants used lack of time as an excuse to ‘deprive’ their elderly clients of their needed attention. However, at another level, I think that their explanations point to the issue of a lack of control or powerlessness regarding having any influence over the demands of their work schedule and the individual concerns of their elderly clients. Here, I want to stress that the issue of time pressure often contributed to this. My observation was that participants’ routines appeared to be rigid and they were often unable to attend to details they felt were essential. In effect, the immigrant healthcare assistants felt that they did not have control and were left frustrated and uncomfortable. For instance, when explaining how she interprets her attitude or reaction, Tabitha’s first answer, ‘this man is like that’ reflects her frustration and lack of control. Yet, in explaining further, Tabitha said ‘*he takes too much of your time*’. This meant that Tabitha was, at the same time, concerned with the issue of time and the workload of her schedule for the day. Similarly, Baaba told me that:

She never responds to the doorbell...you do not know if you should enter or not. And after you have entered, she sometimes ask if you knocked on the door. I say yes. And she says she didn’t hear. But it is part of old age. It is just like that...I can’t spend the whole day at the door. There is more work to be done.

Here, Baaba is also pointing out that, for him, the question of how to behave concerning the courtesy of knocking, with regards to his elderly client’s private boundary, was in fact about his work schedule. When Baaba explained his reaction, he gave a hint about the pressure of time: ‘there is more work to be done’.

Throughout my observation, the issue of the privacy of the home in elderly care deepened my curiosity as I experienced feelings of worry on the faces of the elderly and awkward situations in the daily encounters of immigrant healthcare assistants. Firstly, it seemed to me that lack of privacy and control over the home environment could be problematic for the elderly. This is because, depending on the nature of their healthcare needs, several workers were walking in and out of their houses daily. This could mean seeing five to six different faces or more in a day. With countless sounds of doorbells and busy workers going about their duties, some of these old people seem to be lost in the moments. This need to control one’s own time and the frequency of visits as a privacy issue was echoed in the following brief exchange:

Elderly person: You have come again.

Reeki: Yes. But now it is time for lunch and changing. It was the nurse who just left. We came in the morning. Do you remember?

For some of the elderly, there was also concern about safety. There was one particular old woman who always asked, 'Have you locked the door?' I also wrote notes about a woman who was being dressed for a birthday party: She became furious when the care assistant went directly into her closet and brought out her jewellery box. Her reaction was sharp and straight.

Elderly woman: You cannot take that!

Tabio: I am going to use it to dress you for the party. It is Nicole's birthday. Are you not going?

Elderly woman: I will go. But put that box down. It is from my grandmother. You cannot take it. It is very expensive. You have to ask me first!

As I pursued views on work in the private environment of the elderly Norwegian, I found the situation to be no different in the nursing homes:

Kailla: I never think of knocking. Most of the times, we just say hello and go in.

Dido: You don't know if they are sleeping or not. And you don't want to disturb so you just go in.

Zuzu: Oh! They are always here with us and they know it is us. We are here to work for them. You know, we are their friends!

In the above conversations, attention was not given to the symbolic act of knocking before entering the private space of the elderly at the nursing home. The private rooms of the elderly were seen as a work territory, which the healthcare assistants had the privilege of entering to do their work. This therefore also translated into a situation where clients had less control over their private environment.

From these examples, I interpret the reactions of the immigrant healthcare assistants as not knowing what to do in terms of the significance of the dictates of social norms regarding going into the homes of their elderly clients. In other words, they lacked knowledge about exactly where the boundaries of courtesy lay in a Norwegian context.

However, since such boundaries are mostly invisible and implicit in interaction, at the level of a critical understanding based on common sense (Kvale and Brinkmann, 2009), it could be argued that it was challenging for the immigrant healthcare assistants, who grew up in another

society, to sense where the important and legitimate boundaries in Norway lay (Rubinstein, 1989). And even though the immigrant healthcare assistants acknowledged their uncertainty and stressed the issue of time, they often spoke about the reaction of the elderly Norwegians as an issue of old age. In the participants' use of such phrases as, 'but it is part of old age', 'these people are old', and 'there is no need to be too involved in all the reactions', participants explained how they interpreted their experiences. While clearly crossing the boundaries into people's private homes without their explicit permission, they did have such permission – indeed, a mandate or even a duty to do so – from their superiors in the care sector. Given the time pressure imposed on them, one might even suggest that they did not have permission to wait outside.

Here, I need to clarify that I do not intend to claim that participants ignored the elderly Norwegians because they are old. Rather, it seems that they have some ideas about how things should be with their clients. At the same time, it appears that they feel they need to adhere to a rigid routine, rules, and time pressure, imposed on the immigrant healthcare assistants via a system created to cater to the needs of elderly in Norway. Upsetting these routines placed participants under pressure from time, and this often left them feeling frustrated towards the detailed needs of clients, which they felt as interfering with their routines. In an attempt to ease this frustration, the immigrant healthcare assistants argue that the clients are not to be reckoned with, since they are old and/or too difficult.

Arguably, if the issues of time constraint, rigid routines and heavy workload are imposed on participants by the 'system' (or institution) of elderly care, it could further be argued that the attitudes of the immigrant healthcare assistants are related to how the Norwegian society in general perceives ageing. Ozuku builds on this argument with her story:

When I do not have to worry about my list, I think that I can spend more time with them and give them all the attention they need. I wish I could do more. Sometimes, it worries me, especially when I see that some of them need more care and attention but I am not able to help. If I look at the list and how much time they expect me to spend on one person, I think that the focus is on the old people who can get up from their bed and walk to the shop to buy their own stuff. Most of the old people I work for are not able to do that and they have the right to ask for extra help. Sometimes all they need is someone to talk to. Sometimes what they are saying is old people's talk but I think it is necessary for them to know that someone cares enough to listen to them. The problem is when this delays my work...I need to use every minute for something that helps me

complete the list. It is a difficult situation... We do not treat old people like this in my country. We cherish these last moments of their lives: give them the best of attention and care.

In in the above conversation, when explaining her experience of the issue of time pressure, Ozuku related it to perceptions of ageing in Norwegian society. To illustrate this, she also contrasted the Norwegian context with the context of her home country. In her example, Ozuku mentioned that the difference is associated with how people in her home country 'cherish' the last moments of the lives of the elderly and give them the best of care and attention. In this way, she expressed a different societal perception of ageing.

Nevertheless, what is more important for the current discussion is the process through which Ozuku related her concern with the system. I find this linkage to be interesting because I observed that Ozuku drew on the issue of time pressure and lack of attention to compare and illustrate the influence of the system. To begin with, when Ozuku said that she would have spent a lot more time with the elderly if she did not have to worry about her list, it confirmed my understanding that time pressure is a real issue when providing care for the elderly.

As Ozuku told me in the above excerpt, in some contexts, this bothers her because she believed that some of her elderly clients need more attention: 'If I look at the list and how much time they expect me to spend on one person, I think that the focus is on the old people who can get up from their bed and walk to the shop to buy their own stuff. Most of the old people I work for are not able to do that and they have the right to ask for extra help'.

With this example, Ozuku showed me that her list—or work schedule—is influenced by external decisions (e.g. institutional or policy decisions) that categorize the needs of the elderly to be homogenous. Ozuku's work schedule, in this context, simply means basic work for 'old people who can get up from their bed and walk to the shop'. Yet, as Ozuku stated, 'Most of the old people I work for are not able to do that and they have the right to ask for extra help'. Thus, when Ozuku's explanation was related to external decisions about her work, the meaning of time pressure changed for her. Time pressure was thus conceptualized as an institutional or policy directive and what seems like a general societal perception on ageing.

Further to this, in analysing how Ozuku expressed the meaning of time pressure and lack of attention in the above quotation, I also observed that Ozuku ended the conversation by talking about the difference between elderly care in her home country and elderly care in Norwegian

society. I highlight this as an example to illustrate how, in my conversations with the participants, they reflected on themselves as people with immigrant backgrounds, and who are still struggling to obtain detailed knowledge about the work in elderly care in the context of Norway.

Here, I find it worth mentioning that the challenge of struggling to have detailed knowledge was not always expressed in verbal communication. Rather, I was able to capture some of these through non-verbal means, such as facial expressions and sounds in a voice, which 'speak' volumes. In such moments, participants appeared to feeling a combination of shock and confusion. This will be explored in more details in the following section.

The privacy of toileting in elderly care.

My fieldwork started in the home care sector, and I became particularly interested in this aspect of elderly care after following Tabio to the house of an elderly man I call Magnus. The private nature of going to the toilet may make it unusual for discussion, but it continues to remain a fundamental element in the daily activity of healthcare assistants, as well as the daily well-being of their elderly clients. Magnus appeared to be in his late 60s and he needed assistance to get on the toilet to poo and empty his urostomy bag. Ready with the patient lift, Tabio lifted Magnus and he was put onto the toilet. In what appeared strange to me, I observed that the door to the toilet was not closed. As Magnus was sitting on the toilet with his head bowed, I observed that Tabio shuttled between the toilet and other parts of the room and occasionally interrupted Magnus's private moments by asking 'Is the poo coming?', 'You must try hard, Magnus', etc. All of these questions were met with the frail answer, 'Nei', meaning 'No'. The following conversation between Tabio and myself took place, as I followed Tabio to the next client.

Vyda: Does the man we just visited always have difficulty with poo?

Tabio: Sometimes but not always.

Vyda: Do you think that maybe the poo would have come if you had closed the door whilst he was on the toilet?

Tabio: (laughing in a seemingly mocking manner)...They are used to it...He can poo if you are there or not. It does not matter. He needs to know that we are still around. I have to work very fast and move to the next person before she starts ringing the alarm. I have three persons to bathe today and it is going to be very busy.

On the one hand, Tabio's reaction suggested to me that she did not pay attention to her client's needs for privacy regarding toileting. For instance, when I asked Tabio if she thought that closing the door whilst the client was having a poo would have made a difference, her reply was: 'They are used to it...He can poo if you are there or not. It doesn't matter'. In this response, I understood that the client's need for Tabio to respect his private space was not matched by Tabio's actions, and from her perspective, her presence did not disturb the client's ability to poo. However, by its very nature, the act of toileting can be embarrassing: 'What one used to do all by oneself, now needs the presence of a second person. It disturbs the old routine and causes infringement on one's privacy' (Van Der Geest 2002, p. 239). From this perspective, it could be argued that lack of privacy when on the toilet could represent, for the elderly client, an issue of disrespect or an invasion of privacy.

On the other hand, it could be argued that Tabio's reaction was rooted in her work schedule, which was framed as an issue of time constraint. This was anchored in the remarks: 'I have to work very fast and move to the next person before she starts ringing the alarm. I have 3 persons to bathe today and it is going to be very busy'.

This encounter took place in the early part of the study. However, as the study continued to take shape, it became clearer to me that the time constraint challenge was not unique to Tabio. As experiences unfolded, the immigrant healthcare assistants related accounts that showed that they, too, were dominated by the demands of their work routines and felt powerless to attend to certain important details of their work due to the pressure of time. To better illustrate this, I provide another example from my observation with Ozuku.

Control over the home environment

It was 8:30am and I boldly followed Ozuku to the home of a client. After the usual courteous questions of 'How are you', 'Did you sleep well?', 'Are you ready for the day?', etc., Ozuku asked me to sit down. However, just as I was about to sit down, the old woman spoke up:

Elderly woman: You cannot sit here. It is my place, sit at the other side.

Ozuku: Can she not sit here? (speaking with a very surprised tone)

Elderly woman: No.

Ozuku: Why not?

The elderly woman replied: No! It is my sitting place.

On our way out, Ozuku tried to explain to me that, ‘these people are old and there is no need to be too involved in all the reactions...do you understand?...The next person on the list is not like that. He is more friendly and does not mind if you sit on his sofa...I have so much to do on my list and I need to work extra fast’ (Ozuku).

As I was writing my notes on this observation, several thoughts ran through my head. For instance, first, why did Ozuku ask me to sit down? The house belongs to the elderly woman. She is the one supposed to offer me a seat, not Ozuku. Secondly, when I think through Ozuku’s reaction, I get the impression that little notice was taken of the personal preference or requirement of this elderly woman, for example when Ozuku retorted by asking *why* I could not sit in this ‘special’ space on the old woman’s sofa. Here, I need to say that, my concern was not so much on Ozuku’s question regarding *why* I was not allowed to sit on the sofa. Rather, my attention was held by the contrasting tone of surprise used by Ozuku when she said, ‘Why not?’

Even though Ozuku was not sure why the old woman did not allow me to sit in that place, she did tell me that she had much to do and needed to work extra fast. As a result, there was no need to be too involved in the reactions of her elderly clients. What emerges for me at this point is a difference in position about the ‘special’ space of the elderly woman. To Ozuku, it appears that the home of the elderly woman is a public space—her work environment. Yet, to the old woman, it is her private home. By saying to me that the next client will not mind if I sit on his sofa, I get the impression that Ozuku’s daily routine is based on the assumption that all her clients have the same wishes. As a result, she gave little attention to the elderly woman who expressed an individual need or different wish for her space to be respected. On the other hand, it appears to me that perhaps Ozuku does not appreciate the distinction between the home as a private space and her public work in this private space. I observed that precedence was given to Ozuku’s work schedule and not the small details of her client’s expressed concern.

Most significantly, I see Ozuku as a healthcare assistant who felt dominated by the demands of her work schedule and unable to give attention to the little details of her clients’ needs.

This excerpt from my journal supports my point:

Ozuku received a call from her team leader. I came to know that her colleague had called in sick. A replacement is on the way but a client who is not far from where Ozuku was working needed urgent attention. Ozuku’s routine has been disrupted. Work was indeed done very fast...

With these examples, I want to examine whether Ozuku understood the difference that emerged from the reaction of her elderly client. This is because, by relating her reaction to the demands of her work schedule, it appears to me that Ozuku had an opportunity to pay attention to an individual requirement and provide individualized care for this elderly woman. This, however, was not possible, and was simply glossed over.

Bedroom boundaries

The image of the bedroom as a place of sanctuary and symbol of authority presents an example of Douglas (2002) argument on symbols and meanings. Through her work on ‘natural symbols’, Douglas underlined the vagueness of symbols by arguing that there is nothing like a ‘cross-cultural, pan-human pattern of symbols’ (p. xxxi). Rather, symbols are established within specific rules and these can be cultural, through human interaction and social conformation. Following this logic, it is necessary to interpret the meaning of symbols within their specific context. Douglas’ writing on symbols specifically relates to human bodies, but I incorporate her ideas in my discussion about the bedroom and its symbolic meaning for immigrant healthcare assistants. Essentially, I discuss the bedroom as the most intimate spatial extension of the human body.

In the literature, the symbolic meaning of the bedroom and its accompanying etiquettes appear in discourses that reflect a difference in both cultural and social understanding (Severy, 2011). How immigrant healthcare assistants make sense of these differences, and how this might challenge our common sense knowledge about the private nature of the bedroom, is the next focus of discussion.

The excerpts for this discussion focus on the cultural orientation of an individual or individuals. I begin with some notes from my journal describing situations where the participant and I enter the private homes of elderly clients.

Journal notes:

It was the second time we went into the apartment of this couple and I remember the face of the man as being neither friendly nor hostile. His wife was partially bedridden and apart from occasional short sits in the living area, the bulk of her services took place in the bedroom. She shared the same room with her husband and perhaps out of courtesy or lack of space (since the room was quite small), I noticed that the man always walked out when the care assistants walked in. The first round of visits were in the morning, and both were still in bed. The man, who seemed to have been asleep so

did not answer or hear the call on the door, quickly jumped out of bed as soon he heard the voice of the healthcare assistant in his bedroom. The second visit was to put the elderly woman to bed after she had sat in the living for some time. When we entered, the man was having an afternoon nap. Similar to what had happened in the morning, the man opened his eyes when he heard voices in the bedroom. He reluctantly took his shirt and walked into the living room. In my conversation with Tabio, I was curious to know how she feels working in this peculiar environment with the presence of the other spouse. Perhaps my curiosity was also because it was the first time I was experiencing work in an environment where one spouse was ill and needed constant attention. Tabio calmly explained her feeling to me:

Ooh! Now, I don't see anything wrong. But believe me, the first time I came here, it was not convenient at all! In the first place, it was a bit strange to me that I had to work in the bedroom and with the man around it feels more strange. I knew I would be working in the homes of the old people but it was some kind of feeling around the bedroom... It was as if I am in a strange place...I know that it may sound strange but I do not feel comfortable working in their bedrooms.

In sharing her experience, Tabio accepts that she had to provide services in the homes of the elderly but she also acknowledged the bedroom as a private area and felt strange working there. As she further commented, it seems to her that the bedroom was a guarded area:

I also feel bad that I was disturbing the man. And he is mostly quiet so you don't know what he is thinking. At first, he does not smile at all and does not say a word. I thought he was upset with me or something. I always wish he could be invisible because his eyes follow everything you do from where he sits in the living area. He is like scanning you (whispering and laughing). Now he sometimes say good morning (smiling)...

From Tabio's perspective, she thinks that her work was an intrusion into the bedroom as a private space for the spouse of the elderly person she was attending to:

...I feel bad when I have to go in and out of their bedroom. Or maybe it will be easy if they put bed in the living room for ⁶Sinnove. That will make work easy. I always try to

⁶ Sinnove is the generic name for the elderly woman in this discussion

work very quickly when I am inside there so that her husband can also go back to his bed.

When I asked why she felt inconvenient working in the bedroom, she exclaimed:

Eish! You have no idea. I am always in a hurry to come out when I put her to bed. I am so afraid. I am so afraid that if something valuable or precious gets missing, they will blame me. And the sleeping area is supposed to be quiet and peaceful. Not a place for work. But what do I do?

In the quote above, Tabio explained that the bedroom should be a 'quiet and peaceful' place. While 'quiet and peaceful' may have nothing to do with where Tabio comes from, I see it as a description that implies the private nature of the bedroom. In addition, Tabio thinks that the bedroom is 'not a place for work' and 'we should not be going in and out of their bedroom'. For me, such perceptions, depending on their systematic meanings, could be ingrained in the way Tabio thinks. Not only are 'quiet and peaceful' and 'not a place for work' used to describe the bedroom, but these are descriptions with a particular image which is produced based on Tabio's view of the bedroom as being a 'private' place. For instance, Tabio told me that she feels tense working in the bedroom and perhaps a bed should be placed in the living area. Here, by contrast, Tabio tries to suggest that the living area would be more appropriate for her to provide services in for her elderly client, Sinnove. For me, this contrast finds expression not only in the private boundary of the bedroom but also through cultural difference as a form of negotiating social relationships.

To provide a better illustration of this, I share this excerpt from my journal from a conversation with Oplo, who said:

The problem is that, because she is mostly in bed, we all go inside to work there. I feel uncomfortable working there. This is not my culture. We do not go into the bedrooms of our old people just like that. We do not do that. This is where our parents and grandparents keep their most treasured properties...and all the big secrets (she smiles). But things are different in Norway...I once went to visit a Norwegian friend who has a daughter like me...And the children were playing in the bedroom of their parents. I did not like it at all and tried telling my daughter to come out. But the parent said it is ok...Things are different in Norway. You know.

In talking further about her experience, Oplo included an experience during a visit with her daughter. Here, I see that she tried to compare what happens in the bedroom at her work place

to what happened in the bedroom of her friend during their visit. From this excerpt, it seems to me that she has appropriated the open or public nature of the bedroom as acceptable in Norway, but this is something that is still not acceptable in her culture. To explore Oplo's experience, I think that it is important to include her cultural way of thinking, which she brought in the discussion. As illustrated in her story, unlike the living area, the bedroom of the elderly is supposed to be a private area that carries a lot of respect. In addition, it is a place where the most precious jewels and secrets are kept.

Thus, for Oplo, the bedroom sets the boundary between what is private and public in the home of her elderly clients. Crossing this boundary makes her feel uncomfortable. The bedroom presents her with an image of both privacy and respect, which is rooted in her cultural perspective. The relation to the latter is what makes Oplo's perception of the bedroom relevant for my discussion. Even though Oplo now feels okay about working in the bedroom area, by saying that she tries to work very quickly and then come out suggests to me that her way of thinking about the bedroom as a private area is something that is also maintained due to her cultural norms.

Like Oplo, Tabio's experience regarding the bedroom as a place for keeping valuable items were actively made in relation to her cultural way of thinking. Tabio expressed discomfort at how the spouse of her client follows her with his eyes when she is working in the bedroom: perhaps a feeling that confirms that she is within an environment with precious items and not a working area. From a different perspective, it could be said that the manner in which she described herself as being 'scanned' by her client's husband emphasizes her perception that she is working in a zone of 'valuable or precious items' which must be guarded. And perhaps the attitude of the man can also be interpreted as someone whose sees his private area as being taken over due to his wife's need for care.

Nevertheless, in talking about Tabio and Oplo's cultural ways of understanding the privacy of the bedroom, I am mindful that perhaps this is not necessarily unique. I say this in relation to the work of Norwegian anthropologist Sørhaug (1996) on Norwegian family life. Even though this work is over 20 years old, it shares common themes with those derived from the present study on the privacy of the bedroom and its boundaries. Under the title '*Family*' (*familien*) in Chapter 5, Sørhaug provides an image of the traditional Norwegian home and puts emphasis on the private and intimate nature of the bedroom. In translating his words, Sørhaug seem to suggest that '[t]he corridors arise as a kind of lock between public and private and partly

between internal, domestic functions ... rather, the bedroom becomes the most exclusive and intimate room ... friends and relatives cannot access the bedroom' (my translation) (p. 119).

In summary, Sørhaug makes it known the 'Norwegian bedroom' per se is not always accessible to everyone. In making this comparison, my focus of analysis is to make clear how a private area such as the bedroom turns into a public place through care work. As in Sørhaug's example, the corridor in the Norwegian home serves as an interface where the boundary between the bedroom as a private area and other areas as public is made clear. This description affirms the way in which Oplo drew attention to her cultural myths surrounding the privacy of the bedroom.

The symbolic value of the bedroom as a private area was also highlighted in my encounter with Reeki. Reeki had been working in the private homes of the elderly a little over a year when I met her. She was the participant with the least experience, and her approach to work depicted someone who is extra cautious. In my first meeting with her, I wondered if she felt jittery because of my presence. However, during subsequent meetings, I realized that this was just the way she is. When we met, she was doing a night shift, a shift she told me she was not entirely enthusiastic about since she had two small kids home. During this visit, Reeki had to help an elderly woman with some compression socks. She first went to the bathroom to get them and when she did not find them, she asked the elderly woman where they were. She was told they were in the bedroom. Reeki had disposable shoes covers around her sandals, but I noticed that she took off both the disposable covers and her sandals before going into the bedroom.

Later, the following conversation took place between us:

Vyda: Why did you take off your sandals when you were going into the bedroom?

Reeki: Aaah! Do you go into bedrooms with shoes in your home country? (laughing jokingly)

Vyda: No. We remove everything at the doorstep.

Reeki: It is the same with us.

Vyda: But you had the plastic thing around your shoes. Is that not okay?

Reeki: They tell me it's okay but I never feel okay. When I am working with my friends, especially the Norwegians, I do not take them off because they find it very strange. In addition, they tell me it is fine. But when I am working alone, I take them

off. Sometimes it is not only about what they tell you to do at the job. It is also about how you feel and who you are.

When I initially recorded this in my journal, I did not focus on it very much. But later, during my analysis, I conceded that the removal of sandals by Reeki may be symbolic of the greater respect or attention she places on the bedroom. Strange as it may sound, it felt to me that she was entering into holy grounds where shoes are not permitted, regardless of what is covering them. I do not know why she thinks that the bedroom should be the cleanest place—this is a question I would like to ask if I get the chance to meet her again. But from my cultural perspectives as a Ghanaian, in old days, the floor of the bedroom is where children sleep. Most couples start life in what we call ‘chamber and hall’⁷ and children usually sleep on a mat on the floor. This implies that there is a significant body contact with the floor and there can be easy transfer of bacteria or germs if the floor is dirty. Hence, no form of slippers or shoes are allowed in the bedroom.

When Reeki talks about her approach to work when she is with her non-immigrant colleagues, I got the impression that the issue of having shoes on when working in the bedroom area is in conflict with her moral value regarding respect for the privacy of the bedroom. Her concern is not only about the manner of being allowed in, but also about the appropriateness of going in with shoes. When interpreted as such, I get the understanding that when working with her non-immigrant colleagues, Reeki sacrifices her sense of self in order to discharge her duties as a healthcare assistant. This leads to feelings that are counter to her cultural perspective.

On the other hand, when she is alone, Reeki approaches her work in the bedroom in a way that satisfies her cultural way of thinking. I think that the commitment to this cultural purpose is what brings a different perspective on the experiences of the immigrant healthcare assistants. When further analysing this aspect of my data, I observed that the participants exhibit ambivalent attitudes towards their perception of the bedroom. These perceptions were not in opposition with each other but rather reflect a cultural understanding about the private nature of the bedroom. On the one hand, they want to comply with the daily norm that it is okay to enter into the bedroom of a client without necessarily thinking of it as a ‘private’ area. In other words, the bedroom is a just another working space for the care assistant. On the other hand, this approach to their work seemed to have a negative effect on them since it is in

⁷ A room with one living area and one sleeping area with a curtain dividing the two.

conflict with their cultural understanding and approach. Returning to the theme for discussion, Reeki explained:

I worked in the house of a rich old woman. Everything was made of glass and shining. The Norwegian old people are very rich. I was afraid something would break. We did everything in the living room. One day, she sent me to get something for her under her pillow in the bedroom. I was very shaky. I did not find it and she asked me to check her wardrobe. I was so very afraid that maybe if something went missing, I would be in trouble...Some time ago, there was news on TV where foreigners were accused of stealing money and other items after cleaning people's houses. It makes me so afraid. And I wasn't sure if I am allowed to do that—I mean go into the wardrobe. But I know I am supposed to help...

In the above, Reeki referred to a situation where she was not sure if it was allowed to go into the wardrobe of her elderly client. She also mentioned that she was afraid of being accused in case something gets missing. Here, I see a situation where Reeki was probably not aware of some of the limitations of her job in the homes of her elderly clients. At the stage of this analysis, I could not reach her for further explanation. Moreover, as I am not conversant with the rules of home care jobs, I casually asked a friend who works in healthcare about general approach or rules regarding work in the private spaces of clients, if any. It was explained to me that care workers are generally informed not to be too inquisitive into the private affairs of their clients. This is particularly the case during the early stages of establishing a relationship with clients. Building a relationship with elderly clients is about knowing the limits on what is acceptable or not. The friend who gave me this explanation was not aware of any explicit rules per se, but as she put it, 'If I can arrange her clothes in the closet, why can't I get her something from the same closet if she wants?'

From this knowledge, I analyse Reeki's experience as not knowing what to do in a situation where she does not have the necessary information. The situation becomes more difficult since Reeki is not confident that she has the necessary knowledge, yet she has to make an independent decision and is likely to be in trouble if her decision was not deemed to be appropriate according to the implicit criteria of her work. Reeki is also aware of a media report where foreigners were accused of theft in the private homes of clients and this makes her even more scared.

First, I consider Reeki's situation as negative, with regards to how she experienced work in the bedroom and made meaning of being an immigrant in this context. As can be implied

from her narration, the negative media reports linking foreigners to theft is what made her uncertain about what to do when entering the bedroom of her client. However, when she was working around the living area, she felt comfortable. Prior to this, Reeki had given me a hint about her view of the bedroom area as private when she removed her sandals even though they were covered with disposable shoe covers. Thus, when she contrasted work in the living area and the bedroom, I get the impression that she sees the living area as a more open and public space and the bedroom as a private space. Further to this, she sees this private space as being turned public due to the manner in which care workers walk in and out to discharge their duties.

Secondly, Reeki emphasized that her approach to working in the bedroom is also about 'who you are'. Here, I read Reeki's words in a context where 'who you are' relates to a cultural identity or difference, since she also made reference to a different approach used by her other colleagues when entering the bedroom of their elderly clients. I wish to state here that the approach used by Reeki's colleagues is probably the generally accepted norm but her image and understanding of the bedroom makes her think and do things differently. The point I am trying to make is that, by turning to her cultural identity, Reeki presented me with an image in which I see her ambivalence as a result of her cultural difference. Her culture tells her that the bedroom is not a place for care work. On the other hand, the general norms of her work say that it is. It is in the confluence of these different ways of thinking and the context in which I am able to understand the meaning of her experience.

When I bring the experiences of Oplo and Reeki together, my analysis shows that their cultural understanding and general norms of work within the private spaces of their elderly clients intertwine. Perhaps the issue is not necessarily cultural per se, but participants referred to their cultural way of understanding and this makes it relevant to explore. Critically, in this study, the mutual intersection of certain aspects of participants' cultural perceptions and accepted practices in Norwegian elderly care illuminates points of tensions/ambivalence in the experiences of immigrant healthcare assistants.

As argued by Geertz (1973), cultural values are inherent to an individual and they define who we are. It can therefore be argued that the issues of cultural perceptions can provide a better understanding of the experiences of immigrant healthcare assistants, hence the need explore this aspect. The symbolic meaning of the bedroom is perhaps not fixed. However, as we saw with regards to participants' experiences, the varied meanings attached to the bedroom are connected to a practice that relies upon their cultural understanding. Here, I frame my

argument to suggest that, for participants of this study, being an immigrant while also doing an unskilled job is made meaningful in relation to their experiences in elderly care. These experiences are not only limited to the living room, bathroom and bedrooms of the elderly; they also extend to non-spatial boundaries in the home of elderly clients as in the following encounters.

‘I understand that I do not understand’: Non-spatial boundaries in the home

In the bleak mid-winter of 2015, an old woman I have named Maria experienced a temperature that was perhaps closer to the Sahara desert. In her words, her whole body was burning and was itchy throughout the night. Apparently, Maria’s heating system was set too high for her. When the healthcare assistant (Shasha) whom I had followed to Maria’s apartment had finished working, Maria asked her if the heater could be reduced.

Shasha: But it is ok. The weather will soon change again and you will need it. You know that there is nobody around to regulate it for you when we go. Just take the blanket from your body and you will be fine.

On our way back, I asked Shasha why she did not find it necessary to regulate Maria’s heater. This was her reply:

Shasha: If I make it low and something happens to her, I would be blamed. I think that the temperature is ok...When I started this job, I once made a mistake by giving a certain old man a higher temperature because he said his room was too cold. The next day, the leader called me. When she started talking about it, my heart started beating faster and something was happening in my stomach. I thought something terrible had happened to the man...I thought I was going to lose my job. The night nurse reported that his room was too hot. Now, I have become very careful...I need to follow what the people above me say.

When Shasha talks about being ‘very careful’, she related her explanation to her previous experience. From this, I get the understanding that it is not really about leaving Maria (the old woman) in the cold that worries her. Rather, it is about changing the degree of the thermostat as set by her superior (i.e. the nurse).

When I further asked Shasha how she felt, she explained that:

... It is difficult to know what they expect. The nurse says the room temperature should be this and that degrees. The manager says you have to use your discretion.

The clients also have their wishes and as a human being, I also need to use my head. ...You do what you think is right, but the next day, someone complains and you get more confused and sometimes you end up feeling bad inside. I just think that I understand that I don't understand (*Jeg skjønner at jeg skjønner ikke*).

When Shasha said to me that she understands that she does not understand, I initially did not think much about it. However, in analysing this, I noticed that Shasha displayed an attitude of ambivalence. In the literature, Bengtson et al. (2002) contribute to our understanding of the notion of ambivalence by connecting it to the dilemmas people face in close relationships. In this study, I use ambivalence as a notion to connect to the dilemmas of a relationship between individuals to the structures of an institution. Exploring Shasha's explanation through the structure of the elderly care institution enables me to to examine the interpretation of her experience in connection with how she thinks her superiors (nurse and manager) would act to her decision-making.

For instance, on the one hand, Shasha told me that she has to follow what her superiors tell her to do. On the other hand, she has to use her head to do what she considers to be reasonable. For me, these connections can also create opportunities to break from perceptions which narrowly focus on ambivalence as a reflection of an individual dilemma. Instead, by connecting Shasha's experience to the elderly care institutional structure, I intend to focus on the micro-interactional understanding of how the relationship between Shasha (an 'unskilled' worker) and her superiors (skilled workers) can highlight her ambivalence. The major concern here is the ignoring of the client's request for fear of a management decision that might be contrary to the decision of the healthcare assistant who is actually at the scene. To illuminate this, I refer to a similar encounter, which I recorded in my field notes in the summer of 2014.

Unable to walk unassisted, ⁸Jakobsen was usually put in a chair to relax after the morning routine. On this day of my observation, it was discovered that Jakobsen attempted to walk into the bathroom by himself in the middle of the night. Luck was not on his side and before he could reach the bathroom, he peed on himself and on the floor. The stench in the room was strong enough to merit some detergents for cleaning. After work was done, Jakobsen requested for his window to be closed. In a polite but insistent manner, he received the following reply:

⁸ Jakobsen is the generic name for the elderly client in this participant's account

Dido: I don't think so, Jakobsen. We need to open it a bit. You need to breathe a little.

Jakobsen: But I want it closed.

Dido: (walked to the window, closed it a bit and replied) You need fresh air; it is good for your health. Is that not true?

When we were about to leave, Dido said: 'Good-bye, Jakobsen'. Jakobsen did not reply. He was silent, with an expression on his face that perhaps showed that he was not happy. When we left the room, Dido whispered to me that the client sometimes has breathing problems: 'He inhales very hard to breathe sometimes. If I close the window, he can have problems with breathing and I will be in big trouble'.

In this study, patterns such as the ones above were consistent, and, for me, revealed some of the complexities/ambivalence that immigrant healthcare assistants experience in home care situations. On the one hand, the private spaces of the elderly put additional responsibility and 'independent' decision-making into the hands of the healthcare assistants. Such situations require a careful approach to work to ensure that both the client and the healthcare assistants are safe from 'trouble'.

The ambivalence arising from such situations can be found in the experiences of Shasha and Dido. In the case of Shasha, she was torn between turning down the heaters for the client and following the 'prescribed' degrees. Her ambivalence stems from an experience where she had been blamed before for setting a temperature above the prescribed degree for a client. As she later told me, she thought she was going to lose her job. After this experience, she followed the rules in order to be safe. She also felt that she would be responsible if the client freezes in the middle of the night. Dido, for his part, also did not heed Jakobsen's words to keep windows closed. Dido's explanation was that the client needs fresh air and he would be blamed if something happens to the client. In these examples, the participants referred to the possible consequence of their action ('I will be in big trouble', 'I thought I was going to lose my job').

In putting these examples together, I sought to show that the immigrant care assistants are both influenced and constrained by the policies and structure of the elderly care institution, which seems to strongly identify with or recognize the decisions/autonomy of skilled and semi-skilled care workers. As Shasha said, she needs to follow what people above her say. Here, I read participants sense of ambivalence in relation to debates on professionalization, which were discussed in chapter 3.

For instance, in policy discourse, the contribution of the skilled healthcare workers is couched in terms of ‘expert’ or professional knowledge. Professional knowledge refers to a distinction between the skilled (professional) and unskilled (non-professional) and it is believed that the former is more knowledgeable (Abbott 1988; Hughes, 1984).

Implicitly, Norwegian policies in relation to the professional healthcare worker encourage and emphasize the development of high standards in quality of care outcomes (Care Plan, 2020). In policy terms, the focus is on a professional or skilled workforce without adequate concern for the ‘unskilled’ healthcare worker (Jacobsen, 2015). I argue that implementing policies for high professional standards without adequate concern for their impact on the ‘unskilled’ healthcare assistant is a policy dilemma, which points to the ambivalence experienced by the immigrant healthcare assistants. This, I argue, is especially evident in how participants describe ongoing dilemmas, which in turn point to a separation between the skilled and the ‘unskilled’, with the directives of the skilled coming across as both professional and superior. Most fundamentally, it appears that in setting standards for a professional healthcare workforce, institutional measures are generally seen as making the ‘unskilled’ healthcare worker dependent on the skilled workers, such as the nurses.

A relevant dimension that seems to be left out of the policy focus for the professional workforce is thus the question of the workforce who also has the responsibility to implement policy initiatives for quality of care outcomes in Norwegian elderly care. Consequently, I interpret the ambivalence of the immigrant healthcare assistants as an overlap between policy decisions and workplace practices or norms which have strong influence on the views of individual workers. I argue that such policy measures, as implemented in the private homes of the elderly, have profound implications for elderly care. In saying this, I am inspired by Vike (2017), who in a critique of Norwegian elderly care speaks about the shift of responsibility, from bureaucrats or policy makers and ‘inefficient municipalities’ to ‘service-providing professions that are the default causes of insufficient, inaccessible, or low-quality services’ (p. 138).

The paradoxical concern for this study is that, even as the ‘invisible’, ‘unskilled’ immigrant healthcare assistant remains part of the workforce who provide services for the elderly in Norway, it appears that their particular experiences are either at odds with policy measures or perhaps unknown to the decision makers for elderly care. Participants in this study are racialized immigrants and, as discussed in Chapter 3, a normative concern of Crenshaw’s

(1991) intersectionality approach is the acknowledgement of difference, including racialized difference.

I try to understand intersectionality in a way that is relevant to this analysis by viewing the intersection of policies with individuals as another layer of intersectionality, as discussed in chapter 4. To reiterate, I aim to not only understand aspects of experiences which are intrinsic to the lived experiences of the participants, but also to offer a policy or political framework within which to challenge dominant systemic arrangements in the experiences of the immigrant healthcare assistants. As will be discussed later in Chapter 11, these refer specifically to policy intentions that are substantially different from practice.

From this standpoint, I argue that, as demonstrated in the above examples, a particular way of thinking due to having a different cultural perception or background could also lead to ambivalence. Here, I interpret the ambivalence of the participants as not knowing what is acceptable. The latter implies that the immigrant care assistants are likely to act in ways that are contrary to the culture of work in Norwegian elderly care. This suggests that, when faced with competing demands, participants may be placed in a position where their ambivalence is also influenced by their immigrant background.

Baaba illustrates this with the following:

Nobody has asked me this question about knocking and waiting for an answer before going in to do my work. And nobody has complained about it. These are not the big issues in this job. But if someone should ask me, I will just tell them what I told you. Gunnhild⁹ is like my grandmother. When she hears my voice, she knows it is me. I do not have to spend the rest of the day at the door waiting for a reply...Our grandmothers do not care about that. Maybe others will say that I am not polite because of this. But I do not care so much about that. They already say many things just because they think you are a foreigner...getting the work done is my concern.

Here I think that Baaba has placed himself in a position where his explanation involved a thought process that was also influenced by his cultural background and perception. First, he described the elderly Norwegian (Gunnhild) as his 'grandmother', who he expected to be familiar with his voice. Secondly, as a 'grandmother', Gunnhild was not supposed to care

⁹ Gunnhild is the generic name for the elderly client in this participant's account.

much if her house is entered without waiting for a response to his knock. Finally, Baaba was aware that perhaps ‘others’ might interpret his action as impolite because he was a foreigner. Here, Baaba held a prejudice that, as an immigrant or someone from a different culture, he ‘knew’ the position from which ‘others’ might interpret his actions.

In saying this, I want to point out that as a way of interpreting his experience, Baaba’s explanation was influenced by his cultural way of thinking (‘Our grandmothers do not care about that’) and, at the same time, by his lack of knowledge about his working environment. Alternatively, it could be said that he lacked knowledge about how the elderly in Norway might think about his actions. Further, in mentioning the prejudice behind how ‘others’ might interpret his actions, Baaba seemed to affirm that he thinks about his immigrant background in an unfavourable position. This suggests that, as people from different backgrounds, the immigrant healthcare assistants were exposed to different ways of meanings or interpretations, including their own. I explore some of these differences in the next chapter, through participants’ responses to my curious question: ‘What do you do?’

Chapter 6: ‘We are the fuel and they are the cars’

As mentioned in Chapter 2, the Norwegian state is turned on a strong belief that paid work is a highly important activity in people’s lives. This leads to an emphasis on work programmes aimed at providing employment to members of society—such as immigrants—who are presumed to be at the margins of the labour market. The nature of available paid work receives less attention. In this chapter, I will turn to how participants expressed their work in terms of doing dirty work and how this was turned around as part of the participants’ own identity work to something really valuable and necessary. In so doing, I intend to illuminate how participants reported how their work as immigrant healthcare assistants is regarded by others, and how participants themselves perceive of the work that they do. I will discuss this through the interview questions of ‘what do you do’ and ‘what do you actually do’.

‘What do you do?’

As someone without direct experience in elderly care, the questions ‘What work do you do?’ or ‘Can you tell me about your job?’ were simply aimed at exploring details about the daily activities of participants. Following the technique of interview to the double, which was discussed in the methods section in Chapter 4, I usually asked participants to tell me about their job in the form of a narrative. To do this, I adopted an approach where I asked participants to reflect on instances when someone had asked them about their job and what they had said in response. Indeed, being asked about your job, or what you do for a living is a routine question that most of us encounter, especially when we meet people for the first time. This was true for the immigrant healthcare assistants, too, but the question ‘What work do you do?’ also elicited a distinctive meaning relating specifically to their immigrant background.

Baaba’s account exemplifies this:

Baaba: When people ask me about the work I do, I tell them: I work in *eldreomsorg*. Then they sometimes say, ‘*Eldreomsorg! Spennende* (i.e. elderly care! exciting/interesting)! What do you really do there?’ I then begin to wonder if they are really interested to know more about my work, or they just want hear that I clean ‘sh*t’... Take a look at me, that is what I do. Right?

Baaba’s statement, ‘I then begin to wonder if they are really interested to know more about my work’ and ‘take a look at me...’, tells me that the routine question of ‘what work do you do’ can have complex meanings and interpretations for the immigrant healthcare assistants.

Furthermore, I get the meaning that when faced with the question ‘What work do you do?’, the immigrant healthcare assistants’ identities/backgrounds—both as immigrants and as people doing low-status jobs—suddenly become central for them in their responses.

Dido, the healthcare assistant from Southeast Asia who has been working in Norwegian elderly care for almost 5 years, exemplified this: ‘They already know what I do here. I am a *foreigner* (italics mine), that is my job. I clean the old people. They know already. Don’t they? Or do they just want it to come from myself?’

Tsitsi, also, reacted to the same question as follows: ‘...I told him I am a healthcare assistant and he said “Cool, [my] neighbour who is from Congo does the same job”. Later when I was home, I said to myself, why did this guy tell me about his neighbour from Congo? Is it because he thinks all foreigners do this work?’

These participants did not separate their immigrant identity from their occupation—one that is perceived as ‘unskilled’ and low status. Dido described himself as a foreigner whose job is to clean old people, and further implied that as a foreigner, he was basically expected to be doing this type of job. Tsitsi also implied that foreigners are perceived as doing healthcare assistant jobs in elderly care. In both instances, the participants drew attention to the inseparability of their immigrant identities and their work in elderly care.

While it is acknowledged that immigrants in Norway are highly represented at the lower echelons of low status occupations (Thorud et al., 2014) and are increasingly dropping out of the labour market (Bratsberg, Raaum and Røed, 2016), it seems that this assertion is made even more complex by what is known about how workers in occupations that are associated with low status negotiate their identities.

As discussed in Chapter 3, Hughes’ (1994, 1971) analysis of work and occupations highlights that significant divisions in occupations exist, but also that the general picture is much more complex than it appears. As acknowledged by Hughes (ibid), notions of dirty work in occupations and societal conceptions of dirt (Douglas 1966) are critically important in the construction of individual identity in specific occupations. The immigrant healthcare assistants in this study are particularly aware of the relational and contextual nature of ‘unskilled’ and low status jobs as they attempt to fulfil policy expectations of gainful employment or active work. Time and again, participants recounted examples containing an occupational label that suggests that perceptions about ‘unskilled’ and low status jobs are united by two common denominators: the category of people who do such work and the

nature of tasks which are considered ‘polluting’ or dirty. Asking the participants the question ‘What do you actually do?’ provided me with the opportunity to delve deeper into this connection.

‘So, what do you actually do?’

As a follow up to the question ‘What do you do?’, I often asked participants to tell me specifically what they do by asking the question, ‘So, what do you *actually* do?’ Here again, I asked participants to narrate an incident where they had to answer such a question from someone they were meeting for the first time, who did not know about their work. How participants interpreted the question of ‘what they actually do’ can be found in the following excerpt:

Dido: Some time ago, I first said to people that I am a nurse, then I explained that I am currently working as an assistant and waiting for my papers to be fixed. But I get very upset when some people find it hard to believe that I am nurse’.

Vyda: What makes you think that they find it hard to believe that you are a nurse?

Dido: I know because they continue to ask questions about the work I do as a healthcare assistant. And now I even know more because the conversation turns to me as a foreigner in Norway, where I come from and if I am doing okay and stuff like that... But it is much easier for me to say that I am a nurse because people rarely ask me to tell them more about my job and this also gives me some respect. And it is true, I am actually a nurse...but I do not practice as a nurse in Norway...and I am a foreigner here so I do healthcare assistant work...I am used to such questions so I just give the answer that saves me from more questions.

In explaining how he interprets the question ‘What work do you actually do?’, Dido connected the question to his background as a foreigner. To me, his answer, ‘the conversation turns to me as a foreigner in Norway’, reflects the manner in which Dido enacts his position as a foreigner. Further, in answering the question about ‘what he actually does’, Dido said he would first refer to his status and his background as a nurse, trying to evade the stigma attached to being a healthcare assistant. And when he would try to explain that he is actually a nurse in his home country, his explanation was essentially ‘ignored’, and the conversation would shift to his work as a healthcare assistant. In my interaction with Dido, I observed that he did place an emphasis on being a nurse, and would use his nursing skills even though he was not compensated for this. Perhaps this also explains the reason why Dido gets upset when

explaining the work he actually does to people. From Dido's explanation, it can be inferred that for the immigrant healthcare assistants, the question 'what work do you actually do' can exceed merely meanings about the day-to-day activities of a job. Rather, it changes into a question that is centred around being an immigrant doing a low-status job.

Like Dido, Tabitha told me that:

It feels strange talking about the details of my job when people ask me. I don't know, but it is strange. Maybe I do not want them to know so much. Or maybe I just feel they will not be encouraged to work here if they know so much... And sometimes it is because I am a foreigner and it is always in the news that foreigners have done something bad....

Here, Tabitha points out that, for her, the question 'what work do you actually do' was in fact about whether people would be encouraged to do her type of job. Like Dido, when Tabitha is asked 'what work do you actually do', she in addition linked the answer to her identity as a foreigner.

Related to the above, regarding how being an immigrant is linked to doing low-skilled jobs, Pedro chooses to avoid the question of what he actually does:

Oh! When they ask that question, I immediately consider how they will start thinking about me. If it is someone I have met on the *trikk* for the first time, I try to avoid answering that question...I just don't like talking too much about my job to strangers.

Here, I understand Pedro's sentiment—'how they will start thinking about me'—as the sociological consequence of work that is perceived by society as dirty. In his interviews with me, Pedro tended to reiterate that his job as a healthcare assistant is perceived as unpleasant and is far from being uncomplicated in terms of how people outside the elderly care institution perceive the work that immigrants undertake. In essence, just as the perceptions of being in low-status jobs were an integral part of the identity of being an immigrant healthcare assistant, Pedro tended to highlight the fact that the focus was also evident in talking about what they actually do.

In the above instances, as diverse as participants' encounters may be, when interpreted collectively, they describe the nature of their job in a way that speaks to the unpleasantness of dirty work (Hughes, 1994), the role of dirt in enforcing social inequality (Douglas, 1966) and negative conceptions that reinforce hierarchy among category of people (Crenshaw, 1991). These excerpts from participants also remind us that their accounts about elderly care are

dependent on their sense-making as immigrants. To be clear, the accounts of participants are subjective. What is important here is to recognize the context of working in an occupation and on tasks which are viewed as necessary yet stigmatized. Oplo explained this, in terms of how she interprets the question of ‘actually doing’.

Vyda: Why did you say you feel uncomfortable when people ask what you actually do?

Oplo: I don’t know. I really don’t know. But sometimes I feel that they see many foreigners going up and down and sitting on the bus but they do not know what we do. And sometimes I also think they just want me to say that I do dirty cleaning.

Vyda: Do you feel your work is dirty cleaning?

Oplo: Oh yes! Of course it is! Even if it is not, it feels like it...(long pause) It is not because I do not like my job. It is how people look at this type of job...I can be a cleaner at an office or kindergarten. It is also cleaning. But you do not see the people who make the mess and the people do not also see you directly. In this job, you are in direct contact with the people you clean and this can be sometimes degrading.

In talking about how immigrant healthcare assistants understand the question, ‘What do you actually do?’, Dido, Tabitha, Pedro and Oplo echoed the sentiments of other participants by making a connection between their background as immigrants/foreigners and their perceived low-level position in the healthcare sector.

When I relate the above information to what Baaba and Dido told me earlier on (i.e. ‘I then begin to think if they are really interested’, ‘They already know what I do here’), it emerges that there is a common perception among participants that people already know what they do, so they do not consider it necessary to tell them more. While this pattern could simply be interpreted as reflecting the degrading nature of the healthcare assistant occupation, it emerged that a more in-depth interpretation is also implied by the ‘actually’ in the question ‘What do you actually do?’ This is because participants stressed that talking about what they *actually* do is something they try to avoid completely whenever possible—as a question with an overlapping meaning, the immigrant healthcare assistants felt it is better to ward it off. In our conversations, the subtle ways in which participants conveyed their feelings through gestures and facial expressions, which I interpret as distress and strong avoidance, further articulated their unwillingness to discuss the topic of ‘what do you actually do’.

For me, this is where I became more curious, if not more confused. I had used the word ‘actually’ in many instances without giving it a deeper thought. So why did this same word seem to hold such a significant meaning for immigrant healthcare assistants and did I try to solve this?

Journey of discovery regarding the meaning of the word ‘actually’

To solve the above puzzle, I embarked on a quick journey of words using Google. With over 214,000,000 meanings generated within 0.46 seconds, it immediately struck me that the word ‘actually’ is loaded with meaning(s). One definition in particular, offered by the Cambridge Dictionary, attracted my attention: ‘(adverb/surprise)—used in sentences in which there is information that is in some way surprising or the opposite of what most people would expect’.

The Cambridge Dictionary definition sounded good, but when I tried to align participants’ descriptions of ‘actually’ with the dictionary definition, it occurred to me that something was still missing as they did not quite align. I went back to my data to check the original word: Here, participants used the Norwegian word ‘*egentlig*’. Since Norwegian is not my first language, I did a bit of an exercise by asking ¹⁰colleagues and people for whom Norwegian is their first language about the meaning of the Norwegian word ‘*egentlig*’. Interestingly, none of them had an exact word to capture or define the word ‘*egentlig*’. In the end, the appropriate meaning I landed upon was that the word ‘*egentlig*’ or ‘*virkelig*’ has no hierarchical connotations but rather digs deep to find a truth—a reality—that is not evident on the surface. However, since neither English or Norwegian are my mother tongue, I tried to explore further by using my mother tongue, Ga.¹¹ The corresponding word I found for ‘actually’ was ‘*pɔtɛɛ*’, which is used to emphasize something that is of relevance. I had a brief discussion about this word with my mother (to know the meaning from her ‘tongue’—after all, the language is called mother tongue). According to her, the Ga word ‘*pɔtɛɛ*’ not only signifies relevance but also something that is significant in terms of position and that also attracts the respect and reverence of society. In other words, when some says ‘*mɛni ofiɛɔ pɔtɛɛ*’ (‘What do you actually do?’), they expect to hear something that relates to dignity or an elevated/higher position in society.

¹⁰ I am particularly grateful to my colleague Øyunn Høydal for her extensive discussion with me on the meaning of ‘*egentlig*’.

¹¹ Ga is the language predominantly spoken by the people in the southern part of Ghana.

Significantly, my journey of discovery for the meaning of the word ‘actually’ shows that, like symbols, such meanings are indeed context-dependent, and looking at such expressions from different perspectives can tease out different possible meanings and shed light on different aspects of the relations between people who ask and answer the question, ‘What do you actually do?’

When I reflect on this and relate it to my work, it seems that, for the immigrant healthcare assistants in Norway, there is a similar cross-cultural perspective regarding the word ‘actually’. In my conversation with Tabitha, for example, she implied that in addition to being an immigrant there is an image that her job is not in a highly esteemed sector. Here, I understood her to mean that when she said she feels uncomfortable talking about the details of her job, she also meant that it was because her job would be linked to this stigmatized image. She thus implied that she does not want people to know so much about her job.

The connection between doing a low-status job and being an immigrant also came up in my conversation with Amadu, when I asked him ‘What do you actually do?’

Amadu: Before, I start having headaches and my tongue became heavy...I could not even tell my wife and kids about my job for many years...But you know, things have gotten better. Today, I can handle this question better than 13 years ago. A lot of foreigners do this job. I am not alone. Look at this department. All of us are foreigners.

Vyda: Do you find it easier to talk about what you actually do because many foreigners are doing the same?

Amadu: Come on! I am a man! We do not clean old people from where I come from. But when you are in somebody’s country, you have to do it. I have a wife and kids to take care of. In Norway, ummm... they say it is okay to do this job as a man...what can I do? The work itself is not bad but there are so many issues, especially if you look different like me.

The above example reiterates my argument that when immigrant healthcare assistants encounter the question of ‘what do you *actually* do, they seem to attach two different meanings to it—first, that they have a different identity. As Amadu said, ‘Look at this department. All of us are foreigners’, in which we can see how he connects being an immigrant to how he interprets the meaning of his job. And second, ‘What do you actually do?’ is interpreted as meaning that they do dirty work or occupy low-level positions. Being an immigrant does not necessarily mean that a person does dirty work, but for the participants in

my study, there was a connection. It is in this sense that Dido, Oplo and Tabitha interpreted what they ‘actually’ do by describing their work as ‘dirty cleaning’ and ‘not encouraging’. Thus, while the questions ‘What work do you do?’ and ‘What do you actually do?’ are not necessarily intended to bring forth issues of identity and low status, such questions were interpreted by the immigrant care assistants as capturing their background as foreigners, which was further translated into their occupying low-status jobs. In effect, they tended to slip into a situation in which their job, or the low-status position, is also shaped by their identity.

The next question I discuss is how this conflation of low-status identities is translated into the daily activities of immigrant healthcare assistants.

A job for foreigners

In Chapter 3, I interpreted Hughes’ (1994) designation of dirty work from a perspective that defines boundaries among occupational groups. To recap, the notion of dirty work, according to Hughes (ibid), is consistent with distasteful or undesirable jobs that most people would prefer not to do. The image of doing such a job is further anchored within a hierarchy of authority in which those doing dirty jobs are mostly subordinates. Further, Hughes argues that perceptions around dirty work also draw attention to how outsiders view work which is tainted as dirty, and how this can affect the people who do such jobs.

Tsitsi illustrated this by telling me about an encounter he had had during a basketball game:

I was playing basketball one time with a Norwegian guy. I had seen him on the field before but it was the first time we played together. We started talking and he asked me when I came to Norway and what I do... I told him I am a care assistant and he said ‘Cool, [my] neighbour who is from Africa does the same job’. Then I also asked what he works with. He said he had lost his job and was looking for another one. Then he asked if I liked staying in Norway and I said yes. Later, I asked if he would like to work as a healthcare assistant. I told him they always need more people and he can easily get the job since he is Norwegian...I mean he speaks the language. His answer was Never, no way!...No thanks! (*aldri, nei takk!*)...He said this in a strong but mocking way. Later when I was home, I said to myself, why did this guy tell me about his neighbour from Africa? Is it because he thinks all foreigners do this work? And why will he not work as healthcare assistant since he has no job?...But maybe he

thinks like everyone else. It is a heavy job, the salary is not good and the work is difficult in many ways.

Here, Tsitsi explained how he made meaning of this encounter by being involved in a thought process where he was seen to be a foreigner doing a type of work that his Norwegian ‘friend’ would not like to do. First, the fact that the young Norwegian man talked about his neighbour who works as a healthcare assistant made Tsitsi wonder if it was implied that all foreigners work as healthcare assistants. He also wondered why his Norwegian friend would not work as a healthcare assistant since he had no job. Tsitsi’s bewilderment was emphasized when he pointed out that his Norwegian friend could easily get job as a healthcare assistant due to his background and natural ability to speak the language. When Tsitsi said that his friend was ‘strong and mocking’ when saying that he would not like to work as healthcare assistant, he assumed this was because most people know that the work is ‘heavy’, ‘difficult’ and ‘not well paid’. Here, as someone who is directly involved in the work, Tsitsi was aware of how people think about the work of healthcare assistants and he knew the position from which he was being asked questions about his job.

If we look deeper into why Tsitsi advised his friend to look into becoming a healthcare assistant in elderly care, it appears that he did not think it abnormal for his friend to consider such work, particularly since the young man was out of job. However, it turned out that Tsitsi’s friend had a specific image in mind regarding the work of a healthcare assistant which made him uninterested. We can see that Tsitsi was surprised at his friend’s exclamation ‘Never, No way!... No thanks!’, which implied that his friend would never consider working as a healthcare assistant in elderly care even though he was out of a job and could easily meet the entry-level requirement (i.e. competency in Norwegian).

Here, I ask: *If the elderly are an important policy focus/group in society and if healthcare assistants are important for the elderly, why would this young Norwegian man ‘never’ consider work as a healthcare assistant?*

For one, it could be argued that he thought that healthcare assistant work in elderly care in Norway are for immigrants like Tsitsi. Alternatively, perhaps it is as Tsitsi said, ‘Maybe he thinks like everyone else. It is a heavy job, the salary is not good and the work is difficult in many ways’. Going by this, then, it becomes possible to argue that when participants talk about healthcare assistant work in elderly care, they are indeed referring to comments and attitudes which reinforce public perceptions that healthcare assistant work in elderly care has a negative image. In fact, it was not only Tsitsi who mentioned the unattractive public image

of healthcare assistant work in elderly care—as we have seen, Amadu, Dido and Oplo also mentioned that they have encountered unpleasant views about their work as healthcare assistants.

Another participant, Zuzu, described how she hated news reports that seemed to attribute all the negative issues in elderly care to the work of the healthcare assistants:

Zuzu: Anytime I see in the news that healthcare assistants are being blamed for something bad that happened in the elderly care, I just can't stand it. And when this is discussed at work, they try to say it politely and indirectly that the healthcare assistants must be more careful. I am not saying we are perfect but why do we have to get all the blame?... Some people are reporting that we speak bad Norwegian; others say that we do not know how to do the job well and everybody is saying something to you because they think you have not gone to the school or university. What hits me most is when people use the word 'those foreigners'! Do you know what it means, in my culture? It means you are just nothing...like the stone you know. You are just like a useless object...

Although Zuzu's comments indicate her dislike of negative news reports about healthcare assistants, it is clear that her aversion is worsened by internal discussions (i.e. within the care institutions) which point accusing fingers at the healthcare assistants. However, it is also possible that Zuzu is suggesting something else here, as can be seen in the following excerpt:

When I started this work, I remembered a young Norwegian student who started at the same time as me. Oh my God! I will never forget this (laughing). During break, we sat together and she asked how I was finding the work. I told her so far it is okay but there are already many things to learn on the first day. Then I asked how she is also finding the work. And she said, 'I think it is a bit too hard. I don't know if I can manage to change the diapers my own. I haven't done it before. I heard about doing this kind of stuff in the nursing homes but I think it is more difficult than what I heard and imagined'.

Zuzu continued,

I was not surprised when she stopped after the second day of training. But look at me, I am still here. And who are the people you have been seeing here?... You need that special thing in you to keep working here. There is nothing wrong to be old and there is nothing wrong to need help...I think it is an abuse if people walk away from the old

people because the work is difficult. This is what they should be discussing in the news...Go and tell them (laughing). And remind all the politicians and people out there that they will one day become old and some of them will also need help...It pains me when you sacrifice for this job and you only hear bad things for your efforts. Even inside this work, the nurses are always looking for the healthcare assistants to clean the bodily discharge such as faeces and blood.

When talking about how she experiences elderly care in the above conversation, I observed that the conversation ended with Zuzu talking about the difference between herself and the Norwegian young student who had started work at the same time as her but then stopped. In this study, not only did the participants often reflect on how healthcare assistant work is mostly performed by immigrants. I also observed that participants like Zuzu were concerned about media emphasis that compounded the devaluation of the image the public attached to health assistant jobs and elderly care. With regards to Zuzu's narration, I also wish to point out that she brought up the practical issue of 'who does what' in elderly care when she said that, 'Even inside this work, the nurses are always looking for the healthcare assistants to clean the bodily discharge such as faeces and blood'. This will be discussed in more detail below, in the section subtitled 'Who is who'.

In returning to the questions for this chapter, 'What work do you do?' and 'What work do you actually do?', the quotes and excerpts above indicate that for the immigrant healthcare assistants this question is interpreted as complex with different meanings. While on the surface, this question seems to just be about the details of a job, it has wider meanings, which as indicated connects individual identities as being 'unskilled' care workers in low status jobs.

The significance of such meanings, however, extends beyond public perceptions. Their symbolic and social significance lies in the ability to have an occupational and individual identity which is associated with dirt, given that dirt is further associated with stigma. The latter presents dirt as a threat to social order and as Douglas (1966) further commented, 'eliminating it is not a negative movement, but a positive effort to reorganize the environment' (p. 2). When applied to individuals and occupations, the effort to remove dirt can be seen as the way in which society attends to the threat that dirt poses to its ordered relations and value classifications. Significantly, the fear of contamination from dirt is symbolically embedded in practices of avoidance, which distinguishes members of society (Douglas, 1966).

When applied to the accounts of the immigrant healthcare assistants, I see a common thread running through Douglas' symbolic concept of dirt and Hughes (1994)' normative analysis of dirty work. Both speak to practices that distinguish the acceptable from the unacceptable. Critically, participants' experiences imply that the perception of dirt or dirty work is also designated to individuals of particular origins. Such perceptions produce and maintain a social and moral order that highlights societal boundaries. Such boundaries are not necessarily inherent in the work itself but are imputed by people based on the fact that they are willing to come into contact with occupations which are classified as dirty. Drawing on participants' accounts, I argue that if healthcare assistant work in elderly care is devalued and seen as a job for people with immigrant backgrounds, such perceptions point to the power that segments of society have in defining meanings.

As we have seen, when participants talk about working in elderly care they highlight how they are placed within the labour market, and point to the belief that how others perceive them also has to do with their immigrant identity. Again, this confirms Hughes' (1994, 1958) analysis that work within any given occupation is open to contestation and tensions which require constant negotiation. Significantly, the motivation to reframe work, and in particular work which is seen as dirty, stems from the struggle for prestige and hegemony for identity (Abbott, 1988). The insistence on occupational or professional hegemony, according to Abbott (ibid), is intensively enforced when the specific image or identity attached to an occupational group is threatened or leads to marginalization. This characterizes contexts where occupational groups disapprove being associated with certain activities which threaten their prestigious image. Thus, by drawing on the notion of license and mandate (Hughes, 1971), which in this context is the authority to designate occupational roles and tasks and justify which category of people or skills are needed for specific tasks and roles, Hughes (ibid) pointed out that it is possible to understand boundaries between occupational groups. To illustrate this, I will now turn to a specific account regarding how the task-oriented nature of being an immigrant healthcare assistant can shed more light on participants' experiences in elderly care.

Status through distance: The experiences of the immigrant healthcare assistant with elderly Norwegians

Related to my analytical goal of having an in-depth understanding of how immigrant healthcare assistants ascribe meanings to what they do in elderly care, at this stage of the analysis I want to explore the impact of roles and tasks. In this study, the importance of roles

and tasks as boundary-markers for status inequality is revealed in how participants described proximity, in terms of quality working relations in elderly care. To illustrate this, I suggest the following excerpts from a conversation I had with Kailla:

But tell me, who does the most important aspect of this work? Who gets to the lowest level to feel every aspect of the life of these old people?...Who experiences the strong and dirty smells after they wake up? And who makes sure they are cleaned from their mess before putting the nice clothes and make up on them to look good? It is we the healthcare assistants who have the most contact and work directly for the elderly. That is the most important...Today one person says, 'You have to listen to me, because I am the nurse'. Another person says 'You cannot touch or do this or that because you are not authorized'...You can have all the big names, titles, and technical skills. But if you are not close enough to understand the old people and do not take your time in using these skills on them, maybe it is a mistake to say 'I am this and I am that'...How can they know more about the old people when they do not recognize those of us who work more for these old people?

This statement by Kailla draws attention to the proximity of healthcare assistants to the elderly. Here, Kailla finds it strange that even though she does the most relevant job for the elderly, she is not given much recognition because she is not deemed as skilled or qualified (i.e. *fag*). Kailla's statement about cleaning what she calls the 'mess' was typical for participants of this study. As 'unskilled' healthcare assistants, they engage in services which require contact with a considerable amount of bodily waste. What's more, the immigrant healthcare assistants stressed that perceptions and attitudes towards their work constitute a major source of worry. Perhaps this is particularly true because participants practice in a setting where professional credentials are also valued by the state and/or society.

Consequently, in an institutional structure where skills are valued, occupational groups who do not have authorized qualification and skills appear to be unimportant, regardless of their actual skills. I interpret this to mean that Kailla's concern may be based on two issues. The first is for occupational groups 'Who gets to the lowest level to feel every aspect of the life of these old people?', and the second one is about healthcare assistants who have 'big names, titles, and technical skills'.

In providing care, the way in which Kailla understood the fundamental needs of the elderly was expressed through her emphasis on the importance of having 'close' caring relations. Kailla initially believed that as a healthcare assistant, she would be recognized as performing

a vital role in elderly care. Perhaps this is why she emphasized the notion of proximity as important for the elderly. However, Kailla seems to be aware that experience in terms of skill development is a significant aspect of the resources needed to make decisions for the well-being of the elderly. Thus, as an ‘unskilled’ worker, Kailla might also be concerned that without skill development or authorization, she has to struggle with the limits of her role, especially where decisions require such skills and authorization. Accordingly, we can see that Kailla’s concern extends beyond her imagined all-important role to include her ability to develop her skills to become a skilled or authorized care worker.

From this explanation, it becomes easier to appreciate Kailla’s concern or perhaps frustration about doing important work which is under-recognized. Understandably, obtaining professional skills would enable Kailla to experience elderly care in a way that avoids the tendency to not be able to make decisive decisions for the well-being of her clients.

Before the part of the conversation captured in the above excerpt, Kailla had pointed out that the ability to make a judgement as to whether a given situation necessitates the use of her knowledge as a healthcare assistant or the ‘authority’ of her superiors is not straightforward. In many situations that I witnessed, the immigrant healthcare assistants could not be certain about what would have occurred if they had used their own judgements. In most instances, participants were concerned that their superiors would interpret their decisions as ‘wrong’ even though these decisions would have benefited their elderly clients. This judgment-related dilemma is what emerges as a tension between the healthcare assistants and higher occupational groups.

In the literature, Abbott’s (1988) analysis of professional jurisdiction reveals that occupations comprise many different aspects and many of these aspects are related to the interaction between occupational groups. Inherent in Kailla’s narrative is what I have interpreted as the tension between the healthcare assistants and higher occupational groups. I find it to be of particular interest to explore this tension further, as the participants used it to describe some of the variations in their work. For example:

Pedro: I was once working on my own when suddenly a staff who is a *helsefagarbeider* (*semi-skilled*) came in. The elderly man had a big sore on his leg and the bandage was soaked—I mean the liquid from the sore was virtually flowing out. I was about to put the extra bandage on it to prevent the bloody thing from getting onto the floor. Suddenly, and I mean from nowhere, this *helsefagarbeider* said in a commanding voice, ‘You are not allowed to do this! You have to call the nurse...!’

Herre min! (Oh my God!) I have been in this job for many years and you mean I need to call a nurse to save a situation? Does it mean I cannot think? When such things happen, I feel that people do not expect me to use my head or experience just because I am a healthcare assistant! As they say to us: '*Du er ikke fag*'! (You are not qualified!).

Similarly, Dido said to me that:

Dido: Who has more responsibilities in this job? Is it the nurse, *helsefagarbeider* or we the healthcare assistants? Look at the list, how many nurses do you see and how many healthcare assistants do you see? If the old people need more nurses, you would have seen more nurses on the list. Just last week, a nurse was assigned to help me with a patient who had just come from the hospital after surgery. The only thing she did was to tell me to do this and do that, take this here, put this here, be careful if you have to clean around the incision, and you need to make sure she is in the right position when sitting down to eat and on and on (swinging his hand and talking in a feminine voice). I was just looking at her and the way she was throwing about her weight as if she is the surgeon who did the operation. I think she was just trying to tell me that, 'Look here, I need to remind you of your job and you need to know that I am above you'. But maybe what she doesn't know is that I have many years of practice as a nurse. Perhaps more than her!

Another narrative that speaks to the above points was offered by Shasha:

Shasha: I remember when they first brought the machine to help this man breathe. It is a machine with many parts and you need to know how to fix it well before it can work. I have used it many times and it is not easy because there is something not correct with how the manual describes it. I saw that the *helsefagarbeider* was struggling with it. It was time for the client's nose and chest to be cleared and I suddenly saw that the client was struggling with breathing. I asked the *helsefagarbeider* if she needed help but she said no. But after some time, I was getting a bit impatient because I could see that the man was getting distressed. At the same time, I didn't want to upset my colleague by asking her again the second time. I just went directly to the machine and said that we need to fix this part before putting the power on. She didn't like how I interfered and wrote about it in her report. But you know, some people complain about everything. I made that decision because I think it was best for the client. In the end, his chest was cleared and he could breathe properly.

The manager said to me that we are not allowed to handle the machine alone. I explained what happened and I think she was glad I did. Sometimes, you just have to believe in yourself and do what you think is right.

The above narratives relate to what the immigrant healthcare assistants perceived to be the setting of boundaries by occupational groups above them. The common pattern in these narratives relate to helsefagarbeider and nurses who had not treated the immigrant healthcare assistants in a manner they considered befitting, due to their status. I argue that by exploring patterns of narrations in the participant's experiences, it is possible to understand their accounts of occupational tensions in elderly care. Nevertheless, it is possible to think of the narrations of the immigrant care assistants as perspectives that represent the accounts of individuals or groups (Hughes,1958). This is to say that there could be other marked patterns which were either not clear or not mentioned in these narrations. By taking this stance, I raise an important question about the role of observation in this study, which will be elaborated in the following discussion.

Who is who—Exploring occupational tensions in the accounts of immigrant care assistants

In my conversations with participants, most of them recounted instances of contested tensions between the healthcare assistant workforce and higher occupational groups such as nurses. The recurrence of this tension in participants' accounts made me curious to observe how this occurs in practice. However, in my observations, I did not explicitly see instances of the tensions that participants talked about. As my fieldwork progressed, I started wondering if I was misunderstanding what participants were saying or if this had perhaps been a prior challenge that no longer existed in elderly care. However, I later discovered that when participants talked about occupational tensions, these related to themes of how they are designated with tasks that located them from the bedside to the bath-side of their elderly clients. The presence of healthcare assistants in these locations enabled them to interact more with the elderly and, in the process, develop relationships that were different from the relationships between the elderly and members of other occupational groups, such as helsefagarbeider and nurses. The following is an example of this from my field notes:

A client was being prepared for hospital appointment. (I later got to know that this client does not like the hospital environment.) The healthcare assistant was gentle in her approach to him, both in physical touch and with a gentle voice, saying that the client would be going to the see the doctor. She paid attention to the emotions of the

client by ‘massaging’ his shoulders and back, maybe to release the tension since the client looked a bit moody. As she was helping the client with his shirt, she whispered something that made the client giggle. Once the client was a bit more relaxed because of this, the healthcare assistant started talking about the nice moments the client had when his son took him out for a walk the previous week. The client became fully engaged in that conversation, with some level of excitement. Then came the nurse who said hi to the client and asked if he knew that it was hospital day. With the help of the healthcare assistant, the nurse fixed the catheter and went away. The healthcare assistant changed her gloves, disinfected her hands and paid attention to how she placed the catheter in the man’s trousers. The *helsefagarbeider* came in, helped to lift the man from the sofa to the wheelchair, and gave the client some medicine. The healthcare assistant said the medicine should wait because the client had not eaten. The *helsefagarbeider* said he wanted to see the man taking the medicine. The healthcare assistant said that two of the medicines must be taken after meals. The *helsefagarbeider* went to the medicine logbook and read or maybe confirmed what the healthcare assistant said. He then gave a tablet of medicine to the client, which I assumed could be taken before food, and went away. While seated, the man was in a position where his legs were not placed properly. The healthcare assistant gently put his legs in place and lowered herself to help the client with his shoes. The client gave the healthcare assistant a pat on her back and looked at me, in the direction where I was standing, with a smile.

Here the healthcare assistant demonstrated a great level of attention which was missing during the brief interactions between the client and the nurse and *helsefagarbeider*. By having close working relations, the healthcare assistant also gained a deeper understanding about the daily feelings of the client. Here, the healthcare assistant, though not authorized, demonstrated instant knowledge about the clients’ medicine and was responsive to the client’s need to take the medicine after eating. Observations such as the above not only suggested ways in which healthcare assistants played an important role in the daily activities of the elderly. The proximity of healthcare assistants to the elderly also suggests that they are a potential source of vital information that is relied upon by other occupational groups, as shown in the following conversation with a manager I have named Linn:

There can be few nurses going round to check on all the patients with the medicines. Because of this, they do not get all the time to do other things like paying detailed

attention to the old people. The healthcare assistants play a major role here because even though some of them do not know the medicine, they still note the daily changes in the condition of the old people and we use their reports to make important decisions.

This excerpt illustrates how, through information that is used for important decisions, the healthcare assistants facilitate the goal of providing quality care for the elderly. As described above, these interactions enable them to meet the health, emotional and physical demands of care that are essential to the institutional and state goals of quality care for the elderly.

Thus, I argue that care provided by participants must be assessed in relation to how their proximity to the elderly and deeper insights define quality care outcomes in accordance with the health policy goals of the state. This is to say that policy plays a substantial role in determining the ‘fate’ of the healthcare assistant workforce. It is equally important to acknowledge that as a matter of policy, the need for skill development and high standards while maintaining the expectation to provide basic needs for the elderly are highly valued in Norwegian healthcare and wider society (e.g. Strategy for Skills Policy, 2017-2021 and Prescriptions for a Healthier Norway, 2002-2003). As my hermeneutic methodological approach requires that I illustrate how interpretation for this study occurred through a merger of participant-generated data, my own understandings, and selected literature on policy related document, I will turn to a holistic discussion on policy perspectives in Chapter 10.

That said, to return to my discussion in this chapter, whilst roles and tasks differ according to occupational duties and responsibilities, meanings attached to roles and tasks as a means of identifying occupations (Abbott, 1988) emphasize which roles and tasks are more acceptable or stigmatized (Hughes, 1971, 1994). On the other hand, the emphasis on the latter, as suggested by Douglas (1966) must be additionally viewed as context specific, as it depends on how people who occupy the role further construct the meanings attached to their tasks and identity.

It is clear nonetheless that in the literature on dirty work, one of the practical questions raised is whether people who occupy occupational roles in jobs categorized as dirty actually perceive their work to be ‘dirty’. As discussed in Chapter 3, developments in Hughes’ (1994) conceptualization of dirty work show that contrary to assumptions that dirty work is associated with low self-esteem, it is possible for practitioners of dirty work to build high self-esteem (Emerson and Pollner, 1976; Perry, 1978). Even though my own experience in this study leads me to consider how the work of immigrant healthcare assistants might be

positioned in terms of the typology of dirty work, there is a potential for participants to challenge my own experience. Accordingly, the next discussion provides an account of the place of dirt or dirty work as part of my data in the study of immigrant healthcare assistants in Norwegian elderly care. If it really is important to draw on participants experiences, then using the phrase ‘from the horses own mouth’ becomes possible.

From the horse’s own mouth: How healthcare assistants talk about their work

Up to now, I have discussed perceptions that frame healthcare assistant jobs in elderly care in a negative image. In addition to these, it is important for readers to note how the healthcare assistants themselves talk about their activities in elderly care. Concerning how participants talk about some of these hands-on activities, I refer to two experiences shared by participants. We begin with Amadu’s account:

Amadu: I never get used to the smells of poo and vomit! This is something that greets you every day but I never get used to it...It is about using my hands to clean the mess and sometimes, it feels ‘Gosh!’...and you think about the fact that it is cleaning older people...I mean these are not kids...It can be shameful.

Vyda: But you have your gloves on?

Amadu: Yes! But the gloves are not like the thick ones for cleaning the bathroom. It feels like everything is right in your hands even if you have double gloves. Before I started this job, eating with my bare hands gave me a lot of joy. Now I have stopped because I imagine how I use my hand to clean puke, toilet, and ooh! I don’t want to mention the rest! (making a disgusted face)... I miss eating together with the family...But this is my work. I do it to help them and most of them are happy. It is more important to me... I have never done such a thing before in my life...You know it is you women who do this work back home (smiling)...I try to relate to them as my parents...This is not the same as cleaning my own mother...Family would never allow me to do it.

In order to understand the significance of why Amadu misses eating with his bare hands, I think it is necessary to invite some cultural connotations from the African continent into the discussion, since that is where Amadu comes from. I start with the premise that all societies have beneficial ways of eating. However, scattered in parts of the African continent is the indication that eating with bare hands, and specifically the right hand, is considered divine and fulfilling. Using Ghana as an example, I argue that there are manifold expressions

pointing to the use of bare hands as a strong symbol of respect for food. Ghanaian sayings such as *'Abofra hunu ne nsa hohoro a one mpanyinfoo didi'* ('When a child learns how to wash his hands, he eats with adults') and *'nnine eshe eko nor'* ('My hands have touched food/ I have eaten well') elegantly sums up some of the traditional approaches to bare hands as a vital element in eating.

If I can use myself as an example, as a child, my grandmother taught me that eating with bare hands stimulates a sense of touch and pleasure as one becomes more aware of the texture of food through the fingertips. Perhaps most significantly, it is believed that eating with the hands brings a person into closer contact with nature as the ingredients of food are directly from the ground or nature. Nature here is associated with the 'supernatural' and the hand signifies the 'natural'. Thus, in eating with the hand, a connection is made between the natural and the supernatural and this translates into a humble means of thanking the supernatural for the gift or blessings of food. As far as this cultural information is concerned, eating with the hands is also a sign of family bonding or unity and acceptance of each other. This is because, traditionally, food is served in a big bowl and everyone eats with their hands. Moreover, it is often the case that after a conflict has been settled, the opposing parties eat together from the same bowl (with their hands) to symbolize unity. While this cultural explanation might sound unusual to people who are not familiar with the significance of such cultural bonding, this perspective offers an essential lens through which to understand Amadu's experience. When Amadu said he had stopped eating with his bare hands, and misses this aspect of family bonding, it is because he now associates his hands with cleaning body waste, which he described as 'disgusting'.

This is not to say that people with African backgrounds do not use their hands to clean body waste. To be precise, whether the cultural notions about using of hands are real or perceived, the central concern here also lies in the knowledge that, according to the above example regarding the dictates of Ghanaian culture, the cultural anomaly with shifting the cleaning of human incontinence to 'others' who are not necessarily kinsmen intensifies an already awkward situation which calls into question the dignity of the care recipient and care giver (Van der Geest, 2002).

Thus for Amadu, it is also about the 'disgust' and embarrassment of being exposed to the intimacy of people who are not direct family members. As expressed by Amadu: 'This is not the same as cleaning my own mother'. This statement becomes particularly crucial as it is assumed that caring is synonymous with having an immigrant background. Moreover, the

observation that the immigrant healthcare assistants perform their activities in settings where they are not familiar with and do not have the resources or capacity to deal with some of the demands of these settings becomes important.

In the case of Pedro, who is from South America, the connection between working in an unfamiliar setting without knowledge becomes even closer. With what he understands as an underlying assumption that he already knows his job, Pedro indicates in the excerpt below that the reality is different:

Pedro: They expect you to already know everything and be excellent in this work after a week, but it takes time...It is okay to learn by experience...But when they leave everything on your shoulders and expect fantastic results, it is because the bosses believe in you, which is not bad...I mean this is not the worse job ever but it was difficult for me because I had never been so close to the intimate lives of old people...I remember the first time I had to empty something called a colostomy bag...it was both scary and nauseating. I never knew such a thing existed in the world...but they tell me I am so good (*'flink'*) at my work...just to make me look good but they don't know I struggle with some of those things.

Later, Pedro asked if I had been involved in taking care of the elderly in my home country before. I said 'No'. He made it clear that,

I am sure everybody seeing you going up and down with me believe that I am training you to start work as an assistant. It is like automatic you know...I am not saying you cannot be something else like the nurse or the manager, but that is very rare. The first thing that people think when they see someone like you and me who look different is, healthcare assistant—finished! The rest can come later. And remember that you have to be good because it is assumed that you took care of your mother, your grandmother, your great grandmother and everyone in the village where you come from.

Pedro also referred to the stereotypes of caring as a female job by saying to me that 'everybody seeing you going up and down with me believe that I am training you to start work as an assistant'. Moreover, it is further assumed that as a 'female' I am expected to be automatically good at caring.

Implicit in Pedro's narrated experience is a close relationship between ideas about the power structure of a care workforce with a large number of bottom-level staff who are primarily working-class immigrants. Pedro's experiences and perceptions here mirror Olwig's (2018)

work on immigrant care workers and the ambivalence of dirty care work, in which exposure to dirty work reflects inequalities within healthcare, the nursing profession, and larger society. Thus dirt, according to Olwig (ibid), 'has become a metonym for a larger complex of denigration and discriminatory practices that immigrants frequently endure as foreigners who may have an uncertain legal position, a different physical appearance and limited knowledge of local ways' (p. 45). Olwig attributes this to the negative attitude to symbolically unclean work that is for the most part reserved for immigrants who are at the lowest level of the social hierarchy. The following account from Zuzu illustrates this. Like her colleagues, Zuzu also highlighted her experience with reference to body waste:

Zuzu: This is not normal smell. It is a mixture of smell mixed with plenty of medicines. So it is not the same. And it is different from patient to patient. Before I go into the room of each person, I already know the kind of smell to expect. Some can be nice. But the majority are...ill (pronounced in a disgusting way)...I am very gentle and careful when the patient has a lot of mess and you have to go down and clean. Some of them already feel bad about it. I have to make sure that I do not make them feel worse.

When narrating her experience, I noticed that Zuzu was a bit uncomfortable at the beginning. When I asked her about her perceptions in relation to body waste, she replied curtly that 'this is not normal smell'. Later in the conversation, Zuzu mentioned her endurance has been shaped by the following self-reflection:

I took care of my mother-in-law. Poor woman, she was very sick but children were not always around...As I work here and see these old people, I always think about her...When they have diarrhoea and start vomiting at the same time, it gets difficult for them. It is stressful for us the workers...But this is the work you are assigned to do. That is the only reason why they employ you. To do this type of cleaning and help around with the old people...When you have to take care of seven or more people in this condition, it gets stressful and everyone is also busy so there is little help...When I took care of my sick mother-in-law, the other family members also helped and it was one person so it was not stressful...In this work, it is many people and I am always running to get things done quickly...But I have done this before so I understand them very well and I know how to treat them so that they do not feel bad.

My conversation with Zuzu took place at a time when there was an outbreak of norovirus. This condition made people sick with diarrhoea, vomiting and stomach pains and was highly infectious (WebMD, 2015). The occurrence of norovirus meant extra cleaning of vomit and

diarrhoea, which calls for extra attention. In her account, Zuzu links her caring work to her ability to pay attention and be more sensitive to her client. Yet, she significantly did not ignore the fact that her job was heavy, unpleasant and difficult.

The experiences of Pedro and Zuzu reflect aspects of their daily activities that deal with bodily waste. Both also referred to the stereotype of caring for family members as a female role. In many ways, Amadu's experience was no different. His experience turns on notions of the difficult aspect of his daily activity as a healthcare assistant. His ideas about elderly care meant putting the needs of the elderly ahead of himself. This may have particular connotations with regards to his cultural values, but he did not allow this to supersede his duties. However, this is not to suggest that everything 'glittered' for Amadu. His experience spoke to the reality that it is difficult to disentangle the disgust that accompanies his daily contact with body waste.

For Pedro, the challenging nature of his job was not only related to body waste but the unfamiliar nature of carrying out such tasks and the expectation from his bosses that he already knows how to handle such tasks.

Zuzu's experience is also similar to that of Pedro and Amadu. She acknowledged the stressful situations created by constantly working around body waste. Perhaps it is significant to mention that in talking about her experience, Zuzu expressed herself more in terms of being more sensitive to the elderly due to their situation. The conditions of her past life might have contributed to this. However, in the end, the participants' accounts were all in the same vein: Elderly healthcare assistant work is demanding and complicated and it appears to be a job for immigrants.

Silje, a manager, offered a plausible explanation on why the latter is the case:

This job is not easy for the young Norwegians. It is not because they are lazy. It is simply because it is very heavy. Most importantly, I think that they are not used to being exposed to many conditions of old age and ill health. It is not usual for the Norwegian to see the 'nakedness' of their older people...I remember I had a young Norwegian lady who started this job. She was very enthusiastic—then we started training. She was with me when I had to help an old man. With all the unusual smells, I saw the disgust on her face and she tried to hide her face when I had to take everything out to clean the man...Unfortunately, she stopped the work. And this is the reality. I have seen many of them wanting to do the job but they are exposed to the

other side of life, which is about the challenges of old age and old people's lives and some of the conditions are too much for them to bear. And because the sector does not pay so well, it is easy for them to also quit... The difference in salary between the nurses and the healthcare assistant is not too much depending on how long the person has worked. But when the work is heavy and the conditions are not attractive, and there is always the perception that healthcare assistant work is not nice, it is easy for them to leave... We have the initiative to employ the Norwegians but I hardly get them to apply for these positions. The foreigners are mostly the people who want this job. If you look around, most of the people you see doing the work as healthcare assistants are the foreigners.

The above narrative points to how immigrant healthcare assistants dominate the lower status workforce in elderly care, as well as the difficulties in getting non-immigrants to work as healthcare assistants.

Returning to the accounts of the healthcare assistants for this analysis, I observed that Amadu said he had never done such work before. Pedro, too, highlighted that it was his first time experience. And for Zuzu, even though she had taken care of an elderly family member before, taking care of seven or more frail people in a day could be stressful. At this junction, it is important to note that the routines of the immigrant healthcare assistants are no different from other practitioners of this occupation. Thus, the participants' accounts can also shed more light on what it means, in general, for everyone who works in this occupation. And, as the following example indicates, there is a need for more knowledge-based policies in this regard.

'It is very heavy for me, I feel it directly in my heart'

In the previous section, when Amadu, Pedro and Zuzu spoke about their experiences in elderly care, they mentioned that, 'When I took care of my sick mother-in-law, the other family members also help and it was one person so it is not stressful' (Zuzu); 'I have never done such a thing before in my life' (Amadu); and 'I had never been so close to the intimate lives of old people' (Pedro). Here, I find it necessary to emphasize these statements because I think that the manner in which participants described the meaning of their work reflects different positions from which the work of immigrant healthcare assistants is generally perceived. For instance, in my interviews with managers, it was clear that they perceived the

immigrant healthcare assistants as having a ‘natural’ talent for caregiving, a skill which was often attributed to their cultural background (this will be discussed in detail in Chapter 8).

However, when the immigrant healthcare assistants spoke about their work, some of their stories involved experiences, which contributed to a different perception. This is how Baaba explained his experience after following an elderly man to a doctor’s appointment (at which I was also present):

It is very heavy for me and I feel it directly in my heart (‘Det er veldig tungt og jeg føler det direkte i mitt hjerte’).

Baaba: I had heard about cancer but I had never been in very close contact with the details of this disease before. It is not easy when I have to stand next to him, go through the scans and listen to the doctor explain things. It never gets any better with cancer and the feeling is never good. The first time I came with him, the big machines alone scared me to death. I had this sharp feeling in my stomach as if I was going to faint. But I had to stay strong to support him. At this moment, it was not about me. It was about him. So I had to put my feelings and fears aside to be there for him. I clean his sweat, hold his leg when it starts shaking and put my hands around him after the tests. I am like a son to him. Sometimes you start thinking that this is the work of family members. But you know, in this work, we are also their family. I understand that the daughter says it is too emotional for her to hold her father’s hands through the cancer follow up and scans. So I am the one who has to hold him through the process and we give her the report. I think that to work with old people who have cancer is okay. But it becomes very heavy when you get involved in all the deep details of such a disease and you also stand by them through these moments of pains...I have never done this before. It sometimes feels like you are in a different world. But there is no one to do it. We are the people doing this job and I cannot say no...It is heavy and difficult, especially when people don’t respect you for doing this work...When the conditions are not good and there is no respect for the work, I sometimes wonder if it is good to work or better to stay at home and keep searching.

Like Amadu and Pedro, Baaba said he has never done this before. For him, to be a healthcare assistant ‘feels like you are in a different world’. In this way, his description of his work as heavy and difficult can be regarded as an interpretation in which his perception is different from that generally held about the immigrant healthcare assistants. Further, in Baaba’s explanation, I see how the meaning he makes of his work is connected to immigrants/his

background and perhaps in this case, the issue of staff shortages. When Baaba said, ‘we are the people doing this job’, I understood ‘we’ to be equated to ‘immigrants’ because, after all, Baaba was aware that the focus of my study is on immigrant healthcare assistants. Here, I think that Baaba’s meaning in relation to immigrants was consistent with that of the other participants. Yet I also think that Baaba was more specific in emphasizing the connection between doing a job that is significant but not dignified, by describing his work as ‘heavy and difficult, especially when people don’t respect you for doing this work’.

In Chapter 3, I mentioned that dirty work has intrinsic value for society but it can produce obvious constraints for the value of workers in such occupations. In my empirical data, I see how the accounts of the immigrant healthcare assistants suggest a complex array of ambivalence in relation to work in Norwegian elderly care. To cite Hughes (1994), they ‘perform the lowly tasks without being recognized among the miracle workers’ (p. 53).

In discussing coping strategies utilized by Caribbean immigrants in ‘dirty’ professions in Britain, Olwig (2018) argued that in spite of the major differences among the health care workforce, the immigrant nurses did not depict themselves as victims. ‘Rather, they presented themselves as individuals who had the stamina and will to succeed under conditions of adversity, thereby evoking the image of the resilient Caribbean woman (p. 56). Included in Olwig’s assertion is the awareness of discriminatory practices concerning the British system of nursing, as well as the ‘marginalized’ class background and position of the Caribbean nurses.

Similarly, in this study, notwithstanding the inequalities and marginalization which emerged from the accounts of participants, the immigrant healthcare assistants related to some of the positive attributions in their work in Norwegian elderly care. In a sober, yet proud manner, participant Kailla proclaimed that, ‘we are the fuel and they are the cars’. The essence of this statement is explored in the following section on participants resilience in doing low status jobs.

‘We are the fuel and they are the cars’

When I listened to how participants talked about their experiences through answers to my question ‘What do you actually do?’, I had the feeling that everything was gloomy. This was because the accounts were grounded in perceptions and attitudes which related the healthcare assistant job to the character of doing unskilled low-status jobs and the minority background

of being an immigrant. However, in exploring how participants perceived their position from their own perspective, I observed that this discussion changed the mood of participants and the interview environment.

As expressed by Kailla, during a focus group discussion:

Kailla: We are the fuel and they are the cars! They cannot move without us!

Vyda: Please explain. What do you mean by that?

Kailla: We the healthcare assistants are the fuel. And the old people and the rest of Norway are the cars.

Vyda: I still don't understand. Do you think the fuel is more useful without the car?

Kailla: Oh yes! Fuel is a commodity you can sell in any part of the world and make money. It is a resource that is needed everywhere (laughing). But not the car. Not everyone needs the car! (laughing loudly, and others giggling) And maybe they don't like that we are the fuel. You know what I mean? But we are still here and will be here! (laughing louder).

When Kailla used the metaphor of fuel and cars, I had to think on my feet to follow her reasoning. I observed that she framed her position in terms of providing a vital service. In response to my question, she stressed the connections between the fuel and the car, and in her closing remarks, she emphasized what she meant:

Kailla: Yes! This work is not always the best. And everybody is talking about it like that. But I believe so much in what we do. Everybody says that I am always laughing when things are difficult and they think I am not serious. But I am serious. We help them to live because of our work. If you think about it like that, it will follow you and you will see that we are the best...But I see the old people like my mother and father. You see, it is mostly we the foreigners who are in this job. You need that kind of heart and we have it. If I also go, who will take care of them? That is how come I have been able to stay in this work for all these years. And now, I am taking the course to be *helsefagarbeider*.

In her explanation, Kailla tried to paint a positive or pleasant image by constructing a position of prominence. Her claim to prominence was, as she suggested, is rooted in the particular service she provides which has to do with helping the elderly live. This, she further explained, is rooted in having a kind of heart that she thinks is unique to 'immigrants'. Her metaphor

about the fuel and the car further served to suggest the strength of her positive image of the immigrant healthcare assistant. She described this by using phrases such as, ‘not everyone wants this car’, ‘you know what I mean’, and ‘maybe they don’t like that we are the fuel, but we are still here and will always be here’.

Kailla also offset this with a story of success, regarding her course to be a *helsefagarbeider* (Kailla was offered the opportunity to take this course during the course of this study). She sounded positive about it and seemed to talk about it with pride. Prior to expressing these views in the focus group, Kailla had already told me about this course and her tone underlined a strong connection between the prestige of being a *helsefagarbeider* as compared to being a healthcare assistant. For me, the importance that she attached to this course could also be a way of overcoming the stigma attached to being a healthcare assistant. In the latter part of the discussion, Kailla spoke about an experience of discrimination and her resilience in the face of it. She recalled:

Kailla: ...And when they finished and they were going, they did not even say thanks to me or goodbye. They asked me to tell the nurse if their mother has more pains in the leg and the bandage is wet. When the nurse came to us they started talking about how their mother has improved and is doing well after she came to the nursing home. They kissed their mother, said goodbye to her and the nurse. I was a little bit almost like the air on that day. Everyone was breathing me but did not see me. I could sense that they did not regard me, you know, that assistant who does not know anything. And worse of all, I am a foreigner (pause)...I guess they were saying in their head, ‘To hell with you’...Anyway, I am still in this job and I will now take the course. Maybe it will show that I have some competence and they can talk with me the next time...(laughing).

Vyda: Do you think that showing that you have competence would make a difference?

Kailla: Maybe yes, or maybe no. But I love to support people. It is part of me. Everyone think you are from a poor country looking for money here. I always find it difficult to understand. This work is not about the paperwork (long pause). It is about the human beings. I like to support the old people. We help them to live their last life with happiness. I have learned a lot and sometimes I feel like I am like the nurse because I know so much (laughing). When I started this work, I didn’t know so much. But my manager, and friends helped me. They gave me the chance to learn. Now, when I go to my country, my mother and everyone calls me ‘the nurse’. And I feel so

happy. They come to me with health problems and I am able to help them... This is not my country. But I am always thinking about these old people. They have it difficult at this age and I am here to help them... (solemn tone, long pause). Maybe they will never give respect to me because you can see that I am different. But I have survived and will continue to survive (face brightening up with a smile). And maybe someday I will become a nurse... my dream (laughing).

Here, Kailla spoke about her ethnic identity and that perhaps she is not respected because of it. Drawing positively on her experience, she referred to the many things she has learned and how she enjoys the status of being a nurse when she is back home. Most importantly, she frames her experience with the opportunity to develop her skills in the field of healthcare. At the end of the discussion, she positioned herself as a 'survivor', and someone who is on the path to realising her ambitions as a nurse.

Similar to Kailla, Pedro had this to say:

In many ways, we represent the totality of the old people we work for. We look irrelevant or at the least on the department. And maybe because you are a foreigner, it can feel bad. But we are their eyes, ears, noses, mouths, hands, legs and everything you can think of. I do not know how to say it... Maybe if we the foreigners are not here, there will be a disaster and maybe the government will have to make a new rule that families should take care of their old people... We are the people who come here to do this work all the time.

During the discussion, Pedro tried to put a positive spin on himself and other foreigners by saying that, 'we are the eyes, ears... and everything you can think of. He took pride in his work and described it as 'very important'. On the other hand, he spoke about the downside of his experience by making an implicit link to both his ethnic background and position. During my interactions with Pedro, I noticed that he mostly talked about the low status nature of his job and the fact that he is a foreigner. However, despite the difficulties of his experience, he consoled himself by saying that, but for the foreigners, there would be a 'disaster' in elderly care.

Compared with Kailla, Pedro's difficulty in understanding unpleasant experiences as a healthcare assistant is far from resolved. It is worth mentioning that in spite of the difficulties in participants' experiences, they talked about their job as an important aspect in Norwegian society.

Tabio took another level by asserting that:

Tabio: I do not know how to say it. But it is like their body lives through us and of course we also live through them.

Vyda: What do you mean by you live through them?

Tabio: For me, this work is my life. I spend the greater part of my life with these old people daily. When I see the pictures of their active young lives full of strength and energy and life, and when they tell me their life stories, I learn a lot about life itself. Also, when I see their current condition and how old age and illness has taken away most of their strength, it teaches me to be careful in life. So to some extent, I also live through them...They rely on me to go through the day and I also rely on them to have a healthy life. That is what I mean...do you get me?

For Baaba, the pride in healthcare assistants' work is knowing that they are life givers.

Baaba: We are the ones who give them life. The life is not only about the medicine they take. It is not just about writing the prescription or giving the injection, finished! It is about being involved in every aspect of the life of the people who mean something to you...(pause) It is about digging into the total body to know how somebody is feeling. In this work, you not only work with their physical, you also delve into their innermost being. Can you imagine how it feels like, when an old and frail woman has sores in her private parts and where the 'poo' should be coming from? Maybe you are like her son, but she has to open up these very sensitive and private areas of her body to you. Sometimes filled with blood from the sores, poo which cannot fully come out because of pain and you have to take your time to carefully clean this up. Sometimes, they hold on to you as if the rest of their lives depend on you. You can feel it in how they hold very tight to you when you are cleaning them. Sometimes you just have to cry when you hear the sounds of pain...I have done this many times but I try to hide it from them. You then feel their pain in return. And feel some sort of connection to them. This is not always the pain that comes from their screaming. This is unwritten pain which is expressed without words and it is a connection that you cannot deny. Unless you are not human or you do not work with your heart. It is like their life depends on us and I think we give this life because the life is not just about the medicine and the money. It is being there for them and that is our job.

Dido however corrected Baaba's assertion that healthcare assistants give life by saying that:

Dido: I think it is God who gives life. Not us. But he uses us as angels to give this life.

Following the above discussion, Oplo was proud in saying that making sure her clients maintained very high standards of hygiene is her hallmark as an immigrant healthcare assistant, something that she believes distinguishes her from other caregivers:

Oplo: My clients are a reflection of me and I make sure they are always very well dressed and clean. They choose what they want to wear but no client of mine puts on something dirty. I check the nails, the hair, underwear, everything. And I also make sure I clean up all the stuff for good personal care. It is not everyone who cares about such things. But I have it in my DNA, all the way from my culture...I think it is just knowing that some things like having strong smells are easily associated with old age so I make sure no client of mine smells. And I tell you, these old people like it when they are clean and smell good...(smiling).

In spite of how the healthcare assistant occupation translates into a degrading and low-status position in the care sector, Zuzu expressed her feelings as follows:

Zuzu: On a daily basis, I usually help them with toileting, giving a shower, feeding those who cannot eat by themselves, dressing them to look nice, and helping with their medicines. Then we take them for a walk if it is needed, or help them to join the other residents for activities such as singing, exercise, etc., just the little things to live a normal life. It is true that we are not professionals or do not have high qualifications but the joy of this work is the connection with the old people. I don't see how I can be satisfied in this job without having this connection. It is okay if they don't see this as important...For the old people, this is important for them and I am happy to do it.

For Tsitsi, Baaba, Pedro and Ozuku, they derive honour in the small things that have a positive impact on the elderly:

Tsitsi: Most of them are mostly lonely and need someone to talk to. We are not just here as workers but we are their friends, family and all.

Baaba: In Norway, the system is very different from where I come from. Some of the family members of these old people do not live far from them. They drive along the same street every day but they never stop to check on them. They only visit on

birthdays, Christmas, etc., but the daily life is about having company. The family cannot be here all the time and we are the ones who fill in the gap.

Pedro: Some of them feel like they have been dumped here. It is as if society has given up on them and forgotten about them. But we step in to make them know that as long as they have life, they have hope. We help them enjoy whatever life that is left in them.

Ozuku: This winter is much better. Last winter, there was heavy snow. Somebody needed help and we were very few people at work. The roads were bad and we had to park the car and walk a long way. When we got to the house, the room was too cold and he was freezing because he could not get up. He was sick all over the floor and had poo on himself. Look at the list of all the people we visited today. These are people who need help to keep going. If we do not walk into their house to help, can you imagine how their life will be?

In the above examples, the healthcare assistants appear to draw a sense of prominence in performing tasks that impact positively on the well-being of the elderly. Combined with a sense of pride, the belief that Norway's elderly care would probably collapse without them seems to support Kailla's assertion that healthcare assistants are the fuel and the care sector and society are the cars. In other words, without the fuel, the cars would not be able to function.

Thus far, in this chapter, I have analysed how participants consider their work in elderly care and their position(s) in the hierarchy of occupations in terms of doing dirty work. I have also discussed how participants expressed their work in terms of how work as immigrant healthcare assistants is regarded by others. My data shows that as part of participants' own identity work, expressions of doing dirty work were transformed into expressions of doing work that is valuable and necessary. Grounded in the perceptions of society and the personal experiences of participants, the social meaning of dirty work and the stigma attached to work in elderly care also pointed to perspectives on work in occupations that are 'female'-dominated. Inspired by Crenshaw's (1991) intersectional perspective on the contexts through which gender, race and class backgrounds interact to produce experience, I will in the following chapter turn to an exploration of the gender complexities concerning male immigrant healthcare assistants in Norwegian elderly care.

Chapter 7: Male immigrant healthcare assistants as gender intruders

'The vast majority of migrants are industrious, courageous, and determined.

They don't want a free ride. They want a fair opportunity...

They want to integrate, while retaining their identity' Kofi Annan, 2004.

In chapter 6, I discussed how participants say they experience a low-status position because of both their background and the low-skilled nature of their job. However, in analysing my data, I observed that if the focus is just on background and being in a low-status occupation, much of the complexities and ambiguities of the experiences of the immigrant healthcare assistants will be lost. As with status and background, it emerged that notions such as gender and categories of race, nationality or citizenship and class reinforce structural power relationships, which help to understand the experiences of participants. To set my discussion in perspective, I start with the following excerpt from Tsitsi:

We got some orientation before the work but after I started working, I noticed that the 'masculinity' and 'maleness' in me was eroding. I no longer felt like a man. At the end of my first day at work, I went into the toilet in the basement (because it is quiet and perhaps no one will see me). I looked into the mirror, beat my chest, and started crying. I was just saying in my head, 'Tsitsi, is that me doing a woman's job?'...But you know, this is Norway. My family need to be taken care of. I have to do the work of a woman to fulfil my duty as a man.

Tsitsi narrative above illustrates some of the experiences of male immigrant healthcare assistants in Norway. For instance, in the above quotation, being a man in a female-dominated job seemed to lessen Tsitsi's power ('the "masculinity" and "maleness" in me was eroding') in the institution of elderly care. Further, his status or self-esteem was being weakened due to an integral part of his identity that stresses that care work is for women and not for men. Likewise, in Chapter 6, under the sub-heading, '*From the horse's own mouth...*', I cited Amadu who expected me to know that as an African man, he does not clean his own mother. Yet, cleaning elderly women is part of his job in Norway. Here, being a man, specifically an African man, further lessened Amadu's power as he finds himself in an occupation that tends to position him in particular types of backstage roles ascribed to women in his home country. I understand Tsitsi's experience with a personal sense of awareness that it is challenging, if not impossible, to ignore the usefulness of the interrelated notions of identity—including

cultural identity—to help unpack Tsitsi’s experience. I will try to make meaning of the effect of such identifications for Tsitsi as an African man.

In Hall’s (2000) work on ‘New Ethnicities’, the assertion that identifications with ethnicities and nationalities are important to the identity of different people resonates in Tsitsi’s account. The following comment by Hall (*ibid*) serves as a caveat to my argument:

What is at issue here is the recognition of the extraordinary diversity of subjective positions, social experiences and cultural identities which compose the category ‘black’; that is, the recognition that ‘black’ is essentially a politically and culturally constructed category, which cannot be grounded in a set of fixed transcultural or transcendental racial categories and which therefore has no guarantees in nature. What this brings into play is the recognition of the immense diversity and differentiation of the historical and cultural experience of black subjects (p. 444).

In the context of my discussion, the important point here is that there are specific social roles that are particularly important to Tsitsi’s identity. Understanding how these roles have changed (for example, being a man doing a woman’s job in elderly care) and the intersection of these with notions of gender points to the unexpected consequences in the loss of the uniqueness of Tsitsi’s identity. These conceptualizations are further anchored in gender stereotypes. With regard to gender, I have chosen to focus on how male participants perceive their experiences in elderly care. My focus does not mean that the issue of gender is only relevant to male healthcare assistants. Neither the male nor the female participants in this study specifically interpreted their experiences in terms of how gender differences were played out in their daily activities. My observation, however, was that as the sector is largely gender segregated, my data shed light on how immigrant males represent something new in this sense as well.

A main difference between the experiences of male and female participants was that certain identities and social categories were emphasized more by the men, or were downplayed as a form of resistance. This focus became relevant when I observed how male participants used phrases such as ‘look at me, a whole man doing this job’, ‘I was ashamed to tell my family about my job’, ‘a man bathing old ladies’, etc. in talking about their experiences. Thus, in discussing the subjective realities of participants below, I pay particular attention to how they make sense of their work in elderly care through accounts that first speak to the fluidity of gender identities. I then look at the interwoven process of race, gender, nationalities and class status. In the final section, I highlight how, in practise, the intersection of gender with other

social categories illustrate some of the complexities of how the immigrant healthcare assistants make sense of themselves in the labour market. I then argue that policy is germane to the discussion.

Gender Identities: Negotiations among male immigrant healthcare assistants

At the introduction of this chapter, I mentioned Tsitsi, who talked about himself as man doing a woman's job. Through this contrast, Tsitsi not only highlights the image of gender stereotyping but also the complex image of a man doing what is traditionally seen as female work. Tsitsi's experience is influenced by stereotypical images of gender in his home country:

Tsitsi: I did not come into this work because I wanted to work here...I worked in administrative positions as a middle-manager in my country. In fact, before I came to Norway, I didn't know that men do this type of work. The men who work in the hospitals in my country are doctors or they do the big machine works...I will not do this work back home...In Norway, everything changed. I needed to find a job...It was not easy in the beginning but now, it is okay. I enjoy working for these old people. But the change was very sudden and real.

Vyda: When you say change, what change are you referring to?

Tsitsi: All the change. For instance, the first time I had to change diapers for an old person and it was a woman. Oh my God! I haven't done it before. Not even with kids. At first, it was like a movie...the smells, the shame, and feeling very uncomfortable. It took a long time before I realized that I was doing it for real. But I noticed that the old people were very kind and warm. Some of them say thank you and are very polite...It is that kind of feeling which makes you know that they appreciate the work you do for them. I don't know to describe it...I met a man in a white uniform. I thought he was a doctor but he said he is also a care assistant. I smiled nicely and relaxed my shoulders a bit and I said 'Aha! I am not alone' (laughing). This male care assistant was from Germany and he told me that men do such work in his country. In my home country this is rare and not normal. I will say that seeing men do this type of work was a nice surprise and a big change for me. It is also about the life of these people on the pictures in their room: strong, big, handsome and beautiful. And you see the life when they are old and sick and weak. As I keep doing this work, I see life, which I cannot describe...what it means to rot in your own body and to see the decay of age. It has made me warmer and kind. When I look back and think about myself, I think that

there has been a big change. I have become warmer and nicer like my sister and mother (laughing).

Tsitsi's account highlights how he sees notions of femininity as a stereotype for care assistant work. The occupational context in which Tsitsi finds himself made him feel that he has changed, becoming 'warmer and nicer' like his sister and mother. This reference to stereotyped feminine characteristics is particularly interesting given the fact that, traditionally, men in Ghanaian (in this sense 'African') societies are not supposed to be seen performing direct caring roles. And in cases where men take on caring roles, it is mostly for private reasons and for very close family members. Essentially, such care provision is usually done behind closed doors and not in public.

In his narrative, I get the understanding that what Tsitsi refers to as sudden and real changes has more to do with changes that made him become conscious of the relational and contextual nature of gender in his attempt to fulfil societal expectations through work in a new environment (Donato et al., 2006). Significant for this discussion is the knowledge that Tsitsi's experience of care work in Norway lies in sharp contrast to how he experienced and associated care work as a female-oriented role in his home country. Tsitsi's example is important for two reasons. First, it highlights the reality of gender stereotypes and second, it illustrates the fact that gender performance is more complex as immigrants enter the labour market with pre-conceived notions and constructed identities about gender, which are influenced and shaped by experiences from their home countries (Datta et al., 2006).

Tsitsi's account illustrates how he constructs his experience by using his race and ethnicity and previous class status as social categories that make him different. This also represents the complexity involved in maintaining Tsitsi's gendered stereotypes of social roles as he works in a female-dominated sector. For instance, Tsitsi felt that notions of warmth and kindness are generally associated with femininity whilst descriptions of being tough and hard are constructed as masculine. These perceptions of gender identities are similar to general stereotypes of gender both in Tsitsi's country of origin and in Norway. As we can see from Tsitsi's account, the perception that when men work in hospitals, they must either be doctors or do machine work are some of the pre-conceived notions that reiterate how occupational identities are reflected in gender roles in his home country. This, for me, is a clear example of gender stereotyping.

In Tsitsi's account, I also see the intersection between gender and nationality. According to him, the German male healthcare assistant described it as normal for men to be involved in

care assistant jobs. However, by virtue of Tsitsi's nationality, this is not normal. In terms of racial hierarchy, I argue that Tsitsi's experience is clearly a struggle. My own Ghanaian background and historical knowledge of colonialism and racial and class conflict on the African continent informs my argument that Tsitsi is likely to perceive the German care assistant as having more power as an advantaged 'white' European man. This prejudice leads me to assert that, in this context, Tsitsi sees himself as being racially disadvantaged as a 'black' African man. Racial hierarchy here emerges as a circular process, with 'white' or non-racialized healthcare assistants being superior, above or advantaged while 'black' healthcare assistants with racialized features, like Tsitsi, feel inferior, below or weakened. In many ways, my own thinking resonate with how Olwig (2018) conceptualized racial hierarchy in British nursing as an influence of the history of colonialism, which maintains white supremacy.

It appears, however, that the 'nice surprise' and 'big change' Tsitsi talked about has not necessarily changed his stereotypical notions of what are deemed traditional roles of men and women in his home country. He wishes to be respected as a man and, moreover, a man with middle-class status:

I am not supposed to be doing this job. I told you I was a middle-manager... There was a receptionist vacancy here because of maternity leave. That is like my field and I applied. But they told me 'sorry'... It was like telling me, 'Hey man, you need to focus on your job, that is what we hired you for' (sarcastic laugh)... We are the same in this job but let's face it. The back of a man is still stronger... You saw it last week; two women could not push that machine to re-position the patient's bed. It was me they called... muscles... it helps (laughing with pride and showing me his biceps).

In this excerpt, Tsitsi maintained an idea that reasserted his identity and/or masculine image by linking aspects of his current role as a healthcare assistant with work that demands his 'masculine' strength. Finally, it emerged that Tsitsi did not arrive in Norway with the intention of doing care work. Tsitsi's account of doing work that is feminine-oriented helps me to see how the interconnection with gender, class and nationality can describe the complex process through which he makes sense of his occupation. The tension becomes clear as Tsitsi tries to represent his own identity, acknowledging the current climate that men can do care work yet resisting the institutional arrangement that does not recognize his previous occupational status. On the one hand, I see Tsitsi's resistance as implying that healthcare assistant work is below his class status. On the other hand, it also confirms perceptions of the low-status nature of healthcare assistant work.

The subtleness of race, gender, class and ethnic identity also emerged in my conversation with Baaba, as discussed in the following section.

The interwoven process of gender, race and class status

Like Tsitsi, Baaba is a male immigrant healthcare assistant with racialized features. When he told me about his experience, he intentionally included the fact that, as an immigrant, he feels down-trodden.

Vyda: You said to me that your challenges are endless because you are an immigrant from Central Africa. But you also mentioned that there are immigrants from other countries who work as healthcare assistants. What is unique about your experience that makes it endless?

Baaba: Well, there are other immigrants in this job and I am sure we all have our challenges. But when you are coloured like me, you will see that there are more challenges. I used to work at the section for dementia people and I remember a weekend where it was three male healthcare assistants in my team: a Swedish, Danish and me. The interesting thing is that one of them was studying medicine and the other was a nursing student. I observed that the two of them were stuck together, and in a very silent way, I was made to feel that I did not belong.

Vyda: In what ways did you feel that you did not belong?

Baaba: I mean we were sitting together at the same place during break but they were directly involved with each other and talked about their studies and other things that I had no idea about...I was simply quiet and it is the kind of domination I felt...I felt that I was dominated because I was an immigrant of colour, and the fact that they were into higher studies made me feel more dominated because I knew deep within me I do not match up to them...We were all immigrant men but it is not the same. At least, today, I can talk about it. But I still have the same feeling...that feeling which tells me that as a man, I cannot match up with other men. This happened a long time ago and I am sure these Danish and Swedish guys have finished school and are working as a doctor and nurse...It is a masculine battle to achieve something higher in life... I do not know how to explain it to you...As a man, it is that feeling which makes you sit back and say that, 'Yes! I made it!'...I do not how to explain it. I am sure those two guys made it! Maybe if I had continued working in the field of engineering, by now I would be a manager or supervisor like my cousin in the US...Anyway, let's forget about it

and answer another question, I try not to think or talk too much about it because it does not help.

The above conversation with Baaba arose from a general question about challenges faced by the immigrant healthcare assistants. Baaba, however, related this challenge to his appearance or racialized image as a dark-skinned healthcare assistant in contrast with non-‘coloured’ immigrant healthcare assistants.

Interestingly, in a working environment with three male healthcare assistants, Baaba’s experience illustrates how race can become salient. In explaining how being an immigrant of colour worsened his feeling of being dominated, I see a process where gender, class and race intersect to shape his experience. Firstly, Baaba’s account highlighted that as an immigrant of colour, there was a racial difference between him and the Swedish and Danish immigrants who are not racialized in Norway. Secondly, when related to gender, Baaba drew attention to his ‘masculine’ competition, which made him feel that as a man, he is expected to have higher laurels in life. Knowing that he had not achieved this makes him feel a certain degree of subordination. Closely related to this is the additional category of class, through which Baaba felt that he does not match the educational level of his male colleagues. At the same time, he moved from a professional occupation in engineering to the level of an ‘informal’ job as a healthcare assistant. In an earlier conversation, Baaba had also told me about the low-status nature of his job.

Put together, I see why Baaba feels that he has ‘endless’ challenges. The interlocking of Baaba’s race, gender, class and low-status job have placed him in a position where these social categories worked to his disadvantage. This is what Crenshaw (1989) referred to as multiple layers of oppression that interact to shape the experiences of women of colour and black women. In particular, Crenshaw (*ibid*) asserted that the combined effect of gender, race and class status exacerbate the disadvantage of women of colour.

Conversely, critics of intersectionality argue that conceptualizations of intersectionality that describe women of colour to be disadvantaged could be misleading due to the fluid nature of social categories such as gender, class and race (Dhamoon, 2011; Yuval-Davis, 2006; West and Fenstermarker, 1995). For instance, it has been pointed out that the social divisions that lead to disadvantage are multiplicative and the intersection of social categories can appear in subtle ways that can make categories such as gender and race independent instead of mutually inclusive (Yuval-Davis, 2006)

Whereas these criticisms are valid in their own right, I argue that the social categories and differences that intersected to make Baaba feel disadvantaged were interrelated and occurred simultaneously such that, in practice, it is difficult to treat them as separate categories. In other words, a racialized and gendered difference, in addition to class status, constitute the interwoven process which shaped Baaba's experience of subordination in his work as a male care assistant.

In outlining this, my focus is not to claim that immigrants, and in this case immigrant men, face greater levels of discrimination. Rather, my aim is to explore what the evidence on intersectionality from my data tell us about how the intersection of social categories such as class status, gender and race influence labour market outcomes through conditions that produce systems of advantage and disadvantage. In general, the immigrant healthcare assistants asserted that elderly care assistant work is perceived to be performed by people who are 'unskilled' or with no formal education in care work.

Dido, a nurse in his home country, stated that the connotations of low levels of education and a lack of skills associated with healthcare assistant work in Norway is in sharp contrast to his skills as a nurse in his home country. As a result, his experience of humiliation is due to taking up an unskilled occupation even though he is a skilled care worker in the same professional field. By taking up the position of healthcare assistant in Norway, Dido changed his class status from a skilled nurse to the position of an 'unskilled' healthcare assistant. His feelings of humiliation simultaneously coincide with his discovery that getting approval for his nursing license takes more time and demands more requirements than he had originally thought. Contrary to his previously imagined image of Norway as a land of equal opportunity, Dido stated: 'Even before I came here, I heard that Norway is the best country to work—there is no discrimination and equal opportunity for everyone. Sometimes I wonder if this is really the case...or maybe my story is different because I am a foreigner'.

Seeberg (2012) has also identified the ubiquity of intersections between class, gender and race in shaping opportunities for immigrants. In her work on immigrant care workers and gender equality in Norway, she pointed out that '[T]he presence of such workers brings into view established and taken-for-granted inequality structures of gender and class, shaking the Norwegian egalitarian system at its moral foundations' (p. 182).

Similar to Dido, Amadu, for his part, had moved from a semi-skilled occupation as an auto mechanic to work as a care assistant in elderly care. In our conversation, Amadu told me that he found it extremely difficult to tell his family about his exact work in the nursing home.

This was because he dreaded the shame and comments that would come up, comparing his work with a feminine role. Most significantly, he was worried that his wife might ask ‘if there are no mechanical engineering jobs in Norway that need men’. For Amadu, the loss of his previous social status and comments that suggest that he is working in a ‘feminine’ job were not easy to accept. He therefore decided to tell his family that he got a temporary job as a cleaner in the nursing home. His justification was based on the anticipation that he would look for job as a mechanic/‘masculine’ sector when his Norwegian language improved. At the time of this study, Amadu felt disappointed in himself because he had not been able to find work outside elderly care. Besides the loss in Amadu’s class status, I observed that Amadu was more preoccupied with how his current role as a healthcare assistant was perceived through traditional gender roles in his home country. This speaks to the complicated nature of talking about class when immigrants have to relate to different national contexts where they hold different class positions. Significantly, the practicality of living transnational lives also complicates things for the social analyst, as it becomes difficult to be precise about which society to focus the analysis around and where the boundaries, if any, lie.

For Amadu, the identity and esteem attached to men doing heavy or technical/‘masculine’ work in his home country contrasts with his current ‘invisible’ position as a healthcare assistant, which is further associated with female roles. Speaking in what appears to be a frantic mood, Amadu said:

I am an African man. I need to work for my own money to take care of my family. It is a shame if I sit home and get the money from state support. It is like taking money from my mother to take care of my family. In my culture, this means I am no longer a man. That is not how we do it and you know what I mean... This is not the best but I still took this job and it helps me in another way.

This quote illustrates how Amadu positioned himself in various ways that show how gender was performed and made relevant in relation to his immigrant identity.

I see that the stereotyped image of taking money from his mother (a woman) is an image that goes against Amadu’s masculine image of a hardworking man and thus a moral person, according to the norms from his home country.

From this explanation, we can see that the image of not working or living on state support was also a gendered image. The process of identity construction in Amadu’s account involves a process where notions of gender merge with culture/ethnicity. Even though the categories of

gender and ethnicity/culture may appear to be independent, in Amadu's account, they constitute each other such that the representation of Amadu's culture shapes and constructs his identity, which in turn shapes his experience.

When this interview took place, there were media reports about an incident where immigrant youths were accused of causing trouble in some parts of Oslo. When Amadu told me about why he continued to work in elderly care, he did mention that he was aware of negative media reports that make immigrants appear as not wanting to work, as burdens on the welfare system and as scapegoats for all the issues in society. However, as he explained, to take money from the state takes away his cultural identity as a man. To be precise, 'It is like taking money from my mother to take care of my family'. Thus, alongside the preservation of his masculine identity, Amadu underlined how his immigrant status plays a part in reproducing assumptions associated with immigrants in the labour market. In effect, doing a woman's job helps Amadu assert himself as a moral person in both of the societies to which he relates.

In their work on gender and ethnic identities among low-paid migrant workers in London, Datta et al. (2006) told similar stories about how immigrants were perceived to be reliant on state benefits. In their discussion, they argued that contrary to such notions, a significant number of immigrants work and pay taxes that contribute to the welfare system. In their analysis, the immigrant workers rarely migrated from countries with functioning welfare systems and they believe in hard work. As a result, work was also epitomized through gendered meanings to elevate men masculinity. Also in Denmark, Carneiro et al. (2008) reported that having a job and income were a source of pride and feelings of self worth among immigrants.

Similarly in this study, most of the immigrant men felt that work was part of their social responsibility and this was further justified in terms of earning money to maintain a masculine image of a breadwinner. This resonates with studi

Beyond this, I get another understanding, which implies that elderly healthcare assistant work is seen as a threat to masculine identity when performed at the low-status or informal level. For instance, by 'denying' or finding it difficult to accept their low-status positions, both Dido and Amadu emphasized a sense of dignity to high status or skilled jobs. Thus, the intersection between gender, class and identity explains what elderly healthcare assistant jobs hold for the male immigrant healthcare assistants.

Interestingly, Pedro described how the motivation to earn a living due to the frustration of not getting his dream office job brought him into elderly care. Unlike his male colleagues, Pedro did not emphasize his background or loss of class status. He was initially worried about ‘a man bathing old ladies’ but this was something he learned to overcome with time. What concerned Pedro at the time of this study were his limited opportunities to access jobs outside long-term care. This was something he associated with the feminine connotations associated with elderly care work. According to him,

I tried to be smart by taking off the healthcare assistant position from my CV to apply for other jobs. I went for an interview in a warehouse as a forklift driver, and they asked what I currently do. At this stage, I could not lie because I knew they were going to check...I did not get the job. The excuse was that I did not have relevant background experience. But I know it is because they think healthcare assistant work is for females and if a man is doing it, it means he is not strong enough for bigger challenges...This work is full of ladies so the kind of vacancies they talk about are women’s jobs...You need connections to get into proper job. This is not easy and I am still waiting.

In the context of my conversation with Pedro, I think that ‘proper job’ here refers to work that he perceives to be male dominated. Pedro’s experience sheds light on some of the interesting dynamics between work in a female dominated sector and access to the labour market. Being a male healthcare assistant signalled a lack of skills or an ‘inability’ to transition to work in a warehouse, which Pedro asserts is typical for men. Like his other male counterparts, Pedro perceived it necessary to tell me about his competency in a way that reasserted his masculinity, defined his identity and helped him cope with the degradation associated with doing work that is traditionally feminized.

In studies from Netherlands (Haile and Siegmann, 2014) and the UK, (Datta et al., 2006; and Kofman and Parvati, 2006) it has been re-echoed that limited labour market opportunities compel immigrant men to take up jobs in sectors that have a gender bias towards female roles. To rephrase Kofman and Parvati (2006), there is no single definition of skills that can adequately encompass the different types of skills that immigrants take with them into the labour market. This leads to the next section which briefly touches on how participants’ experiences of gender identities impacts on the Norwegian elderly care.

Of systematic opportunities or systematic discrimination or both?

In recognition of the participants' experiences, I argue that any attempt at understanding the impact of gender on the Norwegian care sector must involve an appreciation of how specific categories of individuals are affected and the attendant challenges of the labour market. This merits special attention with specific reference to immigrant healthcare assistants.

Indeed, Seeberg (2012) pointed out that:

The presence of immigrant care workers has become a necessity to uphold a Norwegian gender regime where Norwegian women increasingly distance themselves from the lower status care work occupations. Immigrant nurses and other job seekers from immigrant background willing to take on the less attractive work are welcomed as cheap, often highly qualified care workers...In practice, this means that the continuation of the Norwegian gender equality project is based on the exploitation of others, clearly at odds with the egalitarian ideology underpinning the project (p. 181–182).

Six years on, the experiences of immigrant healthcare assistants in the present study provide stark examples of Seeberg's observation, above. Specifically, it is the interrelatedness of institutional decisions and how issues of class, gender, race and nationality are embedded in relationships to produce advantage and disadvantage that is of interest here. In situating my argument within policy directives, for instance, the key objective of Norway's Equality and Anti-Discrimination Act (LOV-2017-06-16-51) is to 'Promote equality and prevent discrimination. Equality means 'equal status, equal opportunities and equal rights....and the Act shall help to dismantle disabling barriers created by society and prevent new ones from being created'.

The Norwegian Integration Policy (Short version of Meld. St. 6, 2012–2013) also has a focus on the right for equal opportunities through participation and the utilization of individual resources to avoid dependence on state benefits. In spite of the policy agenda and legal document, evidence from this study indicates that subtle inequality exists in the labour market, particularly for non-Western immigrants.

What comes to mind here is Craig's (2007) discussion on different forms of discrimination, particularly systemic discrimination, which often involves informal activities, procedures, and cultures which are inbuilt into organizational structures and systems of society and are very difficult to identify. My understanding of Craig (ibid) is that the covert nature of

discrimination leads to a lack of consensus about its prevalence and the significance of discrimination on those affected. The difficulty in addressing systemic discrimination in any form is the fact that where it exists, it is likely to be hidden and where it is known, it is expressed as a failure on the part of individuals (Craig, 2007). When understood as formal practices, which are embedded in organizational structures that become part of the system, the complex ways in which the labour market deny individuals in unskilled occupations upward mobility reflects what Craig terms systemic discrimination. Consequently, instances where stereotypes or prejudices, derived from societal and employer's beliefs regarding certain competencies (e.g. 'natural' care giving), are unconsciously associated with immigrants without being clearly related to capacity can reveal covert discrimination.

In such a murky context, reference can be made to Gullestad's (2004) work on culture and race in Norway. Here, Gullestad (*ibid*) suggests reasons to be sceptical about sanguine views which render the Norwegian state/society colour-blind or neutral in inter- and intra-relationships. In principal, Gullestad (*ibid*) argues that the Norwegian state expresses disapproval of any form of discrimination and prides itself in the absence of overt discrimination. With its world-renowned position in influencing international peace negotiations, Gullestad (2004) stated, 'Norway is among those nations in the world that spends the most money per capita on development aid to the Third World. So, when minority people complain of local racism, the innocent national self-image and the associated collective memory are at stake' (Gullestad 2004, p. 182 citing Gullestad 2001b, 2002a). This, according to Gullestad (2004), can be interpreted as an attitude that conceals discrimination, thus leading to double standards.

From historical and covert perspectives, what emerges is the existence of discriminatory systemic practices and negative stereotypes which reinforce each other. When related to this study, experiences of the immigrant healthcare assistant partly reflect the impact of systemic discrimination, though the magnitude of this is open for debate. In effect, when discriminatory practices on the labour market are described or justified as individual problems instead of structural challenges, such discriminatory effects go unnoticed.

As argued by Craig (2007), systematic discrimination is difficult to prove, and I observed this in the present study due to the complexity of trying to determine whether this relates to the boundaries concerning job tasks or low status ascribed to unskilled occupations or if it is a boundary concerning gender, race and/or ethnicities. As shown above, policies, Acts and legislation on employment are proactive in Norway. However, what appears to be a drawback

to such policies, as pointed by Vike (2017), is when managers of institutions feel pressured to minimize the importance of systemic challenges through organizational rationalizations, which justify (for instance) workload issues or under-representation as individual frustrations.

In order to reach a deeper understanding of such practices of inequality, data from this study reveal that the ostensibly neutral requirements for work experience have unintended consequences of inequality for certain ethnic groups, such as the participants for this study. In spite of the 'privileged' class backgrounds, training and skills of participants in this study, the system/elderly care institutions see such backgrounds as inadequate, if not inferior or irrelevant. As a result, the immigrant healthcare assistants were particularly disadvantaged and faced class dislocation as they move from skilled and semi-skilled occupational backgrounds in their home country to becoming unskilled workers in Norway.

More so, as the labour market justifies increased opportunities based on national skills or qualification, the inability of the immigrant healthcare assistants to meet national employment requirements implies that employers adhere to this country-specific competency to maintain a hierarchy where immigrants occupy the lowest threshold. On the other side of the coin, since the state has a focus on a cost-effective healthcare sector, where elderly care has a major part, it can be argued that it is economically beneficial and politically strategic to maintain a category of workforce at the threshold of the labour market. From the accounts of participants, it emerges that in spite of regulations governing equality and non-discrimination, male immigrant healthcare assistants face challenges that appear at the intersection of race, class, gender and ethnicity. Analysing participants' gender identities also revealed other forms of challenges experienced by immigrant healthcare assistants in elderly care. In many ways, some of the challenges point to cultural dilemmas which will be explored in the next chapter.

Chapter 8: Cultural dilemmas in elderly care

In this chapter, I explore patterns in participants' narrations that further bolster group boundaries. When discussing the importance of roles and tasks as boundary-markers for status inequality in chapter 6, I mentioned that participants described experiences which point to tensions among occupational groups within elderly care. To recall Hughes (1971), the concept of occupational division of labour is expressed through boundaries within professions or occupations, and these revolve around mandate and license. My understanding of Hughes is that mandate is used to define what is proper conduct of others toward the matters concerned with their work and license consists of allowing and expecting some people to do the things which other people are not allowed or expected to do (ibid p. 287). In practical terms, the specific mandate and license of an occupational group reinforce occupational or group boundaries (Hughes 1971). Following this, I argue in this chapter that immigrant healthcare assistants clarified their experiences through cultural perspectives, some of which have the potential to reify existing boundaries and thus create distance among occupational groups. However, the distance created in such cases was more than the kinds of distancing occurring among occupational groups as reported in the literature; in other words, it was not necessarily occupational status or hierarchy that created the distance. Rather, I argue that this distance stemmed from a systemic lack of attention to the influence of cultural difference among people working in an unfamiliar context.

My data show that, as people from different geographical locations who work together in a common setting, the notion of culture as employed by the participants relate to two ideas. The first relates to stereotypical conceptions that support what appear to be positive ways of caring for the elderly. The second supports the context of individuals with multiple identities within an adult life, largely influenced by the societies in which they grew up. In using the Norwegian elderly care as a common point of convergence, cultural difference as described by the study participants can be understood as a relationship between a 'guest' and a 'host'. The specific circumstance of being non-Norwegian can be seen in how participants described themselves as 'guests' and thus, expressed a level of indifference to certain symbolic elements in their 'host' environment which they are either yet to be taught or yet to understand. The specific situation of either 'yet to be taught or yet to understand' is my concern here, as we will see below.

'She put the food on the table and told the old woman to get it by herself'

Implicit in this situation is the assumption that the 'guests' have been exposed to at least some of the symbolic elements of their 'host'. In order to shed more light on this social reality, I share the following excerpts of my conversation with Oplo.

Vyda: You mentioned earlier that the challenges in your work are not only because you are not authorized but it is also due to cultural tensions. In what ways do you experience this?

Oplo:...This client was in pain and if I remember, I think she had been admitted at the hospital and came home the day before. She was not talking with me so much and I could feel that she was maybe sad or not happy. I was working with this Norwegian and she was doing the room whilst I was giving her (the client) a bath and dressing her. I put the client in her chair and started cleaning the bathroom. My colleague made breakfast and the next thing I heard was, '12Emma, breakfast is ready' (Oplo said this with an authoritative voice). Can you believe that she actually left the food on the kitchen table and expected her to walk to get it herself? When I saw it, I said in my head, 'Oh my God! This woman is like the age of her grandmother and she cannot take the food to her?'...There are many differences in this work. I am not saying the Norwegians are not nice. But there are lot of things they do that we foreigners never do. There is no way I can make food for my grandmother and command her to go and get it herself. Emma is like a grandmother to me. I can never ask my grandmother to get up and get food by herself in the kitchen...It is the same way with Emma, I cannot ask her to do that. I feel like I do not have respect if I ask her to get food by herself...With the Norwegians, this is different. But I am not Norwegian and it is different for me as well (long pause). Sometimes you just have to listen to that inner feeling which tells you that something is not right. It is that kind of good feeling that tells me I am doing something for my own grandmother. I think that is the way it is. I cannot do that. Maybe it is just me.

In Oplo's narrative, we can easily recognize how cultural perceptions about caring can distance an immigrant healthcare assistant from a non-immigrant colleague. When Oplo told me about her difficulty in asking the elderly Norwegian to get up and walk to get food by

¹² Emma is the generic name for the elderly client in this discussion.

herself, she said it in a pleasant way. In her narrative, she emphasized that when she talked about her difficulty with making such a request from someone who is older than she is, it was a matter of a specific orientation rooted in her cultural identity and values. This is in contrast to the different cultural mindset that made it possible for her Norwegian colleague to 'command' an older person. Oplo knew that I am also an immigrant, thus it seemed to me that she hoped I could understand what she was talking about. The question, then, is, as someone with an immigrant background, what can I observe with the contrast that Oplo is referring to? In other words, how can I analyse her inclusion of cultural values and identity in a way that makes her experience meaningful?

First, I consider how Oplo talked about her identity and value in relation to how this influences her approach to the elderly client as positive. I also consider how she made meaning of her experience when this context changed in relation to her Norwegian colleague's approach. In Oplo's narration, she considered the elderly client to be in the same age group as her grandmother. From a cultural perspective, and in this case using Ghana as an example, grandparents or the elderly are the major sources of oral tradition and the custodians of family history, especially the untold/cherished 'secrets'. This implies that the elderly are generally held in high esteem and the dictates of traditional norm demand that the younger generation serve the older generation and through this process of interaction, it is believed that traditional knowledge is also passed on. As a result, it became evident that Oplo was shocked when her non-immigrant colleague asked 'grandma' to go and get food by herself. The latter was not deemed appropriate by Oplo, and this perception of being different from her non-immigrant colleague emerges through her declaration that 'There is no way I can make food for my grandmother and command her to go and get it herself'.

From Oplo's narrative, we also get an idea of how cultural misunderstandings created tensions. The elderly client was in pain, so Oplo thought that her colleague would have a certain approach towards an older person in pain that would thus inform her colleague's behaviour towards her client. Her colleague, however, had expected the frail elderly woman to get out of bed for her food. Thus, when Oplo said 'there are lot of things they do that we foreigners never do', I argue that she was clarifying her experience of this situation through her own cultural lens.

In addition to the influence of this cultural lens, upon critical reflection, I think that one aspect worth considering here is the issue of relationship. Returning to Oplo's account, she made use of the words 'my own grandmother' and expressed the desire to appear respectful, as opposed

to her colleague who she felt ‘commanded’ the elderly. In addition, Oplo found it important to listen to her ‘inner feeling’, which motivated her to treat her elderly clients with an extra level of care or concern, especially when they have health conditions. I wondered if this extra level of care and concern could have been enacted through Oplo’s gently helping the elderly client to get out of the bed, and supporting her to get the food on the kitchen table. However, such gentle, careful support and guidance would likely have taken more time than either serving ‘grandma’ her food in bed or leaving it for her in the kitchen—time that neither Oplo nor her Norwegian colleague had, given their work schedule. I never had the chance to explore this with Oplo further, but I wish I could have, as Oplo and I originate from different parts of Africa, and my own interpretation of this situation is informed by my upbringing in Ghana; Oplo’s own perspective would likely be different from both a Ghanaian and a Norwegian approach.

My argument here is based on my Ghanaian cultural knowledge of the relationship between an individual and the elderly, especially in times of ill health. Here, illness, depending on the age of the elderly, symbolizes proximity to death. In most cases, tradition demands that the living are at peace with the dead, and any form of disrupted relationship with the elderly is therefore believed to result in ‘bad luck’ for the younger person. The responsibility for promoting this peaceful relationship therefore lies with the younger person in the relationship, and this implies trying to avoid any form of discomfort or tension with the elderly. It is likely that Oplo weighed the consequences of the latter and preferred to take the food to the elderly person since she considered it to be discomfiting and even disrespectful to ‘command’ the elderly, especially as the latter could lead to a ‘disrupted’ relationship. Thus, according to my analysis, I think that Oplo felt obliged to avoid tensions, so that culturally perceptive factors came together to create a distance between Oplo and her non-immigrant colleague in a way that, to Oplo, makes the former appear more caring and respectful than the latter.

Thus far, in the experience of Oplo, I see an involvement of subjective worldviews in the way that the immigrant healthcare assistants feel they are different in their approach to elderly care. Furthermore, in this narration, I see that, this difference is made relevant in the way participants describe a sense of ‘unique’ attachment and admirable values, such as being respectful as immigrants during work with the elderly. For me, the next question is to further analyse how the stereotypical image of attachment and admirable values are made relevant through the process of enacting occupational boundaries in elderly care. I start this exploration through my conversation with the managers.

‘Without them, this sector will collapse’

In my interview with managers, the immigrant healthcare assistants were presented as the hinge on which the care sector hangs. I suggest that we consider the following description of immigrant healthcare assistants from Denise, a manager in one of the elderly care institutions:

‘These immigrants are the ones who hold the sector together and they are very respectful. Without them, I think that the elderly care will collapse’.

In this statement, Manager Denise reveals how the survival of elderly care within the healthcare sector rests on immigrant healthcare assistants. I argue however that such perceptions—however well-meaning—can create a difference based on ‘nationality’ or ‘group’ classifications by pointing out that healthcare assistants who have an immigrant background should continue to be in low-status positions in the Norwegian elderly care.

With regards to the description that immigrant healthcare assistants are ‘very respectful’, all the managers confirmed this notion. For a manager I have named Silje, the smiles and enthusiasm of the immigrant healthcare workers holds her spellbound:

I have been in this work for over 20 years, I have never seen a group of people who are always happy and filled with smiles, and eager to work at all times like these immigrants. I am not saying the other people don’t smile but there is something extra special about how the immigrants carry their smile even when the pressure is high and you think the roof is about to fall on you. Just last week, I was on the shift with one of them. She had to do an extra shift because one of the staff was sick. We had a very difficult patient so we were all exhausted. At least I was exhausted when I was leaving but I know that she did the bigger part of the work. She was on the early morning shift the following day and I was already thinking in my head that maybe she will not be at work. But when I came in, she was already there. She has done the coffee and greeted me with a big good morning and her usual big smile. And I was saying in my head...Oh my gosh! Just look at that...Loneliness is one of the problems we have here and it is always good to have people with such a big heart who make the life good and light for the old people...They have good attachment and understanding to the old people

Here, Silje talks about a key attribute of immigrant healthcare assistants—their warmth and their cheerfulness—which she says has a positive impact on the work environment, especially for the elderly people. I, too, had the impression that the immigrant healthcare assistants were

very outgoing and approached the elderly in a more cheerful manner and related to them with a warm-heartedness characteristic of a ‘mother–child relationship’. Most of the elderly Norwegians seemed to respond to this jovial approach and some of them even had pet names for the healthcare assistant (e.g. ‘my little friend’, ‘teddy bear’) and they shared jokes and laughter together. Comparatively, the few Norwegian care workers I came across were a bit more reserved: I do not point this out as a negative, but rather to suggest that—following Silje’s statement above—in an environment where loneliness is one of the major challenges, the outgoing manner of the immigrant healthcare assistants represents a positive attribute or resource which is needed in the sector. Such an advantage supports why some managers consider the immigrant healthcare assistants as a good human resource for elderly care.

However, I argue that from the perspective of Fraser’s politics of recognition, such differentiated views in terms of which ‘unskilled’ immigrant health care assistants are perceived to be more committed and nicer can also reveal subtle forms of inequality. I illustrate this argument with the following excerpt by another manager, this one named Elizabeth:

The relationship between the immigrants and elderly is very important. If you look at the immigrants in general, they have cultural values and behaviours which are admired by us the managers, their colleagues, and the old people. We get many comments that they are very polite, kind, friendly and respectful. Because of their culture, most of them find it easy to develop warm and personal relationships with the old people...I mean in a professional way...use of gestures such as shaking hands, a pat on the shoulders and in some instances, you see them hugging the patients. To have that respect and be treated with good attention is very good... Not only for the elderly but also for their leaders and other colleagues.

In this narrative, Elizabeth points out that what she regards as the immigrants’ cultural values are an asset in elderly care. This reiterates Silje’s sentiments (above), and findings about immigrant care workers in the labour market in countries such as Finland (Näre, 2013b), Canada (Bourgeault et al., 2010, 2009), the UK (Cangiano et al., 2009) and Ireland (Walsh and O’Shea, 2009). In general, conceptualizations of immigrant healthcare assistants as being politer and kinder were found to be a marked advantage within elderly care; and in many ways, this translates into conceptions in which immigrants become the ideal workforce (see also Näre, 2013b). As Denise stated above, the immigrant healthcare assistants are ‘... the ones who hold the sector together’.

I maintain that such perceptions, where immigrant healthcare assistants are seen as different than non-immigrant care assistants (in this context, Norwegians), can also reveal and/or emphasize the subordination of the immigrant healthcare assistants in the workplace. And essentially, by embracing such ‘attractive perspectives’, immigrant healthcare assistants themselves reinforce structural hierarchies or unequal positions in the care sector. In effect, existing perceptions of immigrants as a compliant and needed workforce can be understood as a manifestation of misrecognition and/or misdistribution, which, following Fraser (2014) can easily lead to exploitation. Similarly, such findings were highly notable in Finland where Näre (2013b) argued that, Finish employer’s misrecognition of immigrant care workers ‘reinforces the social subjugation of migrants in the work places’ (p.76); a situation which according to Näre (ibid) leads to exploitation of immigrant workers on the Finish labour market.

In analysing my data on cultural dilemmas, what emerged from my conversations with the managers was the need to manage diversity. The challenge was not necessarily presented as ‘exploitation’ or misdistribution. Rather, as stated by manager Linn,

‘It is good to have people from different nationalities on the job...You are exposed to different and new ways of finding answers to the situation. As a leader, this sometimes challenges me to think....But sometimes, it is also about how to manage the diversity’.

This excerpt illustrates how having a heterogeneous staff promotes creativity and thinking as multiple ideas are brought to bear on a specific problem.. However, Linn also emphasized that this cultural diversity needed to be managed—my observations about the ways in which this occurred form the focus of my next discussion in this chapter.

When different cultures meet: In relation to the elderly

I began this study with a question about the role and experiences of immigrant healthcare assistants in Norwegian elderly care. As mentioned in the preceeding section, the immigrant healthcare assistants were described as demonstrating cultural traits that were seen as highly important to both the elderly and the care sector. When described in such simple terms, it is perhaps easy to assume that the relationship between the immigrant healthcare assistants and the elderly were not fraught with challenges. However, I only needed a quick glance through my journal to remind me that marked cultural differences could be found in the reactions of the immigrant healthcare assistants to their elderly clients, in certain encounters. Here again, I argue that these reactions represent an important aspect of the critical theory of recognition, as

they stem from the lack of awareness of the influence of cultural difference among people working in an unfamiliar cultural context.

To illustrate this, I present the following accounts:

Account 1:

Breakfast was prepared without asking Willy (the elderly client) what he would like.

Willy did not want bread with chocolate spread and asked for something else.

Immigrant healthcare assistant put roast beef on the bread and decorated it with caviar.

Willy looked at the breakfast with a strange face and said in a very surprised voice:

'Det gar ikke' ('That won't do').

Participant looked at client with an expression of both frustration and surprise/shock and said: *'Hva gar ikke?'* ('What won't do?')

Willy: Caviar with roast beef.

Participant: But that is all you have in the fridge. It is ok. It tastes nice.

Willy: Looking more surprised, if not shocked. But was silent. No further words were exchanged.

Account 2:

Elderly client was frail and spoke with a shaky voice. Participant was in the bathroom and client was trying to get a message across. Participant couldn't hear her very well, and in an attempt to ask for client to speak up, participant spoke loudly in a manner which made the elderly client panic. I saw that the client shivered a bit at the loud voice. She did not say anything again and whatever she needed was not attended to.

Account 3:

Participant poured coffee into a big porcelain cup. When participant took the cup to the elderly client, she asked for the cup to be changed. Client was asked if there was something wrong with the cup and she was told that the cup was clean. She agreed that the cup was clean but she still thought it not appropriate for coffee. Perhaps surprised by this, the participant laughed out loud in a joking but mocking manner. Participant asked, 'Who says you cannot drink coffee in this? But you drink coffee in this always! I also drink coffee in this type of cup'. The elderly client, perhaps out of frustration,

accepted the coffee but said, 'It is wrong to drink coffee in this cup' (*'med det er feil å drikke kaffe i denne kopp'*). Participant was still laughing, though.

Account 4:

It was getting close to Christmas and every aspect of the apartment was in red and white. Participant needed help with some decorations, which were sitting in a box. The big Father Christmas was placed on the window and a female figure was placed under the Christmas tree. The elderly client said those two decorations must be placed together in the hallway in the living room and not on the window. She also wanted the white tablecloth to be on top of the red table and not the other way around, as the immigrant healthcare assistant had done.

Account 5:

On this occasion, the elderly client wanted ham on his bread yet again. I remember that he had made the same request some time ago. He was served with something else, however. The client was sure he had a grocery delivery the day before and that ham had been on the list. He asked if he had run out and the immigrant healthcare assistant said she would check. Feeling helpless in his seat, the client bowed his head low. I felt sad as I looked at him. I knew he had ham in the fridge. I wish I could help him but I felt obliged to 'look in the other direction'.

The above observations illustrate some of what I interpret as cultural disparities in my study. Spontaneous comments, laughter and expressions of shock and surprise on the part of both immigrant healthcare assistants and the elderly appeared to be key features of such encounters. As will be discussed in the following section, it emerged that some cultural codes of Norwegian society were difficult for the immigrant healthcare assistants to comprehend and their clients' ways of expressing these were even more difficult for the participants to understand. My focus for this discussion is not to pass judgement or address the causes of these disparities. Rather, my intention is to highlight the significance of these differences in my data analysis, to illustrate how the social category of being an immigrant healthcare assistant—when related to cultural injustice (i.e. institutionalized patterns of values)—can emphasize an image of 'difference' which has the potential of mirroring the interest of dominant groups in society, which can then be a basis for exclusion and status subordination. I now turn to a discussion of this in relation to ceremonies, food and views about what constitute a family.

Ceremonies—Why all these decorations?

My attention was drawn to challenges with the symbolic significance of Norwegian traditions when some of the immigrant healthcare assistants suggested difficulties in understanding how these traditions were carried out. During fieldwork, I observed that when participants complained about these traditions, the challenge was not about the tradition itself. Rather, it was about the lack of understanding about the precision of tasks surrounding the traditions, and a lack of knowledge about why certain procedures must be followed. Oplo, for instance, felt that there are too many celebrations or traditions on the Norwegian calendar and that these are accompanied by tasks which require that procedures for decorations be followed accordingly:

I do not mind putting up all the decorations and changing the flowers and candles from yellow to red and red to purple and purple to white and whatever. I am here to help them and I think this is part of my job. What I do not like is that at the change of every season, there is always a new thing and something has to be changed. You have to bring out this box with special decorations, put another one away, change this and change that. And sometimes after putting in all these efforts to help, I get the complaint that the white curtains must stand in between the red ones or that particular decorations must be placed by the window and not on the dining table...(using her fingers in a way that depicts the precision for doing this). And sometimes I just go like, ‘Huh, what is wrong with what I have done?’ (silent for a while)...It can be tiring. But what do I do? And what is the benefit of this anyway, when I have more diapers to change? (laughing sarcastically)

What is important here is how Oplo did not see or understand the relevance of why certain decorations must be placed ‘by the window and not on the dining table’. To illustrate this, she compared the need to change more diapers to the need to pay attention to the details surrounding certain traditions. In her example, Oplo seemed to imply that she does not understand the importance of paying attention to the procedures for such occasions, asking ‘And what is the benefit of this anyway?’ In this way, she displayed her lack of knowledge and understanding about a specific cultural phenomena, which is in line with my analysis in Chapter 5: that is, the ambivalence expressed by immigrant healthcare assistants during interactions with their elderly Norwegian clients should be understood as rooted in a lack of knowledge.

In Oplo's narrative, I wish to mention that sometimes the issue of a lack of knowledge was not put into words, but was expressed to me through non-verbal means such as deep breaths, facial expressions and body language. For instance, I sensed surprise and confusion in Oplo's statement when she went silent after saying 'Huh, what is wrong with what I have done?' In addition, there were other moments when she used her hand, particular her fingers, to describe the precise manner in which she is expected to put things in order for traditional occasions. Critically, I understand Oplo's use of gestures or non-verbal language as emphasising the lack of knowledge or cultural difference she was trying to explain.

Importantly, the challenge of cultural difference was not limited to the immigrant healthcare assistants. On the part of the managers, the issue of cultural difference was both delicate and sensitive, and they were not certain how to address it. However, it emerged from my data that while all the managers were explicit regarding the issue of cultural challenges, they ended up talking about them using simplistic or stereotyped notions of ethnic and cultural difference. I find it relevant to explore this through Fraser's concept of misrecognition (which was discussed in Chapter 3) as the views of the managers tended to be entirely different from how the immigrant healthcare assistants described their own challenges with cultural difference.

Managers' perceptions of cultural difference

The manager named Linn, for example, referred to 'some' immigrant healthcare assistants whom she considers to be reliable and hardworking, especially during holiday seasons, like Christmas, when nobody wants to work. However, she observed that some of the immigrant healthcare assistants appeared to be culturally distanced from the symbolic nature of certain traditional practices, which are important in the context of care for the elderly.

Sometimes you think that you have it all because we get people who are hardworking and dedicated to the demands of this job...Maybe you think that the issue with language is improving so one problem is somehow solved. But later, you realize that there are other things which must be addressed. And these things are very important because they have serious consequences to how we plan to deliver quality service to the elderly people. It is very important that the workers are good in the Norwegian culture...our patients are old and I can tell you that at this age, culture means a lot to them...It is difficult to know what to expect after employing people. It is important that we teach them about these cultural differences...But sometimes things just happen and this can be difficult for the older people and the leaders of the institution. There have

not been, like, big clashes because of cultural differences. I mean these people are very hardworking and productive.

For me, the above excerpt raises important concerns which I consider critical for understanding the politics of misrecognition. First to be noted is the perception of having good knowledge in Norwegian culture. This confirms studies that have shown that cultural knowledge can be both an effective tool for and an element of quality care outcomes in elderly care (Walsh and O'Shea, 2009). Here, I argue differently: that cultural knowledge, though significant in elderly care, can also be used as a means of misrecognition or reinforcing inequality. Secondly, this excerpt illustrates that the challenge of not having good knowledge of Norwegian culture can translate into subtle forms of ethnic boundaries or exclusive divides between immigrant workers and non-immigrant workers. I assess this through Linn's use of categories such as 'we', 'them' and 'people'. In this way, I understand the category of 'we' as non-immigrants and 'them' or 'people' as immigrant healthcare assistants. Thirdly, the need to have good knowledge of Norwegian culture is highlighted as a necessity with regards to caring for the elderly.

Finally, though Linn said the immigrant healthcare assistants are 'very hardworking and productive', she also told me that the issue of cultural differences demands serious attention due to the sensitive nature of discussions about cultural differences. Here, I pay particular attention to the sentiment that the immigrant healthcare assistants are 'very hardworking and productive', and understand it to mean that the requirement for having knowledge of Norwegian culture, though laudable, has nothing to do with efficiency (see also Näre, 2013b). In this way, I argue that the issue of cultural differences and the requisite that immigrant healthcare assistants must have good knowledge of Norwegian culture can function as forms of misrecognition or ethnic inequality, especially when used to describe the challenges of immigrant healthcare assistants. In other instances, the idea of cultural difference was expressed in terms of taboos. Using food as a point of departure, I include the following long excerpt from my interview with Linn to cast light on this.

Food: Does it really matter?

Linn highlighted her concern about cultural difference through the following experience:

I remember an incident that happened some time ago during Christmas. It always makes me sad when I remember it and I am already feeling sad, as I am about to say it

(she became quiet, looked down, took a deep breath and shook her head before continuing with the incident).

The expression of worry I got from Linn's reaction before she narrated her experience had made me extra attentive, as I got the impression that this was a very critical moment. She continued:

I was then working at a different place but the memory is always fresh. We were having a good time during Christmas and it was so nice to see how the old people were dressed in their best and excited with the music and performance of the people who came from outside to entertain them. I remember the joy on their faces as they sat around the big table we had decorated. They talked with each other and some of them were singing along with so much joy.

Then it was time for serving. The environment was splendid with the aroma of pork, which was the main delicacy for the day. I made an announcement for the old people to get ready for food and asked my team members to go to the kitchen for us to start serving. At this stage, the excitement was high and I followed up with my team into the kitchen. When I got there, the chef was ready with the food but it was still sitting there on the table. Then I asked my team members to just take it out for us—to start serving. But everyone was just standing there. I thought that maybe they did not hear because there was so much noise from the dining area. So I said it a bit louder that 'Guys, it's time to serve, let the party begin!'

But still, there was silence. I started getting worried and was wondering what was going on. So I said, 'What is the issue? Has something happened? Why is everyone standing and looking at me?' Then one of them said to me, 'But we cannot touch pork'. I was like 'What?! But we need to serve the food and these people are getting hungrier'. Then this person said that if that is the case, they would like to put on gloves before they can serve the food. And he really meant that they wanted to use those thick coloured gloves! At this stage, I started to panic. I am talking of about 40 or so older people waiting for food. For some of these elderly people, this could be their last Christmas and I think it was simply inappropriate and unacceptable to present food to them with the kind of gloves they wanted.

In this narrative, Linn raises important issues that point to group differences among immigrant healthcare assistants. As expanded in the following statement, this difference lay at the feet of

the immigrant healthcare assistants, who according to Linn, ‘save the situation but spoil the show’.

Linn: Four assistants with two nurses and myself were on duty on this day. I think one of the nurses had already left...Anyway, the remaining nurse was from a different country and did not have problems with serving the food. So I quickly mobilized the chef and his assistants and they helped me with the serving. At one point, the chef also had to leave because he was scheduled to close earlier. In the end, it was just three of us who served the food and you can imagine the stress. But at least we were able to ensure that this special food for the occasion was presented in a decent and appropriate manner to the elderly people.

Vyda: That sounds like a good job well done.

Linn: Wait a minute. I have not finished. After going through the hectic time of serving and clearing the table, it was time to serve the wine. And guess what, I got the same response: ‘We cannot touch wine’...Cultural misunderstandings can be problematic and we need to have a good understanding of how to teach people and to address this...I acknowledge the traditions of other people. I was not going to force them and I had to respect this, though it was very tough. It is only sad that I did not get enough people who were willing to respect the wishes of the old people on such a special occasion. But this was Christmas Eve and everyone wants to be with their family. For the Norwegians, this is a very important day on the calendar and most of the staff who also work on such days are those without 100 per cent contracts [full time contracts]. It is a good time for making extra money. These people stepped in to save the situation but they spoiled the show....

In this excerpt, although Linn acknowledged cultural differences, she points to several issues worth elaborating on. Firstly, she points to a difference within the category of staff between those with 100 per cent contracts and those without. I understand Linn’s point to illustrate that, in this context, it is likely to have more Norwegians or non-immigrant staff to be employed on a 100 per cent basis. Secondly, what emerges in this excerpt is a category of immigrant healthcare assistants who are committed to working on occasions when staff are needed yet rare. In this instance, I think that Linn also emphasized the stereotype or difference, in essence ‘othering’: whereby immigrant healthcare assistants are the workforce who sacrifice to work on days when the majority of staff (‘others’) are not willing to work. Finally, although Linn acknowledged that the helpful attitudes of the ‘unskilled’ immigrant

health care assistants (i.e. ‘saving the situation’) turned out to be challenging due to cultural difference (i.e. ‘spoiling the show’), it seems to me that she did not take any practical measures to support the workers she encountered. In this way, from a micro-level perspective, the issue of being different becomes an individual responsibility (cf. Näre, 2013b). At the macro-level however, Vike (2017) argues that, when State responsibility is perceived as an individual responsibility, the structural dilemma inherent in such individual responsibility puts pressure on service providing institutions to operate with capacity challenges. In the end, what emerges is an implicit form of misrecognition, which can operate as a form of discrimination.

In my interview with a manager named Silje, the picture differs slightly, as she perceived this implicit form of misrecognition as an urgent need for capacity development. Consistent with Linn’s experience, Silje observed that:

I do not think the plan is to change what other people think are important for their life. It is ok that individuals have different cultural values. But the most important thing is to find the harmony or create the balance between what is important for us and what is important for the job. Many of these old people did not grow up in the era of mobile phones and iPhones. They had a different way of life and it is important that we keep some of these things active and alive for them...I had a meeting with one foreigner who was mixing the coffee we have made with a little water because he thinks it is too strong and too hot. I mean I understand his explanation but when I got the complaint, I was like ‘Oh my God, how can you serve someone with coffee that is not warm enough? Norwegians enjoy the coffee when it is hot and fresh!’... It is true that these people are old but it does not mean they do not have good taste and will accept just anything. I do not know how long this has been going on. But the older person who complained looked frustrated and I had to talk to the staff immediately....

The good thing is that this staff member was quite new and the person who complained came to this home about a week ago so hopefully, this is not something that has gone on for too long (smiling). But I think this is an example of some of the cultural challenges that come up. Perhaps this staff does not come from a country where they drink a lot of coffee. We cannot just assume that they know. I have to teach him first by talking with him. If we do not start early, it would build up until it perhaps get a stage where it is more difficult to solve.

Here, I observed that on the one hand, Silje's experience is similar to Linn's, as both concern the ways in which cultural differences can be problematic in elderly care. In addition, these differences are seen as the result of having staff from diverse cultural backgrounds. And, as both managers pointed out, the cultural misunderstanding can be attributed to a 'simple' lack of knowledge. Silje puts this succinctly, when she says that, 'Perhaps this staff does not come from a country where they drink a lot of coffee. We cannot just assume that they know. I have to teach him first'.

And for Linn, cultural misunderstandings could be problematic and she felt there needed to be more understanding about how to teach people, to address these issues.

In other words, since the immigrant healthcare assistants likely have culturally-informed ways of doing things which are different in the context of Norwegian elderly care, it is equally critical to 'teach them'. In this way, I argue that the concerns of the managers establish the link between lack of knowledge and the responsibility to overcome or minimize this through training. A further impact of this lack of knowledge is represented in perceptions about family care for the elderly in Norwegian long-term care.

Different views on family care for the elderly.

As a prelude to this discussion, I cite this excerpt from a conversation I had with Amadu:

I have been in this work for very long. I still do not understand how the family members treat these old people. It surprises me a lot...In the part of the world where I come from, we do not treat our elderly this way. We stay by their bedside and see them regularly. It is our culture. We show them love and care for them by being there all times.

In the above, Amadu presented an image of what he means by showing love and care. By referring to his 'culture', Amadu rhetorically used his cultural understanding of how to show love and care to interpret how Norwegians treat their elderly. In addition, it is important to note that Amadu said 'I still do not understand'. From this, I understand that when Amadu expressed surprise at how non-immigrants treat their elderly people, it really is because he probably does not understand the context of how Norwegians show 'love' and 'care' to the elderly.

In my data, I observed that the immigrant healthcare assistants often used expressions such as ‘I do not understand’ and ‘I simply don’t get it’ to describe situations where they talk about marked differences. This how Baaba put it, for example:

I simply do not get it. I see these things as strange. It is very strange to me that I am here taking care of her mother but it felt as if I did not exist when she came to visit her. Come to think of it, these old people are here because they need some help...In my country, family members do this kind of work. It is the family members who bathe, clean the poo, feed, and do all the things that the old people cannot do by themselves. We value the direct support we give to our older people. Even if we do not live in the same city as them, we travel to see them as often as possible...My grandma died just before I came to Norway. She was sick for some time and we lived in different cities. My mother moved to stay with her and I was travelling almost every weekend to visit. I made sure I always visited with her favourite fruits and prepared her special corn meal. You need to see her excitement when she sees me and we always sat together to eat. My mother used to joke that my grandmother’s pain suddenly goes away whenever I visited. Some years ago, I thought my mother was exaggerating. After being in this job, I think that she was right...These are the things we value in my culture...It is not the same here. I know that things are different in Norway but I simply do not get it. If they value the life of their elderly people, maybe they will also value the people who help to keep this life going...Sometimes I feel so much pity for these old people. And I pity the family members who do not know how to value their parents and grandparents.

In explaining what pertains in his country or culture, Baaba mentioned practices that he claims are valued in supporting the elderly. These include bathing, feeding and frequent visits, even if they live in different cities. In addition, Baaba used the excitement experienced by his grandmother to illustrate the significance of these practices. In talking about his so-called cultural practice, Baaba admitted that things are different in Norway—yet, in his words, ‘I simply don’t get it’. In this way, Baaba made a connection between practices which are considered important for the elderly in his country and contrasted these to his experiences in Norwegian elderly care. On the one hand, this can be interpreted to mean that Baaba thinks that his cultural practice of support for the elderly is ‘superior’ than that in the Norwegian cultural context. On the other hand, by saying that he simply does not ‘get it’, I get the meaning that Baaba lacks knowledge about that practices that are considered supportive for

the elderly in Norway. As I mentioned above, when participants used expressions such as ‘I simply do not get it’, it was often used in relation to marked differences. I therefore suggest that Baaba’s explanation must also be understood in relation to his lack of cultural knowledge.

In the examples above, the immigrant healthcare assistants made statements that point to differences in perception about family care for the elderly. Both Amadu and Baaba used expressions such as ‘I do not understand’ and ‘I still don’t get it’ to describe differences in perception which were rooted in their cultural (mis)understanding. For instance, in telling me about his cultural values of support for the elderly, Baaba mentioned ‘if they value the life of their elderly people’... I think that perhaps Baaba said this to illustrate a difference between practices that family members attach to elderly care in his culture and his perceptions about the practices of the family members of the elderly at his workplace. Further on in his narrative, he explicitly said, ‘I still do not get it’, explicitly demonstrating what I am to trying argue here as a lack of specific cultural knowledge. This is to say that Baaba’s approach about elderly care is through his own frame of cultural understanding and not through the Norwegian context of how these practices are expressed or understood. However, this does not mean that Baaba does not acknowledge differences in cultural practices. As he said, ‘Things are different in Norway’. Yet, he still does not ‘get it’.

The question here is, how can the immigrant healthcare assistants obtain cultural knowledge about how things are viewed and done in Norway in the context of elderly care? Who has the responsibility to instil such knowledge? And what opportunities are in place for the immigrant healthcare assistants to fill these knowledge gaps that impact their experiences in Norwegian elderly care? I return to these questions in Chapter 10.

However, as mentioned in my methodology chapter, by chance, I had the opportunity to follow/observe Norwegian healthcare assistants. My experiences with them enabled me to use them as a comparative tool in my analysis of cultural difference, which is the focus of my next discussion.

Killing two birds with one stone: The privilege of different data

I felt privileged to be assigned to a Norwegian healthcare assistant I call Helena, because she was in the newspaper over the weekend with some good comments about how healthcare assistants enable thousands of the elderly to function in their daily life. I think I felt privileged even more because it was the first time I was going to work closely with a non-immigrant and in this case, a Norwegian. This was not the focus of my study, and only become possible

because the immigrant participant had called in sick (two consecutive times) and I think that the manager, not wanting me to go back home, asked if I would like to be with the Norwegian staff member and I said yes. What ensued is captured in the following.

Journal Notes:

On this occasion, I followed the Norwegian healthcare assistant to the house of an elderly Norwegian. I instantly recognized the house when we pulled up at the car park because I had been there on two occasions with the immigrant healthcare assistant. The key thing that made me remember this house was that the old woman had refused to take her shower on these occasions and that this had been discussed at the meeting. After the formality of going through the client's journal, giving her medicine and serving her with food, Helena told the client that she needed a shower. Her response was an energetic 'No!! I do not need it'.

Helena did not say anything. She went into the bathroom and started getting the shower ready. Helena started singing a song. I do not remember the song since I was not familiar with it. Without any effort, the elderly client responded to the song and started walking to the bathroom. Helena kept singing and I enjoyed the blending of voices as they heartily sang what seemed to be an old Norwegian song. Situations like these were not common in my observation. I was incredibly impressed by how the traditional song worked magic between the Norwegian healthcare assistant and the elderly woman.

Obviously, the encounter was a good one as the seemingly uncooperative old woman was convinced to shower without much effort on the part of the Norwegian healthcare assistant. By using a traditional song, the Norwegian healthcare assistant gained the attention of the elderly woman and the result was a harmonious atmosphere without the issue of emotional distance or tension that had characterized my previous visits to the same client with the immigrant healthcare assistant.

Another turning point in my observation of the Norwegian healthcare assistant is illustrated by the following notes on my encounter with an elderly client I have named Anders.

Anders is an active old man who welcomed all visitors by either talking about his knowledge in geography or sharing stories about Norwegian fairy tales. I must admit that I was mostly impressed by his talk about geography because he talks about the country where the healthcare assistants come from. And the first time I met him, he

gave a lecture about my country. The accuracy of his story increased my respect and admiration for him and I wondered if he was a professor in history or geography.

I remember that one of the immigrant healthcare assistants had cautioned me that Anders talks too much and some of the things he says are not correct. As a 'talkative' client, the behaviour of Anders was seen by some of the participants as 'unusual'. As Tabio once said to me, 'you need to focus on the work when in the room because he talks a lot and if you keep responding, you will never finish the work'.

Anders was seen as disturbing the flow of work by talking all the time about German wars, fairy tales and geography. But on the day I visited Anders with the Norwegian healthcare assistant, I observed that the environment was different. In the first place, Anders said that it had been a long time since he saw the Norwegian healthcare assistant and she said it is because she has other routes lately.

As usual, Anders started talking and asked if Helena remembers the story of the couple who had a son called Halvor? Helena responded yes and said something about this boy, which I do not remember. Actually, I had no clue what this story was about. As Helena was doing her work, Anders kept talking and she would occasionally say something or answer a question and they would both laugh. Anders kept saying, '*Du er flink, du husk det mest som meg*' ('You are intelligent, you remember a lot like me').

What was for me amazing about this encounter was the ability of the Norwegian healthcare assistant to fluctuate between two positions. On the one hand, she did not give me the impression that Anders was a nuisance. On the other, her ability to speak to the issue or story Anders was telling and the relaxed working environment pointed to how familiarity can be an advantage in elderly care. I analyse this familiarity as a representative of shared or common culture, which created feelings of understanding for each other. Compared to my previous encounters, here Anders was excited and encouraged to talk with pride about his old Norwegian fairy tales. Clearly, this behaviour, which was seen as nuisance and disruption by the immigrant healthcare assistant, had been handled with little or no stress by the Norwegian healthcare assistant.

A final observation in my encounter with the Norwegian healthcare assistant occurred in the home of an elderly client where we met another Norwegian care worker who had reported at the client's house earlier. This environment was different because it was two healthcare

workers (one *helsefagarbeider* and a *healthcare assistant*) attending to one person. The colleagues mostly talked between themselves, for example by asking the other person to get a bandage or towel, asking if the temperature was normal and asking if the support was firm from the other side when trying to lift the client up. When it was time for the client to be changed, the client requested that I should be asked to go out of the room. Behind the door, I wondered if she felt uncomfortable with me invading her privacy. Or maybe she just saw me as a stranger and not a care giver? In my idleness and curiosity, I decided to get busy by changing the garbage and cleaning the sink of dirty cups. This is something I sometimes do when I am with the immigrant participants.

There were two turning points for this visit. Firstly, when everything was done, the client was informed that the coffee machine had been switched on and she could have a cup when the coffee was ready. In addition, I was told that it was not my job to change the garbage and clean the kitchen sink. Apparently, the client has someone who does this once a week or so. Whilst driving to the next client, I asked the Norwegian care assistant why she did not take the coffee to the elderly woman in her room since she appeared quite ill. Her reply was that, if she does that, the client would stay in bed the whole day and not get up. She explained that walking is good exercise for the old woman and even if it takes half an hour to walk from the bedroom to the kitchen, it is good for her body.

When related to my analysis, I realized that the explanation of the Norwegian healthcare assistant represents a unique perspective worth discussing. This reminds me of how Daatland (1990, 1997) pointed out that Norwegians express attachment to each other by emphasizing values that require the individual to be independent in order to have healthy social relations with each other. From this perspective, I acquired a different lens through which to better understand the decisions of the Norwegian care workers.

Firstly, it is likely the case that the Norwegian care workers are influenced by an orientation and training in which they focus on the self-initiative of the elderly. Thus, by asking the elderly to get food or coffee from the kitchen themselves, it could be interpreted that they were demonstrating this emphasis on individual initiative in their care orientation. Moreover, as explained by the Norwegian healthcare assistant, asking the clients to retrieve their own food and drink is a form of body exercise, which was seen as healthy for the elderly.

Contrary to these views, the immigrant healthcare assistants perceived it as a lack of respect to ask the elderly to go and get things for themselves.

At the beginning of this chapter, I referred to Oplo's experience, in which she found it hard to believe that her Norwegian colleague would ask a frail elderly person to collect her breakfast from the kitchen by herself. The significant point of interest here is that such explanations, as offered by the immigrant healthcare assistants were illustrated with positive comments that imply that when compared to non-immigrants, the immigrant healthcare assistants were 'better care givers'. Subsequently, some of the managers used words such as 'respect', 'attachment' and 'good level of understanding', when talking about the relationships between the immigrant healthcare assistants and their elderly clients and colleagues. This is not to say that the immigrant healthcare assistants did not indeed demonstrate these attributes or qualities. Rather, as argued by Hughes (1971), there are ranges of indicators that deepen boundaries within an occupation. One of these are the meanings individuals and groups attach to their subjective experiences (ibid).

In this chapter, my analysis firstly substantiates what Hughes (1971) argued. The stereotypical images and alternating ambivalences represented in the accounts of the immigrant healthcare assistants illustrate notions that view the immigrants as one group within the occupational divide and the non-immigrants as another group.

In other instances, what emerges are ethnic and occupational boundaries. These ethnic and occupational boundaries are congruent, so that the 'semi-skilled' (*helsefagarbeider*) are mostly Norwegians and the 'unskilled' (*healthcare assistants*) are immigrants. In other settings, this emerges as a situation where staff with 100 per cent or permanent job contracts are mostly Norwegians while immigrants are mostly temporary workers. The relation between such occupational and ethnic boundaries, according to Hughes, reflects an emphasis if not the creation of boundaries in the workplace setting, and the result is an emphasis in hierarchical relations where the unskilled are mostly found at the bottom of the occupational ladder.

As demonstrated, cultural difference from the perspective of immigrant healthcare assistants and managers and from my own observations is problematic in the context of Norwegian elderly care. I however argue that in as much as it is important to acknowledge 'differences', significant to my discussion is how 'differences' risk amounting to a 'stunting of skills and capacities' (Fraser, 2014, p. 203). My position implies that perceptions of cultural incompetency, when related to the experiences of immigrant healthcare assistants in Norwegian elderly care, must be analysed in synergy with the politics of resource allocation or redistribution. By so doing, it is possible to understand the on-going dilemma of cultural difference in Norwegian elderly care as an effect of the politics of redistribution or social

inequality which serve to emphasize institutionalized misrecognition. The effect of the latter, as manifested through status subordination goes beyond the challenge of the individual immigrant healthcare assistant. Rather, as we will see in the following chapter, this permeates through interactions in which the issue of communication becomes significant.

Chapter 9: Communication is not just about words

'Listen to the patient, he is telling you the diagnosis'. Osler (1904)

Several decades ago, Osler (1904), realizing the importance of establishing good relationships between medical doctors and their clients, said to his students: 'Listen to the patient, he is telling you the diagnosis (Osler, 1904). My understanding of Osler's instructions here is that, by keeping the focus on the patient, it is easier to identify their needs and provide suitable solutions. Though participants in this study are not practitioners of medicine searching for a diagnosis, they, like Osler, also believe that by keeping the focus on their elderly clients, they are able to know their needs—and further, that they can understand each other.

At the start of this study, I assumed that the ability to speak Norwegian language would be a requirement to work in the elderly sector. After all, I had learned during my previous work as a journalist that language (both verbal and non-verbal) is a practical tool in any form of communication or interaction. Further, evidence from research points to the symbolic function of language as having an emotional meaning for the speaker, since it demonstrates a powerful sense of identity (Byram, 1992; Dahle and Seeberg, 2013; Degni et al., 2011). And finally, Schyve (2007), Kale and Syed (2010) and Wensing et al. (1998) have each drawn attention to the therapeutic benefit of language by observing that a culturally sensitive approach to communication is critical in the provision of healthcare. This, according to Wensing et al. (ibid), forms the basis of 'safe healthcare' (p. 361).

That being said, the potential challenges of language barriers in healthcare situations have also been emphasized. For instance, in separate studies conducted in Canada, the UK and Ireland, Bourgeault et al. (2010, 2009), Cangiano et al. (2009) and Walsh and O'Shea (2009) found that immigrant care workers had difficulty understanding the English spoken by the elderly people they provided services for. Coupled with the challenges of accents, colloquialism and dialects, the authors reported that (verbal) language barriers between immigrant healthcare assistants and their elderly clients created difficulties during care relations.

My assumptions about the relevance of Norwegian language in the context of this study were confirmed by some managers who told me that applicants who are considered for the position of healthcare assistant must have a certificate in Norwegian language proficiency of at least

level 3 (Norskrøver 3¹³). My impression was that this level of Norwegian language demonstrated a ‘high’ competency in spoken Norwegian. Most significantly, it appears that this dimension of language test requirement is in line with the Common European Framework of Reference for Languages (CEFR), which provides a global guideline on language proficiency as a tool for communication.

As far as the requirement for competency in Norwegian language was concerned, Silje emphasized the fact that,

In this place, we make sure that all the applicants are able to speak Norwegian. During interviews, we put a lot of effort into making sure that the applicants can speak good Norwegian. I mean basic Norwegian, since they need it to be able to communicate with the older people. And this is the only language we speak here.

As the above excerpt makes clear, the ability to communicate in Norwegian is stressed prior to employment as a healthcare assistant. Furthermore, in general, when managers spoke about issues with language barriers, these were described as a challenge for the healthcare assistants hired many years ago than for the newer employees.

...when I say ‘them’, I mean the healthcare assistants who have been working here for many years...Some time ago, it was just okay to say that you can speak Norwegian and you get the job. It is because we needed people and we also believed that people could learn and improve their Norwegian language after they have started work and interact more with the people who speak Norwegian. But maybe this was not working. I am not saying this was the case for everyone, because I do not have all the facts or some sort of evidence or report on this. But what I know is that, at the moment, the requirements are very strict and high. We demand proof of the Norwegian language test, which is at a high level to make sure that language does not create many challenges when taking care of the older people...The issue with language is not so big especially for the new workers because we now follow a higher procedure for language requirements (Manager Denise).

¹³ Norwegian exam B1-B2 is the official language test. Formerly known as Norskrøver 3, B1 is the level needed to function in daily life and B2 is necessary to take higher education (<https://norsksiden.wordpress.com/2017/09/08/norskprove-b1-b2/>).

From these accounts, one might hypothesize that challenges related to language barriers are not a primary issue in Norway's elderly care—or that if this was a challenge, it has been addressed through the sector's new, higher requirements for language proficiency. After all, the immigrant healthcare assistants I met during this study spoke Norwegian and the managers emphasized this in their conversations with me.

In this study, language barriers as a theme proved evasive, as there was no obvious gap between how the managers described the situation, my own observation and what emerged during interactions or conversations with the immigrant healthcare assistants. However, during analysis, by putting fragments of narratives together, I observed that there *was* a gap between how the managers explained the significance of language requirements as a 'solution' to language-barriers and my own observations regarding this. Thus in my analysis, I tried to detach my assumptions and observations and the perceptions of the managers from what these fragments of narratives were pointing at. Through this reflexive engagement with my data, it emerged that a corresponding, yet evasive, theme around language barriers was represented on two levels. The first relates to the practical or instrumental function of language during communication and the second points to language as a symbolic tool for communicating identity.

This is how we do it: To know what you mean is part of me

¹⁴During this study, I did not come across many situations where the issue of verbal language was prominent. My main observation, however, was that both the elderly and the immigrant healthcare assistants make use of various gestures or non-verbal approaches in their interaction. Examples of these include touch, smiles, hugs, winks, pats on the back, certain facial expressions, sign language and other special codes of communication. In many instances, I found it difficult to understand some of these modes of communication, yet the elderly clients and the healthcare assistants seemed to understand them and they played important roles in complementing verbal communication.

¹⁴ It is worth mentioning that this discussion is quite contextual since I did not observe the Norwegian healthcare assistants long enough to take note of this.

As evident in my notes, the immigrant healthcare assistants were warm and caring in their approach to their elderly clients. The intensity of this was even greater when it was an early morning shift and the clients were still in bed. A warm, jolly greeting of ‘Good morning!’ would be said, usually accompanied by a touch and multiple questions about their sleep, health, general feelings and sometimes jokes about dreams. The following field notes speak to this:

Account 1:

After a hearty greeting of good morning with all the possible questions you can think of, I was hoping that the elderly client, whom I have given the generic name Olav, would say something in return. But Olav was silent. Hands still clutched in each other, I only heard the word, ‘*jeg skjønner*’, meaning ‘I understand’.

The next thing I saw was that Baaba quickly ran into the toilet and came back with a big bowl. He held it close to Olav’s mouth and it came out: brrrrr.....big, yellowish vomit with a smell that took up the entire space of the room. He then rushed to flush it out.

Account 2:

Shasha: No, this is what you mean...I knew it.

Elderly woman: How did you know?

Shasha: To know what you mean is a part of me...(mild smile).

Elderly woman: You are intelligent

Shasha pats her client on the back and they end up hugging each other.

Account 3:

Dido: Are you okay?

Elderly woman: Yes.

Dido: Are you sure?

Elderly woman: Yes.

Dido: Look at me and smile if you are okay.

Elderly woman: (Turned face to a different direction and did not smile)

Dido: (Went closer, put hands around client and started whispering)

Elderly woman: (Started talking to Dido).

Dido: I will sort it. (Elderly woman started smiling; Mood changed to a brighter face)

I did not hear what was said, but I later came to know that she had been trying to call her son and daughter since last night and neither had responded. Dido ‘sorted it’ and one of them promised to call. During the second round of visits, the daughter had called and the elderly woman was happy and thankful to Dido. They would be visiting with her grandchild during the weekend and she was looking forward to it.

Account 4:

The elderly woman wanted something from her kitchen cabinet and said a word, which I tried to make note of but did not get. I think the healthcare assistant did not get it either because she kept going back and forth with different items.

Later, the elderly woman used her hand to symbolize something.

Then the healthcare assistant said, ‘Oh this one! How did you call it today?’

The elderly woman said the word.

Gigi: Is that a new name from the news yesterday?

Elderly woman: No, it was the name we had before television was introduced.

(Both laughing...)

Laughing together was a frequently observed characteristic during the interaction between the immigrant healthcare assistants and their elderly clients, depending on the participants’ schedule. I observed that sharing laughter was a way in which the older people expressed satisfaction about the care provided for them.

In instances where verbal communication was a challenge, I observed that the immigrant healthcare assistants seemed to have mastered the cues of non-verbal communication and that this has facilitated a positive relationship between them and their elderly clients. However, in other instances, the theme of language was reflected in the ways participants’ experience of relationships were informed by their low-skilled status and immigrant backgrounds.

‘Is there a Norwegian here? Do you speak Norwegian?’—The comments that strike our souls

Appearing frequently in the experiences of participants were spoken and unspoken remarks about their competency in the Norwegian language. As Pedro explained:

I have experienced very tough situations in this job. It is not just about the heavy lifting and other things that break your back. The problem is not so much with the old people. But it is the kind of attitudes and vibes you get from the other people. The problem is that you provide all these things which are important for their life. But people don't see it.

Vyda: What makes you think that people do not see your work?

Pedro ...It is the kind of attitude you get from people. I feel that sometimes people just look down on me because I am a healthcare assistant. I will try to paint a picture to help you understand me. It is like guests who come into a house and there is a maidservant or garden boy or cleaner or whatever...In the end, the most important person is not the maidservant or cleaner who worked hard to make sure that these guests have a clean house, healthy food and whatever. The focus is the person who controls the house because he is the most powerful and most important...Do you get me? I mean do you understand the scenario I am trying to present?

Vyda: I think I do. But please help me to understand this more by bringing it directly into elderly care. When you say people give you some kind of attitude, who are the people you are referring to?

Pedro: For example the nurses. They think that all that matters is the medicine...And the family members. When they show up, they think that the most important person is the nurse. So they ask, is there a nurse here I can talk to? Then I say in my head, '*Herre Gud!*' Just go, you will see them in the uniform! (Laughing). And some of them say it straight in your face: 'Is there a Norwegian here?' The moment they say this, it has two meanings. It is because they think you are not speaking good Norwegian...or as we say, you are no good as a 'foreigner' (using fingers to make a sign like inverted commas). Or it is because they do not see us as someone who is knowledgeable about the condition of their family members. I have heard this many times and we all know this. But they hear me speaking Norwegian! Even if it is not so clear to them! (Looking frustrated and placing his hand on his chest)

Vyda: How do you feel when you get such questions?

Pedro: I think it is rude. I think it is not nice. Because we all speak Norwegian...These are some of the things that break me apart. Because it is like no matter how hard you try, it hits on a rock. And like an egg...poof! It breaks!...And

they think the person who is Norwegian is the nurse and they have all the answers in the world about health...Let me tell you one secret. For the old people, what they need most is the company. The medicine and everything is important. But for some of them, their throats and bodies are so used to the medicines that they no longer feel the effect. The biggest disease is loneliness and isolation. It can kill you easily. We are the ones who keep them company. We are the ones who make sure that their last stage in life as old people is lived with happiness. We also make sure that they take part in the activities and motivate them to go on when they feel like giving up. This is what keeps them going and for me, this is what I see as the main duty of a healthcare assistant.

As shown in the above chat with Pedro, the healthcare assistants see themselves as providing a service that is looked down upon and not acknowledged because they are not seen as possessing the requisite knowledge. The fact that their position is not acknowledged is painful enough. And in such situations, Pedro pointed out that comments like ‘Is there a Norwegian here?’ hurt even more and ‘break him apart’.

I argue that Pedro’s narrative also suggests that there are divergent experiences in how the immigrant healthcare assistants encounter language, and that there are different ways in which they make sense of this. These differences seem to depend on various social contexts in which their low-skilled status and immigrant background appeared to be significant depending on whom they encountered. For instance, Pedro mentioned how the nurses and family members of the elderly make comments that, to him, hold different meanings. In order to explore these differences, I divide my analysis into two sections. The first section focuses on the experiences of participants with nurses and the second section will focus on participants’ experiences with the family members of their elderly clients.

‘I cannot roll my tongue and say it perfectly like a Norwegian but I speak it’

In analysing excerpts from my data, I observed that other participants also expressed many of Pedro’s perceptions and feelings, although different participants emphasized different things. For instance, I observed that the topic of language crept in during discussions on relations between the immigrant healthcare assistants and senior colleagues within the hierarchy of the elderly care institution. These were expressed in statements such as the following:

Shasha: But what is the issue here? (Seeming frustrated) What language am I speaking with you now? Is it Norwegian or what?...I cannot roll my tongue and say it perfectly like a Norwegian but I speak it. I do not get the problem. And the old people

understand me. I do not have many problems with them on that. If others do not understand me, I think it is their problem...

Vyda: But you said you cannot roll your tongue like Norwegians. Does it give you problems?

Vyda: Not with the old people. At least they have not said that to me.

Vyda: But is there anyone who has said that to you?

Sasha: No...Huh! Yes, actually this girl. Some time ago, a nurse from Eastern Europe said that my Norwegian is not good because she think an old person did not understand what I was saying when she was around.

Vyda: Okay. What happened?

Sasha: I asked her what she meant by that. And she said the old man kept saying, 'Huh? Huh? Huh?' ...So it means he did not understand me.

Vyda: Was that really the case?

Sasha: No. Some of these people are very old and do not hear properly so you need to keep repeating what you say and speak a bit loud. But I ignored that nurse. She does not know about these old people. And she thinks my Norwegian is bad. But she is not any better. She likes to make people feel bad just because she thinks you work under her...In this work, you have to listen more to the old people...That is more important.

In the above, in Shasha's statement—'I cannot roll my tongue and say it perfectly like a Norwegian'—rolling the tongue to say it perfectly here becomes a descriptive standard that indicates the ability to speak Norwegian well. Shasha, however, not only used this description as indicating fluency in Norwegian, but also as an image that connected fluency in Norwegian language to her occupational status. She explained that the nurse who made this comment 'thinks you work under her'. In other words, comments about Shasha's spoken Norwegian were not only about her poor linguistic skills but were also a kind of mutual process—between the nurse and Shasha—of relating her language ability to her occupational status as a low-skilled worker. This process of relating language to a low-skilled occupational status often marked the position through which the immigrant healthcare assistants interpreted their experiences in relation to comments on language.

To expand this further, I share the following example from my conversations with Oplo:

I was extremely stressed when I started working here. In the department I worked in before being transferred here, my manager was very different. She encouraged me to speak more Norwegian and she was nice and kind enough to correct my report when I had written something which had some mistakes in the sentence. But then I met this Eastern European nurse who made me feel like I do not belong here. And this had everything to do with her complaints that she doesn't understand anything I am saying. She was always saying, 'You have to speak Norwegian, what language are you speaking, you have to pronounce it this way so that I can understand'. Oh my God! I was so stressed working with her...I am not sure why she does that. It is so hard when you are treated like that. And there was nothing I could do because I was mostly working in the evening and she was like the leader or boss for these shifts. It was very difficult with her complaints. I remember she said to me that I need to call her any time the old people have difficulty understanding me...But surprisingly, the old people never gave me a signal that they do not understand me. I think we understand each other well. But it was like she was checking on me all the time...I got a kind of feeling that she was always looking over my shoulders. It is like she was just waiting for something to go wrong or she felt that I would do something wrong. I felt so uncomfortable and there was so much tension for me when I was working in her shift. It is as if I did not know how to do anything... I was very careful when I had to talk. It was difficult for me to know what to say, how to say and who to say it to. It was very stressful...and this nurse was special...And of course, I also know that this has something to do with the fact that she thinks she has more education as a nurse, she is the boss and knows everything. And who is Oplo? The healthcare assistant who is not educated like her....These are some of the indirect things people say to you through their actions. It gets right into you and it puts you in your position...They are above and you are below, finished!...It is extremely stressful.

From Oplo's narrative, I first get the understanding that in Oplo's interpretation, complaints about her spoken Norwegian do not necessarily mean that she cannot speak Norwegian. Here, even though Oplo was unsure why the Eastern European nurse complains about her spoken Norwegian, she did mention that, to her surprise, the elderly people do not seem to have challenges in understanding her. Most importantly, Oplo interprets such complaints to mean that she does not know how to do her work and, as she put it, 'I also know that this has something to do with the fact that she thinks she has more education as a nurse, she is the boss

and knows everything. And who is Oplo? The healthcare assistant who is not educated like her'. From this statement, I also understand Oplo as interpreting the nurse's complaints as an indirect way of entrenching her (the nurse's) status as a skilled and educated care worker. Therefore, in my analysis, I regard the comments made by the nurse as a statement linked to Oplo's own occupational status. In this way, Oplo's occupational status as a low-skilled healthcare assistant informs how she interprets the meaning of comments about her language competency.

Like Oplo, the experience of Shasha, also illustrated above, points to knowledge that the nurse's complaints about her competency in Norwegian were an attempt by the nurse to make Shasha feel inferior to her. And it is through interpretations such as these that I try to explore how language is made significant in the experiences of the immigrant healthcare assistants through interactions with their superiors in Norwegian elderly care.

'The silent killers'

In addition to comments from senior colleagues, participants also shared experiences about comments from family members of their elderly clients—in most cases, these feelings and perceptions were similar to those discussed earlier. Baaba, for example, experienced what he calls 'silent killers':

Baaba: I think that if someone says something funny about me or my country...like ...we lost in the world football finals, or we drink too much when happy, it is fine for me. I remember a weekend that I was with this old woman and she was having a good time. I had gone through the normal routine of bathing, changing and feeding her. I found an old dressy skirt with a shirt which she said she wanted to wear, so I dressed her in that. I really took my time to give her some nice make-up. You know, in this work, I have learnt to be a hairdresser and make-up artist as well (laughing). I know that old woman. I hardly see her getting visitors. She is often sad and looks worried. I like it when I can keep her company and do small things to make her feel good. She wanted to listen to music so I had even opened some music on my phone and had it on her table. On this day, one of her family members showed up. I was cleaning the bathroom and singing with her when this woman entered. She completely ignored me, as if I did not exist. Then she asked the old woman about her health, asked who dressed her up, and she said it was I. Then she came to the bathroom door and said '*hi*' in a snappy way. I replied back with '*hi*'. Then her first question was 'Do you speak

Norwegian?’ I said ‘yes’. Then she asked, ‘Is there a nurse around?’...When I was new in this job, I used to ask myself many questions when people ask if I speak Norwegian, since the language I speak with the them is of course Norwegian. Now, I know from experience that when I get such comments, it is because I obviously look different and have a different accent. But how does that affect the work I do? I take care of these people from my heart and it’s a bit sad when you get that from the family members (Taking a long pause and a deep breath). And I can tell you that she is not looking for any nurse. She wants a Norwegian to talk to. I know the tricks. I get such things a lot.

Vyda: But is it possible that maybe she needs some information from the nurse?

Baaba: If there is anyone who has information about her mother, it is I. She saw me with the mother and not the nurse...When such things happen, I start asking myself, what is wrong? Do I look like a criminal? Why can’t these people also talk to me? Some time ago, I tried to ignore such comments, because maybe my Norwegian was not too good...(laughing). But it was disturbing me so I asked some of the other foreigners about their experience and how to deal with it. Some of them said, ‘They are not supposed to tell you that!’ Others said, ‘It is like that and I should just bull sh*t it’. Others also said I have to be bold and talk back at them, that ‘I can speak Norwegian!’ I used all of these suggestions but it did not work very well. So now, when they ask if I speak Norwegian, I say ‘yes’, in a polite but annoying manner. And I try to speak some Norwegian back to them. But then when they ask if there is a Norwegian around, then you know that you have reached your limit. It has nothing to do with my Norwegian. She will not talk to me because her mind is made up. I am a foreigner and not good enough! Finished! This is like killing me softly, you know! It goes straight into you and kills you silently for the rest of the day. But what happens when they leave, the bell rings and the next moment, you are with their mother or father giving them support for the rest of the day. Is it not funny?

As I went through my notes on my encounter with Baaba, my attention was drawn to words and phrases I had scribbled, such as ‘expression of pains’, ‘very solemn tone that depicts sadness/sorrow?’, ‘fighting back tears’ and ‘sighing deeply’. It seems to me that Baaba mostly expressed sorrow or sadness when telling me about this aspect of his experience.

Encountering such comments was a big challenge for him in his work. In his narrative, Baaba pointed out that he experienced such comments because he is a foreigner. Moreover, he specifically attributed this to the fact that, as a foreigner from a non-European country, he had

racialized features related to his hair and skin colour that makes him look ‘different’—he feels that his experience is related to his racialized features. Inasmuch as Baaba found these experiences to be painful, it seems that having to cope with it was much more difficult. As he said, the unpleasant comments mostly come from the family members of the elderly people he provides care for. The irony rests on the fact that, as soon as their visit ends, he is the one who goes back to provide the daily comfort and care for these old people.

In an attempt to cope with the situation, other foreigners advised Baaba to ignore such comments. And still others have urged him to be bold and talk back, since such comments were unacceptable. These coping mechanisms or tips seem to encourage Baaba to, in essence, accept things as they are by ignoring the comments, or to stand up for himself to prove that he is capable. Unfortunately, neither of these strategies seems to have worked for Baaba. Perhaps this is what he referred to as the ‘silent killer’: an expression that captures the ambivalent situation in which most of the participants experienced their daily life as immigrant caregivers.

When Baaba used the word ‘silent’ he also implied that this was a kind of experience that is not talked about. Furthermore, I think that Baaba used the word ‘killer’ to capture the agonizing effect of working hard to help the elderly yet having his contribution seemingly disregarded, ‘as if [he does] not exist’. In Baaba’s experience, I get the impression that comments that make him feel inadequate obviously affect him in several ways, and I also get an idea of how participants in this study struggle with unpleasant comments, and how these become woven into their experiences and perceptions—as when Baaba further explained that the family member was not actually looking for a nurse: ‘She wants a Norwegian to talk to. I know the tricks. I get such things a lot’.

When following how language barriers, as a theme, emerged in the experiences of my participants, I was curious to understand *how* they attempted to resolve such challenges. I observed, however, that most participants had a focus on telling me *why* they encounter such challenges. Amadu had this to say:

Do you think they will give me the same respect they give to someone with white skin or blond hair? I think we have to be open here and say it as it is. We sometimes try to hide and dream that one day this will change. That is not the situation now. And it will continue to be like this until someone sees the value of our work and gives us the big push to be recognised. The rule to respect people in the workplace is general. But there are different people in the workplace, and the rule does not apply to people like me

and the cleaners. Look around and tell me. Who are the people doing the jobs like mine? And who are the people pushing the trolleys with injections and medicines? That is what they see and that is what they know...They even teach them in the schools...So even the small boy on the streets does not respect you because of the colour of your skin. They see you as someone who comes to Norway on the boat through the terrible sea to enjoy benefits. And sadly enough, the adults feel the same. It will not change.

The above narrative from Amadu followed his description of an encounter with some family members of one of his clients.

Amadu: I was full of smiles when I saw them because I had not seen any of his family members around since they brought him here. I quickly took off my gloves and tried to greet them by extending my hands. I don't know if they think my hands were dirty or what but I got that hand shake attitude¹⁵ which tells you that they don't want to touch you...(trying to demonstrate it with me). And they had a little boy who said openly that he will not greet me. But I understand him, he is just a kid. But do you know what?

Vyda: No. please tell me

Amadu: The questions I expected started coming. I do not remember everything. But I think the daughter said, 'Norwegian or English?' and I said, 'Norwegian but I can also speak English.' And a young man, who I believe is the spouse of the client's daughter, also asked, 'Are you the only one working with Kjetil¹⁶?', and the moment you hear that, you know what to expect.

Thus, for Amadu, it was not difficult for him to know that when asked if he was the only one working with Kjetil, it was implied that the family members expected someone 'more competent' to be around their father. But Amadu's story did not end there.

Amadu: Like a surprise, a nurse came to us to check on him. And suddenly, the atmosphere changed. They greeted her nicely, introduced themselves, and talked about

¹⁵ Attitude handshake as used here refers to situations when you try to shake someone as a form of greeting but the other person responds in a way which depicts that they don't want to shake you. For example just extending the fingers or withdrawing their hand quickly during the shake

¹⁶ Kjetil is the generic name of elderly client

how long they have travelled and that they are staying in a hotel or something like that. And they started asking questions about their father's condition. The nurse told them what she knows and when it got to a difficult question, she said she had to go and check on the report to tell them...I was laughing in my head. I already knew this. I was standing by him when it happened and I am the one who wrote that report.

Vyda: Do you think that maybe they found it easier to talk with the nurse because of her Norwegian?

Amadu: Huh? But I was speaking Norwegian with them. And that nurse is not Norwegian. I do not remember where she comes from but she is from Europe.

Vyda: So what do you do in such situations?

Amadu: It makes me sad. But it will never change. I cannot change how I look...Oh, maybe with plastic surgery...(laughing). It is just sad. (very long pause). I remember another thing—later when I went to Kjetil, he asked me if I am okay. I think that maybe he felt what happened and did not like it. I do not know. But he doesn't often ask me that question. And I saw that the words were not coming so I touched him and he also held my hand very hard. I told him I was fine. Inside me, I know I was not but I tried hard so that Kjetil can have a normal day. And for me, that is the (using tongue to make a clicking sound) most important thing, that I get along with my client and he is feeling okay. The family members just come and go. He is with me all the time.

When I asked Amadu about how he handled the language issue, I assumed that he was going to tell me about the practical measures he has taken to address it, for example taking Norwegian lessons. Instead, however, I noticed that his narrative was informed by his immigrant background. When he referred to his immigrant background, he rhetorically shifted the focus onto language, and placed an emphasis on how he is treated. Later, the focus changed again, to how he gets along with Kjetil, which is 'the most vital thing for him'. In analysing this, I observed that, like Amadu, the other participants appeared to have the same focus. For instance, in telling me about their experience being discriminated against with language being used as a 'scapegoat', both Shasha and Oplo, like Amadu, focused their attention on their elderly clients. In Shasha's words, 'the old people understand me', and in Oplo's, 'I think we understand each other well'. In other words, for the immigrant healthcare assistants, the ability to understand their elderly clients and vice versa were seen to be critical during interactions.

Other participants expressed similar concerns during focus group discussions:

Dido: It is about spending the little time with them and trying to fix the things to make them happy...We speak with them and they understand us and we also understand them...What is the fuss about?

Gigi: The most important people are the old people. And as long as I am able to make them happy, I am happy. The rest can say whatever they like about my Norwegian. I still try. It is not my language. I can never be perfect.

Tabitha: Before I started this job, the first question was ‘Do you speak Norwegian?’ and I said ‘Yes’...I believe my Norwegian was good enough to work with the old people and that is why the manager employed me. The other people around the job are also important...If the old people are fine, then I am fine. But if they have big problems to understand me, then maybe they can ask me to stop this job.

In these excerpts, Dido explained that the most important thing for the elderly clients is to spend time with them—and though language is obviously important in these interactions, *spoken* language is not necessarily a required component. For Gigi, the most important thing is her ability to make the old people happy. Likewise, Tabitha is happy as long as the elderly clients are fine with her level of spoken Norwegian. Thus, while language is seen as important, the ability for the clients and the healthcare assistants to understand one other—however this is accomplished—is presented as something that is more critical.

Returning to Dido’s experience, we can understand it as simultaneously introducing the importance of paying more attention to the clients via interactions where language is not necessarily the primary focus. While this challenges the ‘language’ paradigm which implies that high competency in spoken Norwegian is an essential component of care work, drawing on the experiences of the immigrant healthcare assistants, I add that instead of emphasizing the policy focus of language requirements, it might be equally useful to obtain knowledge that can contribute to policy understanding about the active or practical ways through which the elderly and their healthcare assistants are creating meaningful relationships in elderly care through non-verbal language. This I think calls for a reflection on the policy focus for language requirements and what happens when the policy formula breaks down, as is briefly discussed in the following.

When the policy formula breaks down

In the above analysis, I have provided examples that show that when the immigrant healthcare assistants talked about their experiences with language, they mostly related this to their unskilled status and non-European immigrant background, which was identifiable via their racialised features. Analysed in this way, the experiences of the immigrant healthcare assistants could be understood as suggesting that language barriers should not be emphasized as a significant challenge in Norwegian elderly care. Instead, a focus on positive relationships between the elderly and their carers was considered to be of greater significance.

Nevertheless, I suggest that these accounts should not be necessarily interpreted to mean that there were no challenges during interactions between the immigrant healthcare assistants and their elderly Norwegian clients. As pointed out in Chapter 8, cultural disparities emerged as a significant influence in the daily activities of immigrant healthcare assistants in Norwegian elderly care. Most significantly, my data show that in talking about language, the challenge with diverse cultures usually springs up. In such situations, Byram (1992) observed that language, both verbal and non-verbal, are not the only requirements needed to understand people of different national groups. What is equally significant, according to Byram (ibid), is awareness of ‘cultural meanings and values’ which are embedded in the specific language of a national group. The topic is discussed in the next section.

Language and culture: Two sides of the same coin?

From a political perspective, it has been argued that language is a significant tool for national identity and allegiance to the state (Byram, 1992), and from a therapeutic perspective, language and culture have been identified as essential ingredients to ‘safe care’ (Wensing et al., 1998, p. 361). To clarify this a bit further, I refer to my discussion at the beginning of this chapter regarding competency in spoken Norwegian as a prerequisite for working as a healthcare assistant in elderly care. In this discussion, it was pointed out that language can be recognized as a tool for national identity. For instance, when the development of the Norwegian language was set in motion, pioneers such as Knud Knudsen (1812–95) and Ivar Aasen (1818–96) used Norwegian language as a mark of identity and a means of distinction after Norway’s independence (Haugen, 1959). From this perspective, the Norwegian language became a national heritage, which incorporated the beliefs, values and shared meanings specific to Norwegian society (ibid). My understanding of Haugen (1959) is that aspects of

these beliefs and values are not easily translatable and might remain inexplicable to ‘outsiders’ unless they study the history and internalize the peculiarities (i.e. culture) of the language.

Evidence for this, according to Norwegian anthropologist Seeberg (2003), can be traced in how fundamental values that form society and national identity are incorporated and become particular as a means of socialization and communication between and beyond national borders. For me, the precise overlap between Haugen’s (1958) and Seeberg’s (2003) observations is that language embodies ways of thinking, acting and living which are enshrined in the culture of a social group. This point applies more generally to political discussions on the considerable role of Norwegian language for fuller integration. Combined with its therapeutic effect as the ‘basis for safe care’ (Wensing et al, 1998, p. 361), it makes sense to argue that requirements for Norwegian proficiency are of both symbolic and practical benefit in elderly care. However, data from this study show that this simple formula seems to break down as the immigrant healthcare assistants have ‘learnt’ to speak Norwegian language, yet they have difficulties in understanding the connotations or perceiving the symbolic ways of thinking of the culture associated with the language. It is the awareness of the relationship between Norwegian language and Norwegian culture which suggests that, for the immigrant healthcare assistants, work in elderly care involves more than the mere acquisition of competency in Norwegian language.

The inclusion of social studies as a fulfilment of language acquisition by the state is indeed essential. In addition, one of the priority areas of the Policy on National Strategy for skills 2017–2021, is to strengthen basic skills in Norwegian as a major labour market requirement.

My concern is what appears to be the simplistic and purely instrumental terms on which the language requirement policies are designed and implemented, without what seems to be a lack of attention to the identity of the learners and their ability to grasp the embedded historical values and meanings.

In practice, all the immigrant healthcare assistants in the present study learnt Norwegian as a third, fourth, or fifth language. Though they seem quite happy and perhaps proud to be communicating in it, the cultural reality warns of the complexity of the situation in elderly care. In the case of the immigrant healthcare assistants, the fact that they attended courses in Norwegian language and society does not necessarily mean that they are self-sufficient in shared values and meanings of Norwegian ‘traditions’ and the significance of these values to their elderly clients who likely grew up in this society. Thus, the extent to which immigrants

are expected and encouraged to use Norwegian seems to emphasize its practical function, without due attention to the symbolic function of language as a tool for conveying delicate emotional and cultural meanings to the elderly, which in turn can affect the quality of services offered. Indeed, the potential to grasp or internalize a language and its culture are far more complex than the national requirements set in a pedagogical or training framework. Moreover, to avoid the error of speculation on what can appear as a debate on cultural immersion, I reiterate that the challenges of the immigrant healthcare assistants draws attention to a national commitment on opportunities for continuity in learning. The essence of this resides in an institutional and policy framework, which takes the issue of training to be vital for the elderly care assistant workforce.

From this standpoint, it is perhaps possible for immigrant healthcare assistants who are ‘outsiders’ to Norwegian society to reflect on how the relationship between language and culture are essential and enacted in the environment where their daily activities take place. Most significantly, this opportunity for continuity in learning and reflection on work practice would make policy makers discover that the investment in training which ends after a couple of weeks is not necessarily going in the intended directions.

To conclude this chapter with an insider’s perspective, this quote from Zuzu centres on the specificity of this challenge, and relates it to a systematic solution:

Go and tell them that we need help. In future, some of them will be at the nursing homes or need help in their homes...It will still be immigrants who are going to do this job.

These kinds of sentiments expressed by the participants in my study reflect the urgent need for rapid attention to elderly care. It is evident from this perspective that to talk about Norwegian elderly care without national or policy attention to the practical challenges in the field of elderly care raises implicit political and perhaps ethical questions about the state’s motives in providing for its elderly citizens. This leads to my next chapter on critical aspects of policy initiatives in the context of my study on immigrant healthcare assistants in Norwegian elderly care.

Chapter 10: The desire for recognition and training

'Professional competence is seen as a luxury because, after all, care for the elderly is seen as the natural capacity of any woman'. (Vike, 2017, p. 141)

In talking about occupations and work (Chapter 4), I mentioned that a substantial amount of a human's lifetime is spent on work or work-related activities. It follows then that it should be of significant interest both in a Public health perspective or labour market policy perspective to have an understanding of how work influences its practitioners—and further, that the latter is of the utmost necessity due to the high investment by the Norwegian welfare state in preparing unemployed individuals and groups for the labour market.

Norwegian labour policy initiatives are of particular significance to the development of the care assistant workforce. In Norway, the Labour and Welfare Administration (NAV), implemented a state framework designed to meet the employment needs of the unemployed. NAV was established by the Labour and Welfare Act of 2006, and the state has considerable influence in determining the budget of NAV and how this budget can be used to assist the labour market needs of the population. For instance, in 2017, the Norwegian State invested over 400 billion kroner (1/3rd of their total budget) in NAV (NAV Facts and Figures).

Out of this budget, over 34 billion kroner were allocated to work assessment allowances and an additional 9 billion kroner was invested in labour market schemes (ibid p. 8).

Furthermore, the need to 'give priority to measures aimed at assisting those with weak qualifications in the labour market' was emphasized in a government white paper on work, welfare and inclusion (Report to the Storting No. 9, 2006–2007). Relevant to my discussion is the following observation from this white paper:

Securing and developing our welfare society is challenging...The ageing of the population will lead to fewer persons of working age.... Significant portions of the welfare state's expenses are related to...the fact that too many people are excluded from working life and the society in general. To protect and develop the work abilities of individuals, work must be carried out under satisfactory conditions...and with opportunities for self-development, learning and social participation (ibid, p. 3-4).

Given the gloomy projection regarding the future workforce and the need for work to be carried out under satisfactory conditions through development and learning, the ambition of

the State is to facilitate a sustainable workforce. In adhering to this, it appears that work inclusion policies such as Active Labour Market Programs have focused more on entry-level training for the care assistants and paid little attention to the necessity for skill development beyond the in-house service training at the commencement of work (*opplæring*). I find this issue to be very significant because it gets to the heart of participants' experiences. Here, I take readers back to Kailla's wish to be self-sufficient in making decisions for her elderly clients, which was discussed in Chapter 6. In this discussion, I showed how the nurses perceived Kailla's unskilled position as something that could jeopardize the safety of the elderly clients. Following this logic, therefore, Kailla was not allowed to engage in making independent (even if responsible) decisions. Kailla, however, believed that she was indirectly involved in making such decisions on a daily basis. Thus, with some 'formal' training, she would be able to expand her individual capacity by making autonomous decisions, which would provide essential rewards to her elderly client and herself.

The flexibility of labour policies and priority measures aimed at assisting people like Kailla have facilitated her entry into the care assistant workforce. As noted earlier in Chapter 1, the care assistant workforce is perceived to be occupied by individuals without standardized Norwegian healthcare qualification or training. With a huge national investment in preparing the unemployed for the labour market and with a focus on the self-development and learning needs of its workforce, it makes sense to argue that the state has a focused directive to prepare individuals for the labour market. Thus, in a culture where training and self-development are valued, it makes further sense that there would be a keen interest in how the training programmes for care assistants meet the quality of standards set by the state's healthcare sector, by paying closer attention to the necessity of developing competencies.

Closely related to the value placed on self-development and training programmes is the degree to which the state is willing to modify regulations on skill development following in-house training. Even though Kailla, for example, had received in-house training before the onset of her employment, her account confirms that skill development remains a major challenge for the care assistant workforce. As pointed out earlier, the welfare state has a responsibility for overseeing the training and developmental needs of its human resources in the labour market. Thus, looking at it from the bigger picture, it becomes clear that beyond the ability to do the most important aspects of her work in elderly care, Kailla was also thinking about the need for the development of her competencies, and the importance or prestige attached to being a professional or, as Kailla said, having 'technical skills'. An important

question for Kailla might therefore be, ‘How can I use added benefits from training to improve and expand my services in elderly care?’

When Kailla talked about her work as a healthcare assistant in elderly care, she also referred to her inability to meet requirements for making autonomous decisions, based on specific qualifications. The lack of these qualifications implies that, though Kailla is working, she is shunted into a position that makes it harder for her to be more responsible and autonomous. In this way, when participants talked about their role in elderly care, they also refer to the necessity for skill development: Their perception here is that the care healthassistant position is ‘unskilled’, and that the healthcare assistant workforce lacks the capacity to make professional decisions regarding their elderly clients.

Subsequently, by fusing the descriptions of participants with my observations and interpretation of situations, and as expounded by policy directives, I maintain that it is possible to understand the degree to which the state is willing to pay attention to how regulations and policies (e.g. training programmes) are able to meet quality standards set by the healthcare sector. Most significantly, participants’ experiences make it possible for us to understand how the emphasis placed on skill development and the lack of this significant resource can be a barrier to the provision of quality elderly care from those working in closest proximity to the elderly.

Policy expectation

As has been illustrated in previous chapters, for the immigrant healthcare assistants in my study, their problems did not end once they beat the odds and found a job: Stereotypical perceptions of how immigrants provide care and differences in cultural conceptions shaped their experiences. In Chapter 2, I mentioned that historically, the demand for immigrant labour is activated through state-operated systems of labour recruitment. In practice, this expectation is expressed through policy initiatives and other forms of regulations aimed at supporting newcomers to become better acquainted with Norwegian society. I therefore argue that policies are one of the most important influences on the decision to become a care assistant in elderly care—and remain in this occupation. In order to get a clearer picture, I turn now to a brief exploration of relevant policy and legislation in Norway. The Introduction Act of 2003 for example, regulates schemes aimed at strengthening chances for newly arrived immigrants with refugee backgrounds to participate in society through work opportunities (Thorud, et al., 2014). The schemes include labour related training as well as training in

Norwegian language and social studies. Significant to this discussion is also the Job Opportunity Scheme established in 2013, the aim of which is to ‘increase the employment rate among immigrants not participating in the labour market, who need basic skills and who are not covered by other schemes’ (Thorud et al., *ibid*, p. 46).

From a socio-cultural perspective, I interpret the above to mean that, it is expected that immigrants have a fair knowledge of Norwegian culture and society prior to employment. The policy expectation appears to be that participants can be employed after the basic training because applicants are then largely acquainted with the knowledge of Norwegian society/work culture.

In contrast to this, I argue that my observations of situations in which participants lacked fundamental cultural knowledge—such that caviar is served with roast beef and Christmas decorating is not done in accordance with tradition—are significant. In other words, in the present study, these kinds of cultural dilemmas among the immigrant care assistants draw attention to the active distinction between policy expectation and policy practice. In this case, the Norwegian social anthropologist Gullestad (2006) suggests that it is essential to explore the dilemmas of cultural differences among immigrants from an institutional perspective instead of focusing solely on the dichotomy that creates a boundary between nationals and non-nationals. Principally, Gullestad (*ibid*) draws attention to the challenges of a new culture, in a way that suggests that challenges of immigrants are deeply entrenched in political boundaries that make newcomers feel out of place.

I therefore argue that, irrespective of the legislative claims made by the state in the ‘public’ arena, the care assistants—in the ‘private’ confines of their elderly clients’ rooms and homes—are engaged in activities that require more than an introductory programme on social studies and language if they are to be fully acquainted with the cultural context of their work. Following this argument is the expectation to reach quality norms that are explicitly stated in the sector. By exposing such concerns, my interest is not to dwell on the dilemmas of the immigrant healthcare assistants, the plight of the elderly or the challenges in elderly care. Rather, I am concerned about the inertia of policy prescriptions and the cumbersome process of change. Given that there are several studies and propositions which correspond to this observation (Christensen and Guldvik 2014; Gullestad, 2006; Seeberg, 2012; Vike, 2017), I argue that these issues are not due merely to a lack of awareness or recommendations. Each of these authors—and others—have unequivocally questioned the inertia of policies and legislation in the delivery of elderly care in Norway. And, as demonstrated by the present

study, the challenges still persist, which makes me question why so ‘little’ seems to be being done. As the following example illustrates, there is a need for more knowledge-based policies in this context.

What is more important? To work or sit at home?

In discussing Baaba’s experience in Chapter 6, I mentioned that I would return to Baaba’s statement: ‘When the conditions are not good and there is no respect for the work, I sometimes wonder if it is good to work or better to stay at home and keep searching’.

My interest in highlighting this statement stems from political debates and research evidence about high levels of unemployment among the immigrant population and efforts by the state to keep this population in the labour market (Bratsberg, Raaum, and Røed, 2016; Thorud, 2014).

Prior to the above, Baaba had told me:

It was not easy for me to get a job and I am grateful that I can work here... I think that they have to treat us nicely. When I say nicely, I mean in how they give the contracts, training positions, and other benefits. How can people survive when they have a 20% work contract?...There are people out there who do not want to work. It is true that some of them are lazy. But I can tell you that it is not only about being lazy. It is also about what happens when the people like us are working and doing this type of job. This is very important...

On the one hand, Baaba seemed to say that it is important to have detailed knowledge about what is happening in the employment practices or working world of the elderly care workforce: When Baaba said ‘people like us’, I think he means ‘immigrants’ and when he said ‘doing this type of job’, I think he means low-status jobs. On the other hand, Baaba’s experience shows that there is a likelihood that people will choose to stay home instead of work, as a result of unfavourable employment practices. I get this meaning from Baaba’s statement, ‘When I say nicely, I mean in how they give the contracts, training positions, and other benefits. How can people survive when they have work for 20%?’

It was not only Baaba who drew attention to employment practices. Appearing to feel frustrated and drained, Kailla told me, ‘The work is heavy but what do you do?...By working here, I have made friends with many people from my country. The good thing is that we find

ourselves in the same boat and we encourage each other. But most of the time, we have to work, work and work. But our bodies need to rest, rest and rest (laughing).

And as Tabio explained it, ‘At least I am happy I have a job. It is better than begging like those people on the street... Things could be better’. This is reminiscent of Amadu’s words from Chapter 7: ‘I am an African man. I need to work for my own money to take care of my family. It is a shame if I sit home and get the money from state support... This is not the best but I still take this job and it helps me in another way’.

In the above excerpts, we have Kailla stating that through her work, she has been able to establish a network with other colleagues from her home country; Tabio suggesting that her employment in elderly care means that at least she does not have to beg for money on the streets; and Amadu explaining that at least he is able to enhance his masculinity by making his own money rather than receiving state support.

In spite of these kinds of positive ‘spins’, however, I observed a common thread that appears to unite the accounts of the participants—for example, when Kailla draws attention to the contested nature of her work by saying her friends at work are in the same boat as her and they ‘try to encourage each other’; when Tabio says, ‘things could be better’; and when Baaba says, ‘they have to treat us nicely’. These phrases together suggest that in spite of the healthcare assistants’ emphasis on the positive effects of having a job, there may be a cumulative consequence of having certain jobs, which requires further critical exploration. Pedro’s experience speaks to this:

I was saying yes to everyone including the cleaner...(laughing). And anytime there is a need for extra work on the shift, it is natural that they are asking people like me who do not have a 100% contract. It is like everybody knows your situation... You need extra hours to get a good pay check. How can you say no?

In describing a similar trend, Tsisti reflected on what he described as doing ‘double shifts’ to survive:

Tsitsi: This work is stressful. The stress is not only because it is heavy. But is also because you are always thinking of how you can get extra shifts to pay the bills. This means that you are sometimes doing double shifts.

Vyda: What are double shifts?

Tsitsi: Like you finish work at 15:00 and someone is sick so the boss asks if someone wants to work and you just have to say yes. That is how it is it. You do not have many choices. Either accept it and you can have the money or say no and your bills are waiting.

And for participant Gigi, it was about her inability to say no.

Gigi: sometimes I am tired, but I can't say no.

When analysing these excerpts, it became clear to me that Pedro, Tsisti and Gigi's narratives each draw attention to the significant effects of job-related stress and its impact on both the employees and the quality of care outcomes. There have been several studies indicating that employees with temporary working statuses or conditions are more likely to experience job-related stress (De Cuyper et al, 2009; Ferrie, 2001; László et al., 2010). Further, job insecurity due to lack of a permanent contract has been generally identified as contributing negatively to the health and well-being of employees (Silla et al., 2009; Vander et al., 2012).

In addition, a number of studies and reports have also identified the impact of staff shortages on quality of care outputs. For instance, in a study on the relationship between nurse staffing and quality of nursing care in the US, Sochalski et al., (2008) reported that workload has a significant effect on quality of care outcomes for patients: In situations where there was a good ratio of employees to patients, tasks were performed as planned and this had a significant outcome on the quality of care received by patients and vice versa (ibid).

Similarly, in the UK, reports such as the Care Quality Commission (2012) pointed out that staff shortages and workload pressures led to poor standards of care for the elderly. With specific reference to immigrants care workers, Cangiano and Shutes (2010) found that the challenges with staff shortages for elderly care and issues of workload pressures made immigrant healthcare assistants more task-oriented. In the end, essential elements of quality care for the elderly, such as paying attention to their needs through interactions and talking, were not given much consideration. Although quality cannot be reduced to quantity—i.e. more hands does not necessarily mean better care—there is a causal link between the two. That is to say that not enough hands leads to poorer quality care.

In Chapter 5, I discussed how, during interactions with the elderly across private/public boundaries, the immigrant healthcare assistants displayed uncertainty that could be interpreted as a lack of cultural knowledge. In such environments, I observed that pressure from participants' work load translated into situations where certain concerns of the elderly were

either misunderstood or not given significant attention. Consequently, by looking at how workload pressures affects quality standards of care outcomes for the elderly (Care Quality Commission 2012; Cangiano and Shutes, 2010), it could be argued that the stress associated with not having good contracts could be an important indicator as to why the immigrant healthcare assistants may not give adequate attention to certain aspects of their clients' personal needs.

In saying this, it is worth mentioning that, in this study, the focus was not to measure such correlations or relationships between job contracts and their impact on quality of care or the well-being of the employees. Moreover, it was not established that the immigrant healthcare assistants provided services below the required care standards. However, in analysing the participants' accounts, I noticed that on the one hand, the participants tended to understand or describe their working conditions as exploitative. On the other, when I analysed participants' accounts through a policy perspective, I observed a tendency to spin being employed as a positive.

In my analysis, I see the experiences of participants to be something in-between being exploited and/or positive. But more importantly, I could not find the appropriate language to capture this. And to some extent, it seems that my inability to fully capture this in appropriate language is in accordance with how Brown and Smith (1993) conceptualized changes in the UK's National Health Services with regards to financial regulations and service cuts. For Brown and Smith (*ibid*), policy shifts aimed at deprofessionalisation and deregulation of terms and conditions in health and social services were presented as responses to a need to regulate cost. Such deregulations, according to the authors, exploit the labour of care service providers, especially women, without the workers necessarily seeing the real aims of policy makers. In such situations, policy discourses are embedded in the language of reforms, which is not only hard to define, but challenging for those affected to articulate the impact on them. Thus for Brown and Smith (*ibid*),

Unless we can quickly find and develop a language to describe what is happening...we risk the ever worse exploitation of ourselves as workers, carers and patients. It is for this reason that the language in which these so-called 'reforms' have been couched must not pass into the rhetoric of public policy without scrutiny' (p. 192; cited by Aronson and Neysmith 1996, p. 69).

In referring to Brown and Smith (*ibid*), my intention is to draw attention to how the authors argued that certain policy strategies could have a double edge by showing a commitment to

care for the needs of its target population while the consequences of such strategies point in the direction of exploitation. A discussion of this perspective and its impact on the immigrant healthcare assistants is the central theme in the next section.

The system: Individual experiences intersecting with policies and institutions

As we have seen in earlier chapters, in the literature, the nature of occupations are traditionally defined and understood in terms of how occupation speaks to skills (Abbott, 1988) and contamination (Douglas, 1966; Hughes, 1994, 1971). While this classification is in itself not exhaustive and may be challenged in many ways, the general assumption is that in the occupational landscape, certain types of work are believed to be superior or higher status than others.

Since this study is about experiences, let us turn to the experiences of Amadu. My reason for choosing him is that his experience illuminates policy perceptions which I find salient for my discussion about the system. Further, his experiences were representative of those shared with me by other participants.

Vyda: You mentioned that you do not feel valued by working as a healthcare assistant and you also feel that society has neglected the elderly because they are old. Can you tell me how you have experienced these? I would be happy if you can give me specific examples.

Amadu: I got to know more about this job at *voksenopplæring*. I remember the teacher said that without the language, getting a job in Norway is difficult and due to the level of our Norwegian language, it is a good idea to try elderly care...It is true, when I applied, I got the job instantly. Before starting this job, I was told that I need to be interested in people and be interested in my job...After doing this for over 10 years, I can tell you that they want people to work every day but there is no respect in this job.

At this, Amadu had become very quiet with a look on face on his depicting someone who is in a deep moment of reflection. He shook his head and continued:

Amadu: ...Some time ago, I saw that the insulin on an elderly person was empty. I needed to get her onto the toilet. I called the nurse to help disconnect it from her hand. She told me directly that she has other urgent things to do on her list and the insulin tube can be disconnected later. It is true; she was busy. But I cannot keep the client

waiting. I mean the need to go to toilet cannot wait forever. I know that I am not supposed to disconnect the tube so I took the empty drip from where it was hanging, asked the client to hold it and helped her unto the toilet. This became a big issue because it was reported that I tried working with the insulin drip and I am not 'authorized' (*fag*) to do that...The manager warned me. But I think that she did not want the nurse to feel bad so she just said that I should try to follow what the nurses say...This nurse was obviously having a stressful moment but at the end of the day, it felt like I am not motivated or valued for my efforts.

At this stage, I could sense a hint of anger/frustration in Amadu's voice.

Amadu: And this is not because I did something bad. It was simply because someone was concerned with my qualification instead of what I can do...In this job, you need to be tough not allow such things to affect you. It is like you are trying to do your best for the old people but you cannot give them the very best because there are many rules to battle with. I am not saying the rules should be changed. I am only saying that the healthcare assistants should have rights and the support to develop our potentials. We try to say this to the managers and I know they understand because some of them started work as healthcare assistants. But they give all the explanations that show that there is not enough money. They say it politely by telling us that 'we do not have enough resources' but I feel that it is because they do not see the importance of our work. And it is more distressing when I read that the state is using millions of kroner for things like renovation and other projects and nobody is passionate about the old people here who worked hard and paid taxes. It is as if their life is finished so they get the lowest of everything. And those who work for them also get the lowest of everything...Low salary, low jobs and low everything ...I feel that the state devalues me as a healthcare assistant by giving me low wages. The salary issue is another long story for another discussion. After working for over 10 years, my position is the same. That is also another long history. I tried applying for work in the shops but they tell me I do not have the relevant experience...The job I do is clear; I am the cleaner, the cook, the counsellor and the one trying to make the elderly independent where possible. I am interested in people and I am interested in my job, but the state is not interested in my salary and me. In the news, they always talk about the nurses...My job as a healthcare assistant is also very important. The public believe that I am just a cleaner who is washing the bodies of old people. But in my work, I think that I help

people who are part of society. Old age is an important stage in life and in my country, we see it as a blessing...It is a matter of knowing that these old people still have a life in them and it is matter of knowing that old age can be more meaningful when society is concerned about the details of the life of their elderly.

Unsurprisingly, the need for high standards of care is the subject for intense policy and political debates, at the centre of which is the focus on a professional healthcare workforce (CARE Plan, 2020). What is significant for this study is how policy makers account for or address the ‘unskilled’ workforce in Norway’s elderly care as an ambiguous or invisible part of the healthcare workforce. In other words, from a policy perspective, what meaning can be derived from the ambiguities expressed by the ‘unskilled’ occupational group or healthcare assistants in the Norwegian elderly care? Here, I suggest that it is crucial to expand the analysis of the accounts of the immigrant healthcare assistant to include how their experiences are modelled along the Norwegian welfare system, especially as it pertains to resource allocation. This is what I discuss in the next section.

Recognition and redistribution in the lives of healthcare assistants

Drawing on Fraser’s analytical framework, which was discussed in chapter 3, I argue that Amadu’s explanation of feeling devalued and disadvantaged as an immigrant healthcare assistant is shaped by the allocation of material and non-material resources in society.

Although highly debatable, the allocation of state resources is expected to be framed along policy initiatives based on the principle of ‘need’ and ‘equity’. Thus, the allocation of resources and extra funding to state structures and institutions is expected to be based on the need to support improved and effective workforce performance, among other things. In this case, a redistributive understanding of social justice includes, for example, the allocation of extra material and non-material resources to support the participation and achievement of healthcare assistants such as Amadu. Due to participants’ concern about their continued disadvantages, especially because of subordinated working status and racialized differences, the issue of resource allocation or economic redistribution and cultural recognition becomes extremely important in pursuing social justice. This becomes particularly crucial given that work in the care sector continues to be organized along a hierarchy, which perpetuates class disadvantage through fair access to training/qualification or educational resources and benefits.

The way in which Amadu described how his work around the insulin drip of an elderly client landed him in trouble is largely associated with his lack of skills (i.e. not authorized/'ikke fag'). We first notice that the nurse saw Amadu (a *healthcare assistant*) as someone who is unskilled. With this basic view, we also saw that the manager tried to explain that Amadu has to be trained to perform such tasks. According to Amadu, the manager said he must follow what the nurses say. My interpretation of this is that, due to the association of tasks with skills, Amadu's endeavour to help this elderly client was seen as a potential hazard. In this scenario, the elderly client; not being able to go to the toilet when needed was not considered a potential hazard. The focus was solely on health/medicine and not on meeting other needs such as the need to go to the toilet: - which is an aspect of quality in elderly care. Amadu's inability to support his elderly client created distance and when this occurred, Amadu as an 'unskilled' worker felt disconnected and distressed about not being able to use his experience or initiatives. Here, I think we should pay attention to the fact that, according to Amadu, elderly care work is closely bound to the goal of 'being interested in people and being interested in one's job'. Such goals are in accordance with policy interests related to quality of working life, as stipulated under Section 4-2 of the Norwegian Working Environment Act ('*Arbeidsmiljøloven*') of 16 June 2017, which is broadly concerned with participation and development of self-determination for employees.

The request by Amadu for healthcare assistants to 'have rights and the support to develop potential' illustrates how resource allocation can be a powerful element that determines matters of social justice. This confirms Fraser's (2008) argument that within the realm of politics, matters of resource allocation 'furnish the stage on which struggles' for justice are played out (p.17).

What Amadu emphasizes in his experience is that, as a healthcare assistant, he is not less 'human' because he is an immigrant. At the same time, Amadu also explains why it is very important for him to point out that his job is beneficial to society and this is exactly why he does not want to be considered as being 'less'. In this way, Amadu expresses his resistance to the norm of being told that 'we do not have enough resources' in response to the question about training opportunities. When Amadu said that the state devalues him as a healthcare assistant, he also indicated that the principle of economic or redistributive justice is a significant feature of fairness or equity in the context of training and self-development for the practice of immigrant healthcare assistants.

For Amadu, what is critical here is supporting ‘unskilled’ healthcare assistants like him to attain standardized training and qualification like his more privileged semi-skilled or skilled colleagues. Such an achievement could make immigrant healthcare assistants like Amadu proud, as they can easily participate in important decision for their elderly clients, easily mix with everyone at work and have the right to predictable schedules allowing for maintaining a social life outside work. In addition, the desire for training, when provided would also enhance the quality of work as well as the health of the workers in a longer perspective. Following the desire for skill development is the need for cultural recognition.

Cultural recognition

I argue that a healthy sense of self becomes central to minimize the dilemma of cultural misrecognition expressed by participants. To explore this further, I turn now to an excerpt from my conversation with participant Gigi.

Gigi: We have a rule that says that everyone must be respected. But I think that this rule is about respecting the older people and respecting everything that is above people like me. The family members walk pass me because the first thing they see is my immigrant background which for them is inferior. I used to be very sad but the other immigrants told me this is normal. But I do not think it is normal. I think this purely weak and an excuse for not respecting human beings who are different. I still feel sad sometimes but now, I try to let them know that my background is part of me. I do not need to be like everyone to do this job. In fact, I am able to do this job because , it is part of my upbringing to be strong in very difficult situations.

Here, Gigi emphasizes how she is approached with disrespect because of her immigrant background. She further shows that it is through social interactions that her different background is misrecognized. Gigi’s experiences are reminiscent of those presented and discussed in Chapters 6, 7 and 8, where being an immigrant is made relevant within participants’ experiences in elderly care. By pointing to the relevance of her cultural upbringing: ‘In fact, I am able to do this job because in my country, it is part of our upbringing to be strong in very difficult situations’, Gigi expresses how resilience becomes a shield against misrecognition. . In addition, Gigi demonstrates that by incorporating the meaning of her upbringing or background into her work, her ability to work as a healthcare assistant becomes more meaningful.

In line with Fraser's model (2008), the issue of recognition is a question of social status and it is akin to a politics committed to overcoming status subordination. My argument, along the lines of Fraser is the need for policy and practice to explore the relationship between micro and macro level understanding of cultural injustice in its specific context and not necessarily from a broader perspective. The challenge with the latter is that when cultural misrecognition is approached from a broader perspective, it impedes how resources are allocated and this distorts a better understanding on how to address distinct oppressions in specific contexts (ibid).

This focus brings to light some of the specific concerns raised by the immigrant healthcare assistants. As mentioned earlier, for the immigrant healthcare assistants, status subordination involves disrespect for their background/cultural distinctiveness and patterns that trivialize or reject their knowledge due to the complex ways in which the semi-skilled and skilled are exalted or acknowledged above 'unskilled' healthcare assistants who have more contact with the elderly. The focus involves a critical policy commitment to maximize 'hitherto under-acknowledged distinctiveness' in line with the integration policy goal, which is framed by the concern to promote and ensure greater respect for cultural diversity to enhance the esteem and participation of marginalized individuals and groups in society.

As noted in previous sections, cultural misrecognition for participants is also associated with 'low' expectations and lack of understanding about the position or role of healthcare assistants in elderly care. As pointed out, the lack of implicit understanding necessitates intragroup/occupational group tensions whilst low expectations undermine a healthy sense of self and the ability of the immigrant healthcare assistants to participate equally during social relations. Following this logic, when cultural injustice is approached as an issue of status of subordination, allocation of resources is approached in a way that is compatible to supporting immigrant healthcare assistants to access the benefits of capacity development for a healthy sense of self in social life. I argue that such an approach to the pursuit of equity can impact on the labour market policies, as it would be focused on transforming healthcare assistants as a significant human resource to mitigate concerns of chronic drop-out of immigrants on the labour market, as mentioned by Brastberg, Raaum and Røed (2017). In addition, since the issue of cultural injustice is intertwined with struggles for redistribution or economic injustice, a policy focus that is concerned on reifying distinctive identities or healthy self-image has the added advantage of addressing cultural and economic injustice simultaneously to overcome status subordination. In the context of this study, such a policy targets precisely what

immigrant healthcare assistants, as a subordinated workforce, need to be able to participate equally with their peers in social life. The effect of this is seen to be stronger because it is not only the immigrant healthcare assistants who bear the responsibility. Rather, the challenges of economic and cultural injustice points arrows to the responsibility of policy makers.

By casting light on the general challenges of recognition and redistribution due to undervalued work in society, participants' accounts also raise questions about the structure and operation of state systems that depend on low status work as a significant aspect of institutional arrangements. It became clear in this study that the latter is largely linked to how Vike (2017) analysed the political language of the Norwegian welfare state in the domain of elderly care. In an article entitled, 'Welfare Municipality: Universalism, Gender, and Service Provision', Vike pointed out that,

Thus in elder care in particular, a process of proletarianization is clearly taking place. Unskilled workers are increasingly hired in nonpermanent, part-time jobs, and thus the workforce becomes seriously fragmented. (Vike, 2017, p. 140-1).

Taking into account the multiple ways in which the experiences of immigrant healthcare assistants intersect with the institutional arrangements of the care sector and the ways in which immigrants are exclusively incorporated into the labour market, I find Vike's perspective relevant for this discussion. Vike points to an elderly care workforce which is perceived as the natural capacity of any woman and stereotypically female employees. This fits with the 'immigrant' stereotypes in this study, in which immigrants were seen as having natural caring backgrounds.

From this perspective, it also becomes important to examine how concerns regarding resource allocation by the immigrant healthcare assistants are connected with the self-interest of policy makers to provide quality services with less money. In theory, such government policies can be separated but when analysing lived experiences, it is troubling to separate state decisions from quality standards. In turn, this can affect how frontline workers negotiate and deal with challenges in providing services in elderly care. At the time of this writing, the immigrant healthcare assistants in the Norwegian elderly care setting are perceived to be deprived in terms of 'qualified' skills. Yet Norway's ageing population have created the need for healthcare workforce in elderly care and it is 'unqualified'/ 'unskilled' workers such as immigrant healthcare assistants in this study who have the closest contact with elderly people in the Norwegian care sector. The Norwegian state has the responsibility to provide better care for its aged citizens (Christensen 2012) and it is endowed with the potential of

influencing decisions through programme designs, implementation, regulations and practices (Willensky, 2002). How state decisions impact on elderly care and what this means for participants of this study is explored in details in the next chapter.

Chapter 11: Traps and gaps of policy initiatives

In this chapter, I want to highlight some of the major contexts within which the experiences of the immigrant healthcare assistants are located, through the eyes of managers in Norway's long-term care institutions. As recognized by the managers who participated in this study, immigrants continue to be a vital part of the care assistant workforce in Norwegian elderly care. However, an array of challenges resulting from policy decisions raise questions about the ability of the immigrant healthcare assistants to provide services to the level of professionalism and quality standards stressed in healthcare policies. Specific policy-related issues that emerged in the present study relate to significant gaps between the stated purposes of policies and the reality 'on the ground'. I call these 'policy traps and gaps'. For the purposes of this discussion, I use the term 'traps and gaps' to describe how the implementation of policies aimed at prioritizing workforce challenges and the concerns of the elderly population is largely constrained, thus affecting the objective of quality services in elderly care. These will be discussed in relation to the following sub-themes: traps and gaps between policy purpose and reality; traps and gaps of 'unskilled' workers; traps and gaps in cultural knowledge; traps and gaps in occupational dignity; beyond the working environment.

Traps and gaps between policy purpose and reality

A recurring theme in the experiences of the immigrant healthcare assistants has been the issue of ambivalence that can be understood within the context of policy. In an institutional context characterized by budget cuts and where various occupational groups 'compete' with each other to maintain occupational jurisdiction and hierarchy, the status of unskilled workers is kept low through the cost-cutting strategies of the institution. It is in such contexts where occupational groups which are not formally recognized and with low bargaining power—such as immigrants—are utilized to provide services for the elderly. Immigrant healthcare assistants are thus a means to filling the gaps and needs in elderly care. In my interaction with the managers, they made it known that whilst the activities of the immigrant healthcare assistants are facilitating, in that they provide a rational response to the institutional turbulence of staff shortages, they are constrained in the manner in which the work is carried out. For example, as a manager named Elizabeth told me,

It is unfortunate that we cannot afford to put all of them into the sponsored training.

The money is not there. I do not think there is anything we can do and I cannot think

of any other way of giving them the skills we talk about when we cannot afford. We just continue to make use of the in-house training. That is all we have for now.

And for manager Denise,

The complaints from the family members and sometimes from the news puts a lot of pressure on us as managers to work harder on the services of the healthcare assistants. I know that we are doing our best and the workers are also trying. But when I sit back and think about some of these complaints, I mean especially from the news, I just ask myself, what is happening? Because it is the same news that talks about the cuts in budget for healthcare sector and at the same time, there is so much expectation...I am not saying people should not demand for the services they want. That is their right. And the truth is that the sector has a number of challenges with high levels of quality. But my point is that as a manager, I feel a bit under pressure when I have to stretch the limits of the resources I have and we still get the demand for extra or more. I think that sometimes it is also not fair on these workers.

In interpreting the experiences of the immigrant healthcare assistants and through an analysis of my interviews with managers and observations, I realized that the issue of a lack of knowledge and training were brought to the fore regardless of how much the immigrant workforce is emphasized as vital. Firstly, through my own observations, I noticed that the reality of the activities of the immigrant healthcare assistants is far from the emphases on professionalism and quality of service output central to political discourses. As we saw in Chapter 5, the need to manage multiple tasks in response to the complex institutional hierarchy in elderly care meant that the immigrant healthcare assistants tend to make decisions based on fear of administrative consequences instead of experiences from training. Indeed, some of these immigrant healthcare assistants even have other forms of qualification or education from their home country. However, they are involved in daily care and prolonged contact with elderly Norwegians in a sector where they have limited skills needed to realize the professional status/quality stressed in policy documents.

Secondly, the nature of work routines for this workforce makes it extremely impractical for the immigrant healthcare assistants to divest themselves from their mundane work activities to take up training for professional skills. As a result, they expend a huge amount of energy looking for opportunities to do extra work, a factor that compels them to continue working in their current low-skilled status instead of engaging in skill development in response to policy measures for professionalism.

A third aspect, closely related to the routines of the immigrant healthcare assistants, is the concept of flexibility, which illustrates a major challenge of policy measures that highlight the need to cut down on costs. Owing to the latter, the institutional arrangements of the healthcare sector, and in this case elderly care, point to the need for flexible working terms. In a sector which is constantly challenged by staff shortages, some of the managers did not share the demand for flexibility. This is illustrated in the following excerpt from my conversation with a manager named Linn:

Linn: I think it is sad that some of the healthcare assistants think it is the decision of the managers not to give them the 100% contract. We need people to work and as you can see, I was late for this interview because I had to be on the phone to arrange for extra help. This happens most of the time and it is not good for me as the team leader and also for the staff...I am happy when I have the full team at work so that everything goes on smoothly and nice for the older people. But this is not always the case...It is like I am doing the work by keeping my eyes on what is going on around the patients. At the same time, I have to be monitoring the alarm from where I sit to respond for any call for help. And at the same time, I also need to keep my ears and eyes alert to check the phone and emails for a staff who cannot come to work because they are sick or for some other reason.

Vyda: Is it the case that staff are often sick?

Manager Linn: It happens a lot. These people are mostly exhausted. It is not only sickness but someone can also have a sick child or other things that just come up. But I think it is mostly the exhaustion from the work...The work is flexible to allow for these things but I think that when the job contract is not fixed, the staff are mostly looking for the opportunities to work more. I have been in that position before. I started this job as a healthcare assistant so I know that situation very well. I wish I could do something about this...It is peaceful for me when I get the full team and it is peaceful for the staff when they have a good and fixed schedule. It takes some of the stress of the job away...This is the ideal but it is not the case. The state is keen on keeping the cost low because the expenses are very high. It is expensive to take care of the patients and it is equally expensive to hire the permanent staff...I am sure you know about this already (giving me an ironic smile).

In the above conversation, it appears that the imperative for flexibility reflected in temporary job contracts was explained as a necessity that underpins the policy to cut down on cost.

Though this policy measure generally cuts across the entire healthcare workforce, I observed that for some reasons, the healthcare assistants are expected to be the most ‘flexible’ workers in elderly care. Linn offered a possible explanation to this:

Linn: Because the work does not demand any special skills, it is assumed that anyone at all can do it. But this is not true. This work has changed and it keeps changing all the time. Some years ago, it was not like this with many machines and computers and technical items. Now there is much technology in the work...The healthcare assistant must be knowledgeable to know how to use the remote to position the bed at the correct angle. They must know how to use the machines to lift the old people...they must be able to read the systems which are monitoring the old people and inform the nurse or leaders when they feel that something needs attention...It is also assumed that the work for the nurse and healthcare assistants and even the managers is the same in the entire elderly care sector. This is true but I think that every institution has a different style or approach on how to maintain the quality standards. That is why you can sometimes hear that some institutions are ‘better’ than the others are. The point I want to make is that, for me, I think it is important to maintain the standard that my team and I work with and of course, to always improve. But there is mostly a demand for extra hands for the healthcare assistants and when you cannot get the internal staff to fill this demand, I have to look outside.

Vyda: When you say ‘outside’, what does it mean?

Linn: We sometimes rely on the temping agencies. The people from these places are equally good but most of them are moving around to different places and do the same thing differently. So sometimes, it is a bit of a chaos. First for the older people, second for the other staff they work with and third for us, the managers, because we get all the complaints.

Vyda: But you said to me that you have nurses who do not have 100% contracts. Do you experience a similar chaos with them?

Linn: Not really. I mean the nurses are specialists in their job and it is not often that I am on the phone to the temping agencies looking for extra nurses. But on occasions when this happens, I do not get many complaints about the work itself. It could be just the personal issues or characteristics of a particular nurse or individual but not the standard of the work the person is doing...And almost any nurse starts work with a

good percentage of work contract after their education. It might not always be 100% but it is good enough and it progresses faster if you compare it to the healthcare assistants. Do you get me?

Vyda: I think I do...

In this excerpt, the imperative for flexibility as a policy measure to cut down on cost is not only a trap in the working environment of the care sector. Rather, in order for this policy to function, a core group of workers are expected to be the most flexible, due to their 'unskilled' status which means that 'anyone' can be called in to fill the gap. Arguably, the expectation that the healthcare assistants are more flexible underlines the point made by Hughes (1971, 1958) that the division of labour in an organization is embedded in how occupational groups are expected to function. The functions of an occupational group, according to Hughes (ibid), are believed to be rooted in tasks that represent the expectations of both the institution and society regarding the role of occupations.

Similarly, in Atkinson's (1984) model of labour flexibility, flexibility is a calculated strategy by an organization to cut down on administrative costs by having a workforce that helps to meet this demand through flexible working arrangements. In such an institution, Atkinson argues that employers employ a fixed number of a core group of employees who usually consist of full-time employees who carry out major activities. Surrounding this core group of employees are the peripheral groups that shield or support the core group in response to changes in the demands of the job. Atkinson further categorized the peripheral groups into two. Group one consists of employees who have permanent contracts but less job security and fewer opportunities for career advancement. Group two on the other hand comprises employees with more flexible terms of work, who are mainly part-time workers or with short-term working contracts.

In this study, there are striking similarities between Atkinson's descriptions of peripheral employees and the policy of the state on flexible working patterns, as it pertains to the immigrant healthcare assistants. Given that policy discourses emphasize the need for professionals or a highly skilled workforce, it is ironic that rather than being seen as worthy of investment, healthcare assistants' skill development is not given considerable attention. This notwithstanding, work which demands a considerable level of training and skill is left to a group of workers who are looked down upon as unskilled and mocked by perceptions of being in a low-status, unattractive occupation. As this study has shown, this remains a core feature of the experiences of the immigrant healthcare assistants.

In Chapter 2, I mentioned that policy discourse on elderly care assumes that the critical workforce for the elderly are professionals such as nurses and doctors, and as a consequence, these policy documents do not make any significant reference to healthcare assistants. In an article challenging such perspectives, Jacobsen (2015) argued that such assumptions do not reflect the reality of Norway's elderly care workforce and it is critical to examine the question of constraints within such perspectives. This includes paying attention to the growing number of immigrant staff who represent this workforce. Similarly, Abrahamsen and Kjeldvik (2013) have observed that there is heavy utilization of immigrants in the Norwegian care sector. Although the immigrant healthcare assistants I encountered continue to provide services within the parameters of their work, it is evident from their experiences that they do their work within a general mode of ambivalence which is susceptible to influence from the macro-level characteristics of how the care sector is organized.

This not only gives an impression of how the Norwegian elderly care is organized but also raises new questions about the challenges created by the solution of having a workforce with a heterogeneous background, whose training needs are not given attention.

Traps and gaps as 'unskilled' workers

Another conspicuous policy-related issue that emerged in this study is the way in which policies are developed and discussed. As discussed in Chapter 2, a significant achievement of the Norwegian state is the establishment of an active labour market policy which is expected address the issue of integration or social inclusion and improve standards of living through career opportunities. As evidenced from this study, the experiences of the immigrant healthcare assistants indicate that the political decision to provide career paths for marginalized groups—such as immigrants—to enter the labour market has been established. In addition, a national provision has been made under the ¹⁷Competence (*Kompetanseløft*) Enhancement 2020 initiative to strengthen health services in Norwegian municipalities. Primarily, immigrants or persons with a foreign language working in municipal care services are the target group under the first strategy of this initiative.

¹⁷ I am grateful to Taylor Vaughn at the Velferdsforskningsinstituttet NOVA, for bringing the *Kompetanseløft* initiative document to my attention.

Significant for my discussion here is the emphasis of this policy initiative to increase the quality of municipal care services through an increased access to qualified health professionals. Similar to policy initiatives such as the Active Labour Market Programs (cf chapter 2), what is missing in the Competence (*Kompetanseløft*) Enhancement 2020 initiative programme is the mechanism to assess its impact on the lives of target groups, such as the immigrant healthcare assistants. From the findings of this study, it can be argued that the policy aspiration for the employment and skill development of an ‘unskilled’ workforce is far removed from the reality of doing work with paths to career advancement.

Whilst the immigrant healthcare assistants expect to progress in their jobs, the reality is that there are more constraints than opportunities. Admittedly, this presents us with the image of a gap between political measures for enhanced pathways through work-inclusive initiatives and the reality of career traps in the working environment. Most significantly, the emerging issue of a workforce that is rooted in the assumption that it will be occupied by a particular group or population—in this case, immigrants who are positioned as low-skilled workers in a never-ending cycle of career traps—casts a slur on the international image of Norway as a country grounded in strong egalitarian principles, with equal opportunities. This observation underscores the importance of policies that are driven by careful examination of the realities of the system rather than political considerations. It also emphasizes the importance of evaluating policies that are developed to promote viable options for specific groups through policy initiatives, such as activation programmes. For instance, how easy is it for an immigrant healthcare assistant to take up skill development for career development when they do not have the qualification for entry requirements and they do not have the means to pay for such training privately?

Thus far, this study’s findings indicate that the impact of an untrained workforce with diverse backgrounds who deliver care for the elderly Norwegians has not been fully challenged in policy discourses. By moving beyond policy discourses that focus on an imaginary care sector, policies would have the potential to connect the actual issues confronting the care sector with the demands for improved quality of care for the elderly.

Most critically, the ambivalence experienced by participants of this study should perhaps challenge the policy makers to consider other critical effects of delivering quality of care at the lowest possible cost. Some of these effects, as observed in this study, illustrate what I term the traps and gaps of cultural knowledge.

Traps and gaps of cultural knowledge

In Chapter 8, I quoted a Norwegian elderly man I called Willy, who said that caviar spread on top of an open roast beef sandwich was ‘unimaginable’ (*det går ikke*). In this study, several factors related to knowledge, and specifically cultural knowledge, were critical to understanding the experiences of the immigrant healthcare assistants and the quality of care services they deliver to elderly Norwegians. This suggests that the cost-effective focus of policy measures and the demand for professionalism and quality of care outcomes is complex—and perhaps also just as ‘unimaginable’ as caviar on roast beef.

Significantly, while staff training is important for the practice of the care workforce, this is particularly important where elderly care relies on immigrants from multiple backgrounds. For instance, in analysing the experiences between participants and elderly Norwegians, it emerged that differences in understanding and moments of tension were the result of the lack of knowledge, and specifically, lack of a shared cultural knowledge. I therefore want to emphasize that the lack of cultural knowledge has real effects in the daily activities of the immigrant healthcare assistants in elderly care. For the elderly, there is evidence to show that the issue of cognitive decline in old age implies that care relationships, which are built on shared cultural understandings, have the potential to enrich the quality of their interaction during care delivery (Walsh and Shutes, 2013).

As discussed in Chapter 8, I observed a significant difference in care relations when the Norwegian healthcare assistant incorporated aspects of her knowledge of Norwegian culture during interactions with an elderly Norwegian. Though this is not often acknowledged in policy documents, my observation indicates that, for the elderly Norwegian, care relationships which connect with their own cultural outlook contributes positively to their care experiences. Likewise, for the healthcare assistants, their relationship with the elderly clients and their experiences in the care sector shape their perceptions, which can either promote quality care or create barriers with profound outcomes (Nolan et al., 2004; Bowers et al., 2003).

Feeling overwhelmed by a lack of confidence, and not knowing whom to turn to for help, the descriptions from the immigrant healthcare assistants imply that, in most cases, their individual or cultural knowledge served as a frame of reference rather than referring to specialized training or skills. Admittedly, the descriptions of ambivalence between the immigrant healthcare assistants and their elderly clients draw attention to some of the layered complexities of policy perceptions surrounding elderly care. Perhaps the most difficult to disentangle is how the various themes of ambivalence are interwoven in the political fantasy

of professionalism and quality of care outcomes, and the reality of lack of support for investing in the training needs of the immigrant healthcare assistant workforce. These factors affect the care relationships between the immigrant healthcare assistants and their elderly clients. As expressed in the excerpts below, the challenge of lacking knowledge of differences in cultural understanding raises questions about quality of care outcomes:

Oplo: I never understand it fully. She is always occupied with how her surroundings should look. You need to put the purple candles on that particular table. You need to change the room into white and red decorations for Christmas. The next time it has to be decorations with yellow chickens and Easter eggs!...Of course I want to help but I do not have the time and there is always the list to follow...I told her I would come back to fix the decorations for her. I saw that she was not happy but I need to move to the next person. I have to choose between helping the next person and fixing up decorations. I do not see the decorations to be necessary...she was sad but these people are mostly sad and it is not my fault when I cannot help with the extra things when they ask for it. I have to focus on what is more important.

Manager Silje felt that to some extent, the challenges around cultural knowledge could be a constraint to the quality of care relationships and outcomes:

I think the bottom-line is that we do not have many Norwegians working as healthcare assistants...When we talk about cultural issues, it is important to teach the care assistants about the things which are valuable to the older people. The experiences of these old people are different from this new generation. And I think that in talking about the things that the old people need in order to enjoy their stay at the institution it is important that the people who take care of them know the history. It is equally important that we teach them to understand the culture, like the traditional way to celebrate 17 May, birthdays, anniversaries and maybe Christmas and New Year. Then we can talk about the traditional food we eat on these occasions and how to serve it and the special songs we sing. These small things make a huge difference for these old people. And they are also important for creating quality and positive connection between the immigrant staff and the older people who live here...Maybe if we have more Norwegians in the system, they can easily help with some of this knowledge because some of these things are the standard in most Norwegian homes. But in the current environment, it is people from different backgrounds who do not know so much about the traditional customs or maybe they do not understand why many things

are done differently and this can be difficult for the older people and for the immigrant staff as well...In the end, everything is about teaching them. Everybody can learn by just looking at what is happening around them and do the same. But it is a different thing when you teach the people to understand why things have to be done the way they are done. This is what we need to keep the standards at a good level or higher levels...They need the training and support to know these things. We are doing our best but there is always room for improvement...

From the above narrations, Oplo's experience and Silje's observation point to a significant gap between the political fantasy of professionalism and quality and the reality of the lack of training for the immigrant healthcare assistant workforce. In an environment where training is understood to be costly, the managers were aware of and very sensitive to the complex and multifaceted issue of cultural traps and gaps, but they remained unsure how to address it. The fundamental challenge concerning training for a workforce with such a culturally diverse background was highlighted and observed as an impediment to the delivery of high quality care, which is mentioned in policy documents. As evident in this study, the lack of a shared cultural knowledge leads to situations where distinct appreciation and acknowledgement of the cultural needs of the elderly Norwegian was critically lacking or neglected. As illustrated in Chapters 6 and 8, the elements of social and cultural aspects of life that the elderly in Norway value were often restricted during interactions with immigrant healthcare assistants.

In the above descriptions, it can be argued that if the institution of elderly care adopts an approach to care with a strong focus on how to facilitate training for the immigrant healthcare assistant workforce, it is likely that care relationships and quality of care outcomes could be more satisfactory. However, in policy discourse, the priority seems to be more on cost-effective measures, which implies that more value is placed on cutting resources for training-related funding. In the end, these policy measures have an impact on the value placed on elderly care and the delivery of meaningful and quality care outcomes.

Traps and gaps of multiple cultural backgrounds without detailed standardized training

The specific focus on cost-effective measures and the failure to focus on training needs, together with a policy emphasis on the need for a quality and professional workforce, has created a situation where humane elements of elderly care relationships—which are built on factors such as shared cultural knowledge (Walsh and Shutes, 2012)—were viewed as secondary within care relationships of the elderly in Norway.

The dominant perception about the lack of policy focus on the immigrant healthcare assistant workforce was evident in this study. This was apparent in situations where the reactions of the immigrant healthcare assistants demonstrated utmost ambivalence, which I analysed as a lack of cultural knowledge. As evident in my observations, this lack of cultural knowledge led to situations where the elderly were misunderstood and sometimes described as difficult or overly demanding. These misunderstandings led to tense moments where the elderly Norwegian seem vulnerable and distressed. For the immigrant healthcare assistants, this lack of cultural understanding was stressful and confusing.

For the managers in elderly care, the use of repetitive statements about challenges with a multi-cultural workforce and the need for a more efficient training, especially on Norwegian cultural orientation, represented their concerns about the adverse effects of the lack of resources for training and education. However, like the women in Vike's (2017) work, the stereotypical notions about immigrants as 'natural caregivers' also revealed both the failure on the part of management to reinforce the demand for training and the effect this has on care relations for the elderly in Norway. Unlike other studies that pointed to language/communication barriers between immigrants and their elderly clients in care relationships (Bourgeault et al., 2010; Cangiano and Shutes, 2010; Martin et al., 2009), the findings of this study revealed that, in the Norwegian context, tensions in the relationship between the elderly and their immigrant healthcare assistants have more to do with a lack of cultural knowledge than language difficulties.

Traps and gaps of dignity

The issue of dignity and work retention was a further interpretation that shaped the experiences of the immigrant healthcare assistants. As we saw in Chapter 6, participants talked about tasks which were described by them and by others as dirty as a symbol of their low-status jobs and the lack of respect in their position as healthcare assistants. This finding clearly shows a disparity between Norway's contemporary policies for work inclusion and the existing challenges of the labour shortage. As a policy measure, the focus on an all-inclusive and integrated workforce is designed to cut down on the number of people who depend on social services (OECD 2009; Brochmann and Hagelund, 2011; Halvorsen and Stjernø, 2008). However, the immigrant healthcare assistants felt that it remains challenging to work in elderly care since it is not perceived to be attractive. On the one hand, they think that the services they provide are crucial to the sector yet, on the other hand, these services are either looked down upon or not recognized as important.

Most critically, the emphasis of healthcare policies on professional care workers, coupled with a lack of funding and working in an environment that gives considerable respect to skilled occupational groups, meant that policy measures can be described as not paying attention to the critical needs of the elderly care workforce. The latter further translates into one of the means through which perceptions about elderly care as unattractive and the indignity attached to the work of healthcare assistants is made visible. During my fieldwork and in analysing data for this study, I could not help but conclude that the experiences of the immigrant healthcare assistants challenge policy discourses on issues of staff shortages and staff retention in elderly care. Given the visibility of career traps and the real danger of having immigrants entangled in this cycle, there is considerable effort by older healthcare assistants to encourage newcomers to enrol in more respected and visibly acknowledged positions as nurses, rather than work in invisible, unacknowledged, and/or unauthorized positions as healthcare assistants.

As we saw in Chapter 9, it appears that because of a political climate that emphasizes professionalism, there is an increased expectation on the part of society and, in this case, family members to demand quality standards for their elderly loved ones who are receiving care. Additionally, given their daily contacts with the elderly and due to perceptions about who is capable of providing the quality standards stressed in political debates, the immigrant healthcare assistants felt constrained in their interactions with the family members of the elderly clients, and this was described as an uncomfortable source of tension. The recurrence of these highlighted the effect of the demands of policy discourses in the working lives of the immigrant healthcare assistants who deal with the complaints of the family members. As captured in Oplo's experience, this can be not only demoralizing but also confusing:

It is never easy to understand and I never get it...I mean everybody can say anything to you just because they know you are not the nurse. And it is true, I am not a nurse. The nametag on my uniform says healthcare assistant. And that is what I am. But it gets so depressing when these family members think you do not amount to anything because you are an assistant and worse of all, it is sad when they are not nice because you are also a foreigner...

In addition to feeling demoralized and confused due to the climate of demand for quality standards, it appears that policy measures for professionalism have increased the hierarchical structure between the skilled and 'unskilled' healthcare workforce. In several ways, this was

reflected in the imbalance of power in the relationship between nurses and the immigrant healthcare assistants. As recounted by Pedro:

These nurses can sometimes make you feel like you are simply trash! They silently try to make their position known to you by asking you to do the job, which they think is below them. I mean just look at what happened. She could have just taken the tissue to clean the nose and mouth of that man after attending to him. It is just saliva mixed with the food he ate and runny nose! But she came and called me! And I do not blame her because the injection she gave is seen to be more important than the cleaning I did.

The above tension was a common theme in the experiences of the immigrant healthcare assistants in my study. At the macro-level, these can partly be understood as a reflection of the demands of policy measures that demand increased quality outputs and professionalism. In Chapter 6, I mentioned that due to the unskilled and low-status positions of the immigrant care assistants, they feel bounded by institutional structures and organizational policies. As a result, they look up to their senior colleagues, such as the nurses and their managers, as a point of reference in decision-making. I also mentioned that in terms of complaints about quality standards, it is the immigrant healthcare assistants who experienced being more vulnerable to accusations as a result of complaints from both nurses and family members. Certainly, embedded in these challenges is a state-level concern about how to address these practical and contextual factors involving skill development or training for the immigrant healthcare assistants. This is probably more crucial because, while these findings are fundamental to work in elderly care, the outcome of these challenges goes beyond the working environment.

Beyond the working environment

During my fieldwork, I observed how the constraints of policy measures manifested in the private lives of the immigrant healthcare assistants. This was evident in the ways in which the focus on acquiring extra work dominated the lives of participants. I understood this focus as a reflection of the strains that comes from the disconnection between the policy measure on flexibility and the impact this has on management policies in the care sector. In this study, I saw clear parallels regarding how the immigrant healthcare assistants felt bound by the institutional policy demanding flexibility, as demonstrated in the following extracts from my field notes:

For the third time, my appointment with him was cancelled because he was called to work. This happened after I had turned up at his apartment and it was explained that he was just about to call me. He was very apologetic and started complaining about how difficult it is for him to have a life, even on a day like this when he was supposed to be off. His wife came to the living room with tea and he spoke with her in a language which I did not understand. I could sense however that there was bit of tension in the air. He later explained that his wife is unhappy and complains when he has promised to spend time with her and he suddenly needs to go to work. However, he brushed his wife's complaints aside by telling me that situations like this happen all the time and she doesn't understand the schedule of his work. In his words, 'this is the work I do to help pay the bills. If I sit home, there would be disaster because you never know when you will get the opportunity again'.

I went out together with the participant to get the train, as we were going in the same direction. He continued telling me how he feels bad about not being around for his wife and missing out on almost all the important social events. 'I do not have a choice. Until I get a permanent job, I do not have a choice. I have to continue doing the extra shifts until I get the contract. That is the life for me'.

In simple terms, I think that it is easier for the management to enforce the concept of flexibility on the staff members who do not have 100% work contracts. In this study, it seems that the immigrant healthcare assistants were indeed more bound by the institutional policy for flexibility. This was worsened by the knowledge that, due to the nature of their work contracts, the focus on working extra remains a priority, and this affects their inclusion in family life and social activities. In effect, managers conceptualized the healthcare assistants' flexibility as a personal trait attributed to their cultural backgrounds, but in my analysis it emerged as a result of poor working conditions.

In this second example, I share the following statements from participants:

Ozuku: You do not have the freedom to do anything. I just found out that they will need someone to work tomorrow and I have said yes. I have plans to go out with my friends but I just have to cancel it.

Tsitsi: They had the *julebord* last week. I wished I could go. But I had to work. Sometimes I wish I could go out to relax and just have coffee with some of the people

I have known at this place. I think it is also a good way to know people outside the job. But the time is not there. You either work or miss the money.

Pedro: In a way, the work is not bad. It is the conditions that make it stressful. I have learnt good things but I have also developed some bad habits. I cannot keep my eyes off the phone. It is not because I am doing social media like the Facebook and stuff. I am always watching the messages to see if they will send out a signal for extra help. It is so bad that I stop in the middle of almost everything in order to work. I know that some of my friends say I am not reliable because of this. I cannot organize my whole life. It is like there is no routine in my life. But I depend on this job for my life. If I can get another job, I will change. But the type of job I would like want people with degrees and other qualifications. So it is the same everywhere.

In these extracts, the infringement of policies on the private lives of the immigrant healthcare assistants were explained as worsened by their inability to find other jobs. The fact that they do not have a choice makes them more bound by the institutional policies demanding flexibility. In this case, the issue of flexibility is not a choice, but rather a cost-effective policy which is easy to implement on low-status occupational groups, such as the immigrant healthcare assistants. In a working environment where staff have less freedom and limited opportunities, emphasis was placed on survival. As a policy issue, the situation thus becomes more challenging, as captured in following field notes:

It was indeed a huge sigh of relief when I finally had the chance to interview Dido. This arrangement was made possible by the manager who agreed that the participant would be compensated for coming to the work premises on his day off for the interview. In addition, he was promised that his team leader would be asked to excuse him in case she needs extra hands. The interview took place uninterrupted. After the interview, we decided to walk together to the train station. But first, Dido wanted to check some information from his department upstairs. I stood at the reception waiting and he came back with a funny smile. He has been asked if he could work and he said yes!

The reality of being overburdened by cost-effective measures, which translates into flexible working hours, is made evident through work contracts that imply that the healthcare assistants are mostly doing the extra work. The latter is often the result of working extra in order to make up for a work contract which is not 100%. As explained to me by one of the participants, regular working hours are 7.5 hours per day, and overtime ranges between 2 to 6

hours. This means that, in practice, some of the immigrant healthcare assistants end up working between 9.5 to 13.5 hours a day to fill the gap in their work contracts.

My data suggest that the female healthcare assistants were more vulnerable to the effects of this:

Reeky: It goes directly into my heart when my little girl is sad because I have to cancel an appointment to go to the playground or shopping with her.

Tabio: Now my kids are big enough to do things for themselves. But I feel guilty when I am not home to serve them fresh, warm food. I mean I know I cannot do this every day but it is nice if I am able to. My mother did it for me. I know I have to do it for them. It is our tradition. But look at this job and me. The only time I have is the time for sleeping. No time to enjoy special moments with the family.

Oplo: To have a balance in life is very important. I had a boyfriend who broke up with me because he complained that I was not making time for him. I mean there were other issues but my work schedules was one of his complaints...It affects you in every aspect of your life.

In short, these inter-related factors explain the context in which the disconnection between policy measures and the reality of workload in elderly care has implications for the private life of and measures for social inclusion for the immigrant healthcare assistants.

Chapter 12: Conclusion

Prior to generating data on the experiences of immigrant healthcare assistants employed in Norway's elderly care, I explained in Chapter 1 that I take elderly care as a field where Norwegian policies meet to constitute a frame for my question: What are the roles and experiences of immigrant healthcare assistants providing care for the elderly in Norway?

I have explored this question through the following sub-questions:

- What are the challenges of the Norwegian elderly care system at the interface between policies of immigrant integration and policies of elderly care?
- What can policy makers, researchers and the wider society learn from the immigrant healthcare assistants' perception of their roles and experiences when providing care for the elderly Norwegian?

Through my analysis/exploration, I have shown that the main findings can be understood as a gap between policy initiatives and reality, the undervalued/misrecognized nature of healthcare assistants and challenges to obtaining training, poor working conditions in complex situations, and policy-level failure to pay attention to the needs of the workforce caring for the elderly.

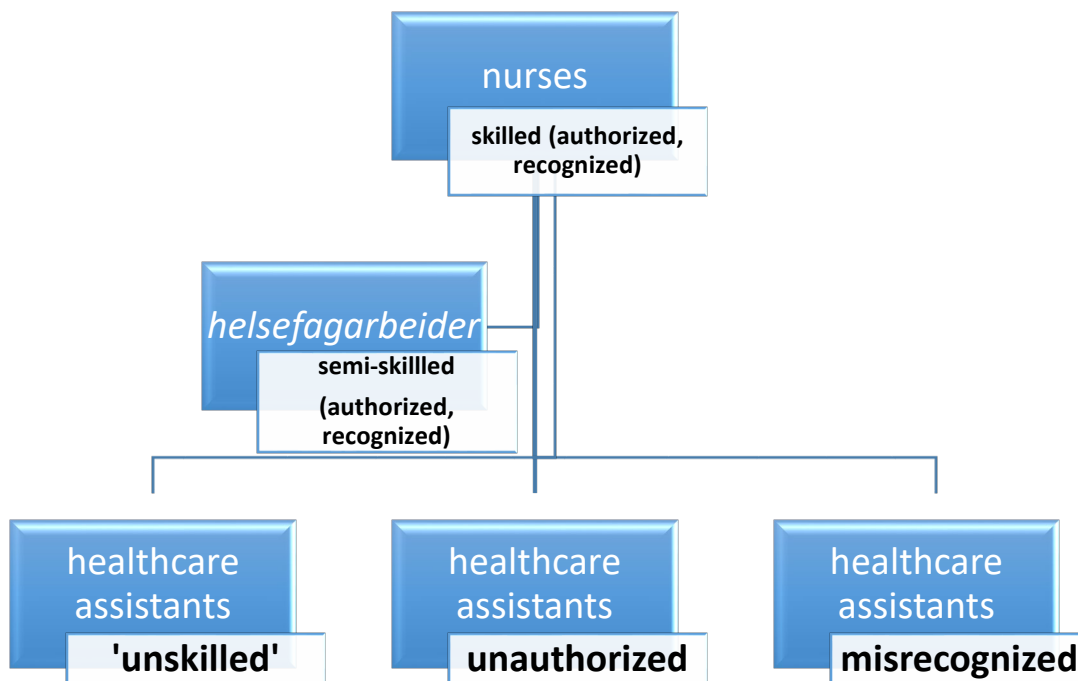
This chapter aims to discuss the implication of my findings for policy and practice within the politicized context of elderly care in Norway. It is organized in four sections. First is a focus on the central concerns that emerged in the study. The second looks at policy implications for the immigrant healthcare assistant workforce. Third is the study's contribution to scholarship, and in the final section, suggestions for future research are provided.

Central Concerns

The misrecognition of healthcare assistants and challenges to obtaining training

Norway's active labour participation policy is built on the premise of the significance of doing a job that individuals like and find interesting. As demonstrated by the immigrant healthcare assistants and their managers, the intersection of policy perceptions on active labour policies and the reality of hierarchical relations in the care sector is challenging and conflicts with the necessity for career progression.

In general, my data illustrate that the workforce in Norwegian elderly care is organized into three key groups. These groups were described or identified by their skills or qualification and status and/or their ethnic background, as illustrated in the diagram below:



At the top of this hierarchy are the nurses who are certified or formally trained to work with the various needs of the elderly.

Following the nurses is the occupational group known as *helsefagarbeider* (semi-skilled). This category of the workforce acquires nationally accredited and standardized education and trainings to assist nurses with a range of tasks geared towards the promotion of health and wellbeing for the elderly. Important information concerning this occupational group is that, to qualify as a *helsefagarbeider*, one must either spend two years as an apprentice after completing Norway's upper-level education (*videregående*) or take exams as a practical candidate after five years of work experience (Sketne, 2015; Skåholt et al., 2013).

At the bottom of the hierarchy is the undefined, unauthorized and unskilled group of workers with unstable paths in career progression. This occupational group has neither a fixed name nor fixed working conditions. At the workplace, they go by interchanging titles such as *pleieassistent* or *hjelpepleier* (i.e healthcare assistants). The lack of skill development for this workforce has led to outcomes which can be understood as being undervalued or misrecognized (cf. Fraser 2008).

This last category of workforce formed the major focus of my study. As such, I observed that their tasks include bathing, feeding, helping with sanitary needs, taking the elderly for various

appointments (such as health check-ups, walks and social meetings), playing games, and bridging the gap of loneliness. In addition, they constantly communicate with the elderly through various means and they engage with family members of their elderly clients under different contexts, such as in the private home environment or at the institutions of care.

I believe that information about this category of the workforce is crucial for an understanding of the hierarchical structure of the Norwegian care sector. Firstly, the absence of this workforce category in official documents suggests that the decision-making processes for quality of care outcomes and professionalism can be interpreted as mere idealism. This seems to reflect a politicized agenda around Norwegian elderly care which is very different from the reality of what elderly care looks like ‘on the ground’.

Secondly, as demonstrated through narratives, perceptions about the undervalued nature of healthcare assistant jobs in elderly care are reflected in policy initiatives that make it difficult and impractical for the immigrant healthcare assistant workforce to obtain education and training to achieve professional status or career progression.

Thirdly, in addition to doing work which is described as heavy, dirty and unattractive, policy measures on budget cuts and demands regarding flexible working conditions translate into a situation wherein the immigrant healthcare assistants experience working under part-time contracts yet taking all the extra shifts caused by staff shortages.

Finally, when taken together, the experiences of the immigrant healthcare assistant workforce reflect how policy initiatives have failed to pay attention to the complex nature of healthcare workforce needs in the sector. The practicality of what it means to have a flexible working environment reinforces the challenge for the immigrant healthcare assistants to be socially included on arenas outside of work.

Poor working conditions in complex situations

In this study, the issue of working without ‘good’ contracts also emerged. In addition, a connection was made between working to take care of the basic demands of living, such as paying bills, and taking part in activities for social inclusion. The principle effect of working to make up for part time and temporary contracts, as demonstrated in this study, is a situation where the immigrant healthcare assistants seem to experience social exclusion. This is of primary concern since it points to a general challenge regarding how policy initiatives can downplay the effects of policy measures. The general challenge of policy initiatives to assess and distinguish reality from policy intentions means that the lived experiences of occupational

groups such as the immigrant healthcare assistants are not given significant attention in policy determinations. This is supported by the ways in which policy documents maintain a focus on quality care outputs without a corresponding focus to invest in resources for elderly care. The current experiences of the immigrant healthcare assistants create and/or reiterate an alarming image of a workforce that is increasingly comprised of immigrants who experience a cycle of career ‘traps’ in low-status occupations.

The healthcare assistant positions are left to a category of people, such as immigrants, who often do not have recognized education or training and are not privileged to afford the financial requirements for private tuition for skill development in healthcare careers. Furthermore, with fewer career opportunities due to the lack of skill development, the immigrant healthcare assistants often find it challenging to find other jobs.

In view of this, the policy perception for the professional healthcare workforce and the lack of resources to support training for occupational groups who lack these skills conflicts with the necessity and demand for skilled healthcare workers, as stated in policy initiatives such as the Competency (*Kompetanseløftet*) Enhancement (2020).

Policy implications

Policy-level failure to pay attention to the needs of the workforce

In a welfare regime that is rooted in an obligation to take care of its elderly citizens (Christensen, 2012; Vike, 2017), quality care for the elderly is more of a state responsibility than that of a lone individual. Against this background, a major objective outlined in the current elderly care policy is the promotion of quality elderly care in terms of medical and social support (Care Plan, 2020).

As demonstrated by the analysis of data for this study, the relationship between the skills of the workforce who are in close, continuous contact with the elderly and the requirements regarding providing quality care, in terms of a high level of professional expertise, represents two different views. As the level of professional competency rises through investment in development programs, effectiveness and quality care outcome are expected to be achieved. The managers of Norway’s long-term care institutions concur that a key challenge with the primary workforce lies with training. Both the managers and the immigrant healthcare assistants at these long-term care institutions are worried about the tendency to segregate the unskilled category of healthcare assistants due to the lack of financial resources for continued

learning or training. Ironically, it emerged that structural and institutional arrangements indirectly prevent the ‘unskilled’ immigrant healthcare assistant workforce from participating in those training programs required to secure skilled or professional expertise. I therefore argue that the policy concept of promoting quality elderly care represents opposing views, as it aims to supply care workers with professional expertise yet its implementation tends to decrease the opportunities for the unskilled to become skilled. As illustrated in my analysis, this influences the skill capacity of the immigrant healthcare assistants, which in turn affects services for the elderly.

To sum up, the central challenge regarding the implementation of innovative policy ideals is a state responsibility in terms of focus and an institutional budget for capacity development. It can be argued that the idea of quality elderly care from a competent workforce is another political ideal with contradictions and double communication. As this study has been conducted within the discipline of social policy, a critical question that arises for me at this stage is the implication of such knowledge for social policy.

Contribution to social policy

In exploring the experiences of immigrant healthcare assistants in Norway’s elderly care, several contributions can be inferred: I highlight three of these.

The first contribution concerns a re-direction in policy focus, which I have attempted to do by drawing attention to some of the nuances and discrepancies that relate to important discussions regarding policy measures towards Norway’s demographic challenges and labour market initiative programs for unemployed populations (such as immigrants). Elderly care and labour policies play significant roles in determining the supply of professional workers for quality in elderly care. This finding further contributes to an understanding of how:

- Relations in the home environment during care work can contribute to better care or undermine this possibility for the elderly (Chapter 6)
- The interwoven process of gender, race and class status impacts on male immigrant healthcare assistants (Chapter 7)
- Cultural discrepancies can occur in the context of doing work in unfamiliar settings (Chapter 8)
- Language barriers can be connected to a workforce that does not fit the ideal of a professional (chapter 9)

- A confluence of the above, merged with unrelated policy measures, creates traps and gaps in Norwegian elderly care (Chapters 10 and 11)

The second contribution concerns policies affecting work and the crucial boundaries to overcome these so that work can be more fulfilling. This includes efforts to broaden public understanding regarding work, in general, and elderly care work, in particular. Key aspects to this understanding is the motivation to develop skills, such that individuals can assess opportunities for progress in their work. A specific contribution of this understanding in my analysis centres around the disparaging ways in which participants are viewed by the public as being in occupations that primarily involve ‘wiping buttocks’ of old people. It could be argued that such issues of critical concern are beyond the control of policy makers. However, policy makers have a duty to protect the legitimate rights of its national workforce. In line with the findings of this study, I argue that the onus lies with a political responsibility aimed at balancing the tension between skilled and unskilled occupations through feasible policy initiatives that are of collective benefit to Norwegian elderly care and its low-skilled workforce.

Finally, this dissertation has provided a cultural script for decoding the experiences of the immigrant healthcare assistants. In this way, I argue that it is best to see things from the reality of the experiences of the immigrant healthcare assistants who form a crucial target population for the state’s labour market initiatives. As participants have the last word concerning their own experiences, I conclude by giving voice to one of the participants:

Zuzu: ‘Go and tell them (laughing). And remind all the politicians and people out there that they will one day become old and some of them will also need help and it is the immigrants who will be providing this help’.

In this light, I conclude that no meaningful implementation of policy initiatives can be attained with regards to Norway’s ageing population and labour market concerns without a keen interest in the experiences of immigrant healthcare assistants who, in many ways, represent a key barometer for strengthening the state’s focus on long-term care.

Contribution to scholarship

This study offers insights into Norwegian national policies by analyzing linkages between elderly care, experiences of healthcare assistants, and overarching goals of policies aiming to ensure that people from immigrant backgrounds actively contribute to the welfare state through work. Highlighting the experiences of immigrant healthcare assistants, the study

provides knowledge on how the goals of the State's action plans and strategies can be adapted to the realities of elderly care. While offering new perspectives through insights into the experiences of immigrant healthcare assistants, this study finds that the issue of capacity building for healthcare assistants is the responsibility of policy makers and a challenge for the recognition of immigrant care workforce in the Nordic care sector (cf. Näre, 2013b, Vike 2017).

Beyond the context of Norway, this study contributes to international scholarship chiefly in the following two ways:

Theoretically and methodologically, I have drawn on intersectionality as a perspective to understand the experiences of immigrant healthcare assistants. In applying this perspective, I have tried to combine Crenshaw's (1991) traditional notion of intersectionality (i.e how disadvantage occurs because of multiple identities) with discussions of intersectionality from an institutional vantage point (Collins, 1999; Browne and Misra, 2003; Seeberg, 2012; Weber, 2001). Even though intersectional processes have an impact on both individuals and institutions, much of the discussions on intersectionality have had a focus either on individuals (Crenshaw, 1991) or from the institutional vantage point (Collins, 1999; Browne and Misra, 2003; Seeberg, 2012; Weber, 2001). This study has addressed the theoretical gap between individual and institutional approaches to intersectionality by drawing attention to a level where multiple social categories of individuals overlap with institutional policy practices to influence opportunities and experiences.

The second main scholarly contribution of this study concerns work as a significant component of welfare state policies. Here, the focus is on how the perspectives of immigrant healthcare assistants as an increasing part of the elderly care workforce can challenge understandings of the effects of work on individual identity. With the help of Hughes' (1984) and Abbott's (1988) theory on work and occupation, my analysis demonstrated that work does not only mean earning a living or contributing to the general welfare of society. Rather, by looking at how subordinated work in elderly care is designated to immigrants, and how immigrants negotiate their identity within the elderly care labour force, this study contributes to the scholarly dialogue of how work can be made meaningful or relevant to the enactment of identity in society (Hughes (1984) and Abbott's (1988)).

Way forward

Looking forward, into the future, there is foremost a need to develop policy and research aimed at bridging the gap between policy makers and researchers by prioritizing the needs of elderly care as identified by researchers. In terms of policy, these include paying attention to the experiences of the immigrant healthcare assistants, as identified in this study and a range of other studies—such as those conducted by Christensen and Guldvik (2014), Dahl (2003, 2006) Gullestad, (2006), Jacobsen (2015), Seeberg, (2012) and Vike (2017).

Secondly, within the context of policy debates on the workforce needs of the healthcare sector, the dominant rhetoric rests on knowledge that has been generalized and is assumed to apply to all sectors of the healthcare. This generalized assumption, as evidenced in policy documents, has led to growing traps and gaps in elderly care where the unskilled workforce, e.g. immigrant healthcare assistants, are not given attention. This point to the importance of obtaining knowledge that is specific to the elderly care institution and labour market. With regards to research, at the time of this study, there is little information about the effects of integration programs and their contribution to career progression within the labour market. In addition, the quality of caring relations between immigrant healthcare assistants and their elderly clients concerning cultural misunderstandings in the Norwegian context are not specifically known.

Thirdly, another under-researched area that needs significant attention is the issue of standardized/formal skill development among an unskilled workforce with diverse backgrounds. Understanding how skill development impacts caring relationships for the immigrant healthcare assistants and how this influences the wellbeing of elderly Norwegians is essential for determining quality of care and demands for the professional healthcare workforce. Moreover, separating the workforce needs of elderly care from those of the general healthcare workforce is equally important as the basis for developing policies that could help to define the currently undefined or unspecific area of elderly care.

I think that future studies in the above-mentioned areas would produce knowledge that could inform policies or re-shape existing policies on integration and labour activation programs, as well as produce knowledge in the specific area of immigrant healthcare assistants within the unskilled workforce in elderly care. From the findings of this study, I argue that without such knowledge, there is a risk that the identified gaps and traps in elderly care will continue, if not escalate. This could imply that policy debates would continue to demand quality and a

professional workforce without knowing how other policy initiatives impact the actualization of these policy demands.

Finally, as a means of using my Ghanaian heritage to enrich this study, I draw attention to the need to bridge the gap between policies and practice with the use of symbols known as *adinkra*. Traditionally, the ‘adinkra’ symbols are reflective of concepts that develop because of changes in society. An example that relates to the debate on policy gaps in this study is illustrated through the symbol called the *boa me na me mmoa wo*:



The symbol *boa ne me mmoa wo* literally translates to ‘help me and let me help you’. It represents different shapes that merge into what is meant to depict a closed shape. It is a symbol that calls for cooperation and independence. On occasions when this symbol is used in Ghana, the message relayed is that when vulnerable individuals are helped in society, their competencies and skills become enhanced and they in turn become resourceful to society.

Perhaps the story behind this symbol can be used to explore how policy initiatives can be specifically designed to meet the needs of targeted individuals and groups, such that these populations will in turn benefit Norwegian society.

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Appendix A. Request to Participate in a Research Project



REQUEST TO PARTICIPATE IN A RESEARCH PROJECT.

Topic: The Role and Experiences of Immigrant Care Workers in an Aging Society: The Case of Norway.

I am by this letter inviting you to participate in a research project on *The Role and Experiences of Immigrant Care Workers in an Ageing Society: The Case of Norway*. I am a student at the Høgskolen I Oslo og Akershus and I am conducting this study as part of my Doctoral degree at the Department of Social Work and Social Policy. I have identified your institution as one of the several institutions that is actively involved in providing services for the elderly in Norway. I would therefore like to include you in this study since I believe you have immigrant staff who are qualified to speak about their experiences in elderly care. I would like to provide you with some information about the project and what it means to participate if you decide to take part in the study.

Purpose of Study

The project seeks to examine the role and experiences of immigrant care workers who provide services for the elderly in Norway; particularly as semi-skilled and low-skilled care givers. I am interested in examining services provided to the elderly people in nursing or residential homes (institutional care) as well as home care. I am conducting this study because I want to learn more about how care provided by immigrant care workers fit into the Norwegian family system and the state. By this, I want to find out how factors such as staff shortage, language barrier, cultural differences and ethnic background of immigrant care workers complicate (or perhaps simplify) relationships between immigrant care workers and their elderly Norwegian

clients. The study will consider practical aspects of the work of elderly care by focusing on relations between immigrant care workers and their elderly clients.

Explanation of procedures

The study will involve a one-on-one interview and a focus group discussion which will last for about one to two hours. The interview and focus group discussion will be held at different times/date. During this time, participants will be asked about their experiences with elderly care in Norway. As part of the study, I will also like to do some observation to get a practical aspect of what goes on in the daily working life of participants. All interviews will be conducted at a place and time which is convenient and safe for both participants and researcher. With the permission of participants, the interviews will be audio-tape recorded to ensure an accurate recording of views and to aid in data analysis.

Colleagues of participants

As part of the study, colleagues of the participants (i.e. immigrant care workers), would be asked questions about their working relations and experiences with participants. It is therefore required that the colleagues are informed about the study and give their consent to participate.

Rights of participants

Participation in this study is on voluntary basis. Participants have the right to refuse to answer some of the interview questions and by informing the researcher, they can decide to withdraw from the study at any time without any consequences.

Confidentiality

Information gathered during the study will be reported in an aggregated manner to protect the identity of participants. However, with the permission of participants, anonymous quotations will be used. The name of participants and their place of work or other identifying details will not appear in the publication of results from this study. It is hoped that results from this study will be published in the form of as research paper, presented during professional meetings and published in professional journals.

What will happen to the information about you?

All personal data provided for this study will be treated with confidentiality. Data generated for this study will be kept in a locked office. Names will be kept separate, and replaced by a code in the data material. Personal data and tape recordings will be destroyed when the study is completed. The project is estimated to end on **31.10.2017**.

Risks

There are no known risks associated with this study. The only potential discomfort could be in the form of possible emotional feelings when talking about certain aspects of your experiences.

Benefits

It is generally acknowledged that you play a significant role in the elderly care sector based on the job you do. However, there is lack of knowledge on your unique experiences. By participating in this study, you will help to provide a better understanding of the role and experiences of immigrant care workers in the Norwegian elderly care sector

In addition, you may find this interview to be rewarding and enjoyable since most people who do the same work as you do not get the opportunity to share their experiences with an immigrant researcher who is very interested in the topic for discussion.

I would like to assure you that this study has been notified to the Data Protection Official for Research, Norwegian Social Science Data Services (NSD) and it has been reviewed and received approval. They can be reached on: [Tel:- +47 55 58 21 17](tel:+4755582117) or email: - nsd@nsd.uib.no

Further questions

In case you have further questions regarding this study, please feel free to contact me or my supervisor through the details below:

Researcher:

Vyda Mamley Bjørvik

Høgskolen I Oslo og Akershus

Postboks 4, St Olavs plass.

0130 Oslo.

E-post: Vyda-Mamley.Hervie@hioa.no

Telefon (office) : + 47 672 38 079

Mob : +47 414 63 274

Supervisor

Professor Marie Louise Seeberg

Norsk Institutt for Forskning om Oppvekst, Velferd og Aldring (NOVA)

Senter for Velferds og Arbeidslivsforskning, HiOA.

E-post: marie.l.seeberg@nova.hioa.no

I look forward to your participation in this study.

Yours sincerely,

Vyda M. Bjørvik

Appendix B. Consent form

CONSENT FORM

For Participants and Colleagues.

I have read the information letter about a study on: - The Role and Experiences of Immigrant Care Workers working with elderly Norwegians. My participation in this study is voluntary and I have had the opportunity to ask questions related to this study and I have received satisfactory answers.

I have been informed that I have the option of allowing my interview to be audio-tape recorded to ensure an accurate recording of my views and to aid in data analysis.

I have also been informed that results from the study may be included in the publication of articles and quotations will be used in an anonymous manner.

I am aware that I can refuse to answer certain questions and I can withdraw from taking part in the study at any time without any consequences; but by simply informing the researcher.

I am also aware that if I have further concerns regarding my participation in his study, I may contact the Supervisor of the researcher or the Norsk Samfunnsvitenskapelig datatjeneste AS (Telefon: - +47 55582117)

With full knowledge of the above, I agree to take part in this study.

Participant's Name (please print) _____

Participant's Signature _____ Date _____

Researcher's Signature _____ Date _____

Appendix C. Interview Guide Managers

Interview Guide for Managers

1. Profile of workforce

- How many immigrant care workers do you have?
- a) From your experience, what are some of the advantages in working with immigrant care workers? - Probe
- b) Based on your experience, do you think that some particular nationalities have particular skills needed in elderly care in Norway?
- c) What are some of the challenges in working with immigrant care workers? Probe:-
How do you handle these challenges?

2. Impact of immigrant workers on elderly care

- a) From your experience, what do you think about the impact of immigrant workers on the quality of care to elderly people?
- b) What is the general relationship between immigrant and non-immigrant staff in providing care for the elderly?

3. Care relationships

- What type of relationships do you feel immigrant care workers have with elderly people?
- Do you think the elderly openly accept immigrant care workers? Probe how/how not.
- What are some of the positive/negative comments you receive about immigrant care workers? i.e. from both clients and their family members?
-

4. Future of elderly care and immigrant care workers.

- What are your views about the future of immigrant care workers in Norway's ageing society?
- Do you think there will be more national citizens or immigrants taking care of the elderly?

- 5. Is there anything you will like to say/add to the discussion?

Thanks for your time and views. I appreciate it very much.

Appendix D. Interview Guide Main Participants

Interview Guide

Topic: The Role and Experiences of Immigrant Care Workers in an Aging Society: The Case of Norway.

**Before the start of every interview, researcher will briefly introduce topic and discuss issues of consent and other relevant information with participants.*

Introduction: (explore reasons why participants work in the elderly care sector)

- Why did you apply for a job to care for older people?

At work:

- Describe your typical day at work
- Can you tell me about the exact work you do for the elderly clients?
- How do you feel about this job?
- What is unique about the type of work you do?

Roles/skills:

I would like to know about the kind of skills you use in your job:

- What particular skills are needed or recognised in your day-to-day work?
- Do you think you have any particular skills which are not formally recognised in your work?
- Is it possible/ not possible to use these skills?

Working relations

- When you accepted to work with the elderly, what were your expectations in terms of the type of work you will be doing?
- What is the relationship between you and elderly Norwegians?
- Can you tell about a particular situation/incident in your working life where you think you had very good/positive feeling about your work with an elderly person? What do you think created this positive relationship?
- Explore opposite of the above

- What do you think is the general attitude of your elderly Norwegian clients towards immigrant and non-immigrant workers?
- Can you remember an incident that made any of your clients complain about how you cared for them or your attitude towards work?
 - o Explore issues related to language, ethnic background and cultural differences and discrimination.
 - o Do you interact with some of their family members? What are your experiences?
- What is the relationship between you and other staff who are above your position?

I would like to know about your elderly clients:

- How do you describe older people in general?
- How is your attitude towards the elderly changed since you started here?
- What do you think about the future of elderly care Norway?

Work experience across different care settings for the elderly

- Do you have experience in working in other working settings like homecare?
- How different are these working environments?
- What do you think is the most important quality of life issue for the elderly in homecare and in residential homes?

Ethnicity

- How important is ethnicity in your role as a care worker?
- Can you tell me about a specific experience to support your view?
- Have you ever been restricted from doing a particular job for an elderly because of your ethnicity?

Future:

- Where would you like to work in the next 5 years?
- *If participant wants a change in field of work, probe why and if they still want to remain, find out why.*
- How do you see the future of immigrants working in elderly care in Norway?

Explain.



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Appendix F. NSD Feedback and Approval

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 20.08.2014.
Meldingen gjelder prosjektet:

39467 *The Role and Experiences of Immigrants in an Ageing Society: The Case of
Norway*

Behandlingsansvarlig *Høgskolen i Oslo og Akershus, ved institusjonens øverste leder*

Daglig ansvarlig *Vyda Mamley Hervie*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 31.10.2017, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Inga Brautaset

Kontaktperson: Inga Brautaset tlf: 55 58 26 35

Vedlegg: Prosjektvurdering

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Avdelingskontorer / District Offices:

OSLO: NSD, Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no

TRONDHEIM: NSD, Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrre.svarva@svt.ntnu.no

TROMSØ: NSD, SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. nsdmaa@sv.uit.no



Prosjektvurdering - Kommentar

Prosjektnr: 39467

The purpose of the project is to examine the role and experiences of immigrant care workers who provide services for the elderly in Norway; particularly as semi-skilled and low-skilled caregivers in long-term care sectors as well as home care.

INFORMATION AND CONSENT

The sample will receive written and oral information about the project, and give their consent to participate. The letter of information and the consent form is somewhat incomplete. We ask that the following is changed/added:

- "Data generated for this study will be kept in a locked office. Names will be kept separat, and replaced by a code in the data materiale. Personal data and tape recordings will be destroyed when the study is completed.

Estimated end date of the project is 31.10.2017."

- It should be mentioned in the letter that The Data Protection Official (NSD) is notified about the project.- In the consent form, the following should be deleted: the first " YES NO" and "I agree to the use of anonymous quotations in any publication that comes of this research. YES NO"

We ask that the revised letter of information is sent to personvernombudet@nsd.uib.no before contact with the sample is established.

REGARDING THE PATIENTS

We recommend that the researcher reminds the participants about their legal confidentiality, and ask them not to mention any names or identifying background information about the patients to the researcher.

Only patients who consent to the researcher's presence will be observed. They should be informed that the focus of the observation is on the caretaker, and that only anonymous information will be registered about the patient.

COLLEGUES

If colleagues of participants are going to be asked questions about their working relations and experiences with the participants (i.e. immigrant care workers), both colleagues and participants must get information and give their consent to this.

DATA SECURITY

There will be registered sensitive information about the informants, relating to ethnic origin or political/philosophical/religious beliefs, and trade-union membership.

The Data Protection Official presupposes that the researcher follows internal routines of Høgskolen i Oslo og Akershus regarding data security. If personal data is to be stored on portable storage devices, the information should be adequately encrypted.

In publications, the data will be presented in anonymous form, so that no individual can be recognized, either directly or indirectly.

PROJECT END

Estimated end date of the project is 31.10.2017. According to the notification form all collected data will be made anonymous by this date. Making the data anonymous entails processing it in such a way that no individuals can be recognised. This is done by:

- deleting all direct personal data (such as names/lists of reference numbers)
- deleting/rewriting indirectly identifiable data (i.e. an identifying combination of background variables, such as residence/work place, age and gender) - deleting audio recordings.