social sciences

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Surfacing Gender: Designing Care Homes for Women in All Their Diversity

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Abstract: Reflecting on findings from over ten years of research, four studies, and a focused two-day workshop, this article argues that it is past time to surface gender as a critical consideration in reimagining care homes to create conditions of dignity and respect for residents, workers, and families in all their diversity. Considering care homes as an indicator of equity in welfare states, we deploy a concept of gender that acknowledges the relationship between bodies and social relations, and an inclusive concept of women that interrogates the differences among women. We outline the reasons that make care homes a women's issue, explaining why women are the majority of care home residents and staff across jurisdictions in high-income countries. We draw insights from our workshop and research studies to discuss how gender is both ignored and embedded in care home design and offer considerations and possibilities for designing care homes for women in all their diversity.

Keywords: gender; equity; diversity; care homes; women; work; care; nursing homes; bodies; aging

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Citation: Armstrong, Pat, and Susan Braedley. 2024. Surfacing Gender: Designing Care Homes for Women in All Their Diversity. *Social Sciences* 13: 669. https://doi.org/10.3390/socsci13120669

Academic Editor: Barbara Fawcett

Received: 24 July 2024
Revised: 22 November 2024
Accepted: 5 December 2024
Published: 12 December 2024

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1. Introduction

Variously called long-term care homes, nursing homes, care homes, and homes for the aged, these places, intended for those who need 24 h, seven-days-a-week care, are primarily places for women, with care provided mainly by women, many of them racialized and/or immigrant. Yet care home policy, design, organization, and practice rarely acknowledge or consider this deeply gendered structure, offering a clear example of how gender can disappear from consideration in an area where women are the majority of workers and/or service users. The outcome is that gender inequalities are often reinforced in care home policies and practices, and opportunities to address them are lost.

In 2012, Armstrong et al. proposed that

> "the very concrete case of long-term care, especially for the elderly, can be used as an overall indicator of equity, and thus, of the extent to which there is a state devoted to the welfare of its citizens. By equity, we mean treating both those who provide and those who require care in ways appropriate for their needs and that maintain their dignity, as well as their capacities". (Armstrong et al. 2012, p. 49)

As feminist political economists committed to research that contributes to equity, we have been arguing for almost a quarter century that gender should be central in policy, planning, organization, and daily practices. In this article, we reflect on our many care home-related research projects to report on our progress in addressing a series of questions about gender as it is institutionalized and organized in care homes. Further, we consider what care homes can teach us about the broader gender relations embedded in everyday life. How can and should gender be considered in planning, building, operating, and organizing care homes? How can we take general patterns of gendered needs and preferences into account

without ignoring those who do not fit the pattern while also challenging assumptions about those patterns? How can care homes assess and address the many inequities of gender, race, class, age, ability, and immigration status to produce conditions of work and care that support dignity and respect for the many women who work, live, and visit in care homes? At many points in our research, addressing these questions has challenged, even daunted, us (Braedley 2013). However, we remain convinced they are important questions worth pursuing.

The gendered nature of care has received considerable attention from feminists over the years. As a recent review of the literature explains, "much of feminist work has focused on categorizing, qualifying, and recognizing care work" (James et al. 2024, p. 2). Another large body of literature focuses on care as a relationship (for example, Fisher et al. 1990), while an extensive literature on both gender regimes and care regimes (Anttonen and Sipilä 1996; Jenson 1997; Walby 2020; are examples) explores how context matters in the ways gender is understood, expressed, and taken up across jurisdictions.

Building on and contributing to this literature, our theoretical approach begins with the recognition that context, gender, and other social locations such as class and race, as well as the search for profit, matter (see Armstrong and Armstrong 2018). We also assume that the conditions of work are the conditions of care, that both paid and unpaid work require skills, and that care is a relationship requiring not only managerial and financial resources, but also structural and cultural support. We assume that gender shapes who lives, visits, manages, and works in care, and how both residents' lives and care work are organized and valued. Gender influences policy decisions and public ideas about the location and funding of care homes, it shapes regulations, work organization, care models, and much worker education and training. We assume that gender is always present, even, and perhaps especially, when it appears to be missing. Considering gender means addressing not only the needs and preferences associated with gender, but also addressing inequities among gendered bodies, gender relations, and within and across diversities within gender categories.

In moving towards a more comprehensive gendered analysis of care homes, then, it is important to note that women are the majority of care home residents and workers and that these facts are reflected in assumptions about the skills and value involved in care home work. However, we also seek to identify other gendered assumptions built into care homes. For example, care home organization and practices tend to reflect and reinforce ideas about women's 'place' in society as a homemaker and natural nurturer, through activities like getting women residents to fold towels and cook, and through practices that assume any female relative can provide care (Armstrong 2023; Braedley and Martel 2015), or by assuming that male workers, usually racialized and/or immigrant, cannot do care work appropriately and put women residents at risk when they do (Owusu et al. 2023; Storm et al. 2017; Storm 2023; Gaviola et al. 2024). The dominance of women can lead to the incorrect assumption that care homes are appropriately designed and organized for women, but not for men. Helgesen et al. (2016, p. 185) provide just one example of this tendency, noting "it is reasonable to assume that male residents are at particular risk of not receiving person-centred care as they inhabit a largely 'female domain'." At the same time, research that attends to racialization and immigration status among workers and residents (Jeong et al. 2020; Simmons et al. 2022), provides limited gender analysis.

Rooted in historical materialism, our feminist political economy approach assumes that, "[t]heory and evidence must always be in dialogue with each other" (Thompson 1993, p. 275). Therefore, we begin our conceptual discussion of gender with a brief description of the empirical basis for our thinking. Next, we outline our concept of gender, and then draw from both theory and evidence to take up the question of why care homes are places in which women work and live, including asking which women. We do not stop there. To contribute to equity, we must not only link theory to evidence and vice versa but go further to consider policy and practice action that can address inequities. Therefore, we lay out considerations and possibilities for designing care homes for women in all their diversity.

We argue that it is past time to surface gender as a critical consideration in reimagining care homes to create conditions of dignity and respect for residents, workers, and families in all their diversity. The article is intended as a prompt for further research and policy development, a prompt informed by years of empirical research and its related, ongoing dialogue with theory.

2. Our Research

We come to these questions as feminist political economists with long-standing interests in gender, work, aging, and equity matters. Between 2010 and 2020, our international, interdisciplinarity team was funded to employ multiple methods in a search for ideas worth sharing on how to make life worth living for care home residents and the work worth doing for care home staff in Canada, the U.K., Sweden, Norway, Germany, and the U.S. We are white women, and our team members are scholars living in North American and European countries. The team has included women and men of a wide range of ages and career stages, from emerita to new graduate students. It includes scholars who are queer and straight, white, racialized, immigrant, and living with disabilities. Some of these scholars' publications are cited in this article. The details of our research methods are described at length in our book, *Creative Teamwork: Developing Rapid, Site-Switching Ethnography* (Armstrong and Lowndes 2018). Central to this work were our rapid ethnographies conducted collaboratively by our international, interdisciplinary research team. Based on scoping research methods using publicly available care home data and key informant interviews, we purposively selected care homes with reputations for quality care, then researched each of these homes over a week-long, team-based, intensive rapid ethnography. Subsequently, we built on this research in studies focused on Canada, Norway, and Sweden to explore further issues of unpaid work, the future of care homes, and labour force challenges (see Armstrong 2023; Armstrong and Braedley 2023; Armstrong et al. 2024). These studies included key informant interviews, secondary data analysis, policy analysis, and a literature review. In each study, we sought to make gender central to our analysis. While we documented multiple ways that gender pervades the organization and conditions in care homes, including care relationships, we left many questions unaddressed about how to design, construct, and organize care homes, and deliver care with gender in mind.

Because our research takes an iterative approach designed to inform policy and practice, we did not stop there. To help think through how to address these questions of design, construction, organization, and care delivery, in 2023 we organized a two-day intensive collaborative discussion-based workshop on designing care homes in Canada for women in all their diversity. We brought together individuals who have experience in the field to think through what such a design would look like for the many women who live in care homes; the many women who do paid work in care homes; and the many women who provide unpaid care and support for residents of care homes. The workshop included people who have done paid and unpaid work in care homes, people who research care homes and women's work in them, and people managing or making policy for these homes. It included white, racialized, and Black women, able-bodied, differently abled, queer, and straight people, people in their 20s, 30s, 40s, 50s, 60s, and 70s, newcomers and long-settled women, and women from a variety of cultural and spiritual communities, including Jewish and Muslim women. The group did not include any Indigenous women or trans people, although they were invited.

This article reflects on what we have learned in our discussions and analysis from that workshop, our team's studies of care homes, and our team's continuing research work. It is grounded in the concrete issues identified in our research and by workshop participants as critical to designing care homes for women in all their diversity. We encourage readers to imagine with us what an equitable care home might be, including how diversity and differences in context can be taken into account, as a contribution to both care home design and wider conversations about advancing equity in ways that take diversity into account.

3. A Word on Sex and Gender

Traditionally, the term sex was used to talk about biology, while gender was used to talk about social relations (Canadian Institute for Health Research 2021). However, the dichotomous categories of male and female bodies became increasingly contested, as did the notion that bodies exist outside contexts and histories. "Physical capacities do not exist outside—autonomously from—power structures and productive processes. Nor are they beyond human control and manipulation" (Armstrong and Armstrong 1984, p. 32). Most commonly now, the term gender is used to conceptualize the complex relations resulting from the ways that biology, embodiment, power, and other social relations influence each other, erasing prior binary understandings of human gender identification and gender categories (Fausto-Sterling 2000). Yet, as Karen Messing, a Canadian expert on occupational health from a gender perspective put it,

> "Yes, most physical, social and psychological characteristics of women and men overlap; yes women and men and everyone else should be able to access all jobs. But—there are areas where there is little overlap in physical characteristics, where many women (and a few others) are disproportionately affected by the fact that workplaces are designed for the average XY body". (Messing 2021, p. xvii)

On this basis, she argues that "above all, we need to develop ways to protect each other while we struggle together to adapt the workplace to our bodies and our lives" (Messing 2021, p. xv). We add that it is not only workplaces that need to be adapted, but all our physical environments for living and working.

We recognize that 'women' as a category is itself contested at the same time as many of those who self-identify as women, or are identified by others as women, are treated as a single category. Gender is about identities, bodies, and social relations characterized by persistent inequities, interwoven with inequities of race, immigration status, age, ability, and sexuality. It is shaped by and shapes forms of capitalism along with colonialism and is expressed at all levels of scale. Gender hierarchies are constituted and expressed in power relations, divisions of labour, consumption and accumulation regimes, intimate and emotional relations, and discourse and culture (Connell 2009).

So, how do women's bodies and lives matter in care homes? We aim to consider them in a non-essentializing way, to allow for the realities of men who become pregnant, women with penises, and non-binary people who menstruate. We deploy a generous definition of women in our research and theory, including all those who identify as women and all those who are identified as women, even if only in discreet (frequently medical) contexts. Workers and residents bring their biological and embodiment histories and realities related to menstruation, pregnancy, fertility and birth control, childbirth, abortion, breast-feeding, menopause, hormone therapies, sexual violence and trauma, medical violence and trauma (often associated with childbirth, hysterectomies, and fertility/infertility), and the gender-specific ways that women's bodies experience aging, illness, and disability. All women have gendered vulnerabilities to toxic substances and physical, social, and organizational hazards, and distinct patterns of disease symptoms when compared to men. Women's paid and unpaid work histories are also important to consider. Most women work in feminized sectors, including health care, social care, education, personal services, hospitality, and retail. Many women also do significant gender-segregated unpaid work, including housework and care for family and friends. These histories mean that women's bodies—whatever their identities—are shaped by gendered job- and task-specific exposures to hazards, repetitive movements, interactions with equipment, supplies, and people, and much more (Messing and Cox 2024).

Further, there is a growing body of clinical research on patterns of gender differences in, for example, responses to psychotropic drugs (Keers and Aitchison 2010), heart attacks (Milner et al. 2004), and nutrient impact (Morley 1993). Significant to the care home population, there is little research on gendered differences in how dementia may affect individuals, including on how care homes can adapt to different needs. However, research

indicates that cisgendered men have had higher overall mid-life dementia risk and lower late-life Alzheimer's disease risk compared to cisgendered women. Transgender men, transgender women, and non-binary adults had higher overall late-life risk compared to both cisgender men and women (Brady et al. 2024). Research also indicates that there are gendered patterns in how people with dementia are understood and treated for the disease (Resnick et al. 2022), although there are questions about whether these patterns are based on gendered stereotypes or on clinical differences. In our care home research, however, we found little evidence that such differences were considered.

In sum, there are patterns across men's and women's bodies and lives, and in gender relations. These patterns should be identified and addressed, even as individual lives are considered and universal patterns rejected. Further, women's individual and varying bodies and lives are affected by stereotypes and assumptions about women as a group that are embedded in and reinforced by organizations and institutions, shaping power relations that oppress and subordinate women, albeit differently.

These patterns of gender inequities and social relations shape care home regimes, including who lives and who works in them. In the next section, we discuss why it is women who work and live in care homes, and which women are involved.

4. Surfacing Gender in Care Homes

4.1. Places Where Women Live

Women are the vast majority of care home residents in all the North American and European jurisdictions we have studied (Braedley 2013). Why is this the case? There are multiple reasons. Women tend to live longer than men and do so with more chronic conditions, although the differences vary with context and culture. Men tend to have more respiratory and cardiovascular diseases, infections, cancers, and autoimmune diseases, and die from them. The pattern for men is partly a result of smoking, alcohol, drug use, occupational risks that have increasing consequences with age (Dattani et al. 2024), and gendered patterns in failing to seek routine medical care. Men also show gendered patterns of difficulties in making and maintaining social networks that prevent social isolation and loneliness, which in turn increases men's mortality risk. This is especially the case for unpartnered men (Milligan et al. 2015; Holt-Lunstad et al. 2010). And because men in heterosexual relationships tend to be older than their wives and to die first, older heterosexual women are more likely than men to live alone without a partner to care for them at home. In addition, widowers are more likely than widows to form a new relationship.

Due to the inequitable gendered divisions of labour in paid and unpaid work that leave many women with lower lifetime earnings and fewer pension benefits, older women tend to be poorer than men (OECD 2022, Box 10). As a result, older women as a group are less likely than men to be able to afford private pay alternatives for care. As the chair of the board at a U.S. nursing home told us, he had no intention of going into a nursing home. When his wife could no longer care for him, he would just hire another woman.

Further, not all women (or men) access nursing home care when they need it. Black, racialized, immigrant, Indigenous, and LGBTQ2+ older adults are under-represented among nursing home residents, due to both the limited number of homes that offer culturally and linguistically appropriate care, and to systemic discrimination that makes nursing homes not only inhospitable but unsafe for some and unavailable to others (Grigorovich 2013; Streeter et al. 2020; Shippee et al. 2022).

4.2. Places Where Women Work

In wealthy welfare states, the "vast majority of care home workers are middle-aged women. One in five are foreign-born" (OECD 2020, unpaginated). A growing number of these workers are also racialized and/or immigrant. Women make up the majority of paid and unpaid care workers throughout the economy, so it is no surprise that this is the case in care homes (OECD 2020), especially in clinical and support services positions. Regarding chief administrator positions, women tend to have more of these jobs than in other economic

sectors, often through promotion from clinical nursing management jobs, but men remain in the majority, according to available data from the U.S. (Cheon et al. 2022).

In all the jurisdictions and facilities we have studied, these places are called 'homes' and 'home,' as a social idea, has long, close associations with women's work. Policymakers' explicit aim is to reproduce as much as possible the 'homelike' conditions of a private dwelling (Braedley 2018; Braedley and Martel 2015), although it is seldom explicit whose home is being replicated. In some care homes we studied in Canada, the U.S., and the U.K., for example, artwork portrayed only white, middle-class people, religious services were Christian, and the food and the music reflected white, Christian, middle-class tastes despite the fact that many racialized, non-Christian, and working class people worked in these homes and lived in the communities surrounding these homes. Across jurisdictions, the operating notion of 'home' was associated with gendered divisions of labour that assign women to caring, including food preparation, laundry, and cleaning toilets, doing so 'naturally' as an expression of their gender. Further, the enormous amount of daily labour involved to produce a 'home' is commonly invisible and taken for granted unless left undone, as are the skills, responsibility, and effort involved in the work.

The assumption that any woman can do this work without much formal training plays out in care homes and is reflected in the ways homes depend on women's unpaid work to supplement paid work, labour often described as family care (Armstrong 2023; Streeter 2023). Although there are significant jurisdictional differences in the division of labour and in the training provided, the majority of care home work is carried out by those with titles such as personal support workers, care aides, or care assistants: jobs that have limited formal education requirements. The work is often defined as providing assistance with daily living, implying that such assistance is what any woman does daily at home. The contributions to care involved by those who do the cleaning, food service, and laundry are particularly undervalued, defined as ancillary rather than as core care work (Armstrong 2013). Gendered understandings of care as embedded in different forms of care organization sharply emerged in our ethnographies. For example, in one Ontario care home with rigid, almost factory-like work organization, women personal support workers complained about men's limited caring skills, and that their approaches were often unwanted by the mostly women residents, while men complained that they were left with the heavy lifting. At a different Ontario care home in which workers enjoyed more autonomy, men care workers were considered a masculine 'compliment' to feminine caring, preserving the association between women and care in ways that continued to naturalize this relationship, while also involving men (Storm et al. 2017).

Years of feminist research and writing have challenged the notion that women's domestic work, typically hidden in the household, is unskilled and done well as a natural or instinctual expression of their gender (Armstrong 2013). Further, feminists have pointed out that support to people living in care homes is not the same as care in the household (Szebehely 2005; Daly et al. 2011); rather, it requires considerable skill and effort to assist people with multiple complex physical, mental, and other challenges—most often combined with dementia—to bathe, eat, walk, and socialize. This undervaluing of skill and effort is reflected in care aides' low wages and their limited control over their work process and schedule. Further, this lack of attention to the complexity of this work makes it dangerous, and our research has identified some ways to make these places safer for women's work (a few examples are: Armstrong and Messing 2014; Braedley et al. 2018). Reflective of the societal devaluation of both women and older people, care home policy and practice have yet to apply these insights to improve conditions.

Indeed, it could be argued that gender is considered in many aspects of funding and organizing nursing homes, but in ways that take advantage of the devaluation of women rather than in ways that benefit women. Low wages, inadequate staffing, limited autonomy, and low funding levels suggest low values placed on older women and those who provide their care. As we noted in our introduction, nursing home funding levels, care quality, wages, and working conditions are indicators of gender equity in welfare

states (Armstrong et al. 2012; Anttonen and Sipilä 1996). Norway's higher spending on care homes may well indicate a higher value placed on both older women and on women's work (OECD 2023, Table 10.12), reflecting more gender equity. But Norway, like all the jurisdictions we have studied, has some labour force practices that reflect long-standing assumptions about women's care work, showing that there is more to be done. For example, men account for only 10 percent of Norwegian nurses (Dæhlen 2024), the exact same percentage as in less gender-equitable Canada (Yang 2024).

As this section's discussion has shown, care homes provide an extreme case example of a traditional gendered and racialized division of labour and of the undervaluing of women's work (Syed 2020), including the ways in which women's undervalued assignment to caring is implicated in shaping their health, income, and other conditions of later life. Even the words attached to these places, such as nursing, care, and home, are words that have strong associations with traditional femininities.

5. Designing Care Homes for Women in All Their Diversity

Given the deeply gendered structures that shape care homes, how could they be funded, designed, and operated in ways that produce conditions of dignity and respect for the many women who live and work in them? How could nursing homes be transformed to address inequities instead of reproducing them? In 2023, we drew on our research experiences and relationships to facilitate a workshop to take on this challenge, highlighting areas requiring not only attention but transformation. Our workshop participants agreed that accommodating both common gendered patterns and ones that do not fit the pattern is no simple task but can be done. In what follows, we identify some critical opportunities to transform care homes by taking gender into account, and briefly describe policy and practice directions that advance equity in the following areas: funding, regulation, conditions, and accountability; physical location and structures; activities and services; and education and training.

5.1. Funding, Regulation, Conditions, and Accountability

Our research has shown that long-term care home systems tend to be underfunded, highly regulated, and often intensively surveilled by funders through extensive data submission requirements in Canada and the U.S. that require workers to spend time entering accountability data instead of providing care (Armstrong and Braedley 2023). These conditions were critiqued by our workshop participants as a reflection of the gender inequities that shaped care home regimes in Canada. As one workshop participant who works in a care home put it, "we are highly contained, restrained, and blamed." Our participants pointed out that current regulation regimes, typically enacted to enforce quality control in publicly funded but often private, for-profit as well as public care homes, result in the regulation of women. Staff are surveilled in ways that require them to work harder, faster, and with more risk to themselves and those for whom they care.

This surveillance implies that women cannot be trusted to have and apply the knowledge and skills required. As one manager told us, "I am working in a box, tied down with regulations that dictate everything I have to do," limiting her abilities to address many issues important to residents and workers. A care aide explained,

> "people . . . do the job of the personal support worker and none of these people want to make a mistake or mess up. But they have so much work to do in a little time period, and in that time anything can happen. There are so many regulations that staff are scared. People used to fight for overtime shifts, but not anymore".

The regulations are often carried out in contexts characterized by low funding, low staffing levels, precarious employment, and profit-taking. Across most of the jurisdictions we studied, significant numbers of workers are employed on a part-time or casual basis (Armstrong et al. 2024; Laxer et al. 2016; Jacobsen et al. 2018), even though the overwhelming majority of women want and need full-time paid work at adequate wages. In our studies, such precarity is particularly common for newcomers and/or racialized women.

These women also lacked control, not only over their employment status but also over their shift schedules, leading to constant disruptions in these women's lives that made it especially difficult for them to combine sufficient paid work to pay the bills with their care for their families.

Such conditions mean that residents experience hurried care from tired workers who do not have time to get to know them, with the risk that they will not receive the care necessary to ensure their health and well-being. Despite constant resident surveillance through data collection, an expert in long-term care data at our workshop explained that policy makers are working with a lack of comprehensive data and, especially, data that adequately capture gender and diversity. This absence contributes to policies based on evidence that does not reflect quality of care, quality of work, or quality of life. Further, this evidence does not consider that this is mostly care by women for women.

How could these conditions be addressed? First, policy makers responsible for care home funding, regulations, and accountability regimes need to take seriously that the conditions of work are the conditions of care and to recognize the gendered consequences of those conditions. This means more is required than an essential increase in funding and the establishment of adequate minimum staffing levels and full-time employment. The goal for care home systems should be respectful, dignified conditions for residents, workers, and families, developed in ways that are based on an understanding of the structures that embed gendered inequities and discrimination. This means that care homes should be understood as public services that benefit everyone in society and are accountable to the people who live in them, the communities they serve, and the wider public, as well as to funders. Further, it means that one size does not fit all residents, families or employees. Further, systems in other countries can learn from care home regulation in Germany, Sweden, and Norway that, in contrast to the heavy surveillance in Canada, the U.S. and U.K., placed greater trust in teams to ensure accountability and greater autonomy for staff, allowing them to respond to individual needs.

Care home policy should ensure the human right to quality care when needed. This means that families—and especially the women in them who provide most of the unpaid care—should be able to provide some care in ways that do not drain their bank accounts and their energies or place a heavy burden on women's unpaid work. It means that those who work in care jobs should receive living wages for jobs that offer permanent full-time employment and time to provide needed care.

As well, care home work needs to be valued and visible, with a clear acknowledgement of the skills and knowledge needed to provide for frail people with complex care needs. As our workshop participants employed in long-term care homes pointed out, their work is often taken for granted and invisible, perhaps most especially for ancillary workers. One participant recalled that during the height of the COVID pandemic, a government leader "thanked the nurses, the doctors, and maybe the PSWs [personal support workers]. But he didn't mention the cleaners who were most exposed!" Cleaning, food preparation, and laundry, traditionally women's work in households, require specific skills in care homes. Housekeepers are responsible for work that maintains infection control, as are laundry workers. These workers often chat with residents while they clean and deal with linens and clothing, frequently alerting nursing staff to residents' issues that come up in these regular conversations. Restricted budgets mean kitchen workers face difficult challenges in providing tempting food for residents who often have poor appetites, require a range of specific textures and nutrients, and present a range of class-based and/or cultural preferences. All this work requires specific expertise and skills and carries significant responsibility for residents' health and well-being. Meanwhile, many of these workers face racism, sexism, harassment, and violence in various forms on the job, yet are told by supervisors and managers to "suck it up" (Braedley et al. 2018).

Equally invisible is the unpaid work most frequently done by workers in addition to their paid work, or by relatives and volunteers (Armstrong 2023). In our studies, such

unpaid work was most common in Canada, the U.S., and the U.K., where staffing levels are low, the work is most precarious, and almost all this unpaid work is done by women.

In the care homes we studied, women's care home jobs seldom offered clear career tracks for advancement, reinforcing understandings of care work as unskilled and of the women who do it as incapable of or uninterested in skill development and advancement. Given labour shortages internationally in the sector (Armstrong et al. 2024), this failure to provide career advancement is not only discriminatory, but counterproductive. However, in Germany, apprentice positions allowed for on-the-job training and some skill recognition while offering appropriate pay. Even more promising were programs in some care homes, such as at one care home in the U.S. and one in Eastern Canada, that offered tuition cost reimbursement for sector-related training and certifications. Other promising organizations across our research sites worked to promote people from within their staff ranks to management positions.

In sum, care work needs to be understood as an amalgam of highly coordinated, discretely deployed clinical, social, and bodily care requiring a broad range of skills used with discretion and judgement in ways that take individual residents' needs and preferences into account within the context of congregate living and gendered histories and relations. As we and our team have explained elsewhere (see, for example, Armstrong et al. 2024; Choiniere et al. 2016), accountability regimes tend to focus on tasks and on requiring constant recording by staff, rather than on measures that would indicate the time and autonomy available for staff to respond to residents' social and medical needs. Residents as well as relatives should be included in the reporting, and there should be indicators to assess racism and other inequities. Equally important, such measures should indicate the quality of working conditions for staff. While they should record such obvious indicators as staffing levels, full-time vs. part-time employment, and benefits like sick leave and pensions, they should also include indicators based on a gendered understanding of health and well-being that would include an assessment of the impact of the conditions on workers' lives outside their paid work, thus acknowledging the specificity of women's family involvement and responsibilities.

These considerations would go a long way to ensure care homes are designed for women in all their diversity. While accomplishing these aims is a long-term project, there are promising practices showing the way. For example, in Norway and Sweden, we noted that care home workers were paid at least the same wages as hospital staff with similar qualifications, unlike in Canada, where care home wages were significantly lower than for comparable jobs in hospitals and other health care organizations. Also promising, and in contrast to common practice, we were told that in a recent Canadian union contract with one employer, all staff were offered full-time employment, were required to be consulted about their scheduling, and had the right to know their schedule in advance and to switch shifts with colleagues, thus allowing them to organize their lives and responsibilities outside paid work.

There is much more that needs to be done. Building on the knowledge and experience of those who do the work and those who need care is an essential foundation.

5.2. Physical Location and Structures

Care homes' physical location and building design have important gender implications and effects: "[w]e shape our buildings; thereafter they shape us" (Churchill in Hansard 1943). The evidence on care homes suggests that the quality of work and care can be affected significantly by location and physical structures and need attention to gender (Armstrong and Braedley 2016).

Location is a gender issue in many ways. The majority of those who enter a care home to do paid or unpaid work are women, so getting to and from the care home is a women's issue. Women are less likely than men to own a car, in part because more of them live on low incomes and care home wages buy few luxuries. Women are thus more likely to depend on accessible, safe, public transportation. Yet, care homes are often located in

areas with poor or no public transit. In rural and urban areas in many jurisdictions, care homes are often located away from town centres and major routes, making travel more treacherous, complicated, and inconvenient for women travelling alone in all kinds of weather conditions. We found that safety is especially a concern for staff whose work shifts mean regularly arriving at or leaving work in the dark and travelling at off-peak times.

Location is a gender matter in other ways. The inequitable gendered division of labour in families typically means that women are more responsible for childcare and care for dependent adults. In our research, we noted that some care homes have eased conflicts between familial care and paid care work by co-locating childcare facilities with a care home, while others included staff's older, disabled family members in co-located day programming. In care homes located in areas with easy access to shopping, we learned that staff and visitors found it convenient to buy groceries on the way home, and residents enjoyed buying necessities and treats, either accompanied by a visitor or staff, or, when possible, on their own. Locating care homes so that the community surrounding the home can come in and the community inside can easily go out, as Jacobsen and Ågotnes (2023) explain, can allow residents (and workers) to maintain their connections to the world, and not incidentally allow some who work or visit there to walk to the care home. To isolate a care home means to isolate the women involved and make their lives more difficult.

At our workshop, one researcher told us about 'care blocks' in Latin America (see Mahon 2024) developed as a policy response to feminist initiatives aimed at shaping more equitable cities. Our research found a similar arrangement in Norway, where a care home was built into the town hub that included the town cinema, a swimming pool, a cafeteria, a spa, a childcare centre, and other services. Located across from a shopping centre and a church, a woman can take her daughter to a swimming lesson and run her errands, while the grandmother in the care home can wheel herself to watch her granddaughter in the pool. Grandma can also go out for a stroll, even in a wheelchair, in a safe and familiar space. Workers can drop their children at the daycare, pick up groceries, and go for an exercise class after work, all within easy distance of the care home.

A confounding issue related to location is affordable housing for workers. In our studies, workers commuted long distances by transit and by car, as they could not afford to live near the care home even when housing was available nearby. In at least two cases, however, care homes had organized affordable housing available to staff. In one jurisdiction, a care home owned an adjacent building that had been made into modest but pleasant apartments. Organized to address high housing costs and as a retainment incentive, these apartments were available for below-market rent to new permanent staff for a one-year period with the possibility of a one-year renewal, allowing new staff to accumulate some capital, pay down any debt, and develop a positive credit rating crucial to obtaining a lease or mortgage. Having housing that was both close by and affordable, while important to all workers, was especially important to women, addressing their concerns for safety, security, and familial responsibility.

The arrangement of care home spaces inside care homes, as well as the equipment and furnishings, also have gender implications. Private rooms and washrooms are especially important for those who are gender fluid, non-binary, or trans, allowing them to maintain privacy and safety. But private washrooms support all residents by ensuring uninterrupted, private continence care and continuous access to a toilet, as Sara Abdou (2023) shows, and make infection control easier. Access to washrooms also has a gender dimension, as incontinence affects twice as many women as men, and especially residents who have given birth. Washroom accessibility is also important for staff, and especially for women, due to menstruation and the risk of urinary tract infections caused by failing to urinate when necessary. In many care homes, there are insufficient staff toilets, with men's washrooms seldom used due to low numbers of men workers, while women's washrooms have line-ups and are often located far from work areas (Abdou 2023).

Our research in five provinces across Canada showed that gendered bodies are not considered in designing spaces and equipment. Cupboard shelves were frequently too

high for many women to reach. Cleaning carts were too heavy for many women to push. Carpeted hallways and lounges make pushing a wheelchair heavy work. Physical strength is especially an issue in laundry rooms, where heavy wet clothes contribute to high injury rates (Armstrong and Day 2017). The physical demands of pushing and lifting can be particularly difficult for many women, as Messing (2021; see also Messing and Cox 2024) points out. Much care home work is physically demanding, 'heavy' work, but design can make it easier and safer for the women who do it.

We also noted many physical design and equipment issues that affected women residents. We saw chairs and equipment that could accommodate large bodies, but there were no chairs to accommodate smaller people, most of them women. Women residents complained that they had to balance on the edge of a dining chair with their feet dangling in a position that was both uncomfortable and undignified. Women also complained that their closets were too small to hold the range of clothing essential to their dignity and identity. Few homes had laundry services able to launder residents' garments, such as wool cardigans and blouses with trims, that could not withstand hot-water machine washing. We heard many families complain that their mother's favourite sweater was shrunk beyond recognition. We also heard about and saw undignified storage of clothing and materials (Armstrong and Day 2017). Diapers were often piled on bedside dressers, announcing to visitors that the residents suffered from incontinence. Residents and staff told us repeatedly that care home failures to deal with incontinence in a dignified manner—including having supplies neatly stored out of sight, accessible, private toilets with sufficient space for both a resident and care aide, and washrooms located close to activity rooms that offered privacy, including with regard to sounds, sights, and smells—can mean, for example, that women residents do not participate in activities for "fear of having an accident".

However, when women were involved in designing care home spaces for living and working, we saw promising practices that addressed gender issues. In one Swedish home, housekeeping staff designed a new cleaning cart that was lighter, easier to clean, and fit more efficiently into corners and awkward spaces. In a Canadian home, housekeeping staff designed colour-coded cleaning materials that were effective in ensuring that there was no cross-contamination, thus improving infection control. In the first case, women took their physical capacities and safety into account, while in the second, they demonstrated their knowledge of the work and skills in preventing disease spread and the inappropriate use of dangerous chemicals. Another promising example of involving the women most involved was industrial designer Sara Abdou's (2023) approach. She interviewed residents, families, and staff to design new cupboards for bedrooms and bathrooms that could effectively and respectfully store continence care materials. We also saw care homes that had designated staff places for rest, comfort, and restoration where staff could go to pray, address their grief, and take time to check in with their households and families. In short, we learned that when provided with opportunities, women are improving the conditions of work that are the conditions of care by building on their knowledge to redesign care homes.

5.3. Activities and Services

In our research findings, care home activities and services tended to reinforce gender stereotypes or failed to consider gender. Dining and food services provide an example of how gender matters, along with culture and language, were often unconsidered. People tend to experience a decrease in appetite as they move into old age. Yet, in many of the care homes we studied, residents were presented with a loaded plate at each meal. Women told us they were so overwhelmed by the amount of (often unappetizing) food provided that they ate little. Across jurisdictions, there were more promising care home dining room services. Some dining services were offered by bringing a warming cart to each table, with a staff person consulting residents about their choices in amounts and kinds of food. Some care home dining services provided food choices that included a variety of culturally specific foods, while others presented residents with a selection of small, attractive 'hors d'oeuvre'-sized food choices, designed to arouse appetites and interest in eating.

Care home design often neglects that staff, too, need to eat. Shift work can mean working all night, when kitchens and nearby food outlets are closed. In our studies, we visited many homes that had no staff food service beyond a vending machine. Requiring staff to pack meals for long shifts ignores the high demands on these women workers' unpaid time. Promisingly, we also visited care homes that offered low-cost meals to staff and free meals for those working overtime or double shifts. For those on overnight shifts, meals were cooked fresh during the day and provided in an easily reheated container.

Gender is often taken up in resident care home activities, but typically in a stereotypical way, for example when there are cooking activities for women and workshops set up where men can do repairs and fix cars. Based on traditional divisions of labour, such activities demonstrate the complexity of recognizing gendered patterns while also accommodating those who do not fit the pattern. Ensuring that activities are structured to welcome everyone is one way of addressing these gendered divides, but it requires making every effort to understand the structures that support and embed exclusions. As is the case with physical design, asking staff, residents, and families to consider this puzzle can help create more accessible and equitable activities. Yet, gender, race, and class stereotypes penetrate social relations and proposed solutions, so even more must be done. Too often in our research, we saw activities that had residents with dementia folding and refolding towels, giving them gendered busy work, rather than meaningful activities that could stimulate their well-being. More promisingly, we saw art activities run by artists trained to work with residents living with dementia and disability. Residents, including those who had never been involved in artistic ventures, those with significant dementia, and even those with sight impairments, worked with clay, paper, paint, and other media, creating regularly in a designated studio space. This activity included women and men and seemed to work well for those from a variety of genders and sexualities, cultural and ethnic backgrounds, abilities, and language groups. We saw choirs made up of residents with dementia. We also noted culturally specific music integrated into the daily life of care. We have also observed activities aimed at engaging those with higher cognitive and physical capacity, such as a resident-run coffee cart that provided a daily coffee hour for staff, residents, and visitors with help from a community volunteer with developmental disabilities.

5.4. Education and Training

In our extensive research in care homes and with workers, families, residents, managers, and policy makers, the topic of gender in education and training seldom came up. An exception was excellent care aide training that covered gender identity and sexuality, but also assured that those who conformed to the normative categories of woman or man were well understood. Further, some homes had excellent training for families, staff, and residents on sexual harassment and racism.

However, there was an overall absence of training on how women's gendered histories may affect their experience of providing or receiving care. These histories include women's religious, cultural, family, and other backgrounds and experiences, including paid and unpaid work. They include women's experiences of trauma, such as domestic violence, sexual assault, rape, and other unwanted sexual attention, pregnancy, childbirth, STDs, and hysterectomy. Any of these experiences can come into play during care, for residents and for workers, and especially around toileting, bathing, and bed care. Further, whether they are men or women, staff with experiences of trauma involving men may have difficulty providing intimate care to male residents.

Past pleasure and joy also need to be considered. Women are sexual beings who enjoy pleasure, including in old age. While we noted that men's sexual interests and activities received support and attention in some care homes, we did not see sexual activity as a category in care plans. We seldom observed support for women's sexual activities, and quite often, discouragement of it (Brassolotto and Howard 2018; Daly and Braedley 2017). Training and education that can help all those involved in designing, organizing, and

providing care homes to consider these gendered histories can provide a solid basis for designing services and activities.

6. Surfacing Gender Going Forward

Our main purpose in this article is to argue that gender matters in all aspects of care homes and for all those who live, work, manage, and visit in them. We have conceptualized and described many of the gender dimensions and considerations within this context, including how gender inequities are reinforced, by reviewing our evidence to show why and how gender should be central to care. In designing care homes for women in all their diversity, we need to learn from what is present in and absent from care home design, organization, and practices, and to consider equity in all these dimensions.

There is much work remaining. We have only touched on the wide range of care home issues that have gender implications, identified only some of the hidden assumptions that perpetuate inequities, and noted only some of the ways we need to take gender and diversity into account. However, while it is challenging to do, we need to undertake gendered analysis continually, identifying both when gender inequities are reinforced and where strategies have been effective in 'building in' gender and diversity in equitable ways. To do so, we need to learn from those who live, work, manage, and visit in the homes, attending to similarities and differences. Finally, we reiterate that care homes offer a useful indicator of equity in welfare states, and a benchmark for policy makers and advocates. Care homes expose the ways that gender in all its diversity penetrates social structures and social relations within specific contexts. While we conclude that there is a long way to go in surfacing gender, there are also promising ways forward.

Author Contributions: The authors contributed equally to conceptualization, analysis, writing, review and editing. P.A. was responsible for funding acquisition and overall project administration, while S.B. managed technology and student supervision. All authors have read and agreed to the published version of the manuscript.

Funding: This article draws on data from the following funded studies: Learning from the Pandemic? Planning for a Long-term Care Labour Force (SSHRC 2020–2024). COVID-19, Families and Long-term Residential Care (SSHRC 2021). USD 24,850. Changing Places: Paid and Unpaid Work in Public Places. (SSHRC 2018–2021) Extended. Reimagining Long-term Residential Care: An International Study of Promising Practices (SSHRC 2010–2020); Healthy Ageing in Residential Places (CIHR); Changing Places: Unpaid Work in Public Spaces (SSHRC 2017–2020).

Institutional Review Board Statement: The studies noted in this article were conducted in accordance with the Declaration of Helsinki, and the protocols were approved by the Ethics Committees of both York University and Carleton University. They include protocols numbered 2011-254 (Reimagining and HARP), e2017-231 (Changing Places) and 2023-034 (Learning from the Pandemic).

Informed Consent Statement: Informed consent was obtained from all participants in the studies noted in this paper. Workshop participants were informed before registering that the workshop notes would be used as a basis for publication.

Data Availability Statement: Data from these studies will be archived by York University but is currently unavailable due to ethical restrictions.

Conflicts of Interest: The authors declare no conflict of interest.

References

Abdou, Sara. 2023. The Design of Long-Term Care Homes: Dignity and Safety in Continence Care. Master's thesis, Industrial Design, Carleton University, Ottawa, ON, Canada.

Anttonen, Anneli, and Jorma Sipilä. 1996. European social care services: Is it possible to identify models? *Journal of European Social Policy* 6: 87–100. [CrossRef]

Armstrong, Pat. 2013. Puzzling skills. *Canadian Review of Sociology, Canadian Review of Sociology* 53: 256–83. [CrossRef]

Armstrong, Pat, and Hugh Armstrong. 1984. *The Double Ghetto: Canadian Women and Their Segregated Work*, rev. ed. Toronto: McClelland and Stewart.

Armstrong, Pat, and Hugh Armstrong. 2018. Theory matters. In *Creative Teamwork: Developing Rapid, Site-Switching Ethnography*. New York: Oxford University Press, pp. 1–21.
Armstrong, Pat, and Karen Messing. 2014. Taking gender into account in occupational health research: Continuing tensions. *Policy and Practice in Health and Safety* 12: 3–16. [CrossRef]
Armstrong, Pat, and Ruth Lowndes. 2018. *Creative Teamwork: Developing Rapid, Site-Switching Ethnography*. New York: Oxford University Press.
Armstrong, Pat, and Susan Braedley, eds. 2016. *Physical Environments for Long-Term Care*. Ottawa: Canadian Centre for Policy Alternatives.
Armstrong, Pat, and Susan Braedley, eds. 2023. *Care Homes in a Turbulent Era*. Cheltanham: Edward Elgar Publishing.
Armstrong, Pat, and Suzanne Day. 2017. *Wash, Wear, and Care: Clothing and Laundry in Long-Term Residential Care*. Montreal: McGill-Queen's Press-MQUP.
Armstrong, Pat, ed. 2023. *Unpaid Work in Nursing Homes. Flexible Boundaries*. Bristol: Policy Press.
Armstrong, Pat, Hugh Armstrong, and Jacqueline Choiniere, eds. 2024. *The Labour Force Crisis in Long-term Care: The Right to Care*. Cheltenham: Edward Elgar.
Armstrong, Pat, Hugh Armstrong, and Tamara Daly. 2012. The thin blue line: Long term care as an indicator of equity in welfare states. *Canadian Woman Studies/Les Cahiers de la Femme* 3: 49–60.
Brady, Brooke, Lidan Zheng, Scherazad Kootar, and Kaarin Jane Anstey. 2024. Sex and gender differences in risk scores for dementia and Alzheimer's disease among cisgender, transgender, and non-binary adults. *Alzheimer's and Dementia* 20: 5–15. [CrossRef]
Braedley, Susan. 2013. A Gender Politics of Long-term Residential Care: Towards an Analysis. In *Troubling Care*. Edited by Pat Armstrong and Susan Braedley. Toronto: Canadian Scholars Press, pp. 59–70.
Braedley, Susan. 2018. Reinventing the nursing home: Metaphors that design care. In *Ageing in Everyday Life: Materialities and Embodiments*. Edited by Stephen Katz. Bristol: Policy Press, pp. 45–61.
Braedley, Susan, and Gillian Martel. 2015. Dreams of Home: Building (In)Equity in Long-term Residential Care. *Studies in Political Economy* 95: 59–81. [CrossRef]
Braedley, Susan, Anna Przednowek, Prince Owusu, and Pat Armstrong. 2018. We're told, 'Suck it up': Long-Term Care Workers' Psychological Health and Safety. *International Journal of Ageing* 43: 91–109. [CrossRef]
Brassolotto, Julia, and Lisa Howard. 2018. *Sexual Expression in Alberta's Continuing Care Homes: Perspectives from Managers and Leaders*. Report. Lethbridge: University of Lethbridge.
Canadian Institute for Health Research. 2021. Sex and Gender in Health Research. Available online: https://cihr-irsc.gc.ca/e/50833.html (accessed on 16 November 2024).
Cheon, Ohbet, Miyeon Song, and Kenneth J. Meier. 2022. Gender differences in performance-driven managerial innovation: Evidence from US nursing homes. *International Public Management Journal* 25: 841–61. [CrossRef]
Choiniere, Jacqueline A., Malcolm Doupe, Monika Goldmann, Charlene Harrington, Frode F. Jacobsen, Liz Lloyd, Magali Rootham, and Marta Szebehely. 2016. Mapping nursing home inspections and audits in six countries. *Ageing International* 41: 40–61. [CrossRef]
Connell, Raewyn. 2009. *Gender*, 2nd ed. Cambridge: Polity Press.
Daly, Tamara, Albert Banerjee, Pat Armstrong, Hugh Armstrong, and Marta Szebehely. 2011. Lifting the 'violence veil': Examining working conditions in long-term care facilities using iterative mixed methods. *Canadian Journal on Aging/La Revue Canadienne du Vieillissement* 30: 271–84. [CrossRef]
Daly, Tamara, and Susan Braedley. 2017. Let's Talk about Sex. . . in long-term care. In *Exercising Choice in Long-Term Residential Care*. Edited by Pat Armstrong and Tamara Daly. Ottawa: Canadian Centre for Policy Alternatives, pp. 69–77.
Dattani, Saloni, Lucas Rodés-Guirao, and Max Roser. 2024. Why Do Women Live Longer than Men? Available online: https://ourworldindata.org/why-do-women-live-longer-than-men (accessed on 14 July 2024).
Dæhlen, Marte. 2024. Is Nursing Not for Boys? Gender Stereotypes in Preschool Surprise Researchers. Available online: https://www.sciencenorway.no/equality-gender-and-society-work/is-nursing-not-for-boys-gender-stereotypes-in-preschool-surprise-researchers/2347036 (accessed on 27 June 2024).
Fausto-Sterling, Anne. 2000. *Sexing the Body: Gender Politics and the Construction of Sexuality*. New York: Basic Books.
Fisher, Berenice, Joan Tronto, Emily K. Abel, and Margaret Nelson. 1990. Toward a feminist theory of caring. *Family: Critical Concepts in Sociology* 2: 29–54.
Gaviola, Minah Amor, Mieko Omura, Kerry Jill Inder, and Amanda Johnson. 2024. Caring for people with dementia from culturally and linguistically diverse backgrounds in nursing homes: A scoping review. *International Journal of Nursing Studies* 151: 104674. [CrossRef] [PubMed]
Grigorovich, Aisa. 2013. Long-Term Care for Older Lesbian and Bisexual Women: An Analysis of Current Research and Policy. *Social Work in Public Health* 28: 596–606. [CrossRef]
Hansard. 1943. *House of Commons (U.K.) 1803–2005 The Prime Minister (Winston Churchill)*. HC Deb 28 October 1943 vol 393 cc403-73. London: UK Parliament.
Helgesen, Ann Karin, Eli-Anne Skaugg, and Vigdis Abrahamsen Grøndahl. 2016. Changing Men's Everyday Lives in Nursing Homes: A Grounded Theory study. *The International Journal of Person Centered Medicine* 6: 185–90. [CrossRef]
Holt-Lunstad, Julianne, Timothy B. Smith, and Bradley J. Layton. 2010. Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine* 7: e1000316. [CrossRef]

Jacobsen, Frode F., and Gudmund Ågotnes. 2023. Bringing the outside in and the inside out: The role of institutional boundaries in nursing homes. In *Unpaid Work in Nursing Homes*. Edited by Pat Armstrong. Bristol: Policy Press, pp. 113–26.
Jacobsen, Frode F., Suzanne Day, Katherine Laxer, Liz Lloyd, Monika Goldmann, Marta Szhebehely, Jacqueline A. Choiniere, and Pauline Vaillancourt Rosenau. 2018. Job autonomy of long-term residential care assistive personnel: A six country comparison. *Ageing International* 43: 4–19. [CrossRef]
James, Yvonne, Billie Jane Hermosural, Ruth Decady, and Ivy L. Bourgeault. 2024. Gender and Healthcare Leadership: Addressing Critical Knowledge Gaps by Explicitly Considering the Gendered Concept of Care. *Healthcare Management Forum*. [CrossRef]
Jenson, Jane. 1997. Who cares? Gender and welfare regimes. *Social Politics: International Studies in Gender, State and Society* 4: 182–98. [CrossRef]
Jeong, Ahwon, Julie Lapenskie, Robert Talarico, Amy T. Hsu, and Peter Tanuseputro. 2020. Health outcomes of immigrants in nursing homes: A population-based retrospective cohort study in Ontario, Canada. *Journal of the American Medical Directors Association* 21: 740–46. [CrossRef]
Keers, Robert, and Katherine J. Aitchison. 2010. Gender differences in antidepressant drug response. *International Review of Psychiatry* 22: 485–500. [CrossRef]
Laxer, Katherine, Frode F. Jacobsen, Liz Lloyd, Monika Goldmann, Suzanne Day, Jacqueline A. Choiniere, and Pauline Vaillancourt Rosenau. 2016. Comparing nursing home assistive personnel in five countries. *Ageing International* 41: 62–78. [CrossRef]
Mahon, Rianne. 2024. The care economy al américa latina: A multi-scalar feminist project. *Social Politics: International Studies in Gender, State and Society* 2024: 1–124. [CrossRef]
Messing, Karen. 2021. *Bent Out of Shape: Shame, Solidarity, and Women's Bodies at Work*. Toronto: Between the Lines Books.
Messing, Karen, and Rachel Cox. 2024. Une tonne de plumes pèse autant qu'une tonne de plomb. Vers la reconnaissance et l'élimi nation des dangers dans le travail des femmes au Québec. *Travail, Genre et Sociétés* 51: 101–18. [CrossRef]
Milligan, Christine, Sheila Alison Payne, Amanda Bingley, and Zoe Cockshott. 2015. Place and wellbeing: Shedding light on activity interventions for older men. *Ageing and Society* 35: 124–49. [CrossRef]
Milner, Kerry A., Viola Vaccarino, Amy L. Arnold, Marjorie Funk, and Robert J. Goldberg. 2004. Gender and age differences in chief complaints of acute myocardial infarction. *The American Journal of Cardiology* 93: 606–08. [CrossRef]
Morley, John E. 1993. Nutrition and the older female: A review. *Journal of the American College of Nutrition* 12: 337–43. [CrossRef]
OECD. 2020. Who Cares? Attracting and Retaining Care Workers for the Elderly. Available online: https://www.oecd.org/en/publications/who-cares-attracting-and-retaining-elderly-care-workers_92c0ef68-en.html (accessed on 22 June 2024).
OECD. 2022. Report on the Implementation of the OECD Gender Recommendations. Available online: https://www.oecd.org/mcm/mcm-2022/Implementation-OECD-Gender-Recommendations.pdf (accessed on 22 June 2024).
OECD. 2023. Health at a Glance: 2023 OECD Indicators. Available online: https://www.oecd.org/health/health-at-a-glance/ (accessed on 3 July 2024).
Owusu, Prince, Susan Braedley, and Palle Storm. 2023. Equity and diversity in nursing home care: Lessons from Canada and Sweden. In *Care Homes in a Turbulent Era*. Edited by Pat Armstrong and Susan Braedley. Cheltenham: Edward Elgar Publishing, pp. 117–36.
Resnick, Barbara, Elizabeth Galik, Rachel McPherson, Marie Boltz, Kimberly Van Haitsma, and Ann Kolanowski. 2022. Gender differences in disease, function, and behavioral symptoms in residents with dementia. *Western Journal of Nursing Research* 44: 812–21. [CrossRef]
Shippee, Tetyana Pylypiv, Chanee D. Fabius, Shekinah Fashaw-Walters, John R. Bowblis, Manka Nkimbeng, Taylor I. Bucy, Yinfei Duan, Weiwen Ng, Odichinma Akosionu, and Jasmine L. Travers. 2022. Evidence for Action: Addressing Systemic Racism Across Long-Term Services and Supports. *Journal of the American Medical Directors Association* 23: 214–19. [CrossRef]
Simmons, Cassandra, Ricardo Rodrigues, and Marta Szebehely. 2022. Working conditions in the long-term care sector: A comparative study of migrant and native workers in Austria and Sweden. *Health and Social Care in the Community* 30: e2191–202. [CrossRef]
Storm, Palle. 2023. Managers' perceptions of masculinity and racialization in Swedish nursing homes. *Gender, Work and Organization* 30: 2175–187. [CrossRef]
Storm, Palle, Susan Braedley, and Sally Chivers. 2017. Gender regimes in Ontario nursing homes: Organization, daily work, and bodies. *Canadian Journal on Aging/La Revue Canadienne du Vieillissement* 36: 196–208. [CrossRef]
Streeter, Christine. 2023. Family workers: The work and working conditions of families in nursing homes. In *Unpaid Work in Nursing Homes: Flexible Boundaries*. Edited by Pat Armstrong. Bristol: Policy Press, pp. 77–85.
Streeter, Christine, Susan Braedley, Irene Jansen, and Martin Krajcik. 2020. *"Its Got to Be About Safety":Public Services That Work for LGBTQ2+ Older Adults and LGBTQ2+ Workers in Canada*. Ottawa: Canadian Union of Public Employees and Egale.
Syed, Iffath Unissa. 2020. Racism, Racialization, and Health Equity in Canadian Residential Long Term Care: A case study in Toronto. *Social Science and Medicine* 265: 113524. [CrossRef] [PubMed]
Szebehely, Marta. 2005. Care as employment and welfare provision–child care and elder care in Sweden at the dawn of the 21st century. In *Dilemmas of Care–The Nordic Welfare State and Paid Care*. Edited by Hanne M. Dahl and Tine R. Eriksen. London: Routledge, pp. 80–100.
Thompson, Edward Palmer. 1993. Theory and Evidence. *History Workshop* 35: 274–76. Available online: https://www.jstor.org/stable/4289239 (accessed on 4 July 2024). [CrossRef]

Walby, Sylvia. 2020. Varieties of gender regimes. *Social Politics: International Studies in Gender, State and Society* 27: 414–31. [CrossRef]
Yang, Jenny. 2024. Gender Distribution of Registered Nurses in Canada 2006–2023. *Statista*, November 13. Available online: https://www.statista.com/statistics/496975/nurse-distribution-in-canada-by-gender/ (accessed on 23 June 2024).

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