‘I work with my heart’:

Experiences of Migrant Care Workers in a Northern, Rural Context

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Abstract in English:

In Norway, long-term care needs are rising rapidly. Due to the dual-earner family model and the fact that many people live far away from frail parents and other dependent family members, the growing care needs may not be met through informal care. Through the Nordic welfare system, formal care services are provided to all citizens in need of care, regardless of their age, income or family relations. Since the 1990s, however, Norway has experienced a shortage of healthcare personnel. In this 'care deficit' situation, skilled immigrants play an increasingly important role. To date, the international literature has examined the experiences of the professional migrant care workers in a limited way. In particular, there is a lack of knowledge of this issue in *rural* contexts where recruitment challenges may be even more pronounced than in urban areas. This article addresses this knowledge gap by examining the spatial and relational experiences of skilled migrants working in the healthcare sector in Finnmark, northernmost Norway. In this study, the informants share largely positive experiences, stating that their care services are highly valued and that caring provides them with a sense of joy and mastery. Moreover, they talk about the importance of establishing trust in the relationship with their users and note that some patients end up becoming almost like family members. The migrants' relationships with colleagues and management at the workplace are also defined by mainly positive feelings, trust and respect. Caring is hence perceived by the migrants as an inherently *sense-making practice*.

Keywords: skilled migrant care workers, rural context, care, relationships with care recipients and colleagues, ageing population

Introduction

Norway[i] is experiencing a rapid growth of its elderly population. According to the census conducted by Statistics Norway in 2015, 14 % of the Norwegian population is 67 years and older (SSB 2015[ii]). This percentage is projected to increase to 17 % in 2030. Due to a relatively young immigrant population and a fertility rate of 1.8, the Norwegian society is not ageing at the same pace as some of the other high-income countries. Norway's long-term care needs are nevertheless increasing rapidly. In the past, frail elderly people, and others in need of care, were mostly cared for by female family members, such as sisters, daughters, or daughters-in-law. Women in Norway still constitute the majority of informal care givers (Isaksen, 2012; Szebehely, 2005). Today, however, almost as many women as men work for wages outside the family sphere (Kitterød & Pettersen, 2006). In addition, many family members live geographically far away from each other. Hence, it has become difficult for adult daughters and other family members to take full responsibility for the care of elderly dependent parents or other family members in need of long-term care.

In Norway, informal care from family members is therefore strongly supplemented by formal care services provided by professional care workers, all of whom are primarily employed in the municipal care sector. Hence, as part of the Nordic welfare model, formal care services are provided at a relatively low expense to all citizens in need of care, regardless of their age, income or family relations (Vabø et al. 2013, Riemsdijk 2010). Since the 1990s, however, Norway has experienced a shortage of healthcare workers, and employers are often unable to fill vacancies (Isaksen, 2012). Skilled immigrant care workers play an increasingly important role in mitigating this situation of 'care deficit' (ibid.). Immigrants currently make up 40 % of the annual increase in registered nurses in Norway (Aamodt, Høst, Arnesen, & Næss, 2011). Among the new registered healthcare workers, this percentage is even higher (ibid.).

Despite the growing share and importance of migrants in qualified health and care work throughout Norway, with the exception of a few studies (Christensen & Guldvik, 2014; Isaksen, 2010, 2012; Riemsdijk, 2006, 2010, 2013), relatively little has been written about this group. Conversely, internationally and not least in the Journal of Population Ageing, the rise of skilled migrant care workers has been widely discussed by highlighting issues such as the role of migrant live-in caregivers (Chowdury & Gutman, 2012; Huang, Yeoh, & Toyota, 2012; Szeman, 2012) as well as the various challenges related to migrants working as care providers in nursing homes and in home-based eldercare (e.g., (Anderson, 2012; Atanackovic & Bourgeault, 2013; Bourgeault, Atanackovic, Rashid, & Parpia, 2010; Browne & Braun, 2008;

Cangiano & Shutes, 2010; Ho & Chiang, 2015; Lowell, Martin, & Stone, 2010; Ortega, Carneiro, & Flyvholm, 2010; Timonen & Doyle, 2010; Walsh & O'Shea, 2010).

Timonen and Doyle (2010) argue that Western eldercare is suffering from stagnation, poor finances and a lack of personnel. The many migrants who are entering the sector may thus appear as saving angels. In view of the relative marginalisation of migrants in many high-income countries, several scholars nevertheless worry that the growing share of migrant workers may lead to a further devaluation of care work and to a degrading of the quality of care relations (Timonen and Doyle 2010, Bourgeault et al. 2010, Browne and Braun 2008, Walsh and O'Shea 2010, Huang, Yeoh, and Toyota 2012). To date, the literature has examined the experiences of the professional migrant care workers themselves in a limited way. In particular, there is a lack of knowledge of this issue in *rural* contexts where recruitment challenges may be even more pronounced than in urban parts of the Western world. This article addresses this knowledge gap by examining the spatial and relational experiences of skilled migrants working in the healthcare sector in Finnmark in northernmost Norway. Drawing on data from a qualitative study, the article analyses how the migrants describe their care relationships with users or patients, as well as with colleagues and leaders at the workplace. The remainder of this article is organised as follows: first, the context for the study is introduced. Then, the relevant literature is briefly discussed, and the adopted methodological framework are presented, followed by an analysis of the empirical data. The article ends with some concluding remarks.

Migration in the context of Finnmark, northernmost Norway

Currently, immigration is increasing in all parts of Norway, including in Finnmark, where almost 10 % of the population comes from countries such as Russia, Finland, Poland, Lithuania, Sweden, Thailand, Afghanistan, Somalia and Nepal. Increasingly, migrants constitute an important supplement to 'native' professional care workers in Norway. Migrant care workers arrive in Norway through public recruitment campaigns of nurses from Latvia (Isaksen, 2012) and Poland (Riemsdijk, 2006, 2010, 2013), through individual labour migration from Southern and Eastern Europe, as refugees or as marriage migrants. In order to work in Norway as, e.g., a registered medical doctor, nurse or healthcare worker, an immigrant must obtain authorisation from the Norwegian Public Office for Health Care Professionals (SAFH). Candidates with an education from an accepted institution within the EU are automatically acknowledged, whereas candidates with an education from other countries are often turned down by the SAFH and must

therefore work in lower positions than would be indicated by their education (Isaksen, 2012; Riemsdijk, 2013). In some cases, these professionals take supplementary exams in Norway or are forced to undergo their entire degree anew.

Studying unskilled and skilled migrant care workers

In this article, care is understood as 'that range of human experiences which has do to with feeling concern for and taking charge of the well-being of others' (Wærness 1984, 188). It is thus a key dimension of social interaction that includes both the emotional and physical work (Twigg, 2000) of assisting people with medication, meals, personal hygiene and social interaction, which are often seen as some of the core activities of care work (Johansen & Fagerstrøm, 2010; Wærness, 1984). For many years now, women from low-income countries in particular have migrated to the wealthier parts of the world offering their care services as au-pairs or domestic workers in private homes (Bikova, 2010; Kristensen, 2015; Lutz, 2008; Parreñas, 2001). The term 'global care chains' has often been used to conceptualise this phenomenon (Yeates, 2004). It means, among other things, that many, often unskilled, female care workers raise the children and clean the homes of the upper middle class while simultaneously trying to provide both emotionally and economically for their own family across enormous geographical distances. In addition and more recently in high-income countries, such as Singapore (Huang et al., 2012) and Canada (Chowdury & Gutman, 2012), but also in middle-income countries such as Hungary (Szeman, 2012), we see that migrant care workers increasingly live together with elderly dependent persons as *live-in caregivers*. The literature on this phenomenon has been largely preoccupied with the challenges of being an often unskilled, female and racialised care provider to a care recipient who is also the employer with the power to fire the care provider (being fired indicates that the live-in caregiver would be forced to return to her country of origin). Although the caregiver – care recipient relationship is sometimes experienced as positive by both parties, the literature reveals that it can also be ambivalent and shaped by discrimination and exploitation (Christensen & Guldvik, 2014; Parreñas, 2001; Timonen & Doyle, 2010; Yeates, 2004).

In recent years, increasing numbers of *skilled* or *professional* care workers have also begun migrating to high-income countries (Atanackovic & Bourgeault, 2013; Bourgeault et al., 2010; Browne & Braun, 2008; Ho & Chiang, 2015; Huang et al., 2012; Isaksen, 2012; Ortega et al., 2010; Riemsdijk, 2006, 2010, 2013; Walsh & O'Shea, 2010). One concern for this research has

been the difficulty of nurses in having their education transferred to the new home country (Isaksen, 2012; Riemsdijk, 2006). Some certified nurses (*from* certain countries and *within* certain contexts of reception) may only become approved as registered healthcare workers or assistant nurses and must therefore 'put up with' less pay, and in addition less professionally challenging but physically heavier and dirtier tasks in comparison to their formal qualifications (England, 2015; Iredale, 2001, 2005; Isaksen, 2012; Riemsdijk, 2006). Other studies investigate *how* migrants are recruited into the healthcare sector (Atanackovic & Bourgeault, 2013; Isaksen, 2012; Riemsdijk, 2006). In recent studies, the relationship between migrant nurses or healthcare workers and their users, colleagues and leaders has been examined (Huang et al., 2012; Ortega et al., 2010; Timonen & Doyle, 2010). These latter studies have been particularly concerned with the ways in which care practices are shaped by relationships between different (mostly *female, immigrant*) caregivers and different care recipients in both home-like and institutional contexts. In the spirit of this last branch of research, this article will analyse how migrants talk about their experiences as professionals in the municipal long-term care sector in the peripheral region of Finnmark, northernmost Norway.

Method and participants

Steinar Kvale (Kvale, 1997) argues that the goal of interviews should be to 'capture descriptions of the interviewee's life world with the intention of interpreting the phenomena described' (1997, 21 my translation). The researcher, in other words, should seek to apprehend the world as it manifests itself from the viewpoint of the interviewees and should try to understand how they see themselves in the context of the changing socio-cultural framework of their everyday lives (Cohen & Rapport, 1995). In this study, I conducted life story interviews with migrant care workers, asking questions about their migration story and how they ended up in Finnmark. I also asked them about their educational and professional background, about their family situation, and their new everyday life in the north. I was particularly interested in their stories about their experiences as professional healthcare workers and about their relationships with users/patients, colleagues and leaders at the workplace.

Potential informants were identified with the assistance of people in leading positions in Finnmark's care sector and via my own personal network after having lived and worked in the region for eight years. I selected the informants for interviews to obtain variation with regard to their migration background, age, family situation, education and professional affiliation. In

total, I interviewed 17 informants (15 women and two men). The informants were between 20 and 50 years of age and had lived in Norway between 2 and 20 years at the time of the interview, with an average of 6 to 7 years. Four of them had briefly lived in the south of the country before moving north, but the rest arrived directly to Finnmark from their countries of origin. The informants came from different countries and had different educational and professional backgrounds. All of them, however, worked in the public long-term care sector, either in residential care centres or nursing homes for frail old people; within the *miljøtjenesten*, a Norwegian umbrella term for home-based health and social care services for people with disabilities or psychiatric conditions; or in the regional psychiatric polyclinic.

The table below shows that some informants were trained nurses in the home country but worked as registered healthcare workers at the time of the interview (Dragoslava, Margaretta). One was originally a trained medical doctor but currently worked as a nurse (Kattrina). Two were medical doctors, one trained in the EU (Evelyn) and one outside the EU (Jelena); they were both finally working as psychiatrists at the time of the interview. Some had higher education from their country of origin in a completely different field (Georgette, Hannie and Irina) but had, for various, mainly labour-market related reasons, decided to start their educational careers anew after settling in Norway. They now worked as a registered nurse (Georgette) and registered healthcare workers (Hannie and Irina). Several of the refugees arrived in Norway as teenagers with only basic schooling from their home countries, but had obtained or were about to obtain a certificate as registered healthcare workers (Ovidia, Palwasha og Qamila). Only one informant had decided to work as an unskilled on-call substitute after having completed the introductory course for refugees (Rafaela from Africa).

The interviews were recorded on tape and took approximately 70 minutes on average. The informants themselves decided on the time and place for the meeting; 11 of them chose to meet in a quiet cafeteria, four invited me to their homes, and two chose to be interviewed in a suitable location at work. All interviews were conducted, transcribed and analysed thematically by the author using a constructivist grounded methodology (Charmaz, 2006). Several informants said it felt good to share their stories and hoped that their participation in the study might contribute to a more nuanced view of immigrants as a resource, rather than a burden on the Norwegian society.

Table 1: Overview of informants (insert here)

Presentation and analysis of findings

Settling in the north

My informants can be divided into three groups: refugees, marriage migrants and labour migrants. The refugees, several of them UN quota refugees from Asia, arrived in Norway to start a new life in a safe and peaceful country. They did not choose to live in Finnmark but were allocated there by the Norwegian authorities on receiving their residence permit and have subsequently opted to stay. The marriage migrants did not choose Finnmark either but came to Norway from Russia or, in some cases, Asia to settle down with ethnic Norwegian husbands whom they had met either online or through mutual acquaintances. This group of women thus settled in Finnmark because their partner happened to live there. The labour migrants chiefly left their countries because of the difficult economic conditions in Eastern and Southern Europe. Having considered various options, they found that Scandinavia and the Nordic welfare states, with their generous income and social security levels, would be a safe setting for a new future and eventually decided to move to Norway. In general, the labour migrants settled in Finnmark because of a concrete job offer there.

All of the informants had invested a great deal of money, time and energy in learning the Norwegian language. All of the labour migrants and those among the marriage migrants with a healthcare education had applied for authorisation from the Norwegian Public Office for Health Care Professionals (SAFH). Most of the applications from the Russian marriage migrants I interviewed had been turned down. Those who were trained as nurses in Russia hence mainly worked as registered healthcare workers, and the two medical doctors currently worked as a nurse and as a psychiatrist, respectively, but only after several years of hard work, trainee duty and many exams before at last obtaining their licenses.

For most of the migrants, Finnmark was very different from 'home' in terms of landscape, architecture, climate and culture. For this reason, many of them had lively narratives of their first experience of settling in Finnmark, such as that of Palwasha, a refugee from Asia:

> Palwasha: Yeah, my first memory is of snow. I came here in February. I had never seen snow before. I was a bit strange. I stumbled and fell many times. It was the dark period; that was hard on us. And the language… that was the worst! (laughs) I could only speak

a little English. That was difficult. So I used to go to a place [provided by the Municipal Office for Refugees] where they helped me with the language and the homework from the Adult Education Center.

Mai: Did you start taking Norwegian classes right away?

Palwasha: I had to wait a while, perhaps a month. At the beginning, I was home three days in a row without going out…

Mai: It can be difficult at the beginning…

Palwasha: Yes, it was. […] And the food was completely different, you know? (laughs) If you don't know the language, it's not easy to read what the food is, so it was hard to figure out what to get.

Mai: What did you eat at the beginning? Did you boil rice?

Palwasha: Right… Rice and eggs… For fifteen days I had only rice and eggs (laughs).

Mai: Mmm… But then little by little…

Palwasha: Yes, little by little we learnt…

Some of the labour and marriage migrants were somewhat better prepared for the northern landscapes. Some of them even experienced settling in Finnmark as exotic, almost like a fairy-tale. This was the case of Evelyn, a medical doctor with her degree from an EU country:

> So it's been very exciting for me [to come here]. It can be very cold here, but there are loads of things you can learn to do when it's cold: you can learn to ski, you can toboggan… And the midnight sun is very special in the summer. Many people don't understand that it can be so light in the middle of the night (…) And the aurora borealis! Ah! I was pretty stunned the first time I experienced the northern lights. Things like that have made me realise that even though I don't live in a big city, there are many exotic things going on up here!

This suggests that migration, or mobility, can create new reflections on the significance of place (of living) and belonging. In fact, several social scientists have argued that increased mobility will make local or place-related dimensions more important to people (Cresswell, 2010; Sheller & Urry, 2006). In this study, the migrants emphasised aspects of landscape and climate in their stories about settling in Finnmark. They also mentioned the combination of short distances inside their place and the long distances outside it as well as the benefits of living in a rather small place, where it did not take long to recognise faces in the streets, the neighbourhood and at work, thus allowing them to develop a *feeling of home* while simultaneously being *away from*

home. I now turn to an analysis of the informants' stories about their relationships with users, colleagues and leaders at the workplace.

Relations with users

Sharing experiences

Margaretta worked as a registered healthcare worker in a municipal residential care centre. She had a Bachelor's degree in nursing from Russia. Margaretta wanted to receive authorisation as a registered nurse in Norway but had not yet succeeded. Although perhaps overqualified and underpaid for her work, she said that she really enjoyed working in municipal eldercare:

> I like to work with people. I like to ask them what they need. I like to give them a shower. Here at the residential care center, we don't have difficult patients. A few live with dementia and are waiting for a place in a nursing home, but they only spend a little while with us. Most of those who stay with us do quite well. So I can talk to them about the old days, how it was here back in the day, and they like to tell me about the war, and the evacuation[iii]. We laugh together. They like to tell me things, and to correct my Norwegian, so I think it's very nice to work here.
>
> Mai: What other responsibilities do you have?
>
> I give them their medicine, help them take a shower, help those who cannot do it to put on their clothes, remind them of mealtimes, or I bring dinner to their room when they're ill. And we arrange activities for them, we make them coffee, talk to them, make appointments with doctors or specialists for them…

Another of my informants, Ovidia from Asia, currently worked as a registered healthcare worker in a nursing home in a department where most patients lived with dementia. She had previously worked with disabled patients and at a residential care centre where the users were fairly independent. She particularly liked working at the residential care centre because she learnt plenty of Norwegian there: 'If I made an error the old people would correct me and say 'This is the way it is!', so I learnt a lot there.' She also told me that she liked it 'very, very much' at her current job, so much that she 'longed to go back' to work on her days off. She explained: 'On my free days I think a lot about the elderly, what they might be doing. I always want to go to work. I like working!' When I asked her what she liked best about her work, she answered:

> The best thing is that when the patients need help, I can be there for them, even though I might be occupied with other things. And when they talk, they teach me so many things. They joke a little… I think that's great. They tell me stories about the old daysand they ask me how I managed to travel that far: '[Your country of origin] is very far away. How did you do it? Did you come alone?' Most of them know where [my country of origin] is. […] They're a bit like my grandparents, I think. When I work with old people, they only teach me good things. That's very nice.

Several informants told similar stories: that they used to help with practical tasks such as meals, hygiene, putting on clothes, cleaning the patients' rooms but that it was also important to have good conversations with the users. In the words of Qamila from Asia: 'Those who can talk explain all kinds of things. They can be between 95 and 100 years of age! It's fun listening to them. They have also escaped [from Finnmark], and they have also experienced poverty.' In other words, the informants suggested that when the elderly patients met healthcare workers who were refugees, they remembered from their childhood how it was when the Germans burnt down Finnmark towards the end of World War II and what it felt like having to leave one's own home. Several of the refugees I interviewed said that this *'shared experience'* made them feel a particular connection to their elderly patients.

Moreover, several of the informants, regardless of their migration background, used familial terms when they talked about their patients. For example, Rafaela, a refugee from Africa, said:

> I have a special patient, Hanna, who I like very much. She's like a grandmother. She's my favourite. I miss them [the patients] when I'm off work for a few days. I miss them in my heart. I think that I'll become like them when I'm old.

Dragoslava, a labour migrant from southern Europe, also spoke in familial terms about the users but turned this idea on its head when she said: 'I like to talk to them, it's great fun. They're like children. I don't know. I feel like their mother in a way.' Later in the interview, Dragoslava again described her patients almost as family members:

> They're like our family. I share a lot of my time with them. If they like to sing, I try to sing. If they like to dance, I dance with them (laughs). It's fun. If they like to go out, I take a walk with them. If they don't want to sleep at night when I'm on duty, I tell them: OK. If you can't sleep you don't need to. We might watch a film or just have a nice time together. I don't force them to do things, of course. If they can't sleep, it's fine.

In this way, Dragoslava conveyed that as a professional healthcare worker, she took the elderly users seriously. She had time for them, and she made sure that the users had a meaningful time in the nursing centre: if the patients wanted to dance, she danced too. Although the migrant care workers provided both physical and emotional care, several of the informants also emphasised that they felt valued by their patients. Thus, the informants described mutual give-and-take relationships with the users through which the migrant care workers and elderly users created meaning for each other.

We who are from Asia are very caring

Working in *Miljøtjenesten* was both similar and different from the work at a residential care centre or in a nursing home. Naveed, a social worker at a home for psychiatrically disabled patients, told me that he spent his days trying to activate the users, go shopping with them, cooking, occasionally helping them eat, cleaning the floor, helping with personal hygiene and communicating with relatives when needed. When asked to give examples of activities, he explained that they might take a walk if the weather was nice, or do a barbecue, go on a fishing trip or to a café: 'I help them manage their everyday life,' he concluded. Irina also worked in the municipal social care service. She had two Bachelor's degrees, one from Russia and one from Norway, but she told me that she had not applied for positions that required her higher education since settling in Norway. Instead, she had worked as an assistant in the healthcare sector, she had followed classes in the evening, and she had hence recently obtained the healthcare worker certificate[iv]. At the time of the interview, she was employed as a registered healthcare worker and worked with relatively young users who needed daily practical help as a consequence of disease or accidents. She told that she found her job stimulating as it placed her own life in perspective:

> I help people with everyday tasks that healthy people with arms and legs like myself can perform. That affects me a great deal. I place increased value on being healthy, being able to make my own decisions in life. […] It makes me conscious of my own well-being and that life can be turned upside down very quickly.

At times, Irina said, she and the users had good conversations. She enjoyed listening to their experiences and how they managed to overcome practical and emotional obstacles. Irina explained that she wanted to help them fulfil their dreams. She had helped some of them apply for funds to go on assisted holidays in the sun and had travelled with one user a couple of times.

When users were depressed, Irina said, she felt it was her duty to lift them up. In such instances, she sometimes used herself so much that she was completely worn out when she came home after the work shift.

Hannie from Asia was also employed as a registered healthcare worker in the social care services and worked with users similar to Irina's. She told me the following:

> I have two users who are autistic. They're very different from each other, but they have their routines. I'm the primary contact for one of them. I'm going to see him after this [interview]. There are quite a few challenges with him. At times, he won't take a shower on his own. Then, you have to use reverse psychology to get him to do it. Sometimes he cooks himself, and sometimes he needs assistance to do it. If I'm there to make him clean his bedroom, he might not want do it. So I have to make agreements: 'Now we clean together for half an hour, and then we can have a cup of coffee and watch TV,' because he loves watching sports. […] He's very interesting but also very dependent on me.

Later in the interview she told me that some users called her in her free time, especially the man she talked about above. If he had taken a shower or had eaten something healthy, he might call and proudly inform her of this. Hannie explained that she did not mind the extra phone calls, even if they came in her free time. She indirectly compared herself with her Norwegian colleagues, saying that she might be a more 'dedicated healthcare worker than some others' and that she did not 'count minutes' like some of her colleagues:

> We who are from Asia are very caring. Some think: 'now it's three o'clock, so I'm done. Goodbye!' I don't think about the time as long as I can help. The users become like family members. I work with my heart. I don't say: 'It's after three, don't call me.' […] I can't bring myself to say no [when they call on her free time].

Although the experiences of the skilled migrants care workers in long-term care in Finnmark were largely positive, many of them also shared challenging experiences. Several informants told me that they were occasionally verbally abused by patients who were upset; one of the nurses and some of the registered healthcare workers showed me claw marks or small scars on their arms as signs of having been attacked by aggressive senile patients. Georgette, who works as a nurse in a closed ward for unstable patients, said:

> Yes, once when I was on night duty… I had just recently started [to work there], and a patient became upset. I wasn't able to give him his medicine, and he started hitting me… I felt unsafe (laughs). So when you're alone on duty, it's a bit more difficult. That was difficult. I knew I had to remember what to do when that kind of thing happens, but when you're nervous and alone it's difficult. So I had to hide in the kitchen and call for help.

Relations with colleagues and leaders

Most informants told positive stories about their colleagues and management at the workplace. Agalia, a psychologist and labour migrant from Southern Europe working in psychiatry, said:

> So I was about to start working there… I was very nervous, but I was surprised to meet very smiling colleagues. They received me with open arms… I felt very relieved… What was I going to tell you now…? I was given a supervisor straight away and an introduction by my boss telling me what to do, that I was allowed to work at my own pace, and that I shouldn't stress… I was very impressed. Because I experienced the opposite of what I had experienced before [in my home country].
>
> Mai: That's great!
>
> I couldn't believe it could be that good! So I immediately felt great appreciation and gratefulness to all my colleagues. If I didn't have such a nice work environment here, I might not have been able to stay.

The healthcare workers in eldercare said more or less the same. Dragoslava, for instance, explained that her colleagues were 'very kind' and that she never had 'experienced any kind of bullying'. Palwasha, moreover, told me her colleagues were 'good at taking care of her', and Ovidia said her colleagues were 'good people'. She explained:

> When there are things I don't know or how I should do things, I ask them [my colleagues]. Then, they explain it to me in a proper way. When there are many patients or users, we look at their journals to see what they can do on their own and what they need us to help them with. So before the new patients arrive, we discuss this a bit…

Irina and Hannie, who both worked in *Miljøtjenesten,* also had positive stories to tell about their colleagues and work environment. Irina said that she valued discussing things with her colleagues; sometimes at work, sometimes when they went hiking together in the spare time, or at their annual work dinners. Hannie explained: 'I have a very flexible manager. If you need

a free day, you can compensate by working it in later, and the salary… Yes, I think it's fair.' Later in the interview, Hannie said that she was allowed to come a little late to work three days a week because she did a particular work-out in the mornings to reduce pain. Margaretta, who was employed as a registered healthcare worker although she trained as a nurse in Russia, also had positive things to say about her colleagues and leaders. She in particular emphasised that she felt her colleagues and the management had confidence in her and that she was 'respected as a professional'. She especially valued her work life experiences in Norway when comparing them to what it might have been like to be employed in Russia:

> Now and then, I dream that I work as a nursing assistant in a hospital in Russia, and it's terrible. There, a head nurse can come and say horrible things to me. People understand that isn't good, but it's still common. Yes, there's a huge difference between the working conditions in Norway and in Russia.

On a direct question from me, most of the informants made it clear that in their experiences, their cultural backgrounds had not been made a problem at work. However, they admitted that the Norwegian language had been a challenge and that they still had to devote significant energy to learning it as well as possible.

Discussion and conclusions

The rural/urban dimension has so far been more or less overlooked in studies of migrant care workers, and research of the subject in rural parts of high-income countries hardly exist. To address the rural gap in the literature, this article sheds light on the spatial and relational aspects of immigrant narratives about working in the healthcare sector in Finnmark, which is often considered the most peripheral and rural county in Norway. Rural places are often described in the media as slow, rustic, old-fashioned and introverted. This study, similar to other studies from Finnmark (Gerrard, 2008; Munkejord, 2014), suggests instead that (work)places in small northern communities may show a particular openness and an ability to include new migrant workers. The awareness that many rural places 'need people' for work and more generally to inhabit the communities, may have a positive impact on the attitudes to immigrants in some communities and workplaces.

Moreover, several scholars have argued that the growing share of migrant workers may lead to a devaluation of care work, to discrimination in the nurse-patient relationship and hence to a

degradation in the quality of care relations (Timonen and Doyle 2010, Bourgeault et al. 2010, Browne and Braun 2008, Walsh and O'Shea 2010, Huang, Yeoh, and Toyota 2012). In this study, there are few traces of discrimination in the care worker-patient relationship. Although discrimination and racialisation may certainly exist between users and various skilled healthcare workers of minority backgrounds in Finnmark, the informants did not emphasise such experiences when I, as a white, ethnic Norwegian researcher, interviewed them about their everyday work experiences. They did tell me about painful experiences in their home countries before moving to Norway, about the often considerable challenges of living in a different natural environment, about their energetic efforts to learn the Norwegian language, and about their hard work to obtain formal qualifications or authorisation to work as a registered medical doctor, nurse or healthcare worker in Norway. Nevertheless, the interviewees' narratives about their current work situations in healthcare are largely positive, emphasising their feelings of mastery and their ability to create safety and confidence in their relationships with the users, some of whom eventually become almost like family members. The analysis also indicates that the migrants see themselves as giving emotional and practical care of a *particularly good quality*. Moreover, the informants' relationships with colleagues and management are defined by mainly positive feelings, trust and respect. Caring is thus perceived by the migrant care workers as an inherently *sense-making practice*.

We live in an ageing society where long-term care needs are increasing at a high pace and where the demand for immigrant healthcare workers will continue to grow. Questions of how to solve challenges related to intercultural caring relationships and the accreditation of qualifications obtained abroad and how to address processes of inclusion and exclusion in both the public and private healthcare sector are therefore ever more relevant. We therefore need more research on migrant healthcare workers, preferably of an interdisciplinary and comparative nature, to better address these questions and acknowledge the importance of immigrants as professional care workers in rural and urban contexts in Norway and beyond.

Table 1: Presentation of the informants

Name, age, country of origin	Migration background, time spent in Norway	Family relations in Finnmark	Education/prior work experience	Position	Location of interview
Agalia (30), Southern Europe	Labour migrant (a few months in Finnmark, 1, 5 years in Norway)	Recently met a (Norwegian) partner	Training as a psychologist in EU. Some previous work experience.	Works as a psychologist	Her home
Cristina (22), Southern Europe	Labour migrant (1.5 years, arrived directly to Finnmark)	Lives with her parents and adult brother	Trained as a healthcare worker in EU. Some previous work experience.	Works as a healthcare worker (combines several part-time positions)	A café – I interviewed mother and daughter together
Dragoslava, (45), Southern Europe	Labour migrant (2 years, arrived directly to Finnmark)	Lives with her husband, and her adult children	Trained as a nurse at a non-accepted institution in the EU. Years of work experience.	Works as a healthcare worker. Part-time position + on-call substitute	Same as above
Evelyn (32), Africa, educated in the EU	Labour migrant (5.5 years in Norway, almost 2 years in Finnmark)	Single	Trained as a medical doctor in the EU.	Works as a medical doctor	Her office
Fredrik (30), EU	Labour migrant (just over 4 years in Norway, 2 months in Finnmark)	Single	Trained as a psychologist in the EU.	Works as a psychologist	Her office
Georgette (33), Asia	Arrived as an au-pair, then became a student (7 years, came directly to Finnmark)	Recently found a partner (Norwegian).	Bachelor's degree (other field) from home country. Trained as a nurse in Norway.	Works as a nurse	Her home
Hannie (50), Asia	Marriage migrant (20 years, came directly to Finnmark)	Norwegian husband (no children)	University degree (other field) from home country. Trained as a healthcare worker in Norway.	Works as a healthcare worker	A café
Irina (40), Russia	Marriage migrant (11 years, came directly to Finnmark)	In a new relationship	Holds two Bachelor's degrees (other field), trained as a healthcare worker in Norway.	Works as a healthcare worker	A café
Jelena (50), Russia	Marriage migrant (13 years, came directly to Finnmark)	Lives with her Norwegian husband	Trained as a medical doctor in Russia. Spent 5 years in Norway to pass exams before obtaining her authorization as a medical doctor from SAFH.	Works as a medical doctor	Her home
Kattrina (45), Russia	Marriage migrant (11 years, came directly to Finnmark)	Lives with her husband and a young daughter	Trained as a medical doctor in Russia. Did not attempt to obtain an authorization from SAFH. Rather took full education anew and became a nurse in Norway.	Works as a nurse	A café at the university college
Ludmila (45), Russia	Marriage migrant (13 years, came directly to Finnmark)	Norwegian husband, two children.	Trained as a nurse in Russia. In Norway she has taken a few courses in management.	Nurse (combines two positions)	A cafe
Margaretta (40), Russia	Marriage migrant (5 years, came	Norwegian husband, one child	Trained as a nurse in Russia.	Works as a healthcare worker	A café in the town centre

	directly to Finnmark)				
Naveed (30), Asia	UN refugee (7 years, came directly to Finnmark)	Lives with a parent and siblings	Trained as a social workers in Norway	Works as a social care worker. Combines several part-time positions.	A meeting room at the university college
Ovidia (22), Asia	UN refugee (7 years, came directly to Finnmark)	Lives with a parent and siblings	Recently certified as a healthcare worker (Norway).	Works as a healthcare worker	A café in the town centre
Palwasha (24), Asia	UN refugee, sister of Qamila (6 years, came directly to Finnmark)	Lives with her husband (just married), also from Asia	Soon certified as a healthcare worker	Apprentice to become healthcare worker	Her and her husband's home
Qamila (22), Asia	UN refugee (6 years, came directly to Finnmark)	Lives with her parents, and siblings	Enrolled in secondary healthcare education, will become healthcare worker after completing the 4-year programme	In training to become healthcare worker. Works part-time in a nursing home as an assistant.	A café in the town centre
Rafaela (45), East Africa	Refugee, (4 years in Finnmark after almost a year in a refugee asylum in another part of the country)	Single	Secondary education from the home country. Has some work experience from the home country.	On-call substitute care work at a nursing home	A café in the town centre

References:

Aamodt, P. O., Høst, H., Arnesen, C. Å., & Næss, T. (2011). *Evaluering av Kompetanseløftet 2015. Underveisrapport 3*. Retrieved from Oslo:

Anderson, A. (2012). Europe's Care Regimes nad the Role of Migrant Care Workers Within Them. *Population Ageing, 5*, 135-146. doi:DOI 10.1007/s12062-012-9063-y

Atanackovic, J., & Bourgeault, I. L. (2013). The employment and recruitment of migrant care workers in Canada. *Canadian Public Policy, 39*(2), 335-350.

Bikova, M. (2010). The snake in the grass of gender equality. In L. W. Isaksen (Ed.), *Global Care Work. Gender and Migration in Nordic Societies* (pp. 49-68). Lund: Nordic Academic.

Bourgeault, I. L., Atanackovic, J., Rashid, A., & Parpia, R. (2010). Relations between Immigrant Care Workers and Older Persons in Home and Long-Term Care. *Canadian Journal on Aging / La Revue canadienne du vieillissement, 29*, 109-118. doi:10.1017/S0714980809990407

Browne, C. V., & Braun, K. L. (2008). Globalization, Women's Migration, and the Long-Term-Care Workforce. *The Gerontologist, 48*(1), 16-24.

Cangiano, A., & Shutes, I. (2010). Ageing, Demand for Care and the Role of Migrant Care Workers in the UK. *Population Ageing, 3*, 39-57. doi:DOI 10.1007/s12062-010-9031-3

Charmaz, K. (2006). *Constructing Grounded Theory. A Practical Guide Through Qualitative Analysis*. London, Thousand Oaks, etc.: Sage.

Chowdury, R., & Gutman, G. (2012). Migrant Live-in Caregivers Providing Care to Canadian Older Adults: An Exploratory Study of Workers' Life and Job Satisfaction. *Population Ageing, 5*, 215-240. doi:DOI 10.1007/s12062-012-9073-9

Christensen, K., & Guldvik, I. (2014). *Migrant Care Workers: Searching for New Horizons*. Farnham, Burlington: Ashgate.

Cohen, A. P., & Rapport, N. (1995). Introduction: consciousness in anthropology. In A. P. Cohen & N. Rapport (Eds.), *Questions of Consciousness* (pp. 1-18). London & New York: Routeledge.

Cresswell, T. (2010). Towards a politics of mobility. *Environment and Planning D: Society and Space, 28*, 17-31.

England, K. (2015). Nurses across borders: global migration of registered nurses to the US. *Gender, Place and Culture, 22*(1), 143-156, DOI: 110.1080/0966369X.0962013.0832658.

Gerrard, S. (2008). A travelling Fishing Village: The Specific Conjunctions of Place. In J. O. Bærenholdt & B. Granås (Eds.), *Mobility and Place. Enacting Northern European Peripheries.* (pp. 75-86). Aldershot: Ashgate.

Ho, K. H. M., & Chiang, V. C. L. (2015). A meta-ethnography of the acculturation and socialization experiences of migrant care workers. *Journal of Advanced Nursing, 71*(2), 237-254

Huang, S., Yeoh, B., & Toyota, M. (2012). Caring for the elderly: the embodied labour of migrant care workers in Singapore. *Global Networks, 12*(2), 195-215.

Iredale, R. (2001). The Migration of Professionals: Theories and Typologies. *International Migration, 39*(5), 7-24.

Iredale, R. (2005). Gender, immigration policies and accreditation: valuing the skills of professional women migrants. *Geoforum, 36*(2), 155-166.

Isaksen, L. W. (2010). Transnational care: The social dimensions of international nurse recruitment. In L. W. Isaksen (Ed.), *Global Care Work: Gender and Migration in Nordic Societies* (pp. 137-158). Lund: Nordic Academic Press.

Isaksen, L. W. (2012). Transnational Spaces of Care: Migrant Nurses in Norway. *Social Politics, 19*(1), 58-77.

Johansen, E., & Fagerstrøm, L. (2010). An investigation of the role nurses play in Norwegian home care. *British Journal of Community Nursing, 15*(10), 497-502.

Kitterød, R. H., & Pettersen, S. V. (2006). Making up for mothers' employed working hours? Housework and childcare among Norwegian fathers. *Work, Employment & Society, 20*(3), 473-492.

Kristensen, G. K. (2015). Hjemme- og lønnsarbeidets mening og verdi - Norske pars fortellinger om det å kjøpe private husholds- og omsorgstjenester. *Tidsskrift for kjønnsforskning, 39*(3-4), 204-223.

Kvale, S. (1997). *Det kvalitative forskningsintervju*. Oslo: Ad Notam Gyldendal.

Lowell, B. L., Martin, S., & Stone, R. (2010). Ageing and Care Giving in the Unitied States: Policy Contexts and the Immigrant Workforce. *Population Ageing, 3*, 59-82. doi:DOI 10.1007/s12062-012-9063-y

Lutz, H. (Ed.) (2008). *Migration and Domestic Care Work. A European Perspective on a Global Theme*. Hampshire & Burlington: Ashgate.

Munkejord, M. C. (2014). Stories of Butterflies in Winterland: Representations of Northern Coastal Realities in Norway. In G. Bonifacio (Ed.), *Gender and Rural Migration. Realities, Conflict and Change* (pp. 23-41). New York & Oxon: Routledge.

Ortega, A., Carneiro, I. G., & Flyvholm, M.-A. (2010). A Descriptive Study on Immigrant Workers in the Elderly Care Sector. *J Immigrant Minority Health, 12*, 699-706. doi:10.1007/s10903-009-9257-4

Parreñas, R. (2001). *Servants of globalization. Women, Migration and Domestic Work*. Stanford: Stanford University Press.

Riemsdijk, M. v. (2006). *Rekruttering av polske sykepleiere til Norge [Recruitment of Polish Nurses to Norway]*. Retrieved from Report 27. Oslo:

Riemsdijk, M. v. (2010). Neoliberal reforms in elder care in Norway: Roles of the state, Norwegian employers, and Polish nurses. *Geoforum, 41*(6), 930-939.
Riemsdijk, M. v. (2013). Everyday Geopolitics: the Valuation of Labour and the Socio-Political Hierarchies of Skill: Polish Nurses in Norway. *Journal of Ethnic and Migration Studies, 39*(3), 373-390.
Sheller, M., & Urry, J. (2006). The new mobilities paradigm. *Environment and Planning A, 38*, 207-226.
Szebehely, M. (2005). Äldreomsorger i Norden - verksamhet, forskning og statistik. In M. Szebehely (Ed.), *Äldreomsorgsforskning i Norden. En kunskapsöversikt. TemaNord 2005:508* (pp. 21-52). København: Nordiska Ministerrådet.
Szeman, Z. (2012). Family Strategies in Hungary: The Role of Undocumented Migrants in Eldercare. *Population Ageing, 5*, 97-118. doi:DOI 10.1007/s12062-012-9060-1
Timonen, V., & Doyle, M. (2010). Caring and Collaborating across Cultures? Migrant Care Workers' Relationships with Care Recipients, Colleagues and Employers. *European Journal of Women's Studies, 17*(1), 25-41. doi:10.1177/1350506809350859
Twigg, J. (2000). Carework as a form of bodywork. *Ageing and Society, 20*(4), 389-411.
Walsh, K., & O'Shea, E. (2010). Marginalised care: migrant workers caring for older people in Ireland. *Journal of Popoluation Ageing, 3*(1), 17-37.
Wærness, K. (1984). The Rationality of Caring. *Economic and Industrial Democracy, 5*(x), 185-211.
Yeates, N. (2004). Global care chains: ciritical reflections and lines of inquiry. *International Feminist Journal of Politics, 6*(3), 369-391.

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[ii] http://www.ssb.no/befolkning/artikler-og-publikasjoner/dette-er-norge-2015
[iii] Towards the end of World War II in the autumn of 1944, the Germans used the scorched earth tactic in Finnmark to halt Russia's Red Army (Finnmark borders Russia in the east). As a consequence of this, few houses survived the war, and a large part of the population was forcefully evacuated further south. Several of the elderly patients in residential care and nursing homes remember this experience from their childhood, recalling that they had to flee southwards with their family before being able to move back north some months later to rebuild their home region.
[iv] This healthcare worker certificate requires two years of schooling at high school level and at least two years of mentored work-experience.