No.155 / May 2006

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IIIS Discussion Paper No. 155

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Abstract: The paper explores the complexities of experiences and positions of migrant women in the 'nursing profession' in a southern European country, Greece, and looks at ways in which a rudimentary welfare state and a large informal economy have created the demand for *les infirmiėres exclusives* and for 'quasi-nurses' which in turn, on the one hand helps this welfare system to be perpetuated and, on the other, has implications on migrant women themselves as, *inter alia*, it contributes to their deskilling, exploitation, marginalisation and exclusion; the multifarious degree and forms that these processes take, to a large extent, depend on cross cuttings of gender, ethnicity and class, as sexism intersects with different forms of 'othering' and racialisation processes in the destination country. The position of these women will also be located in terms of ethnic and national boundaries.

Key words: nurses, migrants, migrant women, Europe, health care, immigration, social inclusion/exclusion, networks.

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1. Introduction

Subsequent to the Treaty of Rome's (1957) free movement of labour, and the Single European Market's objective to abolish formal barriers to the 'freedom of movement', the emphasis on abolition of formal barriers has not been accompanied by an equal emphasis on the abolition of 'informal barriers', such as 'organisational, practical, cultural and attitudinal restrictions which operate at national and workplace levels' (Zulauf 1998:143). In the Greek context, such restrictions constitute both formal and informal barriers to occupational mobility of migrant women who work as quasi-nurses in the host country. Directives translated into national laws on compatibility of qualifications, may, on the one hand guarantee access to jobs in other member states of the European Union, but when it comes to third-country migrants, can also function as barriers to access to jobs at a level similar to that of pre-migration. Moreover the local National Health System (*ΕΣΥ*) often provides informal barriers to migrants when trying to access their experiences and register their qualifications and skills, thus facilitating their inclusion only in jobs seen as being low skilled and hence low paid. In addition, local attitudes and culture often create paths which facilitate and encourage the inclusion of migrant women in lesser jobs, justified in terms of different cultural traditions in training systems and 'others'' credentials.

This paper is structured as follows: it begins with a brief description of migration into Greece and of the Greek National Health System, followed by a note on the research methodology. It continues with an examination of migrant nurses' experiences in Greece, distinguishing between those who nurse elderly people at home (quasi-nurses/carers) and those who work as *infirmières exclusives* in hospitals. It concludes by assessing the implications of the findings for migrant nurses and for the local National Health System. The paper is based on the experiences of a small number of migrant nurses (see section on methods), it

therefore does not aim to draw br oad generalisations. It aims to highlight the need for more practical policies to facilitate health care at home and in hospitals and to make some recommendations based on the issues raised by the interviewees. The paper tries to fill an acknowledged gap in the existing literature on international migration where for several reasons (see Kofman 2000) there has until now been a silence on skilled female migrants and the degree of deskilling experienced by these women through the process of migration (Kofman et al 2000:130).

2. Methods

The qualitative approach was thought to provide the most objective insight in a field where little empirical research has been conducted in general, and none in Greece in particular. In an attempt to collect information on the way in which migrant women in the health care profession, perceive and interpret their experiences in the host country, in-depth interviews were conducted with 18 women (5 from Africa, 2 Indians, 3 from Northern Epirus, 5 from Eastern Europe and 3 Pontians), ranging from 22 to 55 years old, and from various socio-economic backgrounds; 16 interviews were taped. The majority (11) worked as private quasi-nurses (in Greek called '*apoklistiki*', which can also be translated as '*L' infirmière exclusive'*) in hospitals; a few (6) worked as nurses/carers in houses. And one, at the time of the interview was in charge of nursing staff in a public hospital. These were complemented by 9 interviews with key informants: 5 with nurses' associations (Lychnia, Somatio Allileggei, Somatio Evaggelismos) and 4 with major public hospitals in Athens. A thematic interview guide with open-ended questions was used. Due to access problems, the sample was obtained via snow-balling and a systematic selection of employing institutions.

Reflexivity was maintained to allow for diversity of interpretations and for enabling us to provide explanations for the nature of the migrant women's experiences in the Greek context, for the reasons underlying particular attitudes,

perceptions and behaviours, and for evaluating the effect of policies and practices on migrants' experiences and behaviour and by proxi, on the local National Health System itself. The paper explores whether the experiences of the women under study can be explained solely on economic factors or whether other factors such as cultural factors rather than racial categorisation enable these women by creating a niche for this special service but at the same time, act as an additional constraint on these women's employment opportunities and facilitates their inclusion only into marginalised spaces within the host country's health care system. The argument put forward here is tentative and exploratory, a first step towards a more detailed research that I plan to carry out in the immediate future.

3. The context

a. Migration into Greece

Since the late 1980s - early 1990s, women have occupied a central position in the migratory flows into Greece, both as 'dependent' and as 'independent' economic migrants, playing protagonist roles in the migratory process (Lazaridis 2000:49; Lazaridis 2001). Once in the host country, they are faced with the eagerness of employers to hire undocumented workers in a strongly gendered labour market, which leaves little opportunities for migrant women outside the informal labour market (ibid); thus while men have wider, albeit still restricted labour market opportunities, women end up concentrating in feminised spheres of some services, such as tourism, domestic and informal types of nursing. Demand for these services has increased over the years. An ageing population, changing family structures and lifestyles for women and a rudimentary welfare state unable to provide adequate care for people with special needs, the elderly and the sick, make the demand for such services imperative (Lazaridis 2000:50). In the Greek context, research so far has concentrated on migrant women who work as domestic workers, or as prostitutes. There is little, if any, research on

those working as quasi-nurses/carers or as *infirmiėres exclusives*. The paper addresses this gap in the relevant literature. As this paper demonstrates, a hierarchy of labour operates. Conditions of employment and wages depend on the legal status of these women, on whether or not they have work permits, on their ethnic background and stereotypes attached to them.

b. Les infirmiėres exclusives and *Quasi-nurses/carers: why the need?*

The changing structure of the Greek population with declining fertility rates[1] and demographic ageing also due to increasing longevity[2] and changes in family formation, means that the care needs due to the rise in the proportion of the economically inactive elderly persons with increased levels of dependency, are not met by the provisions made by Greece's welfare state. Greece has a 'rudimentary' form of welfare provision, characterised *inter alia* by underdeveloped social services and an emphasis on the role of the family as the core unit of social care; this means that families and women in particular occupy a central position in provision of care for elderly and people with special needs (Katrougalos 1996; Katrougalos and Lazaridis 2003). However, the position of Greek women has over the last 30 years[3] changed, as their increasing social and economic role outside the household started to change. As stated by Lazaridis (2000), these changes did not mean that women's sense of obligation towards the maintenance of the family's well-being weakened or that they now care less for their relatives, but changing economic circumstances started shaping and transforming patterns of practical support. Although there are Open Care Centres (KAPI) run by the local government providing facilities for those capable of looking after themselves and with no need of serious medical or nursing care, it has been and still is socially stigmatising for a family to place a parent in an old people's home or nursing home even if the old person suffers from a chronic health problem (Katrougalos and Lazaridis 2003:78). As a result, the overall population in old people's homes and geriatric clinics in the mid-1990s was only 8 per cent of the total population aged 65 years and over as opposed to 8-11 per

cent in western Europe (Symeonidou 1996:81). As a result many women are expected to take time off work or to interrupt their career in order to look after a dependent parent. Doing this is an important element of reciprocity in the family. Although the institution of 'home help' or 'care at home' was introduced in 1992, this remained weak. However, the necessity of two salaries for the economic survival of the nuclear family has made permissible, what was once culturally unacceptable, that is for women to pay for the care to be bought in. This has become a must as the state, indifferent to the needs of women, failed to make appropriate provisions.

c. The National Health System (ΕΣΥ) of Greece

The National Health System, was established in1983 by the then socialist government (law 1397/83); it is still in large part financed by income-related contributions to insurance funds (also providing pension and sick benefits); public hospitals are mainly (70%) financed from the state budget. However, there are a number of concerns, including infrastructural inefficiencies, unsatisfactory provision of services in terms of equity and erratic organisation of human resources. Staff working in the *ΕΣΥ* are public functionaries and therefore not allowed to practice privately. However, there is a widespread practice of 'unofficial' payments in the form of 'little envelops' (known as '*fakellakia*') to doctors and nurses. This corrupt practice is a means through which patients and their families can exercise choice in the allocation of services and through which doctors and nurses receive compensation for low levels of pay (Dent 1998; Katrougalos and Lazaridis 2003:140). Patients are willing to pay these for better services or for small 'favours', such as jumping the queue for an operation. Often the boundaries between the public and the private sector are blurred, due to the existence of a parallel informal economy that spans both sectors and is often protected by corrupt sectors of administration (Morin 1990). This hidden economy is estimated to constitute approximately 30-45 per cent of the GDP (Canellopoulos 1995; Eurostat 1995; Katrougalos and Lazaridis 2003). It has

enormous implications on employment as it reinforces labour market segmentisation along *inter alia* gender and ethnic lines. Within hospitals it seems that the primary and secondary labour markets run side by side, where the secondary is supported and assisted by the hospital administration. More stable and secure jobs are offered in the primary, whereas *les infirmiėres exclusives* are 'compartmentalised' in the secondary labour market. These features, along with clientelism, and a culture supporting the perpetuation of a patriarchal framework, constitute elements of a complex societal system which lacks the supportive structures necessary for enabling women to reconcile their reproductive and productive roles. Thus their services have become a necessity rather than a luxury in a country where socio-economic changes enabling and necessitating more and more women to enter paid employment and lack of accessible welfare structures has important implications for the mode of health care provision available.

Greece and Italy are the only countries in the EU where doctors outnumber nurses in public hospitals. This generates multiple inefficiencies at the level of in-patient care and has important consequences, of the most important one being the creation of a niche for '*apoklistikes*' (*les infirmiėres exclusives*) due to considerable shortages of humanpower for all areas of nursing care, within the framework of clientelistic politics and a large informal sector mentioned above. The need for this service reflects the basic weaknesses of the Greek Natrional Health System are summarised by Katrougalos and Lazaridis (2003:149) are 'the unequal allocation of human and material resources and the consequent lack of equity and the important problems of the quality of institutional care at the "every day" level'. The increase in demand for better services oblige hospitals to turn a blind eye to private initiatives such as this one in both private and state-run institutions providing health care. In general, the acceptance of live-in quasi-nurses/carers and of '*apoklistikes*' as a solution to the lack of welfare infrastructure and of provision of adequate care in hospitals makes the system complaisant and thus implicitly inhibits the development of universal and

accessible social infrastructures by the government. Therefore, although women from less privileged backgrounds who need to reconcile family and care needs and cannot rely on family members are forced to make use of these services at least on a short-term basis, this particular strategy of care can only be accessibly for long periods of time to families located within higher income groups.

4. *Les infirmiėres exclusives* (apoklistikes) and quasi-nurses.carers: arrival and experiences in the host country

a. Reasons for coming to GR

The majority of migrant women who work as 'apoklistikes' are from Albania. Other countries of origin include East Africa, Russia, Romania and Bulgaria. In almost all cases, the women migrated solo, irrespective of whether they were married or not in the country of origin. Some, like Neli from Bulgaria, took the decision to come to Greece alone, whereas others, discussed the possibility of migrating with the family and the decision was taken jointly. The majority, gave as reasons for migrating to Greece the lack of work opportunities and very low wages in their country of origin. An additional reason given by the Bulgarians and migrants from Albania was the geographical proximity to Greece. Those from Pontos (ex-USSR) and from Northern Epirus (a part of Albania which was once part of the Greek territory), gave as an important reason common ancestral ties with the Greeks, whereas the Africans put emphasis on civil unrest. The majority came to Greece through chain migration, either because a relative or a friend had migrated and found work.

b. Deskilling through the process of migration

All women interviewed were skilled migrants. Most of the women interviewed had college education and/or a professional background. To give a few examples: Neli finished her training as cook and waitress in Bulgaria before coming to

Greece. 'I was unemployed for several months', said Neli, 'then I found work as domestic'. Another Bulgarian woman Zousi, was a qualified teacher teaching typing skills in a college; 'when the computers came in fashion I lost my job and decided to migrate' she said. 'I was unemployed for several months', she added, 'then I migrated and found work as domestic'. Some, like Ritsa, came to undertake training; she studied nursing and music. She started looking after an elderly woman with dementia in the night so as to earn some money to pay for her studies. After a year she stopped working for a while and then found a job in a hospital as '*apoklistiki'.* Ifigenia finished her degree as midwife in Pontos (ex-USSER) before coming to Greece. Chrysa finished her qualifications designing electric circuits, and accountant, worked for a while in an office in Bulgaria as accountant but when she was made redundant she decided to come to Greece. Eleni, a migrant from Albania (Northern Epirus region) had a degree in civil engineer and was studying economics when the political changes took place in Albania and had to abandon her studies and come to Greece. As the process for getting one's skills recognised is long and cumbersome and she needed money to survive, she decided to get any job that was available. An African woman, Mousoumbaka, came to Greece after finishing high school to study nursing. She got a grant which was very low and had to work. She said: 'In those times you went to the chief nurse *('proistameni')* and asked for work; because I was a student nurse I was lucky and got work'. Thus, their migration to Greece is part of the brain drain, the effects of which on both sending and receiving countries have long been acknowledge in the migration literature (see for example Petras 1981; Oommen 1989).

As one can see from the examples given above, trained women leave their countries and enter unskilled jobs. This 'occupational skidding' (Morawsak and Spohn 1997:36) or 'brain waste' (Morokvasic and de Tinguy 1993) is because for a number of reasons, they find difficulties in pursuing their original occupation in the country of destination: qualifications are not recognised, they lack language skills, lack of opportunities to retrain etc. Once in the new job, a tendency to

undervalue activities associated with so called female occupations tend to encourage them to construct their skills as being less worthy and demanding. The majority of the women interviewed started working as domestics before moving on to staff the lower echelons of the health service. This is because the work currently on offer to migrant women is confined to a narrow band of jobs that are traditionally viewed as '"other" women's jobs' and which require little skill. But this does not mean that they are less worthy and demanding.

Once in Greece, they find work trough two different channels; either via the use of migrant networks or through a recruitment agency. It is only after they establish themselves in the host country, that they feel confident enough to rely on individual efforts.

c. Working Trajectories and Experiences in the host country

Neli, from Boulgaria, started working as a domestic, then for two years she worked during the summer as cleaner in a hotel in Crete for very low salary (60,000 drs in 1992) and in the winter as domestic in the hotel owner's household; when she asked for a small pay increase, she was made redundant. She then went to Bulgaria to visit her family and when she returned to Greece she worked for someone who had a Greek restaurant (*taverna*). The employer accused her of stealing and threatened to report her to the police for not having a 'proper visa' (she explained that the visa she had was a false one ('*pseftiki'*). After that she found work via an agency (paid the agency a fee of 25,000drs), as home-nurse, looking after an elderly person who was bedridden because of a stroke. 'The lady in the house mostly wanted company', she said. On top of the basic caring tasks, she was expected to perform tasks she had no experience or skill on, like massage. However, as often is the case, there was no clear cut divide between nursing and domestic work as she also ironed, cooked, cleaned. She regarded this as 'easy work'. They asked her to leave to take someone who spoke better Greek and could keep the old lady company.

She went back to the office, they found her work as a live-in domestic, but she got married to a Greek (2nd husband) and stopped working as a live-in maid. Then she found a job as '*apoklistiki*' in a public hospital. 'The fact that my husband was already working there as porter helped' she said. And she added: 'He asked the person in change, and I got in. I learnt on the job. No papers were required'.

This is how Ritsa described the way she found a job as *apoklistiki*: 'I went to many hospitals and asked if they could include me in their lists for *apoklistikes*; they told me they were full. Later I found a job in Evangelismos (big public hospital in Athens). I went three days to see what the others did and then I started working. There was no interview or any other formality'.

Chrysa narrated her working trajectory in Greece as follows: 'I came to Greece because I heard that whoever comes here makes money … It wasn't an easy decision to take as I left behind my husband and children. I took the bus at 7.30 in the morning and at 11.00 in the evening I was in Greece. My sister in law took me to an agency in Athens which recruited women; it was easy; they take orders through the phone; what woman is needed and for what. The job was to look after a family with three children; the money was very little, only 40,000 drs in the late 1990s, when other women were paid for similar job 120,000drs, but I took it as I didn't want to be a burden to my sister-in-law who was looking after her newborn baby … When we fell out, they refused to let me have my passport back. I got it back only after I complained to the agency about it. The job was hard. I was not allowed to have a day off or to go out, because they were afraid that I would not return. Then I looked after an elderly woman with dementia for two and a half years. When she went to hospital for 13 days she took me with her; I looked after her as '*apoklistiki*' without additional payment. After the old woman died, I stayed on and looked after the husband. He is very old. I help him walk, I cook for him, clean the house, bath him frequently because he is incontinent and sleep in the same room with him at night'. So, for some, there was no clear progression in the occupational ladder between functioning as

'*apoklistiki*', performing the duties of a 'quasi-nurse' and those of a maid. Rather, there was a '*trampoline effect'* in operation: from maid to quasi-nurse back to maid, up to '*apoklistiki*', back to quasi-nurse or maid. And often, the boundaries were blurred.

Almost all women who work as quasi-nurses in private homes develop bonds with clients: ' I know him some years now; I do not want to see him in pain. I try to be there for him', said Chrysa.Relations between employer and employee, although hierarchical, get wormer with time: 'Otan arostisa me frondisane' (When I was ill, they looked after me', said Chrysa. And she added: 'The only problem is with the old man's daughter who is often rude, but I put up with it, because they looked after me when I was ill'. Not only they deliver an emotional surplus to the employers, providing them with an emotional and physical sense of well being with their person oriented caring tasks, but this often is reciprocated.

The only woman who works as a qualified nurse is Ifigenia. She was looking after an old bedridden woman for sometime and then one day she decided to apply for a job in a hospital. She got her degree translated and found work in a private clinic. 'I work like a nurse there' she said. 'Two-three of us look after an average of 40 patients per shift'. The difference between her work and that of the *apoklistiki* is that the former looks after a number of patients whereas the latter looks **exclusively** after one patient.

Neli, who now works in a major hospital in Athens, the Red Cross, described the work of *apoklistiki* as follows: ' You need to stay all night near the patient … I had a case I couldn't spare two minutes to even go to the toilet … I had to take care of him, to bath him, to clean him. To give him his medicine at the prescribed times; but if these are on the bedside table, I always ask whether I should give the medicine and when; I never distribute medicine without asking, its not my job to do so. I learnt by doing. I did not receive any training whatsoever. She said she is reluctant to go and work in another hospital. 'I am scared to go and work

somewhere else, I know how things work here' , she said. 'When I first started working there, I had a problem … a big problem … they treated be badly .. they would not show me where everything was … then, slowly, they started treating me with more respect'.

Another migrant woman Zousi, described a quasi-nurse's 'typical working day' as follows: 'I start at 8.00 in the morning. I have to bath the old woman, I give her her medication, I wash and iron the clothes, I clean the house, cook and so on; I am here day and night; the only day I take off is Sunday'.

Often a dependency develops on the part of the patient. As Zousi said: 'the old woman loves me a lot; she treats me like a daughter. I will die if you leave me, she often says to me'. She has also good relations with the old lady's son who helped her get all the papers ready and apply for the green card.

'We phone in and ask if there is demand. Three- four times a day'. Now they know me and sometime they book me in so that I don't remain without a job now that my husband is ill and therefore not working' Irene said. They always have good feedback about my work. However, the majority of the women interviewed complained for being under-worked. Neli said: 'In this hospital they do not adhere to a queuing system. Some women have work every day. Others, like myself, work a few days. Till now, only two months I had work for 23-24 days per month; the other months I worked between 15 and 20 days on average. The ones who have more work, are not necessarily Greeks. The work depends on the '*perstatiko*' (the case, the patient's condition). Another woman, Mousoumbaka, confirmed that there is uncertainty about work availability and duration. 'It depends on the patient and the nature of the illness' she said. 'You may work for 5 days, have a rest, and then go to the nurse in charge and ask for work'. There is an office in the hospital which allocates/recommends '*apoklistikes*'. There are women who work as *apoklistikes* many many years. Maybe they get offered more work and what are classified as 'difficult cases'. She explained: 'But it is not

a difficult job; even if someone is plugged into a lot of machines, of if wired up, it is not that difficult'.

The majority have no nursing of health care qualifications. They learn on the job. 'No one has ever asked us whether we encounter any problems, what sort of problems, whether we need training, whether we need being explained certain things … no one … Only one time, three years ago, they gathered us for half an hour to tell us how to behave towards a patient .. that's all'.

Some try to transfer the caring skills utilised in the public sphere into the private sphere of the household by persuading patients they have looked after in the hospital to hire them as quasi-nurses at home on a monthly salary when leaving the hospital. Abundance of supply of labour hands often push payment downwards.

Complaints included lack of area where they can change to their uniform, using one toilet, lack of basic cleanliness, crowded hospitals, lack of respect from patient's next of kin, isolation and sexual harassment when working as quasi-nurse at home, and overt or covert racism. 'There was a very big problem of racism here' Neli said. When she was asked to elaborate, she added: 'very few people see you with *kalo mati* (good eye) here.. *I xenoi ine pandote xenoi (*foreigners are always foreigners*) ..* at work, they were asking whether I was an Albanian… its the way they talked to me…'. Some patients object to have an Albanian woman as '*apoklistiki*'. '*then theli xenes*' the chief nurse says', said Irene. '50% of patients, when asking the office to find an *apoklistiki* they say categorically that they do not want *xenes*, and in particular Albanians', she added. 'Lots of times we avoid saying where we come from because we are wary about how the patient may react. Sometimes they go and complain because I did not stay all night holding their hand with the drip', said Irene. Then she went on to elaborate how once a patient got someone sacked because she allegedly smelled of garlic.

However, another woman, Masoumbaka, said: attitudes have changed; now people are used to foreigners. But there is still racism: ‘some when they realise you speak Greek and they can therefore communicate with you, they are happy for you to nurse them; others, when they see that you are black they say “I do not want you, go away”’. ‘Word goes around; you come in and if they are happy with you they recommend you to other patients ‘she is good, she is wonderful’. So theysay ‘I want her – use your name’. This was confirmed by other interviewees.

Yet other migrant women complained about the employment agencies: ‘if you have a problem at work they won’t assist’ said one. But the biggest problem was the fact that they always work nights, which all said is very tiresome, but on the other hand allows them to juggle domestic responsibilities. ‘Most do not let you sleep. “Stay awake to keep me company, I pay you for this” patients say. Patients should not treat us like slaves’, a woman from N. Epirus, Irene, who works as *apoklistiki* in Evagelismos, said. She added: ‘it means a lot to me to hear the patient or the next of kin to say: ‘come on, since we do not need you now, sit down’ … or to give you a ‘small present’ on top of the agreed payment, if they are happy with the services you provide for them’.

There is no solidarity along occupational lines developing: ‘I am happy with the work. I do not know what the others do; I am not interested’ Irene said. There is no close relationship or any form of solidarity developed between them and there seems to be inter-ethnic rivalry, especially between the Greeks and *xenes*. ‘There is racism. Some say ‘you foreigners came here and took our jobs’’ said one of the women. And she added: ‘In terms of the permanent staff, some treat us nicely and others, they treat us like animals’. ‘Some of the Greeks, work for two patients at the time, whereas this is against the rules; we cannot do this, we cannot break the rules; we are worried. . This is not fair to the ones who have no work. We cannot report them either…’ Another one, Eleni, said that they have no

time to socialise with one another, but generally if they work at same time in a ward, they try to help one another if needed. ‘As soon as I finish working I want to go home; I am tired after staying awake all night long’.

Negotiations on how many days/hours they will work and for how much are made with the patient’s family. As soon as there is a problem reported, they are asked to stop. Some call her for one day and are not sure if they will ask her to come the next day too. Sometimes they do jobs which do not fall under their remit. The nurses do not help. One migrant *apoklistiki* helps another one.

5. Networks

The migrant women under discussion enter into a number of multi-centred networks, some working at local, others at trans-national and yet others at both local and trans-national levels:

(a) In the country of origin, they need to engage in a dialogue and an ephemeral ‘business cooperation’ with those networks engaged in cross-border activities, including transport of migrant labour back and forth the borders; such cross border activities interlink with survival strategies of migrant women upon arrival in the country of destination. In such ‘ephemeral networks’, a relationship of trust is established, the vaporisation of which occurs as soon as the agreed bond is paid to the smugglers. Such connections are not broken at will, as, if enable to pay the agreed bond, they enter into world of blackmail and often violence.

(b) When in the country of destination, they often establish ‘bottom-up’ webs of dialogue with already established co-ethnic networks to find shelter and work. They also establish often volatile relationships with local people and other migrants which enable them to find jobs thereafter, and slowly become, to quote Sassen (2000, cited in De Tona and Lentin), key actors in counter circuits of globalisation, in that their earnings become vital contribution to the survival of their families, villages, countries. They also connect with family and friends from home (these are ‘less ephemeral connections’).

(c) They establish links with local migrant associations. These 'solidaristic flashes' that is 'moments of being in touch', are interspersed with periods of free roaming' (Bauman 2004:xii, cited in De Tona and Lentin 2005). These can be broken at will and/or reworked further down the line, depending on the migrant's needs, the association's services and capabilities to create spaces of control for their members in the host country.

6. Concluding Remarks and Policy Recommendations

This paper has looked at the experiences of *apoklistikes* and quasi-nurses which are currently performing the function of what Andall (2003) has called in relation to domestic workers in Italy, 'the service caste' in Greece. Since the early 1990s, they present a major threat as they have been gradually replacing the indigenous working class women who previously performed, and to a certain extent still do, this type of work. They are present in the health care sector in two structurally different ways: first as live-in quasi-nurses/maids, where there is no separation between work and live-in space, and where working conditions are almost impossible to monitor. Unlike however domestic workers who, as stated by Lazaridis (2000:66) are treated as 'disposable nappies', often a dependency develops with the ones who perform a health care function. In some instances, the power hierarchy implicit in the interdependent relationship between employer and employee is somehow turned on its head, with the employer becoming dependent on the service provider both emotionally and in terms of provision of care. This enables the domestic worker to carve out some degree of personal autonomy and often to negotiate higher salary/wage. There is however competition in the sector. Some of the women interviewed were without work permits or a green-card, which weakened their bargaining position with their employers (in terms of employment conditions and pay).

Second as *apoklistikes* in public and private hospitals. They have some degree of autonomy over the days they work. However, this is also challenging as it

involves long working hours and night work, which pose a challenge to these women's ability to perform their mothering roles. We also looked at differences between the circumstances of migrant women working in houses and those working in hospitals in terms of the complexity of gender and ethnic dimensions of the work: some do not want to take care of men; others, especially the Albanians, face discrimination because of their ethnic origin. All women interviewed objected to the racial stereotyping of Albanians but also of the *xenes*.

The work should be regulated to ensure that neither the service provider nor the service user are at a disadvantage. The carers should be properly and legally employed. However, if the demands become excessive, there is the danger of them loosing their jobs to other incoming 'others' willing to accept lower remuneration. Better working relations for quasi-nurses will be determined by their own ability to organise and carve out spaces of control and also by institutional bodies operating in the country of origin.

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MISCELLANEOUS

Sometimes people enter the hospital and distribute little cards with names and tel nos of women who can take care someone at home. Some come in without uniform or bloc for insurance contributions stamps. If detected they are asked to leave. But most of the time they pretend they are part of the family.

Favouritism exists. You have to go to the president of our association within the hospital to complain.

In some hospitals, like the Laiko, the Greek apoklistikes do not allow for xenes to work and take their jobs. Other hospitals, like Evagelismos, has many xenes working there. In Laiko they don't let them; tey do not wait for the proistameni to come and call the police. 'They snatch the patients from us because they accept ridiculously low wages' a woman said.

Assessment

Start as domestic, then nurse at home then *apoklistiki*.

From and econ point of view apoklistiki is better. But insecureity in terms of job. You do not know what may happen. Today yu have work, tomorrow maybe not.

Necessity arises by lack of nurses. 'If it is ever possible for two nurses to take care of all the patients during the night' Irene said.

ASNS

No one wanted to become member of an ass,ociation; they regared it as a waist of their time.

[1] Fertility rate declined from 2.30 in 1965 to 1.32 in 1995 (European Commission 1998:6).

[2] Life expectancy at birth has increased substantially (from 70.7 in 1960 to 75.1 in 1996, which is higher than the OECD average of 73.4) (OECD 1998).

[3] Urbanisation and emigration in the 1960s and 1970s have weakened the traditional family relationships and related inter-generational reciprocal arrangements. This has had implications for the care of dependants, which now falls under the responsibility of the nuclear family and in particular women who now lack the extended family network and mechanisms of support these can provide (for more details see Lazaridis 2000:56-57).

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