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# *Les Infirmières Exclusives* and Migrant Quasi-Nurses in Greece

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**ABSTRACT** The article explores the complex experiences and positions of migrant women in the 'nursing profession' in a southern European country, Greece. It looks at ways in which a rudimentary welfare state and a large informal economy have created the demand for *les infirmières exclusives* and for 'quasi-nurses'. The supply and use of their services, on the one hand, helps perpetuate this informal welfare system and, on the other, has implications for migrant women themselves as, inter alia, it contributes to their deskilling, exploitation, marginalization and exclusion. The multifarious degrees and forms that these processes take, to a large extent, depend on the cross-cutting of gender, ethnicity and class, as sexism intersects with different forms of 'othering' and racialization processes in the destination country. The position of these women is also located in terms of ethnic and national boundaries.

**KEY WORDS** deskilling ♦ Europe ♦ health care ♦ immigration ♦ migrants  
♦ migrant women ♦ networks ♦ nurses ♦ social inclusion/exclusion

## INTRODUCTION

In Greece, as in other countries in southern Europe, since the late 1980s and early 1990s, migratory flows from some countries (e.g. Ukraine, Georgia, Russia, Philippines, Moldova, Ethiopia, Sri Lanka, Bulgaria) have become increasingly female. This feminization of specific flows and the increase in the labour market activity of third-country migrant women is interwoven with racialized identities located within gendered social relations reflecting, as this article shows, patriarchal relationships and a lack of accessibility of welfare structures that enable all women to

reconcile their productive and reproductive roles. Local attitudes and culture often create paths that facilitate and encourage the inclusion of migrant women in poorer jobs, justified in terms of different cultural traditions in training systems and credentials of 'others'. These 'informal barriers' work in close connection with 'formal barriers' to women's inclusion in the formal labour market; for example, according to data from the first regularization programme (1998), migrant women constituted only 26 percent of the total 'white card' population<sup>1</sup> (Cavounidis, 2003: 225).

This article is structured as follows: it begins with the theoretical context, a brief description of migration into Greece and of the Greek national health system and 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 and those who work as *infirmières exclusives* in hospitals. The article is based on the experiences of a small number of migrant nurses (see section on methods), it therefore does not aim to draw broad generalizations. By drawing on the narratives of migrant 'care' workers, it foregrounds the power hierarchy implicit in the interdependent relationship between employer and worker, the volatile nature of this hierarchy and degree to which this interdependency could allow the migrant worker to 'carve out spaces of control'. The article 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). The narratives collected allow for an exploration of legal, institutional, social and interpersonal obstacles that these migrant women face in realizing their skills and highlight women's agency, bringing to our attention how they rely on and create resources to have their existing or 'newly acquired' skills (however tacit these may be) in demand in the arena of paid 'care' work. 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 near future.

## METHODS

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 from different parts of the world (five from Africa, two from India, three from northern Epirus in Albania, five from Eastern Europe and three Pontians from the former Soviet Union), ranging from 22 to 55 years old, and from various socioeconomic backgrounds; 16 interviews were tape

recorded. The majority (11) worked as privately employed nurses (in Greek called an *apoklistiki*, which can also be translated as *l'infirmière exclusive*) in hospitals; a few (six) worked as quasi-nurses/carers in private houses. And one, at the time of the interview, was in charge of nursing staff in a public hospital. These were complemented by nine interviews with key informants: five with nurses' associations (Lychnia, Somatio Allileggei, Somatio Evaggelismos) and four with major public hospitals in Athens. A thematic interview guide with open-ended questions was used. The sample was obtained via snowballing and a systematic selection of employing institutions.

Reflexivity was maintained to allow for diversity of interpretations and to enable us to provide explanations for the nature of the migrant women's experiences in the Greek context, the reasons underlying particular attitudes, perceptions and behaviours, and to evaluate the effect of policies and practices on migrants' experiences and behaviour and by proxy, on the local national health system itself.

## THE CONTEXT

### *Theoretical Context: Gender and Migration*

Social theorists have dubbed the current period we live in as the 'age of migration' (Castles and Miller, 1998) or, as I would say, the 'age of the feminization of migration' as more and more women are migrating and are becoming actors in the migratory process to fill specific labour demand niches that are emerging within the gendered service sector of the developed or rapidly developing countries.

Until recently, most accounts of migration have either lacked a gender dimension, or assumed that women were following men in the migration process, or viewed women workers as a source of cheap labour to serve the needs of capitalism, which feminist migration scholars have challenged, or the emphasis has been on 'push-pull' factors, an approach that assumes that the individuals undertake a cost-benefit analysis of migration and make rational choices opting for destinations where the benefits outweigh costs. A way out of these mechanical accounts of migration (including migration systems theory that tied macro-structural factors with micro structures) has been offered by Giddens's structuration theory. According to Phizacklea (2003: 29), 'this more fluid and dynamic approach to the individual within the migration process is practically helpful in moving us away from the more mechanical accounts of migration which have often pervaded the literature'. Goss and Lindquist (1995) use the structuration approach as a way of analysing the interplay between migrant institutions (such as employment agencies, traffickers, labour recruiters

and various other intermediaries that occupy a central position in the largely corrupt migration business) and the individual. They write: 'individuals act strategically within the institution to further their interests, but the capacity for such action is differentially distributed according to knowledge or rules and access to resources, which in turn may be partially determined by their position within other social institutions' (Goss and Lindquist, 1995: 345). Women's agency in migration is important. Women nowadays take initiatives, make independent choices, pioneer migration chains and occupy an increasingly central role in the social networks that facilitate migration and the inclusion of the migrant in the host society and economy (see Ehrenreich and Hochschild, 2003). The discussion that follows throws light onto the extent to which respondents in this study are in fact agents/social actors. As shown in the empirical section of this study, women play a central role in the migration process but individual capacity for agency is shaped by a number of factors such as their legal/irregular status, knowledge of how the 'system' works, access or non-access to resources, the demand (or lack of) for their skills. Some of the women interviewed have practical skills, others may be considered highly skilled and yet others have both practical and formal skills, derived from formal training and qualifications, yet low skill jobs are not less worthy or demanding or in demand than those that require a higher level of skill. In earlier feminist debates, the gendered division in the social construction of skill and professionalism has been pointed out; here I would like to include the dimension of migration and ethnicity in the social construction of skill. Finally, the work on transnationalism attempts to 'restore a more dynamic, pro-active view of migration' (Phizacklea, 2003: 33). So, over the years scholarly debates on migration have shifted away from a portrayal of female migrants as symbols of traditional culture and representatives of moral norms and lifestyles or as passive objects of migration structures, to viewing them as actors in the migration process. As Lenz et al. (2002: 7) have pointed out, 'gender is interwoven with migration and gendered migration is on the move'. The following sections illustrate, via the experiences of *les infirmières exclusives* and migrant quasi-nurses, some of the points made here.

### *Migration into Greece*

Since the late 1980s and early 1990s, women have occupied a central position in the migratory flows into Greece, both as 'dependent' and 'independent' economic migrants, playing protagonist roles in the migratory process (Lazaridis, 2000: 49; 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 few opportunities for

migrant women outside the informal labour market (Lazaridis, 2000, 2001); thus while men have wider, albeit still restricted labour market opportunities, women end up concentrated in feminized spheres of services such as tourism, domestic work 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 (Lazaridis, 2000), or as prostitutes (Emke-Poulopoulos, 2001; Karakatsanis and Swarts, 2003; Lazaridis, 2001; Lazos, 2002a, 2002b). There is little, if any, research on those working as quasi-nurses/carers or as *infirmières exclusives*. This article addresses this gap in the relevant literature. As the article 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.

*Les Infirmières Exclusives and Quasi-Nurses/Carers:  
Why The Need?*

The changing structure of the Greek population, with declining fertility rates,<sup>2</sup> demographic ageing due to increased longevity<sup>3</sup> and changes in family formation, means that the care needs caused by the rise in the proportion of economically inactive elderly persons with increased levels of dependency, are not met by provisions made by Greece's welfare state. Greece has a 'rudimentary' form of welfare provision, characterized 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 the elderly and people with special needs (Katrougalos, 1996; Katrougalos and Lazaridis, 2003). However, the position of Greek women has changed over the last 30 years,<sup>4</sup> as their increasing social and economic role outside the household started to change. As stated in an earlier work (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 is still socially stigmatizing for a family to place a parent in an old people's 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 percent of the total population aged 65 years and over as opposed to 8–11 percent 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 brought in. This has become a must as the state, indifferent to the needs of women, has failed to make appropriate provisions.

### *The National Health System in Greece*

The Greek national health system was established in 1983 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 percent) financed from the state budget. However, there are a number of concerns, including infrastructural inefficiencies, unsatisfactory and inequitable provision of services and erratic organization of human resources. Staff working in the Greek national health system are public employees and therefore not allowed to practise privately. However, there exists the widespread practice of 'unofficial' payments in the form of 'little envelopes' (known as *fakellakia*) to doctors and nurses. This corrupt practice is a means by 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 make these payments 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 which is often protected by corrupt sectors of the administration (Morin, 1990). This hidden economy is estimated to constitute approximately 30–45 percent of GDP (Canellopoulos, 1995; Eurostat, 1995; Katrougalos and Lazaridis, 2003). It has enormous implications for employment as it reinforces labour market segmentation 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 market, whereas *les infirmières exclusives* are 'compartmentalized' 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 that 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 socioeconomic changes enabling and necessitating more and more women to enter paid employment and a lack of accessible welfare structures have 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, the most important being the creation of a niche for *apoklistikes* (*les infirmières exclusives*), due to considerable shortages of human resources in all areas of nursing care, within the framework of clientelistic politics and a large informal sector described earlier. The need for this service reflects the basic weaknesses of the Greek national health system, summarized by Katrougalos and Lazaridis (2003: 149) as '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 obliges hospitals to turn a blind eye to private initiatives such as this 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 a 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 accessible for long periods of time to families located within higher income groups.

#### LES INFIRMIÈRES EXCLUSIVES (APOKLISTIKES) AND QUASI-NURSES/CARERS: ARRIVAL AND EXPERIENCES IN THE HOST COUNTRY

##### *Reasons for Coming to Greece*

A large number of migrant women who work as *apoklistikes* are from Albania. Other countries of origin include East Africa, Russia, Romania and Bulgaria. With the exception of the Albanians, who tend to migrate *en famille*, in almost all other cases, the women migrated alone, irrespective



of whether they were married or not in their 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 of the women interviewed 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 of Greece. Those from Pontos (ex-USSR) and from northern Epirus (a part of Albania that 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 in their country of origin. They came to Greece through chain migration, because either a relative or a friend had migrated and found work.

### *Deskilling through the Process of Migration*

All women interviewed were skilled. Most had a college education and/or professional background. To give a few examples: Neli finished her training as a chef and waitress in Bulgaria before coming to Greece: 'I was unemployed for several months', she recounted, 'then I found work as domestic.' Another Bulgarian woman, Zousi, was a qualified teacher teaching typing skills in a college: 'when computers came into fashion I lost my job and decided to migrate', she said. 'I had been unemployed for several months,' she added, 'then I migrated and found work as domestic.' Some, like Ritsa, came to undertake training; she was studying 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 an *apoklistiki*. Ifigenia finished her midwifery degree in Pontos before coming to Greece. Chrysa finished her qualifications designing electric circuits and in accountancy, worked for a while in an office in Bulgaria as an accountant but when she was made redundant she decided to come to Greece. Eleni, a migrant from the northern Epirus region of Albania had a degree in civil engineering and was studying economics when the political changes took place in Albania and she had to abandon her studies and come to Greece. As the process for getting one's skills recognized 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 very low grant 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 acknowledged in the migration literature (see, for example, Petras, 1981; Oommen, 1989).

Taking into account that the notion of skill itself is socially constructed,<sup>5</sup> a range of skills are evident in the profile of the respondents. Some have practical skills, others may be considered as highly skilled and yet others have both practical and formal skills, derived from formal training and qualifications. As one can see from the examples given here, trained women leave their countries and enter unskilled or low skilled jobs, jobs however that are not less worthy or demanding than those that require a higher level of skill. 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 it difficult to pursue their original occupation in the country of destination: qualifications are not recognized, they lack language skills, lack opportunities to retrain, etc. Once in the new job, a tendency to undervalue activities associated with so-called female occupations tends 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 require little skill. But, as stated earlier, this does not mean that they are any less worthy or demanding.

Once in Greece, the 18 women interviewed find work through three different channels: via the use of migrant networks, through word of mouth (an employer satisfied with the service provided recommends her to a friend or relative), 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.

### *Working Trajectories and Experiences in the Host Country*

Neli, from Bulgaria, started working as a domestic, then for two years she worked during the summer as a cleaner in a hotel in Crete for a very low salary (60,000 drs a month – approximately €160 in 1992) and in the winter as a 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 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 (she paid the agency a fee of 25,000 drs, that is approximately €67), as a home-nurse, looking after an elderly person who was bedridden because of a stroke. 'The lady in the house mostly

wanted company', Neli said. On top of the basic caring tasks, she was expected to perform tasks in which she had no experience or skill, like massage. However, as is often the case, there was no clear-cut divide between nursing and domestic work as she also ironed, cooked and cleaned. She regarded this as 'easy work'. The family asked her to leave to take on someone who spoke better Greek and could keep the old lady company. She went back to the agency, they found her work as a live-in domestic, but she got married to a Greek (second husband) and stopped working as a live-in maid. Then she found a job as an *apoklistiki* in a public hospital. 'The fact that my husband was already working there as a porter helped', she said. And she added: 'He asked the person in charge, 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 an *apoklistiki*:

I went to many hospitals and asked if they could include me on their lists of *apoklistikes*; they told me they were full. Later I found a job in Evangelismos [a big public hospital in Athens]. I went along for three days to see what the others did and then I started working. There was no interview or any other formality.

Chrysa's narration of her working trajectory in Greece went 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 my husband and children behind. I caught 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 that 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 low, only 40,000 drs [approximately €107] a month in the late 1990s, when for a similar job other women were being paid 120,000 drs [approximately €320] a month, 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 [she and the family], 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 an *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 from being a maid to performing the duties of a 'quasi-nurse', to functioning as an *apoklistiki*. Rather, there was a 'trampoline effect' in operation: from maid to unemployment, from unemployment to quasi-nurse back to unemployment and then to maid, back to unemployment and then up to

*apoklistiki*, back to unemployment and then to quasi-nurse or maid. And often, the boundaries were blurred.

Almost all women who work as quasi-nurses in private homes tend to develop bonds with their clients: 'I have known 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 warmer with time: '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 do they deliver an emotional surplus to the employers, providing them with an emotional and physical sense of well-being through their person-oriented caring tasks, but this is often reciprocated. Nevertheless, this *cosy* interdependence between employer and employee offers a murky picture of the hierarchical nature of the relationship and the manner in which class and ethnicity operate within it.

The only woman who works as a qualified nurse is Ifigenia, from Pontos in the former USSR. She was looking after an elderly bedridden woman for some time and then decided to apply for a job in a hospital. She got her degree translated and found work in a private clinic. 'I work as a nurse there', she said. 'Two or three of us look after an average of 40 patients per shift.' The difference between her work and that of the *apoklistiki* is that her job is to look after a number of patients whereas the latter looks after one patient *exclusively*. It could be argued that there is a need for this exclusive service, given the general lack of welfare infrastructure, but it is simultaneously a luxury that can be afforded only by some and may inhibit the development of universal, accessible solutions for a wider range of patients.

Neli, who now works in a major hospital in Athens, the Red Cross, described the work of an *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, it's 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. . . . When I first started working here, I had a problem . . . a big problem . . . they treated me 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 also has a good relationship with the old lady's son, who helped her get all the papers ready and apply for her green card.

'We phone in and ask if there is any demand. Three, four times a day. Now they know me and sometimes they book me in so that I don't remain without a job now that my husband is ill and therefore not working', Irene, from northern Epirus, explained. 'They always have good feedback about my work.' However, the majority of the women interviewed complained of being underworked. 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 for two months did I have work for 23–24 days a 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 *peristatiko* [the case, the patient's condition].

Mousoumbaka, from Africa, confirmed that there is much uncertainty about the availability and duration of work: 'It depends on the patient and the nature of the illness', she said. 'You might work for five days, have a rest, and then go to the nurse in charge and ask for work.' Mousoumbaka went on to explain that there is an office in the hospital that allocates/recommends *apoklistikes*. There are women who have worked as *apoklistikes* for many years. It could be that they get offered more work, or are given what are classed as the 'difficult cases'. 'But it is not a difficult job; even if someone is plugged into a lot of machines, or if wired up, it is not that difficult', Mousoumbaka said.

The majority have no nursing or health care qualifications. They learn on the job. As one nurse commented:

No one has ever asked us whether we encounter any problems, what sort of problems, whether we need training, whether we need certain things being explained certain things . . . no one. . . . Only once, three years ago, they gathered us together for half an hour to tell us how to behave towards a patient . . . that's all.

Some try to transfer the caring skills utilized in the public sphere into the private household sphere 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. An abundance of labour supply in this area, however, often pushes salaries down.

Complaints about working conditions included the lack of an area where they could change into their uniform; there being only one toilet; a lack of basic cleanliness; crowded hospitals; a lack of respect from patients' next of kin; isolation and sexual harassment when working as a quasi-nurse at home; and overt or covert racism. 'There is 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* [a good eye] here . . . *I xenoï ine pandote xenoï* [foreigners are always foreigners] . . . at work, they were asking whether I was an Albanian . . . it's the way they talked to me.' Some patients object to having an Albanian *apoklistiki*. 'Then *theli xenes* [they don't want foreigners], the chief nurse says', said Irene. 'Fifty percent of patients, when asking the office to find an *apoklistiki*, categorically state that they do not want a foreigner, 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.' Irene went on to elaborate how once a patient got someone sacked because she allegedly smelled of garlic. So the negative stereotyping of specific groups of migrants, such as the Albanians, is contributing to their racialization and marginalization. Racialized hierarchies can affect access to work, one's pay and treatment at work and pose obstacles to migrant women's skills or professional experience being recognized. However, in this case racism is not articulated as a 'colour' hierarchy. Elsewhere (see Lazaridis, 2001; Lazaridis and Koumandraki, 2001), I have shown how the use of stereotypes by the media and public discourse has been used to rationalize the 'demonization' of Albanians in Greece, their exclusion from access to material and non-material resources<sup>6</sup> and their position at the bottom of a socially constructed 'hierarchy of whiteness'.<sup>7</sup> Here, the 'undesirable' often become 'desirable' according to the needs of the patient and the availability or not of 'caring hands'.

However, Mousoumbaka was more optimistic:

. . . attitudes have changed; now people are used to foreigners. But there is still racism: some, when they realize 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 they say 'I want her' and ask for you by name.

This was confirmed by other interviewees.

Other migrant women complained about the employment agencies: 'if you have a problem at work they won't assist you', said one. But the biggest problem was the fact that the nurses were always required to work nights, which, all said and done, is very tiring, 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', commented Irene, who was working as an *apoklistiki* in Evangelismos hospital. She added: 'it means a lot to me to hear the patient or the next of kin 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.'

However, there is no solidarity developing along occupational lines: '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 between the women and other hospital staff and there seems to be interethnic rivalry, especially between the Greeks and *xenes* (foreigners). 'There is racism. Some say "you foreigners came here and took our jobs"', said one of the interviewees. 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 a 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 woman, Eleni, said that they have no time to socialize with one another, but generally if they work at the 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. Sometimes they will be called in for one day and are not sure if they will be asked to come in the next day too. Sometimes they do jobs that do not fall within their remit. The nurses do not help. But one migrant *apoklistiki* will help another.

## NETWORKS

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

First, in their country of origin, they need to engage in a dialogue and an ephemeral 'business cooperation' with the networks engaged in cross-border activities, including transport of migrant labour back and forth across the borders. Such cross-border activities are inextricably linked with the survival strategies of the migrant women upon arrival in the country of destination. In such 'ephemeral networks', a relationship of trust is established, which dissipates as soon as the agreed fee is paid to the smugglers. But if the fee is unpaid such connections persist, and these women are thrust into a network of blackmail and often violence.

Then, 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. This dialogue is either built upon pre-existing contacts or based on new ties formed in the host country. The main places of interaction where new relationships develop are the neighbourhood and workplace. However, on the negative side, old relationships sometimes tend to diminish as migrants become more distanced from one other. Our interviewees attributed this to the lack of time for socialization and the fact that migrants in Athens are dispersed across the city. Having said that, some exhibited a more dynamic perspective, distinguishing between past experiences when they first arrived in the host country and new experiences where the quality of relationships tends to be better, attributing this to their regularized status and gradual improvement of living conditions. They also establish often volatile relationships with local people; the interaction between the migrants and locals and the new relationships and social networks they form in the host country may function as social capital given the important role of intermediaries in finding jobs in the Greek labour market. The extent to which such networks constitute effective social capital depends on the density of the ties. Moreover, they establish relationships with other migrants, who subsequently help them to find jobs, and slowly to become, to quote Sassen (2003), key actors in counter-circuits of globalization, in that their earnings become a vital contribution to the survival of their families, villages and countries of origin. In addition, they connect with family and friends from home (these are 'less ephemeral connections'), thus keeping alive transnational networks.

Third, they establish links with local migrant associations. These 'solidaristic flashes', or '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 reconstituted later on, depending on the migrant's needs, the association's services and its ability to create spaces of control for its members in the host country. The involvement in an association varies from one ethnic group to another. For example, the Filipinos are highly organized and have one of the most vibrant associations in Greece, highlighting the importance of agency in the integration process; whereas the Albanians and Bulgarians are among the least organized ethnic minority groups; there is a general distrust among Albanians in particular of collective institutions. By and large, the number and size of associations do not necessarily reflect high participation rates.

## CONCLUDING REMARKS AND POLICY RECOMMENDATIONS

This article has looked at the experiences of 18 *apoklistikes* and quasi-nurses. Women offering these services, along with domestic workers, are currently performing in Greece the function of what Andall (2003) has called, in



relation to domestic workers in Italy, 'the service caste'. Since the early 1990s, 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. Often a dependency develops with migrant women 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 pay. 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, they are employed 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 working long hours and night work. I 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, especially the Albanians, face discrimination because of their ethnic origin. All women interviewed objected to the racial stereotyping of Albanians but also of foreigners in general.

## NOTES

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1. There were two stages in the 1998 regularization process. In stage one, successful applicants were issued with a permit of limited duration, or 'white card', and at stage two, they were issued with a 'green card'. During the second stage, applicants were required to present proof of legal employment and payment of social insurance contributions. Later on, in the 2004 regularization phase, the government decided that one permit would be granted for work and residence in order to bypass bureaucratic problems and delays encountered in the past. For a detailed examination of the first regularization programme, see Lazaridis and Poyago-Theotoky (1999).
2. Fertility rates declined from 2.30 in 1965 to 1.32 in 1995 (European Commission, 1998: 6).
3. Life expectancy at birth has increased substantially, from 70.7 years in 1960 to 75.1 in 1996, which is higher than the OECD average of 73.4 (OECD, 1998).

4. Urbanization and emigration in the 1960s and 1970s have weakened traditional family relationships and intergenerational 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: 56–7).
5. For example, the domestic sector is socially constructed as an unskilled sector.
6. An account of processes of inclusion and exclusion of migrants from Albania to Greece can be found in Lazaridis and Koumandraki (2007).
7. In the sex industry there is also a hierarchy of whiteness, with the highly desirable Russians and Ukrainians at the top of the hierarchy, followed by other East Central Europeans, and the stereotyped 'roguish' Albanians at the bottom (see Lazaridis, 2001).

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