GLOBAL ORGANIZATION, HOME CARE: THE INTERNAL STRUCTURE OF THE MIGRANT CARE SECTOR[1]

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ABSTRACT

Globalization consists of various interactions between structural and individual level factors. It is a process that determines social structures, and thus the framework of individual level decisions and action, while some of the actors are actively engaged in shaping them. There is a demand for migrant care work in health and elderly care services and is formed at the intersection of multiple spheres of actions (of the state, private sphere, families). The cheap and flexible human resource capacities, providing partly professional and partly familial-type care with long working hours (even around the clock) on a long run, can be recruited among women coming from abroad. The reproduction sector that has been integrated into the global labor market, and has become a notable section itself, raises several new questions, compelling us to examine the interference of three aspects: gender, migration and care. In my paper I aim at demonstrating how women from Eastern and Central Europe got involved in the global care sector, how they contribute to its functioning, and what work regimes have been established within the sectors covered by them.

Keywords: migration of women from Eastern and Central Europe, care work, commodification of care work, globalization

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INTRODUCTION

The Janus-faced globalization is the cause and effect of inestimable positive and negative dynamics, bringing both solutions and constrains. It is both a blessing and a curse, as Arlie Russel Hochschild puts it, as it opens up new opportunities and new problems at the same time (Hochschild, 2000, p. 142). It is a process that determines social structures, and thus the framework of individual decisions and actions, while some of the actors are actively engaged in shaping, producing and reproducing them. Apart from blending, interdependence is also an important feature of the system built on relations and inequalities between nations and regions. The dynamic relationship between transnational geopolitics and economic changes continues to reshape (and partially reinforce) the map of the world, exerting influence on the hierarchical order of countries. The events that took place at the end of the 20th century and fall of the socialist regimes led to the integration of large new regions into a global system. With the collapse of the Soviet influence, Central and Eastern European countries joined the global capitalist system (Koser and Lutz, 1998; Melegh, 2007). At the beginning of the 21th century not only we could witness the deeper and more intensive integration of some regions in the Middle-East and Northern Africa, but we could also observe the intensification and the acceleration of the globalization process. This system is built on multi-layered (sometimes hidden) order of inequalities, such as social gender, social class, the hierarchy of countries and regions, along with the structure of the labor market. However, there is a delusion here. While the national characteristics of economies are fading and global ideology is still at the forefront, the rise of nationalist political forces gain strength, immigration systems increase their regulation on entitlements, movement and residence conditions of foreign citizens, thus introducing new stratification among individuals, with larger units integrated into the system (see also Düvell 2006a). Pei-Chia Lan observes that we live in a globalizing, yet a more and more divided world (Lan, 2006, p. 240).

The reproduction sector has been integrated into the global labor market and has became a notable section itself. This change raises several new questions, compelling us to examine the connection and interference of three schemes:

gender, migration and care (Lutz, 2008). The organization of domestic and care work on global scales indicate the transformation of strategic economic sectors and their reproduction, according to Saskia Sassen, who writes about 'global cities' being formed in imaginary, international dimensions, within which new patterns can be observed specifically along female migration tendencies (Sassen, 2006). Annie Phizacklea emphasizes the eminent inadequacy of defining the phenomenon of women being forced into institutional forms of dependence as an international instead of a global mutual dependence (Phizacklea, 1998). Nicola Yeates boldly defines the global care chain and the globally organized reproductive labor division in general as a migration-industrial complex (Yeates, 2009, p. 86). Pei-Chia Lan observes stratification based on social class, ethnicity and social gender in the hierarchical world-system, which is a result of cooperation and mutual dependence, but along the lines of sustained inequality, structural and stratified diversity formation (Lan, 2006, pp. 29–58). Rhacel Salazar Parreñas studies the sector's largest source country, the Philippines, form where mass female migration has originated and migrated to the developed world since the 1960s, into its reproductive sector: doing housekeeping, baby sitting and elderly care. Therefore, she calls the women from the Philippines the servants of globalization. She believes that on an international level, the division of reproductive labor is defined by global capitalism and gender inequalities both in the source, and in host countries. According to Parreñas, the global system treats the Philippine population as an economic resource of export and defines mass migration as an outcome of this positioning (Parreñas, 2001). Helma Lutz carries this same line of thought when studying Eastern European women joining the global housekeeping sector. Due to the post-socialist political and economic processes, the Eastern European region is being repositioned, which is causing new migration dynamics. After the initial male migration, a feminization has taken place, showing new characteristics of migration. When analyzing the cooperation within society's unseen, hidden zones (households), she concludes that the 'new servants' are not the casualties of a system (of the global labor market), and neither are they the sufferers of the consequences of their own individual activities (agents), rather participants of the tendency formed by the interaction of these two factors (Lutz, 2011).

A new household industry and care system seems to be taking shape. Even though it functions mostly in the shadow economy and the informal sphere, it is an integral part of the global economy, with unique characteristics due to the following factors: the intimate nature of the jobs' social aspect, the social structure that endows care work with gender content, the unique relationship

between the employers and employees – that is strongly emotive with personal and mutual dependence – and the logics of care work which are different from any other areas of employment (Lutz, 2008). Consequently, care work has been marketized, became a commodity, received a monetary value, shifting from the reproductive to the productive sector, reconfiguring economic areas (Anderson, 2000, pp. 112–114; Ungerson, 2004; Parreñas, 2006; Zimmerman et al., 2006).

COMMODIFICATION OF CARE WORK IN THE GLOBAL AREA

Migrant care work fits into the health and elderly care service and is formed at the intersection of multiple spheres of action. A breach has formed in the cooperation of the state, the private sphere and the family. The cheap and flexible human resources, providing partly professional and partly familial-type care with long working hours (even around the clock) on a long run, can be recruited from women coming from abroad. The need for this kind of labor is greatly influenced by the host country's general concept of the family, namely, the idea of its scope of responsibilities and the tasks that can be delegated to institutions. Within Southern European countries, various forms of domestic care are typically prevalent, one alternative being the hiring of a migrant care provider. Italy, Spain and Greece are leading countries in this, but the phenomenon is much more widespread; for example the comprehensive EUROPHARMCARE research reports of 2003 and 2005, involving 23 countries, give account of 17 countries mentioning migrant care providers.[2] The tension generated between cultural standards and moral expectations that support personal, familial, domestic care on the one hand, and the increased female workforce presence in the local society on the other, can be eased by the purchase of reproductive labor.

This enables the traditional model to suffer the least harm, while the female members of the families are turning from care providers into care managers (Degiuli, 2010, p. 774). Involving external labor improves/sustains the quality of life for the families, the elderly can keep their independence and do not lose control over their own lives, while members of the second generation can go on with their usual lifestyles. This latter group can minimize the extra burdens, their time management does not change substantially, they can keep their jobs

[2] https://www.uke.de/extern/eurofamcare/publikationen.php?abs=4 (Downloaded, 7/3/2016), also di Santo and Ceruzzi, 2010, pp. 3–5.

and private life at more or less the same levels they had before the need for care arose. The concept of care constructed by state actors is also a significant factor that forms the well-being of those in need of care. The social and health care system and policies of individual countries also form and control the possibilities, while affecting the mentality on the provision of care by defining preferences and forms of support and by governing and supervising the cooperation of actors within the system. Several researchers have analyzed this, I will mention some of them below. Clare Ungerson specified the following models when studying five European countries, entirely marketized 'informal' care (Netherlands, Austria), regulations and quality control (France), direct payment (United Kingdom), complementary income for households (Austria, Italy), and care providers in the gray economy (Italy) (Ungerson, 2004). Marina Izzo compared the care policies of Italy and Spain and studied their impacts on domestic care (Izzo, 2010). Emmanuele Pavolini also studied Italy and examined the whole social care system, the change of regulations and their far-reaching consequences from the 1980s, until the present day (Pavolini, 2001). Howard Litwin and Claudine Attias-Donfut compared France's conservative-corporatist welfare system to Israel's traditionally social-democratic system that is now turning into a neoliberal one (Litwin and Attias-Donfut, 2009). Hila Shamir studied the models of welfare states and family policies in terms of the United States and Israel (Shamir, 2010). In addition to regulating the care system, the principles of migration-policies should also be considered, as the governments of host countries set up preferences on certain migrant groups, on the labor sectors that are being kept open for migrants, and on the residence of foreigners and on their prospects to legal-administrative integration (Düvell, 2006a, 2006b; Lutz, 2011, pp. 154–184). Consequently, the state regulates the migrant care sector, together with all of the above.

In the Central and Eastern European region, the following political, economic and legal changes were influential:

- Following the 1989 regime-change, borders opened up and, although only to a limited extent, people could travel freely, and working abroad became possible upon conforming to the appropriate administrative regulations and obtaining the necessary permits.
- The period of catching up with the European Union simplified the legal conditions of mobility, somewhat closing the borders with countries that were lagging behind in the catching-up process (e.g. Ukraine), even when the neighboring countries formerly had tight economic and social relations.
- Joining the European Union brought benefits to the post-socialist countries

on several levels. Barriers to traveling to the Union's countries for shorter on longer periods of time disappeared; the labor market of the Western countries – gradually, and with certain checks – opened up to people coming from the East. Some migrant channels became both intensified and shorter, and new ones were formed. The transnational networks became even more modulated and stratified and the change of the source countries' geopolitical situation and their 'promotion' within the global hierarchy had a somewhat beneficial effect on their social image in the host environment.

- Border crossing within Europe became simpler and faster with the extension of the Schengen zone.
- The economical path and potential of countries in the post-socialist region (and their power relations) have changed in the last thirty years, especially during the 2008 global economic recession, which partly modified the migration map of the region. For example, the number of migration channels and the intensity of their utilization decreased, and new groups started to utilize transnational resources.
- The national politics of Hungary and the transborder regulations based on it, the national visa, and the expansion of the circle of the those entitled to citizenship have all influenced the area's migration aspirations and patterns.

In my paper, I aim to demonstrate how women from Eastern and Central Europe have gotten involved in the global care sector, how they contribute to the functioning of this labor market segment, and the systems they have established in the sectors covered by them.

METHODOLOGY

I have been doing ethnology fieldwork covering a number of women from Eastern and Central European countries ever since 2009. First, I examined how women arriving to Hungary from Transylvania (Romania) and Ruthenia (Ukraine) join the care system, how they integrate into the host families, how these parties cooperate, and how all of these influence their life course and self-identity. I conducted in-depth interviews with care providers, clients and employers in both the source and the host countries. I extended my research to include a study on mass female migration from Romania and the Republic of Moldova towards Italy, doing several months of fieldwork in these countries. Since 2010, I have included into the researach care providers' migrating from

Hungary, revealing mobility towards Austria, Germany, Switzerland, America and Israel. In this research phase, I also had a chance to conduct fieldwork in almost all of the countries mentioned above.

During my research, I conducted in-depth interviews for the most part. The language of the conversation was the native language of the respondents, so I used Hungarian and Romanian. The fieldwork yielded a substantial corpus, where a total of 199 interviews were conducted. This has been complemented by an extensive field diary, rich with data, spontaneous conversations, stories not included in the interviews, and other observations. As the labor done in the household sector is illegal in most cases, partly legal in rare cases (I only met one case where the labor was completely legal), the conversations took place right at the sensitive borderline of trust and publicity, and, despite of the anonymity, a great deal of information only could be documented in the field diary. In addition to all this, I also used opportunities offered by the cyber space. The women doing domestic care tend to break their physical isolation with the Internet and virtual associations. They are very active on Facebook, write many emails and chat a lot on various platforms. They introduced me to several of such circles, enabling me to be present in the transnational world they create for themselves in this global virtual social space.[3]

FORMS OF LABOR IN THE MIGRANT CARE SECTOR, STRUCTURE AND INTERNAL SYSTEM

Besides cleaning and baby-sitting, providing care is also part of the household industry sector. Many similarities exist among these jobs, and in some societies, the passage between them is flexible (this is the most obvious in the case of the United States of America, with the Hungarian immigrant women's occupational mobility). At places I examined, certain activities were predominantly done by distinctive groups, and the passage between the care providers for the elderly and cleaners were more substantial. In most examples however, care providers do cleaning for additional income. Transition takes place upon moving in with family members following a family reunification, since they can synchronize their new lifestyle more with a cleaning job (Italy), or when their residence permit expires, and they can no longer work with the elderly as an illegal migrant, but

[3] I outlined the problems of research on the online sphere in more detail at a comprehensive methodological study (see Turai, 2016).

they can do cleaning going from house to house, like as seen in the case of Israel. Thus, there are many similarities in these activities due to the work frames and the reproduction content of the activity, but care work also has some unique characteristics. For example, it has a unique internal structure, stratifying the society of migrant care providers and forming a hierarchical order. Below I shall outline these, along with their benefits and difficulties, and how they collaborate with other welfare services in practice. Significantly, classification is not based on the type of work, but on how the lifestyle is organized (see also Anderson, 2000, p. 28). Discovering the system's internal logic also helps us understand the migrant path of these employees, their dynamics of their residence abroad, their returning to home or their integration into the host country's society, which many – mistakenly – explain with the legality or illegality of their status.

LIVE-IN CARE

The prototype of migrant care work is the so-called live-in care; namely the work organization form when a care provider moves into an elderly person's apartment with a permanent work schedule, and the sole obligation to be with the person being cared for all the time. This type of work is typically done by foreigners, as they do not have their own household or family of their own in the host country where they could go home to after work. Very few local employees would be willing to put aside their private life for longer or shorter period of time to move in with an elderly client for weeks or months. Therefore, a live-in care provider is almost a synonym for an immigrant female employee.

In comparison to other possibilities in the care system (e.g. nursing homes, rehabilitation centers, private *hospices*) live-in care is more than a cheap solution for the care of the elderly. It fits in with the system of expectations at family-oriented societies, which consider keeping the elderly at home more beneficial in comparison to the institutional forms of care. In this sense, domestic care is associated with personal concern, a familial atmosphere, a loving emotional environment, while institutionalization, besides being professional, means impersonality, lack of emotions, and some kind of an abandoned state. The cultural norm suggests certain moral imperatives to the parties concerned, enabling the widespread expansion of live-in care work.[4] This tendency could

[4] Francesca Degiuli (2010) and Elisabetta Zontini (2010) made detailed analyses on how live-in care done by migrants fit into the South European countries' system of norms.

be intensified or weakened by the national welfare care system by declaring its principles of support in benefits and the conditions attached to them, and the elderly care solutions preferred by the administration. When analyzing the practice in Europe, Clare Ungerson places the types of care observed in various countries on a paid-unpaid, and regulated-unregulated axis (Ungerson, 2004). According to the logic of this system, and based on my own findings, I can state that the poorly regulated monetary support or the lack of funding from the state, from the insurance companies (or their minimal role,namely creating family, i.e. informal resources) contribute to the wide-spread expansion of live-in care mostly provided by migrants.

In Italy, in reaction to the great need for care providers, the state gives financial support to the elderly to solve their own care needs, without monitoring the use of benefits (unlike the regulations in Spain, for example). In reality, this is outsourcing the labor, and supporting the privatization of care for the elderly in their own homes, with individual work expectations, ideas and 'protocols'. The financial support system is based on national and local government resources: it consists of a provisional benefit (*Indennita di accompagnamento*), that is given by the state to individuals unable to look after themselves, and an allowance (*Assegno mensile di assistenza*), that is calculated by the local authorities, based on a special assessment.[5] At the time of my fieldwork (2010) the first one was 480.47 Euros, the latter was 256.67 Euros in Ancona (Marche region) where I carried out the research. At that time, the Eastern European live-in care providers' salaries started from 750 Euros, the average was 800 Euros, and the highest one that I had come across was 1200 Euros (but that was for looking after two people). Thus, it is easy to see that employing migrant care providers for permanent presence is comparatively easily accessible even for the broader population. The Austrian support system is similarly permissive. The *Pflegegeld* system introduced in 1993 enables individuals in need of care to receive financial support from the state which they can freely spend (Österle and Bauer, 2011). The monetary transfers and the system of regulations thus opened a favorable setting for employing foreigners in the care sector.

The support system in Israel consists of several components. The elderly in need of care can submit their claim to the National Pension Fund (*Bituah Leumi*) that sends a committee to assess the elderly person's condition, and assess their financial situation. Based on this, they decide how many hours of care is needed

[5] For a more detailed analysis of the Italian support system, see also: Bettio et al., 2006; Simonazzi, 2009; Izzo, 2010; Di Santo and Ceruzzi, 2010, Santini et al., 2010.

a week, which is maximized in 18 hours even for patients who are unable to look after themselves; which obviously does not represent the real need associated with this situation, but the maximum sum that can be granted. Several of the elderly people today are former deportees, and thus they can request additional support from Germany in order to employ a care provider. In addition, there are insurance companies that provide pensions to the elderly based on their contributions. The way the allocated support is spent is partly supervised by the state, as the care providers receive their salaries through a recruiting agency. The initial monthly salary of migrant domestic helpers – not negotiated by the employee and the employer, but defined centrally – was 3200 shekels at the time of my fieldwork (2011), plus 100 shekels of pocket money for the week-end and days off, or 231 shekels in case they worked that day, with additional payed holidays with 351 shekels per day. Naturally, the basic salary and the number of days off increase every year. If state support is not enough for the prescribed salary, it should be complemented with own resources by the elderly.

No state welfare allowance was mentioned to be available for employing a care provider in the other countries examined that can be directly attached to this form of support. In Hungary, care provider allowance can only be claimed by a relative, and it is only a very low amount (net 26,550 HUF in 2016), much lower than the salaries of the migrant domestic care providers (approx. 120–160,000 HUF, depending on the patient's physical condition and the agreement of the parties). Thus, the pension of the patient, along with the contributions of his or her children make up the fund that enables the outsourcing of the care work. The elderly in countries of the 'global West' mostly finance the cheapest form of care available in their country (the Eastern and Central European women are available for employment for about 800–900 Euros) from their own resources, using their pensions.

I only found one example where care was not based on direct monetary transfer; a woman from Vista (Romania) looked after a childless elderly man in Budapest in the confines of a traditionally known contract of support in exchange of an apartment in a condominium.

In addition, they need to provide accommodation for the live-in care provider, that is expected to be a separate room, rarely with separate bathroom, but in practice it is sometimes reduced to a sofa in the hallway or in the shared lounge. According to the agreement, the employer has to provide for full board as well. The individual needs of the care provider are typically not included in the agreement, so how much their different eating habits (e.g. needing ingredients for home-made meals) are taken into consideration depends on the elderly

persons' and the families' goodwill. The benefits beyond payment mentioned above are given in addition to the salary, except for Israel, where the employer can retain a certain amount as a rent; which can depend on the type of housing and its location within the country (for accommodation between 115 and 210 shekels, plus 77 shekels for utilities). Further benefits are subject to individual agreement: The travel expenses of care providers visiting Budapest from across the border are usually paid for; in Israel it is a common practice to pay for the Internet; telephone bills are occasionally covered partly or entirely; and there may be gifts given at special occasions.

Live-in care has both implicit and explicit (defined in the agreement) frames, which can provide the employee with entitlements and protection, as well as obligations. Defining or limiting the private sphere and time-off have an influence on the quality of everyday life. It is a common inconvenience that the space or the room the care provider is provided with is also used by others. In Israel, Marta's[6] client regularly visits her room when she is not at home, as the landlady keeps her money in the only drawer with a lock that is located in that very room. Iza's room (which is an open space) is next to an elevator, where everyone passes by. She did not have room to put her clothes in a wardrobe, but she ended up reorganizing the landlady's belongings, in order to create some space of her own. Andi's room is not entirely private either. The landlord keeps his medication and paperwork there, so he goes there regularly. She was only given a small cabinet and a bookshelf to store her belongings. After living there for two years, her items have piled up, so she took over another shelf for storage, which she received a lot of scolding for. She and her client's daughter recently sorted out the landlady's clothes, who passed away a few years ago, in order for her to be able to entirely unpack her suitcase at last.

Taking some time off is also difficult. Sanda, working in Italy, can only go to church on Sunday morning if she prepares lunch beforehand, at the break of dawn. Hajni can take a break of a few hours when her client's daughter arrives, so if she is late, she has to wait, and if she cannot come, she needs to stay home, missing her break altogether. Mirela looks after an elderly lady with dementia, who is in the confines of a wheelchair, so she cannot be left alone at any time. Despite her labor contract saying otherwise, she does not have any time off. The family members do not take over and they do not provide a substitute carer either. On her day off, she goes for a walk with her wheelchair-bound lady, with whom she is not able to relax, and it is also physically demanding, as she needs

[6] I used fictive names in the study to protect the identity of my respondents.

to push the wheelchair uphill in the evening, which kills her back. The family gave her permission to get a substitute occasionally, but only at her own expense.

Respecting basic human rights can also run into difficulties when living together. The different legitimacies with the shared flat obviously create a legal hierarchy between a care provider and a client. But this does not entitle the owner to check and to go through the personal belongings of the care provider working there. Gabriela, after her experiences in England, came to work to Ancona. She is subject to continuous harassment: the landlord shakes her bedroom door at night, which she keeps locked; he goes through her clothes, including her underwear; checks her bag when she leaves the house and when she comes back; and she also has to show him the receipts of the goods she buys for herself, which he checks thoroughly with a loop. When she tried to stand up for herself, her client replied that the house was his property, and he could do whatever he wanted to.

The level of vulnerability is quite high with this type of live-in labor. The care provider's physical safety is endangered by their client's mental state or aggressive personality. Betti, living in Israel, reported waking up at night with her client pointing a knife at her belly. Sara was hurt by the lady she looked after, she unexpectedly kicked her in the bust and in the belly due to her unprocessed Holocaust memories. Rózsika, working in Berettyóújfalu (Hungary), was exposed to the aggressive attacks of her landlady, who had Alzheimer-disease: she threw a knife, a hack, clippers at her on several occasions, and one night she hit her head so badly that Rózsika had to be taken to hospital.

The care providers' physical dignity is not protected either. In addition to verbal sexual abuse, physical sexual abuse can happen as well. In Italy more, in Israel less cases were mentioned, where an elderly male client took advantage of physical closeness, touching his care provider's intimate body parts when she passed by, or when she helped him with moving or with personal care. These initiations can be accompanied by propositions or blackmailing. In Israel, sexual abuse comes into conflict with firm religious and social standards, therefore female care providers can expect immediate protection. As soon as they came to the recruiting agency with a complaint, they were transferred to another elderly person without inspecting the case in particular, in order for the care providers to not have to go through derogatory or humiliating proceedings of justification and other considerations. In Italy, no authorities get involved in the relationship of a client and a care provider on this level. The trade union, where labor contracts are being made, only provides a formal set of principles, and does not deal with anything but their misuse. Personal difficulties are to

be sorted out within the family, relying on their own judgement and resources. With such circumstances, feelings of shame are certainly a serious barrier of bringing up the subject openly. This, and the expected denial of the elderly person, in addition to the uncertainty of whom the family will believe, motivates the decision to repress reporting on such cases. Timidity and the feelings of vulnerability are enhanced by the narratives on migrants that circulate within the community about some ill-fated Romanians. During my fieldwork, the women repeatedly told me a story about a Romanian woman. Her client went into her bedroom at night, molested her, and when she pushed the elderly man away in defense, he fell on his back and died. The Italian court then gave the woman a prison sentence. Each time the story was told, it was followed by a long, baffled guessing about the adequate dealing with the situation: how much can you push an elderly person? How does one make him leave? How can one block the door at night, etc.? They were all certain in thinking that the Italian society and judicial system will not guarantee any defense for the foreigners in such cases, rather it will favor its own citizens instead. This narration practice can be viewed as evidence to the process of suffering and the generation of vulnerabilities for case providers, which accompanies the occupation, and the construction of the lower level in the social hierarchy.

Being enclosed, loneliness and isolation are inherently part of this type of care, and they also pose the biggest challenge. Staying indoors 24/7 for a longer period of time – for weeks, months, even years – takes a toll even on a healthy psyche. Witnessing an elderly person's physical and mental decline day by day also adds to this burden. Loneliness is enhanced when looking after a client with dementia, as communication is not possible in that case. This state of life substantially reduces the care provider's opportunities for quitting the current employment: there is no time to find other alternatives, build a network of relationships, and it also hinders the acquisition of the local language. In Italy, the strategy for easing loneliness is to talk on the phone with other providers: the female Romanian care providers have contracts with the same phone company, so calling each other is free. In Israel, besides telephone, the Internet also plays an important role: they are active on Facebook, they frequently use chat and e-mail. Klarissz, one of the most experienced Hungarian care providers, with 15 years of previous experience has witnessed a wide range of illnesses and various situations in her clients' homes and families. She has a rich repertoire of strategies for dealing with difficulties, but she also struggles with loneliness.

'My lady has osteoporosis, and uses this walker at home. She doesn't want to be healthy at all... I tell you. But her husband has Alzheimer-disease,

and he's very difficult to handle. I've got everything here that a metapelet (care giver in Hebrew) can wish for. Enough money, time off, but the time in there is awful. Awful. And the man doesn't have a metapelet, they didn't request one for him. Well, he doesn't need any, he looks after himself, but his nature is like, … ouch. […] The thing is that when I started my placement with them, I was already exhausted physically, mentally in every way. I weighed 72 kg, then I lost weight …, I'm not skinny, to be honest, but I've lost about 8 kgs without doing any diet. I used to go running, did exercises and everything: jumping, I bought a trampoline for myself in case I cannot go out. Now without doing anything, I still keepon losing weight.'

Mirela, living with her client with dementia in Ancona, talks about this problem as well:

'You know what? This confinement in the house, sitting by myself… They only provide a TV with three channels, that's all we can watch… there's nothing to watch, but you have to sit there… I can't watch TV in the morning. How about the afternoon? You just sit there. She's shouting, and I just sit. Can't go anywhere, you sit there with her, and she's shouting. That's what is killing you, this confinement, and … you cannot have a conversation, no, not with her.'

Bori, who has done live-in care for the elderly in several countries, sums up her views in a catchy way:

'Well, it is awful, non-stop, day and night, 7 days a week. I just couldn't … not even in good-health… I wouldn't even want to be together with my lover for seven days, seven nights.'

Besides making you lonely and bored, being enclosed also means social isolation. As a migrant care provider's entitlement in the apartment does not amount to much, they cannot receive any visitors, they can only have a social life outside of the house, where they however can spend very little time. The employer controls their private sphere, the employee is only partly integrated into the life of their employer, thus their private relationships are not open to them, only in cases where the employer's social network and their own network are somehow linked or their needs for building relationships meet in some way. There are a few exceptions though, in general they are more permissive within their own ethnic group (e.g. the friends or family members from Transylvania can occasionally visit the care provider in the apartment of

the client in Hungary; and in Israel, in case of a Hungarian Jewish family, the care provider can sometimes receive a visitor from Hungary), or if the visitor is another care provider for the elderly person's own circle of friends. Obviously, during the course of living together, the client's situation can become vulnerable as well. The largest difficulty usually comes from the appearance of a new stranger in their everyday living-space. Due to their age, change is more difficult for them to handle, and as a matter of fact, it is usually not the clients themselves initiating the employment of a care provider, but rather their children. Contrary to my expectations, after accepting the constant presence of a care provider in their private sphere, a change/turnover of care providers is not burdensome for them anymore. From that time on, the real problem is if there is an uncertainty in the arrival, a permanency in stay, or the question of continually of their work there. The human quality of a care provider may also lead to vulnerability. Handling the intimacy, being together around the clock, the deteriorating health and fitness of the client, witnessing the illnesses, dementia, the course of passing away etc. Anticipating the inevitable arrival of death with empathy and competence requires patience, perseverance, flexibility, mental and emotional intelligence, qualities that each care provider has at varying degrees.

The power relations between the parties are easy to observe through the dynamics of adjustment. Live-in care is not only work, but a unique way of life. The carer and the employer(s)' cohabitational habits and every-day functioning are somewhat mutual, but it is not a partnership, as the new arrival needs to attune and adapt to the elderly person's way of life more. This includes adopting to the daily routine, like getting up, the times of meals, shopping, walking, etc. It also includes consumption habits: when and how many times can the care provider have a shower, how much and what they can eat, how and what can they cook, the settings of the heating and the temperature of the apartment, what programs they watch on TV. Furthermore, fundamental question also may be: when do care givers have time-off, the schedule of daily tasks, how often, when and how long can the care provider stay in his or her own room, etc. The people I interviewed told me the following about this situation:

'You must swallow the bitter pill again and again.'

'You have to conform to everybody. Keep quiet, endure.'

'On the one hand, it is a responsibility, 'cos working with such a patient is a responsibility, but I had, I had to endure a lot, 'cos, well, I needed the money.'

The extent of adapting is defined by the personality of the client and the number of people living together and the burden of adapting falls on the employee for the most part.

'I lived with my lady. Well, we went downstairs by half past seven, as they lived in this villa, and then I had a room upstairs with Katinka. We didn't have to look after her at night. She didn't need any care at night, so… […] And then we had to go downstairs by half past seven, and from that time on, up to…well, as long as the family required it, as they usually went to the theater, to the opera, to see her children, and when they got home, we went upstairs, so from that time on we were free, something like from 9, 10 [pm]. […] Auntie Anna was the grandma to them, and uncle Sándor was her son. He had seven children. They also had a grandchild living with them. Well, they built an annex attached to the front of the villa, a so-called apartment, and they also used that for living. And the others… Wait a minute. The other children were in Budapest. And there was a son and a daughter, who were divorced, and they also lived there indeed, and their 26 year old daughter did teaching, she was a singing tutor, she also lived there with them as well. […] But how I got there, to that big family, you know it was a little bit like that. Oh, when I went upstairs, my God, I felt so tired, really! Well, you know, adapting to so many people' – said Ida, who is from the

Partium (Romania) and used to go to work in Budapest.

Besides the difficulties, live-in care also has its benefits. First of all, no expenses, the whole salary can be saved up and can be sent home to the family left behind. Right at the beginning of the care provider's career, it is possible to start repaying the amount borrowed for going abroad. It also makes the commencement easier because it only requires a minimal amount of work organization, one contact person is enough. Also, it only requires a minimal amount of life-organization: no need to look for accommodation or work-opportunities. It gives a certain stability for every-day life: as long as the elderly person is alive, there is a job and a salary.

There are a wide range of tasks associated with this type of labor: surveillance, vigilant presence through day and night, entertainment, keeping company, emotional attention, housekeeping, shopping, health-care and health-management, hospice, personal care, managing relationships within the family, gardening, looking after pets etc. This type of labor has the most flexible work condition, but also it is the most difficult one to keep the boundaries of, consequently, there is significant room for exploitation.

There are two forms of live-in care: permanent and rotation-based.[7] In the course of my fieldwork I met the form of permanent live-in care in Italy and Israel, there are only a few examples of this in other European countries. It means being away from their own family, and living with the employer for a longer period of time. The benefits include getting as much as 12 months' salary when working continuously.

Rotation-based live-in care has been introduced to the global market by Eastern and Central European migrants. It did not have a precedent in the labor patterns of Filipinas and Latin-American women, neither in the labor practice of foreigners from Asia or Africa. With shorter distances, and in the transnational regions where the migration policies allow frequent border-crossing, commuting enables maintaining both a foreign income and managing life at home in parallel. The length of the shift usually ranges from one week to one month, but it can also be longer (only occasionally though for the most part). It might come with a lower income per year, but its advantage is that the time invested is less. On the human side, one important aspect is that it does not take that much toll on the care provider's family relations. They can maintain their life at home, they have a chance to regenerate and to have a more balanced lifestyle. Hanneli Dohner and her co-authors have an important observation considering this: in such cases migration supports staying at home rather than migrating (Döhner et al., 2008, p. 6). From the perspective of work quality, we can observe that burn-out comes slower with this form of labor, the care providers can deal with conflicts more easily, and they are not burdened as much physically as the care providers that work continuously. Rotation-based care work is considered to be closer to non-work then it is to work on that scale, and has less characteristics of institutional labor: no day-off, no regular free hours in the afternoon, there is no defined practice for sick-leave, and the presumptive work protocols are more flexible. Therefore, the employee's rights depend more on individual negotiations and on the actual personal interactions. The feeling of being enclosed and isolated is more intense, and not only for the lack of free hours, but also due to the nature of doing shifts; the care providers do not have an established community, they are not always able to keep track of who is at work or who is at home at any given time.

[7] Literature reports mostly on permanent live-in care, mainly because it is much more common globally. The situation of the migrant laborers working in rotation is studied less; the most important expert studies in this field are done by Helma Lutz (e.g. Lutz, 2011).

Erzsi started her career as a care provider in Italy, she started her work in Sicily. As her mother's health started to decline, she felt the need to be closer to her, and to be able to go home more often. So, now living in Budapest, she goes to Székely Land (Romania) every month, she spends a lot of time with her family, but she feels very lonely in Hungary.

'No friends here, which I really miss. […] None. Masses of Romanians in Italy. Not just many, but masses. When I walked the streets, I could hear people talking in Romanian, wow, I said, I'm at home, I couldn't believe it. And many working like me, with the elderly. Well, usually women did, different from the men. We took breaks at the same time, synchronized them, like here. They had to provide two hours every day, and then you would agree with the landlady the landlord or the family when you want to go out (on your break), from 5 to 7, 5 to 7… As dinner is from 8 there as well. Interestingly it was at 8, same as here. And then I arranged it with my friends as well. Either from 5 to 7 or 6 to 8. And then we could go together and spend those two hours together. It didn't matter if we spent that time in a park, under the palm trees, walking, going to the cinema, whatever, but we were together, and got used to each other. Like you do after two years, don't you? […] It's different here. I have no idea who lives here.'

The ethics of handover is a well prescribed part of the system of doing rotation-based care, with formal characteristics. Regardless of the employer, the care providers usually do handover between themselves, they record the proper mode of practice, and a collegial relationship is formed. There are certain pairs that are familiar with each other. Sisters, or other relatives can work together better from the very beginning due to their standing relationships, or they put more effort in synchronizing their activities that are the source of their income from abroad. Working together without being acquainted previously can also be a well-functioning collaboration. Difficulties may arise in this system however if there are several alternates, or if the alternating person gets to be changed often, or if in some cases rivalry occurs, namely if one wants to edge the other one out, or they presume this of each other, which might start a jealousy-driven dynamic.

The ethics of handover, according to the women working in Hungary, Austria, Switzerland, Germany, are the following:

'Because before… well, before I came, she did a deep cleaning, before she came, I cleaned everything really thoroughly, I treated her with lunch, this is how it was agreed.'

'Well, then I was there at Easter for example. Christmas more or less at home. We scheduled the holidays this way, that's how we agreed. The landlady couldn't be left unattended. She wasn't bed-ridden, but, well, she couldn't be left alone.'

'As she has to look after her grandchildren, she said: »Évi, could you please stay here for two weeks, because I can't come, as I need to look after the grandchildren. « I said, all right.'

Breaching the ethics of handover:
'[…] I'd call at the end of the month, and transfer. I already knew because I saw that lady being everything. The one I was with earlier dropped out, and the old man was fighting for her, for that lady, while his son was fighting for me. But the old man only wanted this Annuska, and that's it. The other who dropped out was a very good lady, Margitka. She left the fridge stuffed for me, so we'd have something to start with, and so did I. When I worked with this Irénke, I did the same, but when I come back, I found the fridge and the freezer completely empty! No meet, no sugar, nothing. He says: »Marika, let's not forget about that half of pork trotters«, the old man loves stew made from it. And I say: »There's nothing to forget about, since that's all there is in the freezer box?! « What could I forget about then?! And this lady… she was like that. His son saw it as well. Well, I don't know. But she took the money. He (the son) said much money was spent, neither me or Margitka spent that much, not once, and still she left the boxes empty. But the old man still wanted her, nobody could do anything about that.'

'No, the alternate is not always the same person, unfortunately, not like with Erzsike. Those two have been alternating each other for years. With us, it keeps changing. I don't know the reason, every time there is someone different, the old ones don't come back. […] It's very difficult for me, because I have to do the handover, which is peculiar. I do the explaining from morning 'till night, and I write down everything. And I'm doing all that to make her job easier, and to make it easier for the old man as well. […] Well, I don't want to talk about what I can find there. […] You can't call this inconvenience. It was inconvenient for me, as I didn't find several things the way I would have liked to find them, same way I have left them. But if that person was like that, she was there for the first time,

and never came back, then that was it. I did my job, the way I used to do it before, and that's it.'

PART-TIME AND LIVE-OUT CARE WORK

The strategy of splitting work and private life means separating workplace and residence. As a result, care gets closer to formal work, even though it is done in the informal economy sector (I did not find any example of this kind of care providers working legally).

Visiting support may target one or more clients at the same time. It requires capital expenditure, since accommodation and all other living expenses need to be covered individually. A migrant also needs to have sufficient funds in a social sense to gather enough working hours. An extensive network of relationships is needed, both in their own group and in the host society, and they also use several advertisement platforms (Internet, written media, shops, streets, etc.). Work organization requires good logistics and time-management.

The working hours are defined, with a clear starting and finishing time. There is some flexibility here as well, but there is no endlessness. The more specifically defined framework allows for less abuse. Care is more task-centered, work-negotiations are clearer and more direct, and as it is for a shorter period of time, there is less room to go away from it. If the task requirements change, the negotiations are revisited. This type of labor does not assume the continuity of the care provider's willingness to work. Work tasks generally include the following: surveillance, keeping company, personal care, feeding, partial health care, and household chores.

Working hours are flexible but can be difficult to predict, which also makes the income less predictable. Finding and securing work opportunities for the near future requires significant time and energy. People cannot rely on this type of income on the long run, as there are too many uncertainties in this setup. Hence, the migrant care providers usually include this type of work in their careers in two ways: as a temporary job or as an additional income. It can be a temporary job between two live-in placements, when they cannot find a proper place for a longer period of time, and they take on some work wherever the opportunity arises in order to survive through a difficult time period. It can also be managed in a work-structure with multiple pillars, or as an additional income in the family-system: in parallel with live-in care on day-offs, besides institutional care work to increase income, complementing self-employed work

with tax-free income, or doing it occasionally as a member of a migrant family. It means more freedom, private life, and less control. Live-in care is feasible for single women living on their own, there are only a few examples of hiring care providers and accommodating them together with a family member (with a child, husband). Family members' visits are limited, especially if they also need overnight accommodation. If a care provider conceives, she needs to go home to give birth, and she can return to work when she is alone again, leaving her child with relatives or family members. Part-time care work allows more for a private sphere, and can be better synchronized with family life. Thus, family reunification leads to quitting live-in care or the other way around. If a care provider can establish herself as a live-out laborer, even temporarily, she can reunite with her child, and can invite family members to the host country.

Angelica's care work ranges somewhere between live-in and part-time labor. She came from Romania to Israel. She had several migrants in her immediate family. One of her sisters works in France, another in Spain. She went to Israel in 2006, paying 2500 dollars to an employment agency. As her own mother became seriously ill she could only stay for a year. She went there again in 2008, after her mother died, when she had to pay again, this time 2800 dollars. She worked then as a live-in care provider, but she could not bear being enclosed and being with her client around the clock. She managed to find a solution to this problem: now she is working with a seriously ill patient, which puts a strain on her both physically and psychologically, but she only spends 10 hours a day with the client. The family employing her is understanding and supportive, they even give her 500 shekels on the top of her salary, as a contribution to her rent. Her accommodation is not very good, and she does not really have a proper private sphere, as four of them rent a two-bedroom apartment in Jerusalem. However, she could at least secure herself some time for recreation by separating her workplace and her residence.

'Do you know what the benefits are? There is a little break. This is the only benefit. That you are not stressed that much, because when you're there, they wake you up day and night… Because I, as Anni's husband working for the state department, he is…a consul… for the state department, and he travels a lot, he is sometimes away for weeks, visiting countries in Europe, in Asia, he goes everywhere, for a week at a time. Those times I'm there around the clock. You see? […] Then I live there. And… I'll be honest with you, after living there for a week I'm so exhausted, and so tired that I'm dying to have some sleep.'

Anna from Transylvania (Romania) did care work to get additional income. Her husband fell ill, could not provide for the family anymore, meanwhile their son got admitted to the university in Cluj-Napoca. Anna, as a mother, felt obligated to support his son's higher education, so she came over to Hungary and took up an assistant position in a hospital in the capital city. As the salary of this type of labor is relatively low, she took the opportunity to look for additional income. She asked for a permanent night shift, which made it possible for her to look after her private client until 6 pm. Work became too much for her, but the old man understood her overcommitment, and let her rest during the afternoons, by choosing not to listen to the radio, nor to watch TV during that time. There were three of them working for him, two of them in shifts, and there was a permanent substitute; all of them from the same hospital department, thus they were co-workers, in a dual sense.

'So this lady at work, from Transylvania, already looked after uncle Jani. And there was another, from Ukraine, they took turns, 15 days one, 15 days the other. You see, he didn't need permanent supervision, he was a mobile patient, as he still is today. […] And then she left for Debrecen to work, even enrolled into some university, and then one more person was needed for uncle Jani. Since we worked at the same place with Sárika, at the department of internal medicine, she asked me if I wanted to fill in Ida's position. It was like that. […] With an automatic washing machine, once a week we washed his clothes, the underwear one load, the colored ones another, and we mopped the floor in his bedroom every day. One of the next-door ladies did the cooking and brought food every second or third day. […] He was alright by himself all day. He watched TV, listened to the radio, read books – you know he had a PhD degree in liberal arts, so he was a real gentleman. And I prepared some cold cuts for him around 3-4 o'clock, whatever he requested, and a cup of tea, then I served them to him in his room, so that was it.'

In Italy, there are many more examples and variations for migrant women to do part-time employment. The reason for this is that the migration system allows one to stay in the country even without any income or with unstable or temporary work. Also, Eastern European migrants stay there continually, unlike the ones on a rotation-base, who stay in their source countries while waiting for work-opportunities (as they do not have any problems of accommodation when they are off-work), and they only go the location of their work when they receive a job offer.

Felicia has a family, her husband arrived from Craiova (Romania) to Italy five years ago, and she followed four years ago. First, she worked as a live-in care provider, but they decided to bring their two children over as well, so they moved in together, rented an apartment. Ever since then Felicia has been doing part-time care work. In comparison, the two types of work have the following differences:

'For those who are single, with no family live-in care is much better. The difference between a permanent and an hourly job is that the hourly job provides more free-time, I mean it doesn't... no, but more freedom, because you are still running around all day. Let's take me for example, I have 3 hours with a woman this morning, when I finish these 3 hours, I'm going somewhere else, because I have 3 hours there as well. But you know what? You can go outdoors! But with a permanent job, you are indoors all day... You may have 2 hours one day, and you run around, work 3 here, 3 there, 3 somewhere else. You see? I now sit there in a fixed job, in the house, imprisoned . And that's why they say that it is difficult to do permanent care, but it suits someone who is not married, who doesn't have a family, because with a permanent job, you don't have to pay for water, for gas, electricity, nor rent.'

Michaela needs to find solutions for more difficult problems. She is from the same town as Felicia, but she is divorced, which makes the whole situation more sensitive. She came to Italy back in 2007, first she earned her living as a live-in care provider. They have five children, she took the youngest one, her 9 year-old daughter to live with her, one and a half months ago. They live in one of her cousin's place. Presently she is working 4 hours a day, but that is not enough to make ends meet. She does not know what to do yet; she does not have any resources or connections.

'I still want to be a live-in, because... How should I put this? You don't consume that much, you don't pay any rent, and things like that. You can save money, you can save money there. As you don't spend on anything, only if you have a phone, or the ones at home need you to send some money, or something like that. [...] She [her daughter] likes it, because she wants to be with me. You see the situation? She doesn't want it... she says: »Mum, I still want to be with you, even if we only eat once a day.« And I can't be far from her either, because she's suffering a lot in this situation I am in.'

CARE-WORK AS PRIVATE CONTRACTING

In the migrant care provider sector, I found an example of private undertaking-based work in Italy.[8] The state's employment structure and migration policies make it possible for citizens of the European Union to establish a contractor status with a care profile, and some Romanian migrants take this opportunity. They can follow through with the necessary legal and administration procedures, and have adequate funds for its maintenance and operation – this type of labor is a private undertaking. Those with less resources join employment agencies and they also work as private assistants – this is what they are called – but the working hours are organized by the agencies, in exchange they pay a percentage from their income to them.

The criterion of becoming a contractor carer is to acquire professional care provider qualification, and in Ancona, the certificate can only be issued by a hospital specialized for the elderly care (INRCA[9]). Many changes have occurred in the recent history of the course. It was not even a criterion for the individuals that came here before. As the number of migrant female care providers grew, the need for regulation arose. The training started with a one-day instruction, which already grew into three months by the time of my fieldwork; which obviously needs to be self-financed, but which only a few can afford. But those who obtain this license can join the most important care work organization circle: they can register on the hospital's lists. This is the primary care network that the relatives of the patients turn to, consequently, the ones on the list always have placements. In addition, they also use their network of relations, and in their case, their Italian contacts have priority, as they already have many acquaintances even within the host society.

According to the official protocol, their task is to give spiritual and emotional support. In theory, the division of labor should be like this in a hospital environment: the official staff of the hospital tend to the patient's physical needs, and the private assistant only provides psychological support as a substitute of the family. In practice, it is different: if a patient has a private care provider, the hospital staff visit him or her much less, and only does the tasks that cannot be done by the care provider who is paid by the family. So, it is a common practice for the private care provider to provide personal care and do the feeding; it is often them who turn off the infusion, and they also administer medication.

They have the highest need for specialization, in the aim to acquire professional competency. They act as professional care providers in the structure of migrant

[8] Other countries also provide legal opportunities for this type of labor for migrants (except for Israel), but the sample only contains examples from Italy.

[9] Istituto Nazionale di Riposo e Cura per Anziani. http://www.inrca.it/inrca/home.asp (Downloaded: 10/19/2016.)

care, they are at the top of the hierarchy. Like the previous group, their way of life also has expenses, and it is hard to calculate the number of working hours per month and the income, but, thanks to the hospital lists, they almost constantly have work-offers, and they earn far more than their fellow care providers. They can steadily maintain their migrant lifestyle, and they are able to bridge the shorter breaks (e.g. with health problems). They have a private life, several of them have family here. They are planning their work in Italy for the long term, many of them plan to take up permanent residency, and they do not think about moving back to their home countries.

In spite of them being contractors, their work is not fully part of the formal economy. One strategy of increasing their income is reducing the amount of tax they pay. On several occasions, the work they start in the hospital continues in the patient's home, where the informal content of their relationship magnifies, allowing them to not give invoices, thus avoid taxation. They already have some experience on how much tax they need to pay in order to avoid the inspection of the authorities and how they can maintain their fine-tuned earning strategy on a long-term basis.

SUMMARY: THE INTERNAL STRUCTURE OF THE MIGRANT CARE WORK

The various care forms described above are all part of a migrant care structure. Each of them has benefits and difficulties, each provides solutions to different situations in life, each developed in various migration policy systems, and can be operated along different setups. They have a relationship of hierarchy, but one can move between the individual employment types/statuses. All that has been written here can be summed up in the chart below, with the most important aspects highlighted.

The structure shows a rather mixed pattern in relation to integration into the economy. The dominance of informal practice is evident, and even if they step into the formal sector, it is only a partial integration. Several permanent live-in care providers have a work-contract, but, as I have mentioned, everyday work is not done according to the contract and permanent care providers sometimes do part-time labor as well, that is solely done in the shadow economy. With live-in care providers working in rotation, work contracts do not come into the picture, even when simplified legal administrative methods are available in the national regulatory system (in Germany and in Hungary as well) in order to legalese the sector (I have only found one exception). Part-time employees

are workers doing temporary jobs in an unregulated form. When formalized, they become private contractors, which makes an invoice-based payment possible, so the working hours that change every day can be officially traced. However, this method of work could only be observed in Italy from among all my research fields covered, as this is the only country where the national economy regulations make these possible for foreigners, thus this is where it was integrated into the migrants' employment practice.

Table 1: Work types of migrant care workers and the structure of these activities

Type of work	Integration into the labor market	Work duties	Features
Permanent live-in	Partially legal Informal	surveillance, vigilant presence day and night, entertaining, emotional work, housekeeping, shopping, health-care and health-management, hospice, personal care, managing relationships in the family, gardening, looking after pets	– dependence, control over the use of personal space and time – relative stability, income that can be saved up entirely – obstacles in the way of promotion (in time, in being informed, sometimes language barriers, preconceptions about opportunities)
Rotational live-in	Informal Very rarely legal		– maintaining double residency, psychical protection – income that can be saved up entirely, no full yearly income – control over the use of personal space and time
Part time/live-out	Informal	surveillance, keeping company, personal care, feeding, partial health-care, household chores	– partial independence – opportunity over the use of personal space and time – instability – financial burdens of maintaining lifestyle
Private contracting	Grey economy: combination of formal and informal	surveillance, keeping company, personal hygiene, feeding, health-care, rarely: infusion, medication	– opportunity over the use of personal space and time – material support for lifestyle establishment – funds for organizing work (financial, social) – social and economic integration

The organization and categorisation of different work types also demonstrated how live-in care providers integrate the least into the host society. Their social networks are only confined to people in their home country and within their diaspora, while the private contractors show significant aspirations towards local communities, and their integration is usually quite advanced. If we compare this to what was said before, the conclusion is evident: the foreign care providers' integration into the host societies do not depend on the legality (or illegality) of their labor in essence, rather on their place within the internal structure of the migrant care system. Planning to immigrate and the practice of returning home confirm this statement: live-in care providers (despite the high number of employees with contracts) are contemplating to return home, the ones that are planning to stay are usually contractors. The ones I met and returned home were all live-in care providers.

There can be some social mobility within the system, and some go through all of the stages. Joining the migrant care sector usually starts as a live-in care provider. The factors that determine whether one leaves this position or not are: the migration policies, the openness of the host society (discrimination), the individual's positioning in the given country and in the labor market structure (self-discriminative ideas and habits), resources (economic, social, intellectual), and the relationship and ties with the family and the society left behind (income being sent home regularly). Permanent live-in care can be modified to rotation-based (and the other way around), changing countries, or when the relationship with the client or with the family changes. Part-time labor is usually at times of a transition period between two live-in placements or between live-in care and the status of a private contractor.

On top of the structure is the private assistant position, but most people work as live-in care providers. These work types have several similarities with respect to tasks, but their position on the work or non-work, emotional work or professional work, reproduction work to production work, informal or formal attitude axis differ significantly and they also differ in terms of assessment and wages.

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