



**PreQual**

## **COMPARATIVE STUDY**

Of the Training and Employment Opportunities  
for Migrant Women in the Health and Care Sectors  
in Austria, Bulgaria, Germany, Greece, Italy and Spain

### Challenges and Recommendations

Comparative Study Report within Phase 1 of Pilot Project	
<b>`Pre-qualification for Migrant Women in the Health and Care Sector`</b>	
under the Community Program Leonardo da Vinci	
	<b>A/04/B/F/PP-158.130</b>

**Produced by**  
**HEALTH CARE ASSOCIATION Team**

**Burgas, Bulgaria, August 2005**

## **The present**

### **COMPARATIVE STUDY**

Of the Training and Employment Opportunities for Migrant Women in the Health and Care Sectors in Austria, Bulgaria, Germany, Italy, Spain and Greece Challenges and Recommendations

**Is based on the findings in the National Study of Partner organizations:**

**Austria:**

Verein maiz

**Bulgaria:**

Health Care Association

**Germany:**

Europäische Bildungswerke für Beruf und Gesellschaft e.V.

**Greece:**

Antigone

**Italy:**

Associazione Delle Donne Brasiliane in Italia

Universita del Terzo Settore

Associazione Nazionale Pubbliche Assistenze

**Spain:**

Instituto de Estudios Politicos para America Latina y Africa

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The content of this report reflects the results of the analyses performed by the Project Partners, and does not necessarily reflect the position of the authorities or the respective National Agencies, nor does it involve any responsibility on their part.

**Preface - 4**

- 1. Definitions and explanation of terminology used - 11**
  - 2. Notes concerning statistics and figures - 12**
  - 3. Project principles and their implementation - 13**
  - 4. Explanation of the methodology used for the Partner secondary analyses - 14**
  - 5. The interview sample – notes and explanations - 17**
  - 6. The reality of immigration in Partner countries – the challenges each country is confronted with - 21**
    - 6.1. General overview of Partner countries` immigration policies - 22
    - 6.2. Structural barriers migrant women are confronted with - 29
    - 6.3. Social exclusion, discrimination and racism in society and in the workplace – 38
    - 6.4. Employment realities in Partner countries for migrant women - 40
  - 7. Health and care systems in Partner countries and the related training possibilities – in view of project goals - 45**
    - 7.1. Overview of health and care sector in Partner countries - 45
    - 7.2. Developments and challenges in the health and care sectors - 54
    - 7.3. Specific trends in the sector and their role in reinforcing precarious work - 59
    - 7.4. Education and training for the health and care sector in Partner countries - 61
  - 8. Migrant women in training and employment for the health and care sector – comparative results from the empirical study in Partner countries - 71**
    - 8.1. Challenges/problems migrant women have to face in training and continuing education - 72
    - 8.2. Challenges/problems migrant women have to face in employment - 79
  - 9. Recommendations to the Curriculum of the pre-qualification training program - 83**
- Annex – Interview guideline - 89**

## **Preface for the Comparative Study**

### **Background**

The basis of the PreQual project is that the health and care sector presents itself as one of the few realistic employment opportunities for migrant women to gain a foothold in the regular labour market. This situation paired with an increase in the labour market demands and forecasted labour shortages in this field (due to demographic developments in the partner countries) has created an opportunity for the partner organisations to address issues of migrant women and their training and employment in the health and care sector.

It must be emphasised here that the primary goal of the PreQual project is to provide migrant women with a recognised qualification and improve the chances for regular work and hence, more secure (i.e. less precarious) working conditions in the participating EU countries. Fulfilling this goal can also lead to satisfying market needs and demands in the health and care sector. Moreover, the background and perspectives that migrant women bring with them should be seen as an enhancement to the organisations they work in as well as to society as a whole. Therefore, given that migration is a fact and that the populations in the partner countries are becoming increasingly heterogeneous, this project can be seen as a contribution to the development of a multicultural society.

Finally another goal of this endeavour is to raise public awareness about the difficulties that migrant women face in working within this field and gaining entry to it in particular and to the labour market in general. It is also an attempt to increase the level of recognition of migrant women's contributions to the health care systems of the host countries.

While acknowledging the fact that this project may lead to the reinforcement of the labour market segregation, it is not the intention to consciously channel migrant women into this field of work. However, we cannot deny the fact that a significant number of migrant women show interest in working in this field and it is our goal to help create adequate support structures to assist them in acquiring essential knowledge as well as to assist them in making choices and pursuing training and a career in this field.

Caution must be taken in using the term “empowerment” for it has become a catchword

that has many definitions with several different applications of the concept. For the sake of simplicity the following are 2 very differing schools of thought with regard to this term: The neo-liberal concept of empowerment in effect puts the onus on the individual to pave his or her own way (i.e. lifelong learning) regardless of existing structural barriers and social conditions. In comparison, the approach to empowerment within the context of this project tends to challenge the status quo and question structural barriers such as racism and social conditions preventing or hindering full social inclusion and participation while developing strategies. This means that issues are not only addressed to solve problems of a particular individual but that strategies are developed on the collective level to deal with these conditions. In view of this, the pedagogy of Paulo Freire was chosen for this project as a means of creating a setting to trigger an empowerment process.

While this is by no means a complete definition of the PreQual project's approach to empowerment, it is intended to place the reader into the perspective and context of the project designers and implementers.

Within the framework of the PreQual project, heavy emphasis is placed on the involvement of migrant self-organisations with the intention of supporting them via appropriate integrative approaches. This process is about reinforcing effective self-representation rather than representation by (although well-intentioned) individuals/organisations from the majority population. In this way, the concept of migrant women as protagonists is encouraged while active participation is facilitated thereby offsetting the balances of power and decision-making.

Moreover, it should be noted that the discussion about whether self-organisations have integrating and/or excluding functions should be given up in favour of the question of the potential and impact of activities in self-organisations that could contribute to fighting racism and reducing social and economic inequalities.

### **Values and approach taken in the PreQual project**

Due to the fact that the essential character of the training course is to be based on feminist and antiracist aspects as well as on aspects of self-advocacy, Freire and empowerment etc., it was essential that these very aspects be implemented at the very beginning of the project. This is reflected in the PreQual project principles (see Project Principles) which, in effect, act as a sort of mission statement and are intended to flow into all project activities. The training course can only truly reflect these principles and they can only be authentic when they are strived for and implemented from the very outset of the project. This includes implementation throughout the process of employment in the project, the degree and intensity of the active involvement of self-organisations, the

interviews (and interview methods) with migrant women, treating their contributions as expert information and not treating the migrant women as information for the “other” experts. Only if these elements flow into the culture of the first phase of the project, can the resulting curriculum (as well as the other products not to mention the project as a whole) reflect these principles.

As opposed to many projects dealing with training and migrants, the very nature of the PreQual project does not concentrate on deficits but rather builds on the assumption that the existing knowledge and experience that migrant women possess is both valuable and useful. Only with this perspective can the innovative character of this project emerge and create a situation where the migrant women are perceived as experts and are actively involved in all phases of the project.

As the PreQual project coordinator, Maiz initiated the idea and insisted on drawing up a set of principles which were modified, further developed and agreed upon in cooperation with all partners present at the kick-off meeting.

However, (fully aware) it must be stated that due to the assorted approaches to didactical methods, working with migrant women, organisational cultures and other conditions there was the acknowledgement that there would be difficulties and hurdles in applying these project principles. What we expected was not a full identification with the principles but to set off a process of reflection to create an awareness and therefore an avoidance of certain pitfalls (e.g. treating migrant women as objects of research).

### **The design of the PreQual project cooperation**

The diverse national and international partners have culminated into a partnership manifesting widespread competencies, experiences as well as their range of contacts to the various target groups as well as their range of spheres of influence. This cooperation consists of a total of 21 organisations from six countries (the operative partners include 8 organisations from Bulgaria, Germany, Greece, Italy and Spain with experience in international projects) whose goal is to develop a curriculum for the pre-qualification of migrant women in the health and care sector.

The participating countries were chosen for different reasons. Among other differences they also have different immigration backgrounds and traditions. However, what they do have in common is that migrant women have limited access to the regular labour market.

While the diversity of the partners presents an added challenge to the successful completion of the project, it also presents an opportunity to address the relevant issues and develop a common product from different perspectives, backgrounds and expertise.

In this way the benefits offset the challenges which we perceive to be an enrichment rather than a hindrance to the project goals and products.

We are aware of the fact that these different approaches and backgrounds are made obvious within this comparative study and we deem it to be important to keep these differing perspectives in mind while reading this report.

### **The national studies**

According to the PreQual project profile and in respect to project principles, the national studies deal with female migration and the labour market and the health and care sector in terms of training and employment opportunities. As with other aspects of the project, it was decided that the project principles would especially serve as a guideline for the staff in conducting and analysing the qualitative interviews.

The methodology that had been agreed among the partner network allowed for regional differences and specific country characteristics to be highlighted. In light of this, it must be stated that the individual national studies solely reflect the views, contents and quotes of the individual partner organisations and their authors and are not always necessarily in accordance with the views of the other partner organisations.

Full versions of the individual national studies (in English) can be downloaded from our project website: [www.prequalonline.org](http://www.prequalonline.org)

### **The comparative study and critical reflection**

The comparative report is based on the national studies delivered by the 8 project partners from 6 different countries. It is intended primarily for the project partners but it will also provide an overview of the legal and employment situation of migrant women and training and occupations in the health and care sector in various EU countries to: Migrant self-organizations and other organizations working with migrants, training institutions, other training institutions and service providers in the health and care sector and labour organizations.

In view of the differences among the partners and their environments and in view of the common product that must be produced cooperatively, there was a need to create a common basis to use for the development of a draft curriculum (Phase 2) for the pre-qualification of migrant women in the health and care sector. Moreover, the significance of this work to the development of the curriculum is that it also includes recommendations regarding both content and methods to be implemented in the pilot training course.

This situation dictated that Health Care Association in Bulgaria summarise, structure and compile the findings of the national studies rather than analyse them. It must be kept in mind that the diversity of the organisations are also reflected in the content of the individual national studies. This in turn further complicated the already difficult task of producing this paper.

While this report in no way makes a claim to being complete, we acknowledge its limitations. Both the concerned individuals and the team of project coordinators were challenged with the effort of remaining aware of the project principles on the one hand and on the other hand, striving to refrain from making personal judgements, suggestions and interpretations. This process allows room for reflection and discussion as well as adaptations within the partnership concerning the project goals and principles.

### **PreQual Project progress**

Phase 2 of the PreQual project includes the active involvement of experts from the health and care sector and, in accordance with the project principles, migrant women. Greece (Antigone), Italy (Uni.TS), Germany (EBG) and Austria (maiz) will each organise and carry out national workshops to develop the curriculum in terms of content, methods and further points while taking into account the country-specific aspects. Training and learning methods are based on didactical principles of “global learning” and “popular education” according to Paulo Freire. This curriculum will not only accommodate the specific requirements within training for the health and care sector, but it will also take into consideration the legal, cultural and social difficulties faced by migrant women while incorporating their broad spectrum of experiences and expertise.

Phase 3 encompasses running the pilot courses in Austria (maiz), Germany (EBG) and Italy (Uni.TS) which span 6 months. The results and the associated materials for the pilot courses will be compiled in a handbook. Evaluation methods, for the PreQual project implementation as well as for the pilot training courses are being used to provide continuous improvement and quality assurance to both the project processes and to the products.

The progress of the PreQual project, as well as its products and results will be published on the project’s website: [www.prequalonline.org](http://www.prequalonline.org)

maiz, August 2005

## **Brief descriptions of the project partners**

**Maiz (AT)** conceived and designed this pilot project and is also the project coordinator. Maiz is an organisation by and for migrant women and has years of experience in dealing with diverse migration issues from both a feminist and antiracist perspective. Moreover, maiz was created with the intention to strengthen political and cultural participation. Drawing from its extensive experience in education, counselling, cultural work, research and above all, political work.

**Antigone (GR)**, is active in issues concerning human rights, ecology, peace and non-violent conflict resolution in close cooperation with the “Ecological Movement” of Thessalonica. To fulfil its mission of studying the above issues and combating racism, xenophobia and discrimination, Antigone undertakes research & activity projects and is developing awareness-raising programs and vocational training programs.

**EBG (DE)** main subject of activities is the provision of extensive spectrum of quality training, re-training and pre-qualification vocational programs, including German language courses. EBG is having special programs for immigrants, migrant women, young people and German re-settlers. The EBG college for `Elderly people care` is of utmost interest to the project. The Association is presented at a nationwide base, with entities in 8 German regions and operations in other European countries.

**HCA (BG)** is a non-profit organization among healthcare professionals. The main target is young professionals` education and training in health and social care themes, as well as research and development in the area of quality of services and good practices identification. In acknowledging the growing importance of immigration to the country, the Association will make every effort that the recommendations coming from the other Partners are put forward within the local network group and contribute to the development of the Bulgarian approach to training and pre-qualification of immigrants.

**IEPALA (SP)** is a migrant self-organisation and is voicing the standpoint of Latin American immigrants in Spain. The organization is involved in a number of areas, mainly in educational projects, research activities, cooperation on regional and national level. IEPALA is organizing a range of trainings specially designed for migrant women.

**ADBI (IT)** is founded as a migrant self-organization in 1994 and aims the integration of Brazilian migrant women and children in the Italian society. ADBI is developing various programs for immigrant children, language training programs, programs for mixed couples and a program for qualified migrant women working in under qualified jobs.

**ANPAS (IT)** is a free, independent and democratic nationwide unitary movement joining Italian Associations that provide public assistance. Through its 850 member associations, ANPAS is involved in services ranging from emergency medical care and transportation to social programs, healthcare programs, and disaster prevention and relief.

**UNITS (IT)** is a non-profit organization, specializing in developing and implementing a vast range of training courses – also for elderly care and family assistants - in cooperation with the regional authorities, voluntary organizations, service-providers, social institutions. Uni T.S. is closely linked with A.N.P.AS in Italy and is acting under its umbrella as its training department. Uni T.S is also extending activities to a number of sensitive projects on social basis.

## 1. Definitions and explanation of terminology used

Our understanding is that the nature of the Comparative Study is to compile the findings of all 6 National Studies and illustrate their common characteristics and differences, by citing, comparing and contrasting different aspects from different approaches, written within a specific national background and expertise in the migration field.

Considering the fact that the present Comparative study steps on the findings of 6 National studies, it is very important to make a note on the terminology used herein, making sure that the understanding of all Partners is correctly reflected and accounted for in the frame of project development.

### **Regarding migration:**

We are restraining here to outline a definition for `migration` and `migrant`, as there is no universally accepted definitions. Besides, definitions may vary according to a different perspective or approach. The Partners agree that migration needs no justification – migration is a fact.

A **working permit** is a legal document giving authorization required for employment of migrant workers in the host country.

### **Regarding the health and care issues:**

According to the definition of the WHO “**health** is a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity.”

`What all theories and models for health and care have in common is that they see the patient as a bio-psychosocial being living in the contradictory context between autonomy and dependency as a result of health problems.` (Austrian Study, p. 19)

At the same time, in an honest attempt to define `care` and `nursing`, it is to be noted that the countries` vocational profiles and vocational training are to be considered separately, for there are country-specific patterns of these occupations.

Care and nursing cannot be separated among one another, as they are penetrating and complementing occupational fields. Nor can care be confined by a lower or different

training background. Rather, it is the setting of care provision that can differ (at home, in hospitals, seniors` homes..)

In the relevant chapter of the Study, aspects and definitions of `care` and `nurse` are listed, as revealed from the Partners that have provided their input .

Yet, it should be noted that nursing is one of the many professions within the health care sector and that it is studied at the highest level of education throughout the EU (tertiary education).

Simultaneously, the field of activity in the health and care sector is growing – this is demonstrated in the occupational title of the advanced certified staff of healthcare and nursing. Beyond nursing the sick this includes the knowledge about the possibilities and methods to prevent illnesses. Moreover, the field of activity extends beyond the classical nursing institutions such as hospitals and nursing homes, to the private sphere of people in need of care, like home care services, health and social communities, training institutions, etc.

## **2. Notes concerning statistics and figures**

From the outset of project development all Partners specified that all statistics should be approached with great caution and critically, as they may present a distorted picture of reality.

The Austrian Partner points out in the National Study: `The report contains some statistical data. However, it must be noted that it is not our intention to emphasize the neo-liberal tendency of using untapped labour potential for the objective of maximising economic profit. Rather, the statistics are meant to stress migrant women`s difficult labour situation due to institutional racism and precarious work situations in light of an increasing need -with respect to both migrant women`s skills and the lack of labour supply in the health and care sector and the high rate of unemployment among migrant women. We would like to put it on record here, that it is absolutely necessary to analyse data critically since it only presents a distorted picture of reality. Labour market statistics on migrants as a group exclusively refer to non-naturalised migrants in Austria. As a result, a large part of maiz` target group is excluded. Among them are second generation women/youth as well as migrant women who, despite holding Austrian citizenship, still face exclusion from the labour market, discrimination and racism, self-employed people like sex workers and women who are in undocumented precarious work situations (cross-border commuters, domestic help, Au Pairs, etc.).

Moreover, labour market data frequently doesn't present the actual qualifications that migrant women possess. This is due to the fact that labour market service counsellors often categorise migrant women into occupational branches in which they imagine to be most realistic. Consequently, the statistical surveys of (registered) migrant women searching for work don't correspond to the reality. Women who may have a higher formal education (e.g. University) in their country of origin are statistically registered as cleaning ladies, domestic help, etc.

There was a deliberate exclusion of data on the number of migrant women currently in training in the health and care professions and /or who are presently working in this sector. There are no figures available shedding light on how many women with a migration background weren't able to gain access to training (due, for example, to refusals from training institutions before the entrance exam, failed entrance exams, high training costs and other legal barriers). Numerous reasons leading to a negative application procedure have been documented at counselling services, however they have yet to be statistically recorded. Among the reasons documented include: Insufficient knowledge of the German language (who did the testing?), too old at the time of application (although the law explicitly states that there is no age limit) and suspected racist motives which unfortunately are characteristic of the labour market in Austria.<sup>1</sup>

There is more statistical information available in the German and Italian National Studies. But again, it has to be considered in a very critical view, aware that it may be presenting the reality in a biased and misleading way. The Bulgarian Study says that ` It has been recognized that the methodology for gathering statistics on in-migration and asylum-seekers needs further elaboration and development on national level.`

During the Partner meeting, the Partners shared an emphasis on the deficiency of reliable statistic information. The main purpose of the statistics herein is to stress migrant women difficult labor situation and link it to the lack of skilled labor supply for the health and care sectors in all countries. Moreover that the Comparative study does not have the purpose, or the possibility, to compare or analyze the statistic information exposed in the National Studies - clear criteria for the collection of these statistics have not been set with the Partners, and each Partner tried to avoid the significance of statistics in order to correctly fulfill the Project Principles.

### **3. Project principles and their implementation**

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<sup>1</sup> Austrian National Study, p. 5

We guarantee that within our project migrant women are not perceived and treated as objects of research.

The partners ensure that the participation and involvement of migrant women as experts within the project is guaranteed.

We support self-advocacy and self-representation of all disadvantaged groups and people.

The main goal of the project is empowerment of migrant women and a contribution to the fight against racism and discrimination in the partner countries.

The partners agree to refrain from reinforcing the ongoing gender segregation within the labour market.

### **Implementation of Project Principles:**

The innovative character of the project includes the honest attempt to achieve the symmetrical involvement of migrant women in all aspects of the project. This desired symmetry is in reference to function, decision-making power and salary appropriate to the position.

The partners shall undertake to network with self-organisations of migrant women in their countries.

We commonly agree upon the guidelines regarding personnel policy within the Leonardo Project with the intent to implement them.

The project partners must use all possibilities to especially address and invite migrant women to apply for open positions. Where possible phrases such as „Migrant women are especially encouraged to apply for this position“ or „Migrants are also welcome to apply for this position“ should also appear in the job advertisement.

Particular effort must be made in publicising the job advertisement among migrant self-organisations.

The Project Principles are of obligatory nature and has been signed by Partners as an irrevocable part of their contracts. However, their implementation does not unfortunately lead to an automatically guaranteed compliance. In a self-critical note here, it must be admitted that not all points of Project Principles have been fulfilled by partners. The reasons for this are ranging from Partner`s different backgrounds and competencies, to the little time for work on project further aggravated by the limited financial resources, resulting in only two Partner meetings in the research and study phase.

## **4. Explanation of the methodology used for the Partner secondary analyses**

What began as several national reports from the partner countries, later developed in the present Comparative Study with the aim of citing, comparing and contrasting different aspects from Partners' different approaches, resulting from their different fields of expertise.

In developing the methodology of research, the Partners tried to observe the Project Principles and their correct implementation.

According to the agreed study outline, the national studies consisted of two parts – secondary analyses and empirical study. The secondary analyses undertook research into the challenges – structural conditions and forms of work - that migrant women are faced with in the partner countries. It also provides an overview of the care sectors of Partner countries, in terms of occupational descriptions, trainings, labor market demands, demographic developments, accreditation and recognition of trainings.

In the core of the empirical research methodology was the implementation of qualitative methods, based on qualitative semi-structured interviews with migrants, migrant self-organization, migrant related institutions, authorities, health service providers. The qualitative interviews have been implemented according to the interview guideline that was first drafted by Maiz. After that the Partners sent their feedback, recommendations and comments to A.N.P.AS and UniTS, who upon collecting and considering, issued the final version of interview guideline.

The topics that were discussed in the secondary analysis form the basis for the following empirical work with qualitative interviews as its keystone.

The open interviews were conducted with interview guidelines designed specifically for each relevant group. The interview guidelines first drafted by Maiz and then further developed in cooperation with the project partners. In accordance with the project goals, limits were also set on the orientation for their content.

The paramount factor in conducting the interviews was to include the perspective of the migrant women both as experts in the development of the interview guideline as well as in the selection of the interviewee.<sup>2</sup>

Maiz set out the research questions, that were pursued in working out the interview guideline and the analysis of the interviews:

1. What challenges/ problems confront migrant women wishing to work in the health and care sector?

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<sup>2</sup> Austrian National Study, p. 39

- a. The labour market in general: legal/ institutional/ social
  - b. During training: structural/ institutional/ subject matter/ social
  - c. At work: structural/ institutional (temporal, hierarchies, etc.)/social (working with colleagues from the majority population/ migrant women, racism, etc.), job profile, cultural concepts of nursing and care.
2. How are these challenges / problems confronted?
- a. In the training / by trainers
  - b. By employers
  - c. By migrant women
3. What recommendations for the pre-qualification curriculum can be derived from the various perspectives?
- a. Temporal – structural
  - b. Subject matter

The interviews were combined with other methods of work – qualitative research, study and examination of documents, empirical methods, identifying the legal grounds.

Additionally, according to the national context the Partners could adapt and modify the content of interview according to the specifics of the country or the interviewee group. The Italian Partners explain that `The interviews were carried out following a format for the semi-structured interview created for each group of interviewees`<sup>3</sup>.

`Special attention was paid to avoid running the risk of researching the migrant women.

In the foreground was the analysis in view of the expert recommendations (based on experience and expertise) for the development of the curriculum.`<sup>4</sup>

The Greek Partner explains, that face-to-face interviews have certain advantages over other methods of data collection - flexibility and immediate opportunity for clarification of meaning, access to specific segments of society, opportunity to observe and assess the validity of the response – as well as some weaknesses (high costs and the interviewer's bias and its associated problems).<sup>5</sup>

In overcoming these disadvantages, the interview guideline gave specific recommendations to the time and place of interviewing – mainly at the workplace for optimum convenience and impartiality, to the warming up information – the provision of accurate information of

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<sup>3</sup> Italian National Study, p. 21

<sup>4</sup> Austrian National Study, p. 40

<sup>5</sup> For more information see Greek National Study, p. 24

project goals and the personal input of the interviewee, the sequence of questions and confidentiality terms.

In Austria `the interviewees consented to .. (Maiz) request to tape record the interviews. Additionally, all of the interviews were completely transcribed Interpretation of the statements exist to a limited extent due to classifying and summarising the statements into the individual subject areas. However, we attempted to leave the statements unchanged as much as possible and to incorporate them in the above-listed structure of the guideline. We are fully aware that through the cooperation between migrant women and women of the majority population the results are influenced by their different respective backgrounds and presented from a subjective perspective.`<sup>6</sup>

The Greek Study is submitting all held interviews in a transcript (after having audio-recorded them) and reflects on the advantage of audio recording, which is that `the interviewer's interpretation of the interviewee's answers is open to independent scrutiny, because the primary methods are available for study by others, maintaining of course the interviewee's anonymity` (p. 24)

In Bulgaria, the interview implementation with the migrant women and related institutions was preceded by a period of familiarization with the Partner on one hand, and with the goals and aims of project on the other. For receiving a thorough and credible expertise, it was very important that the migrant women understood perfectly well the benefits of project and could see their contribution as designers of their own future. As a result two open and friendly discussions were organized in the beginning, problems and difficulties shared in an informal atmosphere, and only after that were the interviews implemented, more like a summary of all said by that time.

At the same time field-notes were taken by all Partners, recording non-verbal signs or interviewee's reaction to a specific question. All notes and written documentation accumulated in result of research is available with all Partners for further reference.

Even after the first round of interviewing, data has been systematically completed by more interviews with officials, experts, and migrants themselves or their associations, depending on the gaps in literature, documentation and accumulated expertise.

## **5. The interview sample – notes and explanations**

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<sup>6</sup> Austrian National Study, p. 40

The interviewee categories have been discussed and agreed among Partners during the first Partner meeting. Each Partner, according to country specific could add more categories. In Italy, including the Trade Unions was very important, because they play an important role in the definition of vocational training schemes, as well as for the definition of the working contract for each working category. Thus, their contribution and point of view regarding is indispensable for project implementation.

The categories of the interviewees are:

- Migrant women in the nursing field;
- Migrant women who are currently attending a training course in the health sector;
- Migrant women who have dropped out a training course;
- and/or
- Migrant women wishing to attend a training course in the health sector;
- Directors, decision makers or senior trainers in educational/vocational institutions delivering training in the health sector;
- Directors, head nurses or management in a health care institution (hospitals, elderly homes, home care,...);
- Policy makers on vocational training (Regional and local government, universities, etc..);
- Representatives of the trade unions.

With the development of the interview guidelines, it has been specified that 1 - 3 persons should be interviewed by category. However, each Partner though could vary with the number of interviews for the different categories, depending on his knowledge in the field, on the expertise delivered from interviewee or depending on the manpower.

‘Time constraints with respect to the completion of this report and a fluctuation of employees in the organisation allowed us to conduct only some interviews.’ is expressed in the German National Study (p. 25), in explanation for the less held interviews.

‘The very tight time constraints with respect to the completion of this report, allowed us to conduct 8 interviews’ is stated in the Austrian Study, but also adding that ‘despite extreme time limitations, we set very high quality and quantity standards (within our limits) for the analysis of the empirical.’ (p. 39)

The interviewed respondents by category in each Partner country are:

Category Partner	Verein maiz	Health Care Association	Europäische Bildungswerke für Beruf und Gesellschaft e.V.	Antigone	Associazione Delle Donne Brasiliane in Italia, Università del Terzo Settore, Associazione Nazionale Pubbliche Assistenze	Instituto de Estudios Politicos para America Latina y Africa
	Austria	Bulgaria	Germany	Greece	Italy	Spain
Migrant women working in the nursing/care sector	3	2	3	4	6	1
Migrant women currently attending a training course in healthcare	1	2*	2	3	4	1
Migrant women who have interrupted/dropped out of a training course	1	2*	3	1	1	1
Migrant women wishing to attend pre-qualification courses in healthcare	1	1	2	2	2	
Directors, senior trainers in professional healthcare training institutions	2	1		3	3	2
Directors, senior nurses or others in healthcare institutions and/or service providers	1	2		3	2	1
Political representatives, authorities related to education and migrant-related issues	-	2		2	2	1
Union representatives	-	1		3	1	

\* not healthcare courses

A very important consideration reflected by Maiz, Austria is that `As much as possible, in assembling our list of interview partners, we strived to achieve to approach a heterogeneous group in terms of country of origin and job within the health and care sector.` (p. 39 )

The Greek partner is describing their sample of research as a snowball sample (or network, according to some authors), finally comprising 21 respondents unknown to the researcher. `The assumption underlying in the whole process is that a person within the snowball sample knows who is more suitable to be included in the study and consequently suggests more participants. Thus, the selection of the sample is also controlled by the respondents, and not by the researcher solely.` (p. 26 ) This is very important considering the project principles and their implementation.

‘The information obtained from the interviews carried out with migrant-women was given first priority, as well as their advice taken as to which institutions and NGO’s to be interviewed and in what reference.’<sup>7</sup>

The Spanish Partner is finding it clarifying that ‘the "selected sample" for the application of the interviews does not respond to statistical criteria, nor looks for a representativeness sample. A deliberate sample was constituted, where it was to represent certain social subjects that by its condition, experience and positions could give to account through their speeches of the experience of the immigrant women in the area of the health and the care, and approach key aspects to outline the courses of objective formation of the project.’ (p. 6)

Since the most important part of the interview research was carried out with the participation of and among migrant women themselves, we should specify their background:

<b>Partner</b>	<b>Country</b>	<b>Migrant women that contributed to project research</b>
<b>Verein maiz</b>	<b>Austria</b>	As an organization by and for migrant women, Maiz involved migrants from its large network, ensuring access of women from different background and experience in the country.
<b>Health Care Association</b>	<b>Bulgaria</b>	Migrant women with recognized refugee status, representing all major immigrant’s nationalities in Bulgaria, in assistance with the only self-organization of migrant women in BG
<b>Europäische Bildungswerke für Beruf und Gesellschaft e.V.</b>	<b>Germany</b>	All born in Turkey and living in Berlin from 11 to 25 years now. The migrants of Turkish descend are the biggest part of German immigrants.
<b>Antigone</b>	<b>Greece</b>	Migrants of all major nationality background, as well as repatriated migrants (Greeks who have lived in USA, the ex Soviet Republics, etc.)
<b>Associazione Delle Donne Brasiliane in Italia, Universita del Terzo Settore, Associazione Nazionale Pubbliche Assistenze</b>	<b>Italy</b>	From the regions of Tuscany and Lazio, some of them Brazilians and also other members of the Italian Partner self-organizations
<b>Instituto de Estudios Políticos para America Latina y Africa</b>	<b>Spain</b>	Mainly Latin American migrant women, settled in Madrid. Latin American female migrants are the biggest part of all migrant women in Spain.

<sup>7</sup> Bulgarian National Study, p. 38

Although Partners used scientific methodology and made an honest attempt to focus on migrant women and the heterogeneity of the group, the sample still cannot be of representative quality. However, guided by and contributing their individual expertise, the Partners as a group are accumulating expertise in the field of migrant pre-qualification.

## **6. The reality of immigration in Partner countries – the challenges each country is confronted with**

The present research does not have the goal to present an in-depth and thorough analyzes of the immigration figures and trends for each country. Moreover, that each country represents a separate case in terms of historic preconditions, impact of immigration over the national economy, legal background, attitude towards immigration, etc. And despite the fact that all Partner countries are situated in Europe, the differences they share in terms of immigrant issues are significant.

However, it has been recognized that the EU Member States have a long tradition of immigration, which, on the whole, has contributed positively to economic growth and labour market adaptability. Over the last ten years, there has been a broadening and diversification in the typology of migrants, of the patterns of flows and of the mix of the sending and receiving countries. Moreover, with the accession of the ten new Member States in 2004, part of past immigration will become internal mobility. Now the citizens across the 25 Member States are struggling to find out the country-specific regulations on their employment rights. For the time being, EU-level and national regulations remain largely unpublished and contradictory.<sup>8</sup>

Meanwhile, as the EU is already preparing for its next wave of enlargement – including Bulgaria - the issue of how to tackle migration to the benefit of all is assuming added significance.

In an attempt to address the complex implications of the EU's enlargement, several EU-15 Member States have introduced 'transitional restrictions' on the movement of the labour force from the new Member States. The central argument behind the introduction of these measures is the desire by the Member States of the EU-15 to protect their national labour markets against the projected influx of job-seekers from the East. Several EU-15 states have explicitly identified the protection of their welfare system as being the main motive behind their moves.<sup>9</sup>

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<sup>8</sup> <http://europa.eu.int/scadplus/leg/en/cha/c10611.htm>

<sup>9</sup> <http://www.euractiv.com/Article?tcmuri=tcm:29-129648-16&type=LinksDossier>

The Comparative study will consider immigration in view of the challenges for employment in the health and care sectors, the recognition of qualifications, formal experience of migrant women, and most of all - the existing linkage between migrant women willingness for employment in the health and care sector and the deepening labor demand existing for years in the same sector.

### **6.1. General overview of Partner countries` immigration policies**

According to the National reports, 7.3 million of immigrants live in Germany, and among them the biggest community of Turks. Germany has a net migration rate of 6.1 with 3.99 migrants / 1 000 population (2002). Nearly 9% of the Austrian population is consisted from migrants, which are more than 730 000 registered migrants living in the country. Again 10% - between 870 000 - 1 000 000 people – are the immigrants in Greece, more than half of which Albanians and Bulgarians. The Italian Partners report about 2 600 000 registered immigrants working in the country, accounting for a fifth of the total population (2001). In the end of 2004, 2 000 000 immigrants resided in Spain on a temporary or other permit, and the huge 32.85% of them coming from Latin America and mainly women. As for Bulgaria, it is very important to note that out-migration is outnumbering in-migration; the immigration of foreign citizens is a relatively new phenomenon and needs to be researched and treated with special attention, but currently around 60 000 immigrants are residing in the country upon authorization, another 11 253 immigrants have been granted the statute of refugees or humanitarian status.

Additionally to the above, IOM estimates that currently there are at least three million irregular migrants in the European Union (2003), despite moves to legalize the stay of half of them. However, this figure can be regarded as an educated guess in the absence of any official count, which would be hard to establish anyway, because of the clandestine nature of irregular migration flows.<sup>10</sup> For example, there are 10 000 Bulgarian immigrants staying legally in Germany and another 80 000 ones, without documents.<sup>11</sup>

Recent global data on female migration patterns are difficult to find. The United Nations estimates that women make up around 48 percent of all international migrants.<sup>12</sup>

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<sup>10</sup> <http://www.iom.int/documents/publication/en/chap13p239%5F258.pdf>

<sup>11</sup> `Monitor` BG daily press, 8 June 2005

<sup>12</sup> <http://www.iom.int/documents/publication/en/chap17p303%5F316.pdf>

The new debate about the future direction of migration in Europe has been prompted by several factors: economic concerns about skill shortages in certain employment sectors; growing awareness of the global competition for the highly skilled; a desire to provide alternatives to irregular migration, and concerns over demographic trends in Europe.

Up until 2003, when amendments to migration laws became effective, migration policy in **Austria** was solely of a protectionist nature and was linked to labour market policy without any focus on the permanent settlement and integration of the so-called guest workers who were mostly young men. There still haven't been any drastic moves away from that strategy except for that now the mantra has become "integration before new immigration". This strategy is one with a strong emphasis on assimilation in terms of understanding "integration" as German language acquisition and adapting to the "Austrian way of life". It was used to legitimise further restrictions on migration to Austria while ignoring migration needs and long-term solutions`<sup>13</sup>

Gearing immigration law in Austria towards the formal and informal labour market situation have in effect established categories of migrants. The objective being to open up the labour market to EU citizens and refugees while implementing instruments such as separate residency and work permits as well as quotas to restrict access to the labour market to third country nationals. The exceptions concern key personnel with special qualifications who are deemed important to the Austrian economy` (p. 7)

In the legislation regulating migration policy in Austria, women are not specifically addressed `....` The virtually gender-neutral, but actually male-oriented legalese pays little attention to the individual and structural living circumstances of migrant women. In fact, several laws put migrant women at a disadvantage in that laws like those which grant women rights only through their men as well as other laws reproduce female migrants' already vulnerable financial and /or legal situations.` (p. 7-8)

In Austria, there are separate laws regulating migration and residency and the permission to work. While residency permits are regulated by the migrant residency laws (*Fremdengesetz (FrG)*), the migrant labour laws (*Ausländerbeschäftigungsgesetz (AuslBG)*) regulates migrants' access to the labour market. This means that migrants must undergo two separate processes in order to be able to legally work in Austria. Migrants must first achieve some sort of residency status and only then can that serve as

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<sup>13</sup> Austrian National Study, p. 7

a basis to achieve access to the labour market. However, by law and in practice, we will later see that residency is in no way an automatic door opener for free access to the labour market thereby creating the informal sector as an alternative means for female migrants to gain an income.` (p. 8)

`All non-EU citizens who intend to settle in Austria permanently and establish their central life here require a permanent residency permit (*Niederlassungsbewilligung*). A permanent residency permit may be issued for self-employment where the central activities are based in Austria, to gain access to the labour market (i.e. work permit) or for purposes of family reunification and is subject to very strict quotas.

The laws regulating female migrants may compromise their living situation such that separation, divorce or annulment of their marriage can endanger their residency status. The consequence is that migrant women who are confronted with domestic violence often endure a relationship or a humiliating situation. There is an accumulation of dependencies and, hence risks of exploitation are further nourished. From this perspective it may be concluded that the structural framework sets the stage for women to be subjected to various forms of violence and aggression.` <sup>14</sup>

`The law regulating migrant work permits (*Ausländerbeschäftigungsgesetz*) for non-EU citizens further complicates the system. The aim is to regulate access to the Austrian labour market by drastically limiting the percentage of migrants to only 8% of the total amount of employed persons in Austria. This maximum national quota has led to the fact that some migrants living legally in Austria (even with documentation of an unlimited residence permit (*Niederlassungsnachweis*)) are actually blocked from employment.

In general, there are four main types of work permits for migrants: the temporary work permit (*Beschäftigungsbewilligung*), the regular work permit (*Arbeitserlaubnis*), the permanent work permit or certificate of exemption (*Befreiungsschein*) and the combined unlimited residence and work permit (*Niederlassungsnachweis*). For simplicity's sake, they can be viewed as stepping-stones where the acquisition of one may lead to the acquisition of the next.` <sup>15</sup>

`A strategy used by many migrant women to circumvent the limited possibilities to enter, live and work in Austria is to marry a man holding Austrian citizenship. Migrant women married to Austrian citizens are automatically granted an unlimited residence permit (*Niederlassungsnachweis*) where unlimited residency is coupled with (theoretically) free

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<sup>14</sup> More information for the Migrant Residency Law see Austrian National Study, p. 8-9

<sup>15</sup> More information on the Work Permits see see Austrian National Study, p. 9-10

access to the labour market throughout Austria. This is the most significant way to obtain access to quota-free immigration. However, this way is not without significant risks as it is one which creates a situation of extreme dependency. A central factor of discrimination is that female migrants who lack independent residency rights also lack an independent economic basis.` (p. 10 incl. more information on other types of temporary work permits)

**Germany** was among the first to admit, that the country needs immigration to compensate for an ageing population.<sup>16</sup>

`On 1 January 2005 the new Immigration Act (Zuwanderungsgesetz) was enforced. It constitutes the first comprehensive reform of the old aliens law (Ausländerrecht).`

`Concerning labour migration the new Act contains new provisions, too: In replacement of the previous system of separate residence and work permits, a residence permit also grants access to the labour market. Foreigners will therefore only have to deal with one authority. Abroad this will be the foreign missions (embassy and consulate visa offices), in Germany the aliens authorities. The labour administration is involved via an internal employment approval procedure where this is required. There are various residence permits that are issued for the purpose of taking up employment (as an employee or self-employed work). Which residence permit applies and which preconditions need to be fulfilled essentially depends on the type of intended employment.` <sup>17</sup> Here it is distinguished between;

- employment that does not require any professional qualifications - it is generally not possible to receive a residence permit for the purpose of taking up employment that does not require professional qualifications. These are only issued under exceptional circumstances if this has been allowed for in intergovernmental agreements or is permitted by legal ordinance;
- qualified employment - in the case of specific vocations it is permitted to employ professionally qualified foreigners. These occupational groups are determined by legal ordinance. In individual cases, a residence permit can be issued for the purposes of carrying out a job requiring professional qualifications if this is in the public interest;
- highly qualified employment and self-employed work - for highly qualified persons the Act provides to be granted permanent residence right from the outset - scientists with special expert knowledge, teachers and scientific workers with specialist functions, senior managerial. Such persons may receive a settlement permit immediately. As a

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<sup>16</sup> Independent Commission on Migration to Germany, 2001:11

<sup>17</sup> German National Study, p. 8

rule self-employed persons receive a residence permit if they invest at least one million euro and create a minimum of 10 jobs

‘The regulations regarding foreigners do not apply equally to all foreigners. A fundamental distinction is made between EU citizens ("Unionsbürger") and so-called "third-country nationals" ("Drittstaatenangehörige"). EU citizens and their family members – even those who are third-country nationals – have special status under European law.’ (p. 7)

‘In order to enter and reside in Germany, non EU foreigners must have permission in the form of a residence permit. Under the old Aliens Act, there were five types of residence authorizations. Under the Immigration Act, respectively the relevant part of it, the Residence Act, there are only two types of them: The temporary (limited) residence permit (Aufenthaltserlaubnis) and the permanent (unlimited) settlement permit (Niederlassungserlaubnis).’<sup>18</sup>

Further on, the German Partner refers directly to the policy connected to household workers: ‘Often women without a residence permit work in private households. The restrictive immigration regulation pushes the migrants into these areas of work. In contrast to other countries, there is no possibility to enter Germany legally as a domestic worker and to obtain residence and work permit (the only exception is a special regulation for the nursing staff from Eastern Europe). The state does not want to introduce arrangements to grant permanent legal status to all undocumented migrants like it occurred in other European countries (some weeks ago in Spain, for example). The attitude of the public, the media and the trade unions towards the issue of migrants’ working conditions is for the most part negative and focused on the "illegality".’ (p. 14)

‘Greek law 2910/2001 forms the cornerstone of the country's immigration policy. It outlines the procedure migrants must follow when seeking to enter **Greece** for employment purposes. ...’ (p. 8)

‘A recent amendment to immigration Law 2910 (passed in May 2003) outlines the procedure for foreigners - those who can financially support themselves without having to work in Greece - to apply for one-year renewable residence permits. This applies to foreigners who can financially support themselves without having to work in Greece, such as pensioners from affluent non-European Union countries.’ (p. 8-9)

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<sup>18</sup> More information on this available in the German National Study, p. 7

`Consular authorities may deny a foreigner permission to enter the country without having to justify their decision. But they must give a reason if the foreigner in question is the spouse or child of a Greek citizen or a citizen of an EU member-state who is living in Greece.` (p. 9)

`Based on this Law, the Organisation for the Employment of Human Resources (OAED) records the country's labor demand and outlines the types of jobs available to migrants each year. This list closely considers the needs of the economy and is approved by the Labour Ministry. It is then forwarded to all Greek consular authorities abroad, as well as to the prefectures around the country.` (p.9)

`Greek authorities abroad then make the list available and register those who are interested in working in Greece. The names of these foreigners are then sent to OAED and to the prefectures. The employers in Greece wishing to hire migrant workers contact their prefecture authority. If OAED determines that the job openings cannot be filled by Greeks or migrants already in Greece, the employer chooses from the list of foreigners and request work permits for them. If the application is approved, the work permit will be issued by the prefect and the foreigner will be able to enter the country.` (p.9)

`Based on law 2910, seasonal work refers to employment of up to six months in one calendar year. Only foreigners outside Greece can apply for seasonal work. Employers who wish to engage foreigners for seasonal employment will have to submit an application to their local prefecture, clearly stating the number of workers needed, the type of work involved and its duration. Employers will also be required to submit bank statements indicating they are able to pay workers' wages for at least three months, as well as cover the costs of their return to their country of origin or deportation. The seasonal work permit, which is valid for up to six months, is issued by the local prefect.` (p.9)

A migrant who has been legally residing in Greece for at least three years may reunite with his or her spouse and children. Migrants who wish to bring their spouse and children to Greece will have to submit an application to their municipality or village council accompanied by a photocopy of their residence permit, a photocopy of their income tax declaration, a certificate verifying their relation to the individuals with whom they wish to be reunited and a statutory declaration confirming these individuals will be living with them. (p.10)

The **Italian** National Study does not give information on the immigration policy in Italy nowadays, nor an overview of the main laws connected to immigration.

In this relation, the study only states: ` Among the workers in this field, trained nurses are hardest to find. Firms are looking for nearly 3,000 trained nurses among non-EU migrants, and in the 88.4% of cases the recruitment is deemed as difficult (October 2004). One of the changes introduced by the Bossi-Fini act (189/2002) was the insertion of the category of the nurses among the recruitments open all year round regardless of quotas. In order to recruit a foreign nurse, a health institution, be it a public or private one, must apply to the Provincial Labour Bureau, and later (when it will be in operation) to the bureau for immigration at the Prefecture – Local Bureau. The authorization to work will be granted only further to the acknowledgement of the educational qualification achieved abroad. Before starting to work, the immigrant will have to be put on the professional roll and to pass an exam of Italian language and knowledge of the ethical rules of the profession.`<sup>19</sup>

However, it is to be critically questioned if these new initiatives by some European governments are designed to facilitate immigration, or rather are they moves to use labor for own purposes and capitalize from low employment cost? Is the longer term perspective to `integrate` or simply `discard` once the labor gap is overcome?

It is very important to note that the reality of Europe`s ageing population puts a heavy burden on the healthcare systems in Partner countries, who are chronically suffering from shortages in their healthcare labor supply. Naturally, a flow of trained health care providers has oriented itself towards the developed countries. Other countries on the other hand have for many years deliberately trained more health workers that can be absorbed into the domestic health care systems. These countries – ex. the Philippines - are taking advantage of the global labor market and are capitalizing on their high quality training programs. Despite the many disadvantages and challenges that these migrants and their countries face – brain drain, disrupted family structure, facing the new precarious working conditions.. – there is a strong reason in favor of such policies. This is the remittance (currency) sent by migrants abroad back to their families, and thus boosting the economy as a whole. The present situation shows that health workers migration to Partner countries will surely intensify in the next years and will target a very clear and distinct priority – the increasing public and private spending for health and care services, as a result of the European demographic changes.

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<sup>19</sup> Italian National Study, p. 14-15

The Partner countries should be able to address and manage this tendency and assess the best means for linking health workers immigration on one side and the demands of the health provision market on the other.

In Italy for example, the non-EU immigration is with prevailing numbers for women. Same is true for Spain, where the great majority of Latin American immigrants are female. Women migrants require special attention mainly because the kind of jobs they typically occupy (incl. domestic work), and are also those where exploitation frequently occurs. But do migrant women receive such attention and are they addressed separately in the legal framework of migration regulation?

None of the Partner reports indicate such approach, although all of them emphasize on the need of prompt measures in this direction.

The Austrian Partner is even more specific, illustrating that `several Austrian laws put migrant women in a disadvantaged situation. These are the laws granting the women rights only through their men, as well as other laws aggravating female migrants` already vulnerable and financial and/or legal situation. ` <sup>20</sup>

## **6.2. Structural barriers migrant women are confronted with**

In approaching the structural barriers, the Austrian Study states that `Aside from the formal legal barriers to residency and employment in Austria, female migrants are also faced with a battery of other structural barriers which inevitably either create or lead to inequalities. Moreover, structural barriers most commonly faced by female migrants are closely related to racism in Austrian society.

Widespread efforts to dismantle such barriers remain non-existent and there are no specific actions on the part of the Austrian Government to include migrants, specifically migrant women, into the Austrian labour market. The Austrian Government's National Action Plan 2005 makes no explicit reference to specific measures for migrants in terms of labour market policy. This reflects the failure to acknowledge the particular circumstances of migrants. ` <sup>21</sup>

### **Nostrification of diplomas:**

`Nostrification / Accreditation is the accreditation and recognition of diplomas, degrees or

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<sup>20</sup> Austrian National Report, p. 8

<sup>21</sup> Bundesministerium für Soziale Sicherheit, Generationen und Konsumentenschutz, 2005

training completed in the home country. <sup>22</sup>

The EC legislation in the area of diploma accreditation came in three distinct waves. Firstly there were a series of **transitional** directives, secondly a series of **sectoral** directives and finally the current phase of **general** directives. Article 47 is a key article of the Treaty as regards the mutual recognition of qualifications. It is this Article that provides the legal basis for EC legislation covering the mutual recognition of diplomas. These Directives refer to the accreditation of diplomas acquired only within the EU.

According to Article 47, nursing and other medical professions are regulated professions and are subject to special EU Sectoral Directives, covering all 25 Member States.

Nurses of general care are subject to 2 directives <sup>23</sup>

**Directive 77/453/EEC** - Council Directive 77/453/EEC of 27 June 1977 concerning the coordination of provisions laid down by Law, Regulation or Administrative Action in respect of the activities of nurses responsible for general care 77/453/EEC

**Directive 77/452/EEC** - Council Directive 77/452/EEC of 27 June 1977 concerning the mutual recognition of diplomas, certificates and other evidence of the formal qualifications of nurses responsible for general care, including measures to facilitate the effective exercise of this right of establishment and freedom to provide services 77/452/EEC

Greater difficulties come with nostrification of diplomas for nurses acquired outside the EU. In these cases, the authorities require an impressive set of detailed documents proving the education and training. Even if part of the training is accepted, the immigrant which would like to work as a nurse needs to go into more training in the country, that usually takes at least two years.

According to the Austrian partner: 'The formal and informal qualifications acquired by female migrants in their home countries are often not recognized in Austria. ... However, due to the length and cost of the procedure as well as no guarantee to improved access to employment suitable to the female migrants' skills and qualifications, nostrification remains an option closed to many female migrants. The consequences of this reality are that well qualified women only find employment in low-paid sectors and due to a lack of

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<sup>22</sup> According to Austrian National Study, p. 11

<sup>23</sup> [http://www.aic.lv/rec/Eng/prof\\_en/dir\\_en/sektoru.htm](http://www.aic.lv/rec/Eng/prof_en/dir_en/sektoru.htm)

opportunity in practicing their skills; a sort of de-qualification may arise. In addition, their low incomes further reinforce dependencies on employers and husbands.<sup>24</sup>

According to the political representatives interviewed in Italy, 'one great and at the moment insuperable difficulty is the recognition of qualifications obtained abroad. This imposes an administrative limit on the enrolment of immigrant women in higher training courses (nursing courses).

A pre-qualifying course in the social and health services sector would be welcomed, if it contributed to overcoming the administrative barriers to recognition of qualifications and curricular and facilitated enrolment in higher training courses.<sup>25</sup> Additionally, the Trade Unions in Italy are testifying that 'most of the immigrants obtained in their country of origin a qualification superior to the one recognized in Italy' (p. 26)

The Spanish Study is emphasizing that: 'It is important to consider, that the immigrants people licensed in infirmary in its countries of origin, must make a homologation process to exert its profession. As much for the nurses as for the institutions in a relatively easy process, that last it has to do with the high labor demand of the professions in the area of the health. In some cases it has been made from its country of origin, as it reports a Peruvian woman: "the Spanish homologation became in six or seven months from Peru. At that time there was much shortage of workers. I directly entered to work (for 15 years)". (EM1)' (p.15)

The Spanish Study continues: 'For the nurse of the National School of Health: "a person who he has a college title student of infirmary in Latin America, for example, does not have no problem to confirm them, just in time to justify the papers" (EI3). Nevertheless the homologation of I title, does not mean a direct access to the labor market, nor an ascent in the labor status of the immigrants, because it is important and distinctive for the labor insertion in Spain.' (p.15)

In Germany 'migrant women coming to Germany are at a further disadvantage in attempting to enter and to obtain well paid jobs in the labour market. Many women find that their professional qualifications are not recognised in their new country or, if they are, then migration can negatively affect working conditions and rates of pay. In many cases

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<sup>24</sup> Austrian National Study, p. 11

<sup>25</sup> Italian National Study, p. 26

professional migrant women are working in areas where they are substantially over-qualified.<sup>26</sup>

The Greek Study reflects on the view expressed by a representative of the Trade Unions: `The big issue is whether migrants with qualifications similar or equivalent to those held by natives have the same opportunities and access to the health and care labor market. The answer is negative for the biggest part of migrants as they are not allowed to take part in any official state contest for working as a nurse at the public sector. This is the worst form of social exclusion as many of these migrants have studied at Greek schools, got nursing degrees at polytechnic or University level, and practically their degree is useless when it comes to the state run labor market! The disappointment is higher among this group of people, because the majority holds a degree with very high grade, which in fact is one of the three criteria for working in the public sector. The barrier still remains, since they do not have the Greek citizenship and are barred from applying to work in the public sector.` (p. 18)

Further on, another representative explains that the Unions are involved in providing information as to `which health degrees from abroad are accepted in Greece and which migrants need to apply for degree recognition.` (p. 47)

A different approach are the Unions in Greece taking towards the legalization of qualification of Greek *palinostountes* – more on pages 30-31 in the Greek Study.

It will be correct to assume that with the deepening shortages of qualified nurses in all Partner countries (except in Bulgaria), it can be expected that soon enough nostrification of nurse diplomas will be given priority and the procedures will be accelerated and facilitated. But even then access to employment will not be much facilitated, due to the impact of other barrier - racism, discrimination and ideological attitudes.

### **Recognition of previous work experience**

In Austria : `The recognition of previous work experience acquired in other countries often appears not to be valued to the same extent as similar work undertaken in Austria. Furthermore, migrant women with specific skills but without the officially recognised credentials are seldom given the opportunity to demonstrate their abilities.` (p.11-12)

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<sup>26</sup> German National Study, p. 14

A wide spread problem with the recognition of work experience among the refugee in Bulgaria is reflected in the Study: `For the purpose of registration at the directorate "Labour Office" the unemployed individual is required to present documents that certify his/her years of service, and/or ex-official years of service, and/or years of social insurance contribution. Refugee women who have acquired their years of service in other countries have to submit to the NSII a document certifying the recognition of these years of service in accordance with social policy agreements concluded with the Republic of Bulgaria.

It is a similar situation with the submission of other compulsory documents – documents certifying the educational background and professional qualifications.

In case the migrant-women fail to provide the above documents, she is considered an unemployed person who has no education and professional qualifications. Due to the lack of years of service acquired in Bulgaria, the refugee is not entitled to unemployment benefits; cannot find a job as employers prefer to hire people who have some education and professional experience; therefore, the refugee is not competitive.`<sup>27</sup> (p. 41-42)

The real problem with recognition of working experience, as formulated by the Austrian partners, is that the individual aspects of recognition are dealt with separately without putting them into context and making relationships.

It has to be made a clear distinction between the recognition policies and procedures of previous working conditions of EU citizens and third-country nationals. The greatest challenge remains again for third-country immigrants, where thorough validation and verification of documentation is needed. But even then there is no guarantee for better and wider job opportunities and prospects.

### **Language**

As the Austrian partner is stating, the acquisition of the host country language is an important component in achieving integration into the society.

` However, language deficiencies are all too often interpreted as individual inadequacies and the ability to speak German often serves to legitimise all other skills, knowledge and experience. Many employers positions concerning language is further reflected in the government's approach to integration – in that everything is reduced to a matter of language without consideration paid to other relevant factors.

Moreover, fluent command of the language devoid of an accent is an unrealistic

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<sup>27</sup> UNHCR, January 2005, [www.unchr.bg](http://www.unchr.bg)

requirement which leads to exclusion of migrant women from the labour market.` (p. 12)

After showing some contradictions in the approach to language as a barrier, the Spanish partner concludes that `The contradictions shows a prevailing status, where it maintains to the direct association between immigrant woman and domestic service servant. When we all know that the ignorance of the language in addition to being an obvious limit is in the formation processes, it is an absolute barrier to accede to any type of information by basic that this is, and for that reason one of the greatest obstacles for the partner-labor integration of the immigrants.` <sup>28</sup>

The Greek report refers to language challenges faced in training; `There are a variety of challenges that migrants face when attending a course in the health care sector. The main difficulty in secondary education seems to be poor language skills in Greek. It should be noted here that Greek is generally regarded as a difficult language to learn as it has a strict grammar with a lot of rules, and a vast vocabulary. Yet, there are no extra classes in Greek language designed and offered to migrant pupils and thus they often learn Greek the hard way, as they proceeded with their studies.` (p. 32)

A comment coming from a Greek training representative, specially in view of nursing and care: `The main pre-qualification is good knowledge of the language as Greek is relatively difficult to learn. More specifically when working within the health care sector, both written and spoken language should be at a very good level.` (p. 44)

The German Study highlights that: `Most of them (migrant women) saw the biggest problems neither in the area of their intellectual and learning competences nor in their social skills but in the area of their language skills. One of the women (who attended a secondary school in Turkey) said to the point: „Biology, chemistry and physics are international, languages aren't“. All women were glad to have the possibility to improve their language skills at the TIO.`(p. 27)

At the same time the German Study emphasizes on the advantages that the good command of the native language is having for the migrant women, as a specific competence, saying that these competences have to be developed and made use of in the host country. <sup>29</sup> Still, the adequate command of German language is listed as one of the many requirements for issuing a permanent settlement permit.

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<sup>28</sup> More information on languages - Spanish National Study, p. 26-27

<sup>29</sup> More information on this in the German National Study, p. 15

The Italian Study opposes two points; 'As far as language difficulties are concerned, only one of the interviewees stated that she had had difficulties at the beginning of the course, the others made no mention of such difficulties. One of the four interviewees, on the other hand, found some difficulty in understanding the legal terminology used during the training course.'(p. 22) At the same time 'According to the training institutions, the greatest difficulties met by foreign students are knowledge of the Italian language....' (p. 26)

The lack or insufficient knowledge of Bulgarian language is outlined at the forefront of the problems connected to employment and vocational training for migrants in Bulgaria. The Study is reflecting in detail the practical aspects of Bulgarian language training, reflecting the migrant women view that the language training is considered as the most important one for them in the country. However, despite all efforts on the part of the institutions, the free possibilities for training and the specially adapted handbooks the acquired language skills at the end of training are not sufficient to compete on the labor market.

The Study is listing several specific recommendations coming from the migrants targeting the long term benefits from language training <sup>30</sup>

It is to be admitted that the language barrier is well understood by all Partner countries and is addressed under variety of forms and measures. Most Partner countries, via their immigration authorities and educational institutions provide free of charge, immigrant - tailored language courses/trainings in one, two or more levels.

In all Partner countries there are language training systems and manuals designed specially for immigrants, and in some countries – Germany, Italy – there are several such systems addressed to the different ethnic groups of immigrants and developed according their mother tongue specifics.

It is to be noted here, that language skills are all the more important when it comes to the healthcare sector: On the one hand, dealing with the delicate and responsible issues of health provision - the language gap can interfere with physician-patient communications, resulting in care that's based on incomplete or inaccurate information. However, on the other hand it must also be noted that the language skills that the migrant women possess have also proved to be quite helpful in that they have often facilitated communication (as

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<sup>30</sup> More information available in the Bulgaria National Study, p. 43

translators or language mediators) between physicians and/or medical staff and patients with a migration background.

### **Ideological attitudes and cultural differences**

‘In Austria, the integration of migrants means their assimilation to a pre-existing, unified social order, with a homogeneous culture and set of values. Integration is perceived as a one-way process, placing the onus for change solely on migrants to fit into a given order. For example, women who normally wear the *hajib*, are often expected to work without headscarves when caring for patients, as it is perhaps thought that patients and their relatives could be alienated by such changes to the outward appearance to staff uniforms as well as to religious values. As there appear to be difficulties in tolerating differences, those differences are often expected or required to disappear.

While the Austrian Constitution provides for freedom of religion, Austria is a predominantly Roman Catholic country with many hospitals being church-affiliated (Roman Catholic). It would be naive to think that differences in ideological positions or attitudes, in Austria and in the health and care sector in particular, can exist without conflict or discussion. However, the context in which such discussions take place and to which end they occur is a decisive factor. ‘<sup>31</sup>

The impact of ideological attitudes revealed in the German Study: ‘For several Muslim women there are more obstacles which are ordered by family members like headscarf, compulsory wedding, forbidden company with German or other non-Muslim. These women end up in social exclusion and depend on the opinions and decisions of male family members (spouse, brother, father).’ (p. 14)

This feminizations of migration to Spain ‘takes to the necessarily recognition of the variable of sort in the analyses of the migratory projects, in the design of formation programs and in the labor insertion of and the immigrants. That is to say, it means that we must advance on the generic one of "immigrant", towards the recognition of the diversity of those thousands of women and men who have arrived here, it stops in many cases of remaining. In this sense the diversity of the women is because of the national, ethnic, racial particularities, of class, age, of health, nuns, policies, ideological, educative and cultural.’ (p. 9)

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<sup>31</sup> Austrian National Study, p. 12

Referring to the success of the Greek integration program for migrants, the Study reveals that `many of the apparent barriers are due to ignorance of cultural or religious differences rather than a rejection of all the above. This ignorance, combined with the likelihood that many people have never experienced a close relationship with anyone outside their own culture, tends to widen the intercultural communication gap.` (more on p. 20)

`Cultural and religious differences, in particular with regard to women`s employment in Muslim families` are considered as a strong barrier by the Bulgarian Partner, expressing the view of the institutions. (p.41)

Cultural differences are a big issue that needs the design of a special approach, when creating the curriculum for the pre-qualification course. We do not feel here the need to expand on the impact that cultural differences have on the interaction between migrant women and the host surrounding, and with the health and care sector in particular, as this is well studied and understood. Most Partner Reports emphasize on:

→ the need for a `course on cultural mediation and intercultural learning` (Greece) – as the most recommendation given by the interviewees;

→ `intercultural communication to be included in all training courses` stemming from the fact that more and more immigrants live in Italy and this affects every profession;

→ for Germany, `cultural mediation and intercultural learning should be an explicit component of the curriculum`;

→ the Bulgarian Partner is suggesting the distinguishing of two learning models - `Social orientation module` and `Cultural adaptation module` among 8 modules that should form the curriculum of the pre-qualification course;

→ the Spanish Partner is narrowing the scope, relating for the `cultural model of the healthcare institutions`, meaning that in the Spanish context this is a form of work shared among patients and staff, that in itself should be taught;

Due to the fact that there are various definitions and approaches to the topic of intercultural learning, it is important for the partners to clarify and analyze their approach to this topic in developing the curriculum within the context of this project.

### **Child care services**

`Due to the lack of extended family support structures, migrant women who work are more or less fully dependant on public childcare services (nurseries and kindergartens). Moreover, since migrant women tend to work in sectors with erratic schedules, they face

more difficulties in coordinating childcare schedules with their jobs. ` (Austrian Study - p. 12)

`The difficulties in reconciling working and private life are even stronger for women with children, who are forced to give up their work and to seek more casual and flexible jobs, thus abandoning all attempts to create a personal strategy of employment.` (Italian Study, p.7)

The German Study gives a thorough survey of the educational trends among migrant children, and considers them in view of family traditions. The low educational achievements builds more barriers for migrant children for future employment and vocational training.<sup>32</sup>

All aspect connected to children - children upbringing, children education and children well-being are of huge importance for the training and employment of migrant women and are influencing their integration in the host country.

It is not realistic to think that these structural barriers can be overcome in the years to come, even if legislative measures are taken. Instead, it is important to assess means that will minimize their effect on the overall integration patterns. Migrant women are confronted with many barriers and they cannot be isolated from each other. They are in fact interrelated and must be put into context.

### **6.3. Social exclusion, discrimination and racism in society and in the workplace**

The conceptual framework of the EU has changed since the 90ies from "poverty" to "social exclusion" (ISG 2003). Exclusion has been introduced as a general term covering the multiple dimensions of poverty.<sup>33</sup>

Poverty and social exclusion are key factors in the racism faced by migrant women. We have already considered the many reasons contributing to exclusion from society: intimidation, linguistic and cultural barriers, lack of knowledge of legal and civil rights and insufficient means to access information, lack of specialised skills, no recognition of qualifications and consequent over-representation in atypical work with the informal economy as the only way to make a living.

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<sup>32</sup> More information in the German National Study, p. 9-12

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[http://www.austria.iom.int/en/images/uploads/National%20Report%20Austria%20E1\\_1089387218.pdf](http://www.austria.iom.int/en/images/uploads/National%20Report%20Austria%20E1_1089387218.pdf)

Social exclusion, xenophobia, discrimination and racism are all connected realities, that have a gender-related orientation.

Under pressure to follow the EU Anti-racism guidelines, Austria finally passed an anti-discrimination law in July 2004. However, there is a lack of political will to both implement the guidelines and to work towards a sustainable fight against racism. Accordingly, faced with both racism and sexism, female migrants are subject to multiple disadvantages..... Despite being unlawful, racism is experienced and tolerated in all spheres of life including work. .... Racism in the workplace manifests itself in a wide range of ways including, being overlooked for promotion, denied training, unfair selection for difficult or unpleasant tasks, being called names, being the butt of jokes, verbal harassment or sustained unfriendly contact or exclusion. Of significant concern is the number of cases where migrant workers are not provided with the same, pay and working conditions as native co-workers. Incidents of racism can become so intense that the situation develops into bullying a migrant out of the company. Furthermore, many female migrants tolerate racist abuse and don't complain about it to their employers solely out of fear of jeopardising their already precarious employment and/or residency situation.<sup>34</sup>

The German Partner puts the stress on social exclusion of young people from migrant families, being triggered at a very early age because of insufficient education and the lack of motivation to start vocational training. (p.12) Further in the Study social exclusion is shown as characteristic to Muslim women, because of cultural differences. (p.14)

Social exclusion bred by the limitations posed from the state-run labor market are to be considered in Greece: The issue is whether migrants with qualifications similar or equivalent to those held by natives, the same opportunities and access to the health and care labor market. The answer is negative for the biggest part of migrants as they are not allowed to take part in any official state contest for working as a nurse at the public sector. This is the worst form of social exclusion as most of these migrants have studied at Greek schools, got nursing degrees at a polytechnic or University level, and practically their degree is useless when it comes to the state run labor market! (p. 18)

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<sup>34</sup> More on racism in Austria – Austrian National Study, p. 13

Additionally, the Study is listing many reasons leading to social exclusions of 'repatriated' Greeks, further aggravated by 'social prejudice, 'stigmatisation' and marginalisation by the community'. (p. 19)

The Study also states that 'Finally, only one interviewee said that she had noticed veiled racism among her fellow trainees'. (p.22)

'Employers often take for granted that migrant workers lack professional skills which can be spent in Western economic contexts, but according to our research, as well as to many other researches, this is not at all true (the education levels in our sample are generally high)' (p.7)

From all Partner countries only the Bulgarian Partner is reporting of practically non-existent racism or discrimination towards migrants in the street. This is due to the very low number of immigrants in the country, to the extent when differences are accepted with curiosity and openness. However, migrant women in Bulgaria admit that they face discrimination, racism and lack of understanding in seeking the services of the health and educational sectors. The employers too, often behave with prejudice and discriminate them from equal opportunities for employment. (p. 46)

Social exclusion is apparent in the lack of access to basic resources and services in society (health care, housing, welfare benefits, social protection) and lack of appropriate services and discrimination in the provision of services in areas such as health, education and vocational training. Because of the structural nature of this discrimination, which amounts to institutional racism, it has long-term effects on the quality of life of migrant women.<sup>35</sup>

#### **6.4. Employment realities in Partner countries for migrant women**

##### **Austria, Verein maiz<sup>36</sup>**

'Globalisation has strengthened the flexibility of the labour market. New social balances of power in the private sphere are arising. To the extent to which more women are pursuing careers, a significant class of service providers is arising. An ever-increasing number of migrant women are building up a part of a social support structure which has enabled women of the majority population to pursue a professional career. While the increasing flexibility of the global labour market has in fact created more equality for many middle class women with a good education, it has done so at the cost of greater

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<sup>35</sup> <http://www.womenlobby.org/Document.asp?DocID=239&tod=1995>

<sup>36</sup> Austrian National Study, p. 14-15

inequality among women in general. Household tasks performed by overqualified domestic workers from Eastern Europe, Latin America or Africa have led to a new division a labour within private households. Such scenarios give rise to mistress and maid divided by different nationalities, social classes and cultures. ...<sup>37</sup>

That said, it must be noted that precarious work is not limited to domestic work. It is present wherever there is labour segmentation, and where there is labour segmentation, there are female migrants. Female migrants are heavily represented in employment in the sex industry, in nursing and care, as cleaning ladies, in warehouse work as well as other sectors characterised by flexibility, poor labour conditions and low salaries and lack of representation on works councils.

Ironically, those with the highest employment risk also face the lowest wages. Aside from the insecurity that is accompanied by precarious work, there exists a range of financial and social consequences associated with this work situation in which many migrant women find themselves. The growth in atypical forms of employment (marginal work, part-time work etc.) has led to an increase in the working poor where significant wage disparities exist between the primary and secondary segments of the labour market as well as between regular and irregular employment.

Further on the Study expresses that 'The relatively high rate of unemployment among migrants is being responded to - if at all - with under-qualified and low-paid jobs and with the promotion of precarious labour conditions by, for example, raising the federal quota of employees (=Bundeshöchstzahl<sup>38</sup>) for certain occupational groups as well as cross-border commuters in the field of health- and care professions.' (p. 24)

### **Germany, Europäische Bildungswerke für Beruf und Gesellschaft e.V.,**

'Research shows that migrants generally are often disengaged by from mainstream education and job opportunities...' and 'are hit by unemployment more often than others'. (p.11, 14)

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<sup>37</sup> The Institute for Feminist Research of the Complutense University (Spain), MAIZ (Austria), Hamburg University (Germany), The Bradford Youth Development Partnership (United Kingdom)

<sup>38</sup> The total number of migrants employed and jobless has to be less than 8% of the austrian labor resources (all employed and jobless majority population and **immigrants**). For the year 2004 the maximum number was 273.267.

Ministry for economy and labor, BMWA, 2005  
Beratungszentrum für Migranten und Migratinnen, 2005

`Female migrants tend to work in stereotypical female occupations in large numbers. These include domestic work, health care, cleaning/ maintenance, child care or other personal services. There is evidence that female migrants in these sectors are at a particular risk of inadequate or even exploitative employment conditions, especially when working in private households, and have limited access to social security. Often, the sectors where female migrants work are “hidden” from data collection and workers’ protection because there are parts of the informal economy.` (p. 14)

### **Greece, Antigone**

`Nearly all domestics in Greece work without residence permits. The largest groups are Philippinas, and Polish, Albanian and Ethiopian women - in the last few years, there have been many newcomers from Sri Lanka and India. Many domestics come to Greece via agencies which often withhold the identity cards of the workers until they have paid the costs of the journey and procurement. Others organise their first jobs in Greece themselves, as well as their place of employment, through family networks.` (p.22)

`On the whole it can be noted that most women work in so-called "live-ins", which means that they live at their place of work and often have over 16 hour shifts every day, except for a few hours of free time of their own on Sundays.` (more on p. 22)

The Study is dwelling on the working status of migrant women that have lived in Greece in many years now and occupied in nursing positions. Even if they hold superior positions like `ward managers` and even `directors` `.. their social profile not regarded as high, in comparison to Greek nurses to similar qualifications and experience, by both superiors and colleagues. Low language skills to seem to be the sole argument against them, as in essence after twenty years of experience, nobody can really challenge their competencies. Often these migrant nurses are called by their country of origin, as a diminishing name.` (more on p.33)

### **Italy, Associazione Delle Donne Brasiliane in Italia, Universita del Terzo Settore, Associazione Nazionale Pubbliche Assistenze**

`So far, migrant women have mostly found employment at the lowest levels of the labour market. The feminisation of non-EU immigration means, substantially, the employment in the fields of nursing and housekeeping, which increasingly need the presence of “night and day workers”, flexible in roles and work hours and adaptable to the needs and

spaces of the employing families. .... The risk is for temporary and provisional jobs to turn into the only contact with the new society, preventing all opportunities for change because it totally takes up spare time as well as both physical and psychological energies. Further to the power of attraction of such jobs, which allow immigrants to earn money and give them the chance to remain in the hosting country, there is another element: a sort of emotional blackmail is triggered between the employer and the employee. The migrants' affective and social isolation and their weakness on the labour market cause them to regard as their benefactors those who are actually their exploiters.` (p.6)

`Whatever the typology of the migratory project and the level of education and professional skill in the country of origin, migrant women are seemingly destined to be employed in the housekeeping and/or care sector, at least for the moment. This situation largely depends on this employment typology, very important in Italy, but other factors also play a major role: the lack of recognition of education and of the professional skills achieved abroad, as well as some sort of segregation on a gender and ethnical basis`. (Italian Study p.7)

The Study continues: ` Similarly, there is the widespread idea that migrant workers are more ready to assume tasks, work shifts and conditions which are no longer accepted by national workers: they are forced to accept conditions dictated by other people. Migrant workers are therefore a particular case in the informal and personalistic regulation of the Italian labour market.` (p.7)

### **Spain, Instituto de Estudios Politicos para America Latina y Africa**

A feminization of the migration to Spain can be distinguished. Meaning that women – most of all coming from Latin America – find jobs in the domestic sector and caring for disabled and elderly people. The increasing number of people over 65 years of age accelerates employment in this private sector, but also in the public healthcare institutions, where many migrant women work as nurses.

`The present situation of the immigrant woman in Spain creates imaginary on "the others" that do not have anything to do with their way to confront the world. Rather they are the result of the confrontation to an adverse context that discriminates, stigmatize and infravalues. The supposed "submission" of the Latin American immigrant woman, has to do but with the pressure of the familiar surroundings which they left in his countries of

origin, the demand of remittances and a clear strategy of survival, in a context that by adverse does not allow them to position itself of proactive way.'

And more ' In spite of its formation and its possibilities of making works of certain degree of qualification, they end up acceding to the lowest layers of the labor scale. The case of the work of the immigrant women overflows the technical category of use and their trajectories of labor insertion cannot be explained only from the strict scope of the economy, without considering the set of social relations which they comprise. (Aparicio, R; Winches, A. 2004)'<sup>39</sup>

### **Bulgaria, Health Care Association**

Bulgaria represents a different case than the other Partners. Most immigrant women are either self-employed (too often as part of the grey economy) or find employment in the network of other migrants and fellow citizens.

In Bulgaria nowadays, there is no labor demand for nurses, nor is home caring spread that often to represent a separate occupation. Only now the occupation of the home carer is gaining importance, but the services can be afforded only by families of high income.

On the other hand, the interviewed migrant women do not have specific interest in working in the healthcare provision sector, but are interested in working as home carers, for this will eliminate many other obstacles they face.

The Austrian Partner goes even further, explaining that 'new social balances of power in the private sphere are arising. To the extent to which more women are pursuing careers, a significant class of service providers is arising. An ever-increasing number of migrant women are building up a part of a social support structure which has enabled women of the majority population to pursue a professional career. While the increasing flexibility of the global labour market has in fact created more equality for many middle class women with a good education, it has done so at the cost of greater inequality among women in general.' (p.14)

A common occurrence is that the employments scenarios for migrant women in the Partner countries do not match their educational backgrounds. Most Studies provide

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<sup>39</sup> More information in the Spanish National Study, p. 9-13

evidence of the high educational standing of migrant women, in some cases surpassing that of native women`.

Only in this case, the presumption that the higher education leads to better chances for employment is not valid. Most women with degrees and diplomas acquired in the home country are working jobs unrelated to their skills, training or occupational aspiration, meaning that the potential they have is not used to the best advantage.

## **7. Health and care systems in Partner countries and the related training possibilities view of project goals**

This part of the Comparative Study is designed to give an overall picture of the health and care sector in particular (and not examine the health and care systems in the Partner countries). It will do so in the view of the possibilities that are available for employment of migrant women, and also the training opportunities they have for qualification and pre-qualification in the nursing and home caring field.

The goal here is not to compare the health and care sectors of the Partner countries, but to show that they share some common tendencies that will further develop and evolve and where migrant women can play an important role in their management and controlling.

### **7.1. Overview of health and care sector in Partner countries**

National health systems throughout Europe face a number of pressures in common related to demography, epidemiology, developments in science and technology, medical demand, and rising public expectations. These pressures are producing convergence in the objectives and activities of these systems in several key areas, including cost-containment, health promotion, expansion of access, primary health care, patient choice, and the linkage between health and social services. At the same time, it is also necessary to recognize the role of political and governmental processes, as well as clinical and professional variables, in shaping different societal responses to health care challenges.

European integration and the trend towards increasing care consumption across national boundaries have made it necessary to improve the coordination of the various national healthcare systems.

#### **Austria**

The Austrian Partner starts this section of Study, providing definitions and theories of `nursing` and `care`, stressing that ` Along with the therapeutic-medical treatment it is

equally important to consider interpersonal relations with a human being as a decisive factor. As a direct attachment figure for the person in care, the nursing staff plays an important role in the mental and physical process of healing.

What all care theories and models have in common is that they see the patient as a bio-psychosocial being living in the contradictory context between autonomy and dependency as a result of health problems. ` (p.19)

`The healthcare and nursing professions are under the jurisdiction of the Federal Ministry for Health and Women, and are categorised as non-medical health professions, advanced certified staff of healthcare and nursing and are regulated by the Healthcare and Nursing Law of 1997.` (p.19)

Geriatric care and vocational training for geriatric care however is under the jurisdiction of the Federal Ministry for Social Security, Generations and Consumer Protection and is regulated by the individual provinces; For Upper Austria<sup>40</sup>, it is regulated by the "Altenfachbetreuungs- und Heimhilfengesetz OÖ" (= law regulating geriatric care and household assistance).<sup>41</sup> (p.19)

`In a 2003 study by the Federal Ministry for Health and Women 310 hospitals were listed in which patients in Austria are cared for. These include of general hospitals, specialised hospitals, rehabilitation centres, convalescence homes, nursing institutions for the chronically ill and sanatoriums and have a combined capacity of 67.708 beds, of which 10.195 are in Upper Austria. Moreover, there are 128.000 employees, of which 19.011 (in 2003) are in Upper Austria.`<sup>42</sup>

` More than two thirds of the institutions are part of the public services.

The nursing and caring of sick people in the general hospitals is predominantly the responsibility of certified nurses and nursing assistants. According to the Labour Market Service this occupational field is characterised by a high percentage of female employees...`<sup>43</sup> (p. 20)

`The field of the healthcare and nursing for the elderly was restructured in 1993 in Austria and is under the jurisdiction of the Federal Ministry for Social Security, Generations and Consumer Protection and of the provinces and municipalities. The Austrian system of nursing care is oriented towards the concept of permitting people who, despite their

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<sup>40</sup> Upper Austria is one of the 9 federal states of Austria, in which Linz is located

<sup>41</sup> BMGF, 2005

<sup>42</sup> BMGF, 2005

<sup>43</sup> ams, 2005

limitations, are enabled to live self-determined lives oriented towards their needs. Furthermore, the system provides a combination of financial support as well as non-cash benefits: the level of care a person needs is graded and benefits are dispersed accordingly to partly cover the additional costs of assistance and care. These are paid for by the federal and the provincial governments and are regulated under constitutional law. In December 2004, the Federal Ministry for Social Security, Generations and Consumer Protection published that more than 300.000 people in Austria are in need for constant care.<sup>44</sup>

The Study gives thorough and purposeful information on the several concepts, existing in the geriatric care field, to provide these benefits for people in need

Home care services / outpatient care: home care nursing services, geriatric care, nursing assistance and household assistance. The objective of these services is to enable people to lead a self-determined life at home as long as possible through adequate assistance. In December 2002, a total of 7.810 nursing/care staff (calculated to the full-time equivalent) was working in Austria of which 56% as household assistants. Home care services vary enormously from region to region. In Vienna, for example, the range of services was three times higher than in Upper Austria.

Generally, it can be said that this sector is spiralling with a tendency towards an increasing need for higher qualified staff. In the province of Upper Austria the need home care services has not yet been fully covered. In 2002, there were 569 people (calculated to the full-time equivalent) working in this field in Upper Austria.

Day-patient care: this is a model with a future potential and constitutes a link between home care services and the admission into a nursing home. The most widespread service is geriatric day-care centres. Insiders in the field are calling for the expansion of this form, which is frequently considered an option for the future. However, in reality there is hardly any demand for it, especially in rural areas. (p. 20-21)

Outpatient care: In 2002, Austria had 770 seniors' and nursing homes with a total of about 67.600 beds. Salzburg. ... In the last few years there has been a trend towards reducing resident places while increasing into nursing places.

21.200 people work (calculated to the full-time equivalent) in these homes – 1/3 of them being certified healthcare and nursing personnel, about one half are geriatric care personnel and geriatric and nursing assistants (there are significant regional differences

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<sup>44</sup> Regulated within an agreement between federation and countries in article 15a B-VG Schaffenberger et al, 1999, help.gv.at

in the structure of qualifications of the personnel and the quality of the facilities). The number of staff has greatly increased over the last few years. The group of the certified healthcare and nursing staff has been marked by the biggest increase (around 116%), the group of the geriatric and nursing assistants grew by about 50% - this represents an increase in higher vocational qualification in the nursing and care sector. This reorganisation is based on a structural change in the care for the elderly: the demand has gradually shifted away from the classical seniors' home towards care and more intensive attendance.`(p. 21)

Residence places: (for those who are classified as requiring not more than level 3 in care; Individuals whose needs progress beyond this level are transferred to either a nursing home or a nursing unit). About 22 % of all the available places in homes in Austria are administrated as residences and account for about 14.600 places. The demand for this offer has decreased because more and more people have housing conditions suitable for elderly people.

Nursing homes: In order to be entitled to a place in a nursing home, there must be a need for a higher level of care (mostly higher than level 3<sup>45</sup>). ...

There are about 21.250 people (calculated to the full-time equivalent) who work in the seniors' and nursing homes in Austria. However, in reality there are many more people working since in this sector, a substantial portion of employees work part-time or by the hour. An Austrian study has referred to "the problem that demand for staff in the care sector has not been met and that partly there is even a " state of emergency" with respect to the demand for staff in geriatric care". (See: Zwischenbilanz 2003, ÖBIG, S. V)`(p. 22)

Other concepts are the assisted living concepts and the short-term care concept. (more on p. 22) The Study also lists two care options for the people with disabilities.

## **Bulgaria**

Bulgarian healthcare sector is still undergoing a deep structural and organizational reform, affecting all aspects of its functioning.

The reform of the healthcare system introduced change of property of the health establishments, privatization of the outpatient care, building of the `General Practitioner` institution, transformation of sources for curative medical care financing, change of payment models of curative establishments.

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<sup>45</sup> There are seven levels of care, in the level 1 to 4 the deciding factor is the time. In the level 5,6 and 7 additional conditions are demanded.

All types of medical and healthcare institutions, and specialized institutions for social services are well presented within the healthcare provision network, evenly spread across the country and sufficient for maintaining good quality of healthcare.

Starting from 1 Jan 2004 and according to legislation changes, Bulgaria gave access to social services to all different bodies and promoted the development of social services by private organizations. Facilitated registration procedures are enforced for these organizations and their activities are channeled in theme actions <sup>46</sup>.

For almost a year and a half now, more than 350 private organization have been registered. The practice shows that at this time, most of them are connected to elderly care. A critical approach to this development is to ask if the transfer of tasks to private organizations is resolving the government of its responsibility? This is particularly dangerous in the field of care and effective administrative and legal protection must be in place to guarantee the rights of everyone involved.

The state is still playing important role in elderly care, through the so called `social patronage` services, which at this time represent the best spread and most important service delivered to elderly people in their natural living in Bulgaria. The requirements and expectations to social workers are described in a `Handbook For The Social Worker` provided by the Ministry, but it is only a pro-forma statement and barely has any practical value.

The medical staff in these private institutions is very much the same as in the hospitals – highly qualified doctors, nurses and nurse-assistants. And again, no special training or education is requested for the nurse-assistants. In general all interested people – mostly women – can apply and be employed within this sector.

In short the real situation in the private elderly-care sector can be described as:

- growing need for services for elderly people, corresponding to the fast ageing of Bulgarian population;
- lack of education and training materials for elderly care workers;
- need to rise awareness in the government sector about the need of education and targeting services to the need of elderly people
- low attractiveness of social sector for young people.

A very interesting case in the last years represent the employment of women for in-home activities, such as elderly care, children care, general home assistance.. The case has

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<sup>46</sup> Ministry of Labor and Social Policy

not been sufficiently studied in Bulgaria yet, but with the growing employment and career-chase of women, the trend will develop and more resemble the reality in the other European countries.

These job opportunities are interesting mostly to retired women, but who are active and need to add income to the very low pensions nowadays. The market demand is targeted at former nurses, school-teachers or other social workers. However, in Bulgaria such employment is not legalized – all wages are paid `under the table` and they contribute to the grey economy.

### **Germany**

`With one of the costliest and most generous healthcare outlays in the world, Germany is the third-largest healthcare provider and the largest within Europe. Health expenditures reached almost 10.9 percent of the country's GDP in 2002. The federal and state governments are responsible for maintenance of the public healthcare system. All insured persons receive healthcare benefits and suppliers of such services are remunerated directly. Roughly 90 percent of the population is insured with the Statutory Health Insurance (SHI), which finances almost half of German healthcare expenditures. Some have both SHI and an additional private insurance. Around 9 percent of the population is privately insured.` (p.17)

`Due the aging population spending on old age pensions, homes, and healthcare is likely to increase. The home healthcare market in Germany is the third largest in the world and the largest in Europe. It was valued at euro 14.62 billion in 2003. The home healthcare market is expected to register a compound annual growth rate of 10 percent because there is expected to be a shift from inpatient care toward homecare.` (p. 18) Which of course means that more migrant women will be channelled in precarious home care work, the process accelerated by promoting immigration policy deprived by ethical or humane considerations, facing the structural barriers we considered before, and without a visible chance for permanent settlement in the country.

`The rapidly aging population, incidence of more chronic diseases and expensive hospitalisation, and the increasing health consciousness of the German consumer are some of the factors influencing the growth rates of the home healthcare segment. On the one hand, labour market can benefit from the increasing demand and the opening up of new market opportunities (domestic and international) due to the aging population; while on the other, patients can benefit from the falling prices of products and services due to

increasing competitiveness. (p.18) It's correct to ask if falling costs of caring services performed by migrants are also a part of the scenario.

## **Greece**

The welfare state in Greece is almost 70 years old and attempts to create a so-called "safety net" for the whole of the population, including the sick, disabled and elderly people. The responsibility for the management of the social insurance system, as well as of the unemployment and family assistance benefits, belongs to the Ministry of Labour and Social Insurance.

The Study is very detailed reflecting on the development of the legislative base, supporting state institutions and structural changes, leading to the recent ranking of the Greek health system as 14<sup>th</sup> out of 191 in a study held by WHO. (more on p. 12-13)

Encouraging though this figure was, the Greek government is pushing ahead with major health care investment, as witnessed in the budget for 2001, in which the sector was given a considerable boost with an 11.5% increase in health spending.

Despite the considerable increase in health spending, health care in Greece suffers from the lack of credibility and low income satisfaction. The main problems are in outpatient care, where the lack of the institution of the general practitioner as a family doctor causes serious delivery, access and referral problems; the limited effectiveness of the emergency care services, the poor organization and low level of development of primary health care and the shortage and bad distribution of quality hospital beds, the majority of which are concentrated in the Athens and Thessalonica regions. Not surprisingly, these are all areas where the public administration and the perennial lack of a coherent health policy resulted in poor planning and the low quality of service provision. (Liaropoulos, 1993). (p.14)

A specific point is made to The recent interest in private healthy insurance should be seen in this context, as a result of widespread dissatisfaction with the public health system and especially with the hospital sector. (p. 14)

## **Italy**

The Italian Study is very detailed and specific revealing the care sector and highlighting its importance to society, but also its complex nature.

Definitions and consideration of the `care` concept are provided, focusing on its multisidedness and complexity. Specific dimensions of care are revealed, the relationship between the `carer` and the cared person is given strong consideration, and the question of who is a `carer` answered.

`In short, the term "carer" is used to indicate people who give assistance to elderly people, adults or minors whose self-sufficiency is reduced and who need full-time assistance to be able to remain at home and/or to ensure the continuation of an adequate standard of life outside the family context.` Adding `In the collective imaginary, care is a female feature...` (more on p.8-9)

`During the last decades, care services have been increasingly entrusted to external workers as Italian women have entered the labour market: where economically possible, Italian families tend to leave services to externals. Private workers, called "carers" when foreigners, work in individual or organized manner for a salary. Often those who work individually don't get a fair remuneration for their job; those who work for an elderly person get worse conditions and wages than those organized in social cooperatives or firms, and are often forced to work off-the-books. In order to allow them to legalize their position, a tax reduction proportional to the expenses for care services has been provided for.` (p. 11)

Further on: `What is the reason for this dramatic change? Indeed, the massive immigration over the last few years has greatly contributed to it. The increasing labour supply has lowered the costs making it accessible to families of medium and upper-medium income. But the public policies have played a role as well: not only because of the insufficient investments on public services (in which we remain last in Europe), but also because of the insistence on programmes of allowances and economic subsidies to families to make them provide by themselves the care services needed by elderly people. Such allocations of money are carried out without any sort of check upon the families and their care skills, or upon the use they make of it; and, although established to enhance the citizens' freedom of choice, such measures (among which the accompaniment allowance, which transfers 500 billion euros a year to families with disabled persons) have ended up nourishing the black market, encouraging the demand for migrant carers by families unable to find different solutions, and preventing all forms of regularization.` (p. 15)

`Italians don't like ending up in an elderly home, like Scandinavians and Californians. Although the over-65's have greatly increased, over the last ten years the number of those who went to live in that kind of structures has not grown..... The explanation to

this inconsistency is that the few well qualified structures are besieged and have very long waiting lists, while all the remaining ones are seen as “parking places for old people” and sometimes as perfect places of social isolation. High prices play a role in this widespread mistrust: the admission to an elderly home costs up to 1500-2000 euros a month, while a carer costs about 700-900 euros.` (p, 15-16)

The Study critically reveals here that `a carer’s salary, 600-800 euros, is not sufficient for her to send money to her relatives (except in the case the family she works for provides board and lodging), because of the high costs of renting a house and using the services in Italy.` (p. 13) Apart from dealing with discrimination in remuneration, the consequences are that migrant women are forced to consent to precarious working conditions, put up with dependency conditions and lead lives in social exclusion.

`According to a research by Alessandro Castegnaro, who teaches Social Politics at the University of Padova, the inflow of carers in Italy results in high savings for the public welfare. For instance, in 2001 the stay of an non self-sufficient aged person in an elderly home costed 27 millions liras to the Region Veneto and 36 millions to families: thus, since 15-20,000 aged people are assisted by carers, the “virtual” saving for public regional finance is about 350 billions liras a year.` (p. 16)

## **Spain**

`This demographic revolution, also is hitting the sanitary system, as far as its infrastructure, its level of consumption, and the necessity of coordination between sanitary and social departments: "Spain has one of the worse urban and social sanitary structures welfare, to welcome with professionalism, means and humanity to the old patients... to take care of 6.9 old million of greater of 65, only has near 200 thousand seats for residences of old, the private majority". (Daily Galicia Opinion, 2002).` (p.11)

`Before this panorama and the impossibility of many families to pay a deprived residence, is generated an increase of the hiring of women who attend the addresses to take care of the old ones. Attention that goes from the support, the personal cleanliness or of the house, until a specialized attention, fortifying an alternative labor market, that in many cases is covered by the immigrants women, with a irregular high percentage of, without labor contract, nor social benefits.

"At the present time one of the occupations less appraised by the Spaniards, as soon as it implies instability and lack of social consideration, is the care of old. This work is practically being into the hands of foreign immigrants by economic reasons, specially women in irregular situation. The last data of the Social Security base in near 100,000 the discharges in this type of occupation between the immigrants, to whom it is possible to be

added other so many irregular ones to them. They are the South Americans, specially Dominican and the Moroccans who take care of those old ones which one lives single in there houses ". (Newspaper of N18 Anthropology. ).` (p.11)

**Healthcare sectors** are organised by each Member States in the EU, and although they are characterized with some diversity – both in funding and delivery of healthcare - they have become increasingly interconnected in recent years. This increased interconnection raises many health policy issues, including quality and access in cross-border care; information requirements for patients, health professionals and policy-makers; the scope for cooperation on health matters, medical education and the management of health workforce, and how to reconcile national policies with European obligations in general.<sup>47</sup> In general, the rise in expenditures in health care provision calls for new ways to raise the efficiency of the sector.<sup>48</sup>

## 7.2. Developments and challenges in the health and care sectors

The most important challenge for the development of the health and care sector – pointed out by all Partner countries – are **the changing demographic characteristics** of Partner countries` population. As fertility rates continues to decline and life expectancy rises, as well as many other reasons, Europe is currently at the forefront of the population ageing process in the world. According to UN high officials, this is a historic phenomenon, because it is the first time ever that there have been more old people than children. <sup>49</sup>

`The demographic situation in Austria is earmarked by a strong decrease in the population growth rate. In addition, the average age, the number of households with elderly people (including the number of single-person households), the number of people requiring care (including the number of people suffering of dementia) and the number of people with disabilities is rising.`

`By 2020 the number of inhabitants in Austria will rise to 8.3 million - every 5<sup>th</sup> person being older than 64 years. The increase in number of elderly people and at the same time the long-term decrease in workforce will lead, on the one hand, to the already predicted rise in people needing care and on the other hand, to a higher demand for staff in the care sector ` (Austrian Study, p. 23)

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<sup>47</sup> [http://europa.eu.int/comm/health/ph\\_overview/other\\_policies/patient\\_mobility\\_en.htm](http://europa.eu.int/comm/health/ph_overview/other_policies/patient_mobility_en.htm)

<sup>48</sup> <http://www.who.org/a/1595>

<sup>49</sup> Can migrant workers save an ageing Europe, by Jonathan Equeter

“The demographic development in Germany is characterised by an ever increasing process of population ageing. This is due to a decline of the birth rate since the 1970s, and an increase in the average life expectancy. ...

The assumed life expectancy in combination with the low birth rates is expected to result in a decline of the total population by more than 10 million by 2050, with the number and proportion of people over 65 years rising to 21.4 % in 2020 (Naegele/Walker 2002). The number of people over 80 years is assumed to rise from 3.4 million in 2000 to 5.8 million in 2020 (Kruse et al. 2003).” (German Study, p. 3)

“At the moment the aging of the Spanish population and the increase of the life expectancy, are influencing among other aspects, in a mean fully increase of the demand in the labor market of people in the area of the care and the health; thus, like in the necessity to elevate the formation and qualification of the professionals in this area, for the treatment of new and diverse pathologies. Of a total of 6.9 million people of 65 years and more, there are approximately million old ones that cannot be worth by themselves, around 400 thousand patients of Alzheimer and other 400 thousands with other type of craziness dementias and neurological diseases”. (Daily Galicia Opinion, 2002).

This demographic revolution, also is hitting the sanitary system, as far as its infrastructure, its level of consumption, and the necessity of coordination between sanitary and social departments: “Spain has one of the worse urban and social sanitary structures welfare, to welcome with professionalism, means and humanity to the old patients... to take care of 6.9 old million of greater of 65, only has near 200 thousand seats for residences of old, the private majority”. (Daily Galicia Opinion, 2002).” (Spanish Study, p.10-11)

“The social care sector in Bulgaria shares the same concern as that in the other European countries – the ageing population across Europe stresses on the growing importance of elderly care. This however, cannot be done without trained medical staff and involvement from all institutions concerned. This field of social work should be given a pro-European direction and good practices should be sourced and studied.” (Bulgarian Study, p.36)

Population ageing will lead to changing demands on health care systems. Ageing will drive up the costs of health care. Older people consume between eight and nine times as much health care as younger, healthy people. In the past it was population growth that drove increases in the cost of health care. In the future it will be ageing that is the main driver. An increase in spending would also be needed on old age pensions.<sup>50</sup>

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<sup>50</sup> <http://www.pjonline.com/Editorial/20021005/bpc/population.html>

Recognizing the importance of relevant training for future health workers, WHO has partnered with the International Federation of Medical Students' Associations in a continuing effort to put ageing in the mainstream of medical curricula and to strengthen the teaching of geriatric medicine in 42 countries.<sup>51</sup>

Are the national healthcare systems of Partner countries ready to face the challenge in providing more healthcare services to their older citizens? If we look at the situation with **the shortages of medical staff**, we shall see that ageing is already pressing the systems, finding them unprepared, at least where healthcare workers are concerned, and especially certified nurses and nurse assistants openings.

‘The role of nurses is getting more and more important and strategic for the management of the National Health Service in Italy. In order to rationalize and optimise medical interventions, the presence of nurses on the territory will become more widespread.’ (Italian study, p. 9)

**These shortages in many countries have lead to changing structures of the workforce.** Shortages of health care professionals mean that new approaches to organizing teams of staff are required; traditional role boundaries may be a hindrance. Skills that have been the province of physicians may become common practice for nurses, while some nursing roles may be taken over by health care assistants. The contribution of informal carers is likely to become more important, and they will have to be considered members of the health care team.<sup>52</sup>

‘We (Austria) now face the problem that the demand in care and in corresponding institutions is increasing and at the same time there is no effective concept to meet this demand. ‘ At the same time, the Study emphasizes that the current discussion on this dilemma, has been mainly taken seriously because of the emerging of financing problems.. (page 23)

‘The labor market opportunities in the health and care professions (in Austria) are estimated as being very good (also for migrants). According to the Labor Market Service, there is a strong increase in the demand mainly in the fields of geriatric care; long term care, outpatient care and home care services.<sup>53</sup> In 2003 the LMS registered 2 476

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<sup>51</sup> [http://www.who.int/gb/ebwha/pdf\\_files/EB115/B115\\_29-en.pdf](http://www.who.int/gb/ebwha/pdf_files/EB115/B115_29-en.pdf)

<sup>52</sup> [http://www.who.int/hrh/documents/en/nhs\\_shaping\\_agenda.pdf](http://www.who.int/hrh/documents/en/nhs_shaping_agenda.pdf)

<sup>53</sup> ams, 2005

vacancies for certified nurses (in Upper Austria 323) and 1 464 vacancies for nursing assistants throughout Austria (in Upper Austria 260). The tendency is continuing to rise. ` (p.24)

`The Austrian Institute for Business Development (WIFO) calculates that by 2005 there will be an additional demand for 30.000 employees in the entire health sector. With measures like expensive publicity campaigns, the federal government and aid organisations want to counteract the imminent state of emergency in the care sector. In October 2003, the Austrian Federal Ministry of Economy and Labour presented the focal point to be qualifications in the health and care professions through the Labour Market Service (AMS).` (p.23)

`In Italy the shortage of trained nurses gets more and more dramatic. The Ipasvi, the nurses' professional association, has stated that Italy lacks 40,000 trained nurses. ....The lack of trained nurses reveals one of the most patent ironies of the Italian labour market: there is a strong demand for labour, but a shortage of supply. Although the professional outlets for nurses are guaranteed, and the job in itself is extremely useful and extraordinarily rich on the relational level, courses in universities only provide 3,500 graduates per year, while the physiological turnover is up to 12,500 workers every 12 months. Such gap, according to Ipasvi, will never be closed by extra-communitarian nurses: in fact, despite their high inflow, only 5,000 foreign citizens have had their professional qualifications recognized by the special board nominated by the Ministry of Health since 1999. ` (Italian Study, p. 10)

`On one hand an aging society (in Germany) will result in a rising need for medical care; on the other toward a declining labour force and employment. Occupational human services in Germany are faced with serious problems: The "care for the elderly" category currently reports a shortage of 20,000 skilled workers. Forecasts for the entire nursing care field predict personnel shortages of up to two million skilled workers within the next ten years.` (German Study, p.17)

In Greece, according to the estimates of the interviewed policy makers, the training system is not meeting the current demands and employment opportunities for nurse positions. It has been estimated that 15 000 more nurses are needed to cover all job vacancies and offer quality care.

Only the Bulgarian Partner is reporting of no shortages of the medical staff – and in particular nurses – for the health and care system. What is specific for Bulgaria is that

there are no qualifications for assistant/auxiliary nurses in the healthcare system. This means that all nursing and caring tasks are performed by qualified nurses, and what is worse some of the tasks are performed by completely unqualified staff, occupied mainly in the maintaining hygiene and cleanliness in the wards. This should be changed in the future, although no indications in this direction are present at this time.

The general conclusion here is that throughout the 25 EU Member-States, the nursing profession is experiencing an increase of their daily workload, while, at the same time, nursing shortages are present in all countries. Why is this happening with a profession that possesses such a great potential and high market demand. The reasons are mainly two; (1) the low status of the nursing and caring professions in all countries and (2) the difficult access to training and practising of the nursing profession, also for immigrants.

In all Partner countries it is an open secret that in a number of sectors – including nursing and home caring – nationals are put off by the working conditions and wages paid to the lowest category of workers.

‘The reason for the lack of Italian nurses are: low salaries, delicacy of the tasks to be performed, uncomfortable work shifts, difficult path to the achievement of qualification (three years of academic studies), without an acceptable overall cost-and-benefit ratio. There are, furthermore, psychological matters such as prestige and social consideration: an important and critical profession as it is, nursing is nevertheless underestimated in the hierarchy of professions in Italy.’ (p.10)

The Austrian Partner adds that ‘only 10% of young job entrants can imagine a career in the care sector’, the reasons being among others – lack of esteem and recognition, irregular working hours, heavy physical burden, excessive mental burden, bad salaries, insufficient opportunities for advancement, sexism and racism, family and job are hardly compatible.

‘The increasing demand of nursing labour is faced with an occupational field that is characterized by cumbersome working conditions, unfavourable basic conditions and a poor image.’ (p.24)

‘... health care in Greece suffers from the lack of credibility and low income satisfaction’ (p. 14) much more evident for the private healthcare sector, whilst the public sector is characterized with higher salaries, and also with a fixed contract ‘for life’.

The Spanish Study is citing a Peruvian woman who works in a health center: ‘salary improvements are needed. For example, I have my sister who works cleaning and ironed,

and perhaps she wins more than a nurse in a job that does not have responsibility. And you go to a residence of greater and they are 600 paying to you, 700? for a professional. It is a shame, pay for a professional who has studied and who values itself professionally. But as people do what wants there is no a unification of wage here ". (EM1) (p.13)

The Spanish Partner is also admitting that the nursing professions is having a very low standing in the public opinion and is considered to be subordinate to the medical profession in general.

Some other Partner reports are also referring to nursing as an occupation of a lower status and acknowledgement.

In Bulgaria, the vast majority of healthcare workers are state employees, and as such are among the lowest paid. Things improved though with the advance of the healthcare reform. It is also true that the nursing profession is having a good status and receives deserved respect and appreciation.

The lack of trained nurses also reveals the shortcomings of the systems of continuing vocational training in most Partner countries, which coupled with the lack of recognition of education and of the professional skills received abroad, deepens the existing gap between labor demand and medical staff shortages.

### **7.3. Specific trends in the sector and their role in reinforcing precarious work.**

The trends in reinforcing precarious work are triggered by two main facts:

1. The impact of ageing population and the growing need for caring services in the institutions and in the place of living, as highlighted before;
2. The developments in society are characterized with the active role of women pursuing careers, and minimizing their contribution to household work and elderly care. The truth is that more than ever now, `women perform multiple functions ... Even with children..., women are willing to work full shifts in the week, to the expense of their free time and with strong problems in concealing familiar and extra-familiar tasks. ` (Italian study, p.10)

The danger is of a long-term perspective: `This is precisely the situation in which migrant workers are seen as a resort, not a temporary one but a trend destined to future growth. ` (Italy, p.13)

The needs for solution to cover care needs are understood by Partner countries. However, it is shame that the interpretation of this is that for the migrant women it is one

of the few possibilities where they can enter the labor market. Once again, the trend breeds racist structures and attitudes towards women.

The consequences of this are thoroughly revealed by the Italian partner : `When faced with the *défaillances* of public assistance, Italian families have acted like entrepreneurs, turning to international labour market providing low-cost supplies. The result is a new situation where the private sector replaces the public sector and where the demand by families including aged persons meets the supply of migrants most of which come from East Europe.` (p.15)

`An ever increasing number of migrant-women are building a part of a social support structure, thus enabling women from the majority population to pursue a professional career. ` (Italian Study, p.)

`...Such employments are generally considered, at least in the workers' expectations, as "short-term strategies", a good chance to earn money, especially for single women, as they provide at the same time work and accommodation, a net income which can be remitted to the country of origin, and, for those who have not legalized their position, the *non visibility*. All of these elements, however, concur to compose a form of occupational seclusion, which stands in the way of planning the creation of personal independence, family reunions and ways of fitting in the autochthon community....` (Italian Study, p.6)

`Exasperating the subordinate situation even further is the fact that, in Austria, informal domestic work without a contract is one of the few work possibilities for foreigners who do not have their documentation in order because it is relatively "easier" to avoid official control in this sector. Additionally, there is no possibility whatsoever of regularising one's status through domestic service, an option that does however exist in the sector of sexual services.` <sup>54</sup> (Austrian Study, p.)

Even in Bulgaria, where home caring is relatively a new form of illegal employment – this tendency is clearly outlined, due to huge number of elderly people, the very expensive accommodation in the specialized institutions of the outpatient care. Nowadays, there are frequent cases where home caring is performed only for food and lodging for the carer, and not compulsory for salaries.

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<sup>54</sup> The Institute for Feminist Research of the Complutense University (Spain), MAIZ (Austria), Hamburg University (Germany), The Bradford Youth Development Partnership (United Kingdom)

The pitfall of precarious working conditions is facilitated by the fact that `No specific qualifications are requested to work as a carer: employers choose their employees on the basis of personal qualities, intuition, good will, readiness to face events of everyday life – even unexpected ones -, and a carer is requested to organize the body of necessary skills to perform her tasks “in the field”, directly at the patient’s home.` (Italian Study, p. 14)

Additionally, ` ... Nets of solidarity and mutual help between people from the same country play a decisive role in finding a job, and this is particularly true for migrant women. Such nets, however, as useful and essential as they may be in the moment of arrival and of emergency, become castrative and negative when the time for a change, especially of a professional improvement, comes. Thus, if these nets of solidarity on one hand help immigrant women, on the other hand they trap them, making it easier to find a job inside the niche in the market which their national group occupies, but binding them when looking for another type of employment...` (Italian Study, p.7)

The role of the private sector in Partner countries outpatient care of disabled and elderly people will be increasing, and the labor demand will attract more female immigration to these countries, giving rise to illegal employment and precarious working conditions. Moreover that no special qualifications are required to perform these tasks, making the labor market easily accessible to female migrants with different background and working experience.

There is an urgent call for the Governments to take quick measures and pass adequate policies for protecting the rights of migrant workers.

`Moreover, if public and private institutions in Italy want to help to resolve some of the problems of immigrants – such as the question of women in the care sector – it will be necessary to begin to think and to feel as immigrants often feel: rejected by society of which they want to feel part, with considerable problems of cultural adaptation and marginalization at work.

Immigrant women, with their differences and their difficulties, want to have the same opportunities as Italians to work and live with dignity.` (Italian Study, p.29)

It is to be stressed that this project does not have the capacity to change these racist structures. The project does, however, strive to challenge the existence and maintenance

of these racist structures while supporting migrant women in gaining entry to the regular labor market. While the first strategy is carried out on the collective level, the second strategy approaches the situation on an individual basis. A separation of these two strategies would be incomplete and inadequate and only a combination of the two would result in an application of empowerment as defined by the project designers and partners.

#### **7.4. Education and training for the health and care sector in Partner countries**

The issue of education and training for the health and care sector is an extremely vast and complicated field, that cannot be covered entirely by the research of this report. Nor a solely comparative approach is suitable to outline the crossing points of all educational systems.

The report concentrates mainly on the education and training for nurses and the occupations below nurse. It is true that most systems share a similar educational curriculum and a similar credit systems for the nurse education. The differences start with the ranking of education, the state`s role in defining the platforms of education, the level of vocational training that the professions has in the different Partner countries, the schemes and opportunities for post-graduate training and the country`s approach for the future development of the profession.

As we have seen before in the Study, in many countries educational models have not kept pace with changing demography and health conditions, all of which should influence the curriculum content in educational delivery models in health care.<sup>55</sup>

The Partner countries differ a lot on the level of maturity of their educational and training systems for health and care, despite the fact that all of them are traditional providers of such education.

The most immature being **the Bulgarian system**<sup>56</sup> for medical staff education. There are 4 Medical Colleges in Bulgaria, whose graduates – qualified nurses - acquire the title `specialists`. The colleges train medical nurses in the following disciplines: medical nurses, obstetrics nurse, laboratory assistants, dental technicians, assistant pharmacists, rehabilitators, social activists. The training starts after the completion of the upper secondary school education only and is preceded by thorough entrance exams. Training

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<sup>55</sup> [http://www.who.int/hrh/documents/en/nhs\\_shaping\\_agenda.pdf](http://www.who.int/hrh/documents/en/nhs_shaping_agenda.pdf)

<sup>56</sup> More information in the Bulgarian Study, p. 33-34

of all medical specialists currently is within 3 200 hours <sup>57</sup>, organized in 50% theoretical and 50% practical training, distributed in 6 semesters; However, according to the EU recommendations, if the Bulgarian nurses wish to work in the other EU States, they should have a qualification of at least 4200 hours (3 full years), which means that there are additional courses and post-graduate trainings established at the moment. There isn't any other way to obtain a `nurse` education in Bulgaria at this time.

Very important here is to note that there is NO accredited training in Bulgaria for positions below nurses – for ex. there are no assistant nurses/auxiliary nurses positions in medical or social care institutions – all these tasks are performed by the nurses themselves, or by other un-qualified staff, like hospital attendants or sanitary officers;

One of the recommendations given by representatives of the expert mission of the European Commission to the Bulgarian system for medical education in Sept 2004 was to achieve a better distinction between the `nurse` and `midwife` positions – both in education and approach. The overall conclusion of the Commission was that Bulgaria made a considerable progress since 2002 in medical staff education – the State`s requirements and the amendments in the educational curricular correspond to the European Directives in that sector. <sup>58</sup>

It has been observed that the vocational training institutions produce enough qualified nurses to satisfy the demand in the sector. Bulgarian is known as an `exporter` of medical staff, and especially nurses, to most European countries and traditionally to the Middle East. These are mainly nurses, with considerable experience in the field who emigrate to Europe – mostly temporarily - looking for a better income for their employment.

There are no trainings, courses or any other forms of training for assistant nurses, home care workers, home assistants or all other service jobs connected to health and performed in the institutions or the home of the service receivers. No efforts on the part of the State or the training organizations are evident at present, meaning that a strong consideration must be given to an obvious deficiency of the vocational system at the time when this labor market is increasing.

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<sup>57</sup> Ministry of Health, 2004, <http://www.mh.government.bg/stat.php?id=417>,

<sup>58</sup> <http://www.mh.government.bg/stat.php?id=898>

The **Austrian system** (p.28-38 in the Study) for education and training on the other hand is amongst the most sophisticated ones, although now it is on the brink of reforms.

The Study is making a survey on the formal possibilities for training, but still cannot be complete because of the complexity and diversity of issue (more on p.39)

In Austria, the healthcare education is regulated by the Health & Nursing Law (GuKG'97), (Both for certified health and nursing care and for the field of assistant nursing). In the field of geriatric care and care for the disabled where any provincial laws exist, there is a remarkable difference. Geriatric care classified as a part of social work and in Upper Austria, for example, it is regulated by the Upper Austrian Geriatric Care Law. In general, only five provinces regulate the geriatric care training with their provincial laws (i.e. Upper Austria, Lower Austria, Salzburg, Vienna and Styria). There is no statutory rule in the other four provinces. Therefore, the accreditation of training is not regulated.

Discussions on the harmonisation of the system and the creation of uniform profiles of professions have been a hot topic for years. In December 2004, a government bill prepared by the Federal Ministry for Health and Women was submitted to the government to standardize the education system in the field of social care professions. It states that the provinces must be committed to regulating the education according to a module and a stages system corresponding to the principles established throughout Austria. The designated objective of this project is the formation of a EU-compatible educational system, an enhanced image of the field and professionalism. Social care professions should be divided into three levels of qualification:

- Assistant level (nursing assistant)
- Specialist level (nurse specialist service)
- Certified level (advanced service for certified nurses - university education)

On the specialist and university education level there shall be different specialisations respect to the target group and the focal points of work: geriatric care, family care, care for people with disabilities, attendance to people with disabilities.

The government bill contains a detailed description of the new occupational profiles, their range of responsibilities as well as a list of training information (content and duration). Government insiders talk about a realization of the reform work already in 2005. However, it is still uncertain, whether and in which form this reform will actually be realized.

At the time being, conditions are different in the various provinces; the following branches of professional work within the caring systems are offered as well as home care services and within institutions:

- nursing assistant - consists of looking after persons in need of care and to assist medical practitioners such as doctors;

Training institutions here include: vocational schools for health and nursing care or approved courses in public or private hospitals. Evening courses (part-time) last two years, full-time courses last one year and is free from tuition fees at public institutions. Full-time course participants usually receive a monthly allowance from the government of about € 220. Courses for nursing assistants are also offered by private institutions, but the tuition fees run up to about € 4,000.

The extent of the training is 1600 hours /40 hours a week. The practical part is 800 hours. It ends with a commission examination. The certificate is valid all over Austria and the fields of work include hospitals for acute or long-term care, seniors' homes, homes for people with disabilities and home care services.

- geriatric care training - qualified caring for the elderly in home care services or within ambulatory institutions;

A person who has successfully completed this training is entitled "nursing assistant with a specialisation in geriatric care".

The training can be completed in two modes: by completing a two-year basic training in geriatric care (including training for nursing assistants) in the amount of 1050 hours of theoretical learning and 800 hours of practical training. The other alternative is a supplementary training of 2 to 6 months after the nursing assistant's training (250 hours). The basic condition to be accepted is the successful completion of the 9<sup>th</sup> school year; in special cases this requirement may be waived. Tuition fees for the courses are either paid by the participants themselves (about 220 € each semester) or are paid by the employer. It is possible to complete this training within a senior's home "in-placement" subsidy program.

- general Health and Nursing care - graduates receive a "certified nurse " diploma from the government which is valid throughout the EU ;

The three-year training takes place in public, private and church-affiliated "schools for general healthcare and nursing". There are no tuition fees and the participants are socially insured including medical and accident insurance as well as for old age

pensions. They also receive an allowance. To be accepted, the successful completion of at least 10 years of school is necessary however, special cases will be taken in consideration. The training is meant to convey knowledge and skills in theory and practice - 4600 hours altogether.

Training dropouts; dropouts can opt to get accreditation for their successfully completed exams and practical trainings or even whole years of training for nursing assistants.

- specialized training – specialised training for extended fields in healthcare and nursing after the successful completion of the basic training for advanced nursing;
- post-secondary schools of University rank - In Austria there is a trend towards driving the nursing and care sciences to become more academic. There is a working committee set, that is partly responsible for the development of nursing science university studies in Austria.

Conditions for acceptance are either the successful completion of the A-level examinations (Matura) or the university entrance exams. The diploma for certified nursing is insufficient.

- voluntary social year – an option for young adults who wish to work in a social institution for one year. Possible fields of work are: hospitals, social units, seniors homes, facilities for children, people with disabilities, refugees or homeless people. This voluntary social year is often recommended and is also used as a pre-practical training for activities in the nursing and care professions. Participants have accident insurance and social welfare and receive a monthly allowance.

The following general entrance requirements - according to GuKG (§98) - are required for most education levels in Austria: minimum age 17 years (or differing according to education 18 or 19, no upper age limit), compulsory school completed, certificate of integrity (extract of police record); residence and work permits, physical and psychological aptitude for the profession. Moreover, the following conditions are stated but differ slightly: reliability, eagerness to learn, ability for independent and self-responsible work, creativity and team spirit, organisational skills. According to the Labour Market Service: Qualifications in the following are increasingly important: communication skills, informative knowledge, high frustration limits etc.

In Greece `an `assistant nurse` diploma can be obtained as early as the age of 20, as part of upper secondary training at the Institutes of vocational training.

The `certified nurse` diplomas are subject to a 3,5 years of intense training within the tertiary educational level at the TEI (Technological Educational Institutes).

In Greece too, education in nursing is stretched to University level. A bachelor degree in nursing can be obtained in one of the 18 Universities and this is the highest possible educational degree in the country.

The Study is stressing that `There is currently a strong demand for educational practice that addresses adequately the multicultural world in which people live. Social inclusion and justice demands such a development and there are many attempts being made with the cooperation of the European Union and the Greek government to address this issue.` (p.20)

Further on, the Study considers the view of the training institutions that `The migration issue does not seem to play a role in the content of current curriculum. However, lectures tend to be less strict with migrant students. In fact some help them in writing up essays or preparing a speech in the class. ...` (p. 44)

Also `... The content of the curriculum is subject to changes that come directly from the ministry of education and there is not so much freedom within the institution to adjust the curriculum to current needs and social changes at a local level. That can be a problem as migrants tend to gather at specific parts of the country.` (p. 43)

The **Federal Republic of Germany** is a Federal state. The Länder are responsible for general hospital care, general medical care outside hospital, care of elderly or chronically sick patients, health education and public health. Germany formally implemented the EEC sectoral nursing directives of 1977 by the Nursing Act of 4 June 1985 (the Krankenpflegegesetz). The federal structure accounts for a system of divided responsibility. Federal law regulates the basic training for nurses and sets out the framework for the training of nurses in general, but it is for the Länder to implement it within the guidelines of the Nursing Act and the rules and regulations for the training and general provisions of exams. Post basic nurse education is left to the Länder. This has resulted in different Länder recognising different types of speciality. In the post basic sector various, mostly independent, organisations and institutions are involved in providing the training. At the basic level there are the general care nurses, and direct entry paediatric nurses. At the post basic level there are a range of specialist titles which vary from Land to Land.

The Nursing Act (Krankenpflegegesetz) protects three titles in basic nursing training:

- Krankenschwester/Krankenpfleger (general female/male nurse) – 4600 hours of training
- Kinderkrankenschwester/Kinderkrankenpfleger (pediatric female/male nurse) - 4600 hours of training
- Krankenpflegehelfer/Krankenpflegehelferin (assistant male/female nurse) – 1600 hours of training

The same period of time is spent on the training of nurses and pediatric nurses (3 years), the aims of training and entry requirements are the same, and both nurses and pediatric nurses are equally admitted to most courses of post basic training. The nursing assistant (Krankenpflegehelferin / Krankenpflegehelfer) on the other hand follows a different route of training (1 year) and the entry requirements are not as demanding; nursing assistants are not admitted to courses of post basic training.

The minimum age for persons wishing to be admitted to basic training is 17 years; the state of health must be suitable for profession execution. Permission to bear one of the protected titles presupposes, in addition to successful completion of the training, the fulfilment of certain other requirements: the applicant must not be guilty of any misconduct, the applicant must not be incapable or unsuited to exercising this profession (physical and mental reasons are mentioned in the Act). The law sets out further requirements referring to the previous training expected by applicants for basic training leading to the titles of nurses / pediatric nurses – (1) completion of an intermediate school education (Realschulabschluss) or equivalent, or completion of another ten-year school education; or (2) Completion of a secondary general school education (CSE, Hauptschulabschluss) or equivalent schooling provided that the applicant successfully attended a preparatory nursing school for at least two years or has completed vocational training with a required training period of at least two years

There is also a provision enabling qualified nurse assistants to start their training towards the titles of nurses/ paediatric nurses; their licence automatically qualifying them.

The **Italian educational curriculum** (p.12-17) for nursing includes several stages, every one of which is certified through a system of educational credits.

Degree in Nursing Its goal is to guarantee the student an adequate mastering of general scientific methods and contents (180 Cfu. 1 credit = 30 hours). This is the degree

qualifying for the practice of the profession (it replaces the former diplomas of Trained Nurse and university diploma in Nursing Sciences). It usually lasts three years.

Specialistic degree in Nursing Sciences Its goal is to provide an advanced education for the practice of highly complex tasks (120 Cfu). It usually lasts two years.

First level master course In-depth scientific study of high continuing education in specific fields (emergency, pediatrics, mental health, public health), which follows the achievement of the degree in Nursing (60 Cfu).

Second level master course Courses of in-depth scientific study and high continuing education in specific fields, which follows the achievement of the specialistic degree (60 Cfu).

PhD It provides the necessary skills to practice research and high-level activities in Universities and private institutions.

All nurses with a recognized degree in Nursing are qualified for the post-degree basic educational curriculum, but this right was extended to all other nurses and pediatric nurses (having a secondary school diploma) by act 1/2002 which recognizes the former diplomas as valid in order to continue studies.

The Italian State recognizes the possibility for non-EU citizens who move to Italy, both for short and long periods of time, to practice a profession in the health field, provided that they comply to certain requirements. Academic and professional qualifications achieved in a non-EU country are not recognized in Italy for the practice of the profession. They can nevertheless be recognized by the Ministry of Health for working in the public health system, further to the filling of a special form, which also indicates the certificates to be submitted. At a local level, Regions define benchmarks for socio-medical professionals to be trained, and to whom a regional qualification is recognized.

For instance, for the Region of Toscana, the main professional profiles are:

Home help (social services sector - helping fragile aged persons, disabled persons, temporarily or permanently non self-sufficient persons in their everyday activities, and can live at the patient's home, or work part-time. Requirements are: being 18 or over, having finished compulsory school, having a residence permit (in the case of foreigners). The course lasts 300 hours (100/120 hours of lessons – 180/200 of training, or three months at the patients' home under monitoring).

Operator for basic assistance - performs direct assistance and care in the patient's environment, be it a private home or in a residential care. Requirements are: having a junior secondary school diploma and being of age by the 31<sup>st</sup> December of the year of

beginning of the course; having a healthy and sound physical constitution, certified according to the regulations in force since no longer than three months. The course lasts 600 hours .

Cultural and linguistic mediator for migrants - a professional person belonging to a migrant community whose intervention in specific situations can identify particular needs of non-EU persons and make them clear, as well as negotiate services by the public services and operators, triggering communication and changing contents and ways of approach. Requirements are: qualification equivalent to secondary school diploma or university degree; good knowledge of written and spoken Italian; good knowledge of at least one lingua franca (English or French). Professional outlets are: first-contact public service, social and health service; school and educational service; judicial service. The course lasts 450 hours.

Socio-medical operator - works in all social and health services, both of socio-supportive and socio-medical type, both residential and semi-residential. The training courses for socio-medical operators can last up to eighteen months, with no less than 1000 hours, articulated in educational modules. Main activities of the socio-medical operator are direct assistance and home or hotel help, hygienic-medical and social interventions and managerial, organizational and educational support.

The point of view of the Unions: `Immigrant women who wish to attend a course of professional training have no privileged channel and often have to make considerable sacrifices, above all if head of the family, in order to train. Nonetheless, for some years now immigrant women have understood that only education and training can give them social mobility and consequently a change of job and improvement of their conditions of work and income. ` (Italian Study, p.27 )

The public university education in nursing in **Spain** is regulated by the Ministry of Education, and is defined within its General Plan as a separate education with a pre-degree status, lasting for 3 years. Although the vocational education in nursing is estimated of very good quality and complying to the EU requirements, it is noted among graduated that it lacks some practical training and is predominantly of a more biological approach, `leaving aside communitarian health` (p. 14). In this respect, the interviewed in Spain say that some of the immigrant nurses there – ex, from Colombia – are better trained and suited, for they obligatory pass one year of practical training as an integral part of their studies.

But even if such potential on the part of immigrants exist, they are hindered from access to the labor market, among other reasons is the lack of recognition of foreign qualifications.

There are much more opportunities and trainings for `assistant nurses` in Spain. (p.17) Many courses are existing, and different certificates are given. The State`s regulation and control over the curricular contents, the fees, or the exigency of courses is very low. There are numerous private centers that give certificates even by post. The result is that there are assistant nurses with very good training and others with much less skills and knowledge and for whom the actual work is the main educational source.

This situation has developed from the high demand of assistant nurses in Spain and the low labor supply. The training centers have proliferated from the situation and are holding non-regulated courses. However, this is exactly the form of education that attracts most migrant women, because it gives them a fast bridge to the labor market, coupled with only a few access requirements. But they soon find themselves trapped in a vicious circle – few requirements – bad training – low professionalism – difficult adaptation to sector requirements.

The Social Services in Madrid (Community of Madrid, INEM, or private companies as subcontractors) are organizing courses for `dependent people caring`, opened for unemployed people and with a very strong practical training. The accent in training is on geriatric care and is created in a way to deliver competitive advantages for the labor market. NGO`s also organize such courses, but the final intention of care differs significantly. They do not always make the clear distinction between geriatric care and domestic service.

## **8. Migrant women in training and employment for the health and care sector – comparative results from the empirical study in Partner countries.**

In highlighting the challenges/problems that migrant women face in training and employment the prime focus is kept on the expertise that the migrant women themselves deliver during interviewing. Migrant women perspective, needs and recommendations are in the core of development of these two chapters.

It must be noted here though, that the different background of the partner organizations and their experience in migration is influencing their approach towards migrant women expertise and may present a subjective view. The following study research also reflects the comments from other interview partners – institutions, trade unions, service

providers.. – in an attempt to give a more complete picture of the reality from heterogenic view. These comments have to be perceived in a constructive way, but also reflected critically, as presenting the attitude of the majority. These factors influence the results and we – as Partners - must be aware of that.

In an effort to summarize the most characteristic problems and challenges faced by migrant women in a clear and straightforward manner we admit that the comparative study cannot be fully comprehensive. It is understanding that the problems/challenges are merging and linked to one another and therefore the study cannot cover all of their aspects and complexity.

The challenges and problems lead the project research directly to systematizing the recommendations to the content of the curricular for the pre-qualification course and are, therefore, very important for the project development.

### **8.1. Challenges/problems migrant women have to face in training and continuing education**

We must give credit to the Austrian National Study, which is most complete revealing in depth the various challenges created for the migrant women by the structural barriers. The Study is detailing them as challenges faced in gaining access to vocational training and challenges during vocational training. All of the migrant women expertise is presented in the form of quotations from the interviews.

#### **8.1.1. Racism**

The Austrian Study is flowing with significant examples of racism against migrant women:

“At the time when I applied at (...) I had an interview with the director of the school. Then I said my name and she pronounced it incorrectly. Instead of “z”, she pronounced my name with “rz”. I politely told her that my name was pronounced with “z”. Then she said “In Austria you are “rz”. What the hell! Can’t I even keep my name?” (Migrant woman, certified nurse working in a seniors’ home) (Austrian Study, p.50)

“Again and again I met people, who said that being a foreigner you really have to pay attention. Than they checked me very much, concerning my abilities and my knowledge (...) I was extremely watched and again and again they emphasized: ,You

know that being a foreigner you have to pay attention, not to mix up Kalium (potassium) with calcium...' (...) Within the intensive are unit. (...)” (Migrant woman, certified nurse working in a hospital) (Austrian Study, p. 52)

“I can remember, that not more than 10 years ago, it was a common thing, and that was the way it was also written within the transcription of training, (...) that if you want to do the training for nursing, you need the Austrian citizenship. In the meantime that has been removed. We- as training institution- never worked on this role.” (Director of a private training institution) (Austrian Study, p. 50)

The Italian Study: `Finally, only one interviewee stated that she had noticed veiled racism among her fellow trainees.`(p. 22 )

A comment from a representative of a training institution in Greece: `As nursing has a relatively low social and professional status, and when this is coupled with someone who has a strange accent or some other sign of migration background, this could create a burden for migrant students.` (p.44)

### **8.1.2. Nostrification**

“...They then said I should send (...) this and then they would see what comes of it. Yes, this was a little silly because this cost me so much and it was for nothing, because I got a letter telling me to translate this and to send it. And then I had to pay for a commission to get together to check my documents. Yes, I had to pay for this and then it didn't achieve very much.” (Migrant woman, currently in training)` (Austrian Study, p.42)

“I already did the nursing training in (...) but I didn't work after and that must be 6 months after the training and only afterwards can you qualify for the state exam. I didn't do this. There was no chance to get a job...I had all my documents, papers and my diploma translated and sent them to Vienna to find out whether nostrification would be possible, but it was not enough. There wasn't enough practical training time, not enough theory and the nostrification for a nurse was absolutely impossible. It was enough for a nursing assistant but then I would have to catch up on a lot.” (Migrant woman, currently in training)` (Austrian Study, p.42)

‘On the other hand, there is normally no difficulty in gaining access to training courses in Italy – for example, retraining courses. There can however be difficulties regarding the recognition of a qualification obtained abroad.’ (Italian study p.25)

A migrant woman in Greece, dropped out from a course: ‘I needed more information on how valid is my degree, (or even better) my nursing degree to be, and how easy it would be to work as a nurse. Also I needed more information about the content of the course and exams. Also, I was not informed properly that in order to get my degree I still would have to sit on national exams and compete with my Greek classmates.’ (p.49)

When I wanted to recognize my degree from my home country, I had to take numerous trips to Athens to visit the Institute of Technological Education (I.T.E.)... So, after a lot of hustle, they decided that although I studied nursing up to when I was 19 years old back home, I should start from scratch over here, in fact I entered the Technological Educational Institute of Thessaloniki (T.E.I.) at the second semester...’ (A migrant woman in training in Greece, p. 54)

In the Spanish Study: ‘An educational of the School of Infirmary of the Complutensian University of Madrid account this situation: "(the formation) it is not worth to him for anything, is not worth to him in the academic sense. Professionally everything is worth to him. For example, I say it by the lawyers in infirmary. There is Latin American lawyers in infirmary and people who have made masters that come here and at the time of working, as nothing else does not exist than the infirmary graduate... nurses are called and they although are licensed or have a masters to be considered and paid like a graduate ". (E11)’ (p. 15)

Extremely difficult nostrification procedures are identified in the Bulgarian Study as one of the biggest barriers both for gaining access to the regular market, as well as for access to training and re-training.

### **8.1.3. Ideological attitudes**

‘The discussion about the headscarf-issue. Last year we had two candidates with headscarves and so we also discussed it. Throughout Upper Austria, there was the discussion among the school directors. It was decided that that was within the realm of the legal body of each institution. Naturally, we then considered, what it would mean when we get candidates who wear headscarves. It’s not necessarily an issue

when they have headscarves, but actually it would be necessary to remove the headscarf based on the legal body of each institution 's position. There is actually nobody in the whole facility that wears a headscarf. It hasn't yet reached that extent because those two candidates didn't pass the test. They were two sisters. But of course we have to take a critical look at this issue and then know what happens with this part of culture. I can't say now, the headscarf- issue is not the problem for me right now. But instead, how these people live their culture. How strong are they connected to their culture? How do they deal with the fact that when they know that as a young women I have to wash a man. I am alone with him, he is naked and I have to wash his genital area. These questions are much more important for me. That I then know, that I can also implement them." (Supervisor of a training institution) (p.43)

Greece, a representative of a training institution: "Migrants may face some problems due to differences between culture of origin and the new culture they live in" (p. 43)

"Another challenge that migrant women face especially in tertiary education is that of assimilation with their Greek schoolmates" (Greek Study, p.32)

In Spain: The inferiority attributed (even by other women) to the immigrants women, being based on the docile, submissive representations and stereotypes of "docile and without education", makes us be considered ignorant perpetual, because our knowledge's are not recognized in quality of knowledge and cultural capital." (p. 13)

#### **8.1.4. Language**

"Much is blamed on the language but we make twice as much the effort to speak the German language and this is not credible. We have to be very careful and we dare not, for example, say "excuse me, I didn't hear what you said". I would rather ask later "What did the nurse mean?", because I almost never dare to ask "what do you mean?" Because, that will again imply "Aha! She doesn't understand German". We are very sensitive because we really make an effort." (Migrant woman, certified nurse working in a seniors' home) (Austrian Study, p.43)

Further in the Austrian Study: "...When instructions are suddenly given and are misunderstood or not understood without further enquiry then this leads to delays or to incorrect actions. The patient is then faced with a problem and then, as a hospital,

we also have a problem ... then it just gets difficult.” (Director of a service providing organization) (p.43)

In Germany ` Most of the women saw the biggest problems neither in the area of their intellectual and learning competences nor in their social skills but in the area of their language skills. One of the women (who attended a secondary school in Turkey) said to the point: „Biology, chemistry and physics are international, languages aren’t“... (p.33)

`As far as language difficulties are concerned, only one of the interviewees stated that she had had difficulties at the beginning of the course, the others made no mention of such difficulties.` (Italian Study, p. 22) On the other hand, the point of view of the training institutions expressed in the Study is that `..., the greatest difficulties met by foreign students are knowledge of the Italian language, spoken and written..` (p.26)

Greece :` Regarding nursing there is the secondary private school which I followed and I could not study at a higher level e.g. University because I would have to go through the National Examinations Systems for University Entrance and my language skills are very poor in doing so.` (migrant woman, p.50)

`.an interviewee mentioned that her language skills were said to be insufficient by her teachers in order for her to present at a conference. She felt she was not offered the support needed doing so.` (Greek Study, p.33)

A representative of a training institution in Greece: `No specific problems in completing the course. However, migrants seem to have some trouble with the language, especially with written language.` (p.43)

Another perspective from the Greek Study: ``During the interviews some of the nursing trainers said that they do help migrant students, as they apply the multiple choice system, during mid-term and final exams. This way they argued, they help migrants to overcome their language difficulties.` (p.35)

In Bulgaria, the language barrier is considered as most important: `There are more difficulties in completing such a course though – again connected to the language skills – (1) difficulties to follow the content of course and (2) difficulties in sitting the written tests in the end..` (p.44)

#### **8.1.5. Child care**

Austria: "...Although for mothers weekends aren't so bad because then the husband is home and can take care of the children. And my husband has shift-work ...and thank God I have a mother -in-law. That also helps a lot, she looks after the children too." (Migrant woman, currently in training)`(p.44)

`Childbirth and elderly care are further reasons to be excluded from education and employment` (German Study, p. 14)

`The needs of children and their better integration in society is very important to all migrant-women – they are prone to drop-out a course, if (4) more attention on children problems are needed or if the situation simply requests it.` (Bulgarian Study, p. 44)

#### **8.1.6. Other challenges/problems**

The application procedures in Austria are specially addressed: "Nobody talks about the exam, nobody speaks about the exam for care-training. People use to talk about peanuts, or do an intelligence test. The intelligence test also includes psychology. It is not directed to the different countries, developing countries, which are not familiar with them." (Migrant woman, certified nurse working in a hospital)`(p. 48)

And expectations challenged: "I came in and there were many people and they asked me, why I wanted to do that. How I was able to finance it? Because a foreigner of his own, a woman in Austria, you have to be able to nourish (?) yourself. And at that time I was also working, I was cleaning and I wanted to attend the school. I said: I am independent and I have a family, my partner is supporting me and my family as well." (Migrant woman, certified nurse working in home care)`(Austrian study, p.49)

Austria: `The number of participants within each training course is limited and connected to financial subsidies for national training programs and to the labour demand within each institution associated to the training institution. A high number of applicants have already achieved a formal educational level and experiences and competences that exceed the admission requirements.`(p.47)

Other challenges during training revealed in the Austrian Study ensue from the concept of diversity and multiculturalism, the concept of care in international comparison, specific circumstances, the practical trainings, mobbing, financial difficulties.. (more on p.50-53)

The Spanish study is referring to a gap between the expectations of migrant women in training and the actual training content: ` False expectations are generated then in the women, who enter looking for to increase their formation or to obtain certifications that finally do not serve to them to make the qualified works to which they are looking for to accede. This no single factor hits negatively to the women, generating to them frustration and lack of motivation at the time of carrying out its work, but that ends up repelling directly in the users of this type of services, that do not find the specialized attention that they looking for.`(p. 18)

Also: `Previous reflected the direct association that becomes between immigrant woman, needed and poor, without different motivations from the economic ones. Economic necessities that they are the simultaneously one of the greater causes of desertion of the reported courses by the institutions and the women, like the schedules in which the courses are distributed the anti pedagogical methodology used in some of them.`(Spanish Study, p.19)

The German National Study is emphasizing on the difficulties for integration into the educational system from early childhood of first and second generation of immigrants. `The chances for young people from migrant families to take up vocational training have changed for the worse in recent years. The reasons for this have to be seen in their low school achievements. Thus the share of migrants who cannot be placed in jobs by the employment office because of bad results at school is rising. Members of this target group often lack the motivation and the basic qualifications to undertake vocational training. This in turn prevents them from gaining access to regular employment; putting them at risk of social exclusion.` (p. 11 and more on p.9-13)

`From the interviews carried out with some immigrant women, currently employed in the health sector in Tuscany, it emerged that they met with various difficulties during training courses. Above all, the problem of dividing up their own time between work and study.....The women all agree that it is difficult to reconcile the demands of work with those of training courses, but they are equally aware of the importance of such courses and the relative qualification.` (Italian Study, p.22) Another main concern expressed in the study is that migrant women `are not able to bear the costs involved in a period of training..` and `..whether it is worth investing in a training course..` (p.23)

Another barrier for participation in courses according to training institutions interviewees in Italy is to `... find a real motivation for what will be their future work. ... sometimes the necessary motivation is lacking for performing the role of assistant, since the priority still remains pay, interest taking second place` (p. 26) Also, recognized is the barrier that migrants `are not fully aware of the professional opportunities offered by the training course` (p.26)

`... the timetable of these courses is not considered in view of migrant possibilities to attend, and if (3) occasional employment comes across, then the course can be dropped...` (Bulgarian Study, p.44) In relating the Bulgarian training experiences and challenges, it is to be remembered that Bulgarian vocational system has a significant difference compared to that of other Partners: there is no vocational training/qualification offered at any level or required by the employers for all positions coming below `nurse` position. There is no such term as auxiliary nurse in Bulgaria. All the activities performed by the auxiliary nurses in other countries, in Bulgaria are done by accredited nurses. Or, by completely unqualified staff that is occupying these positions.

`The course so far was not what I expected it to be... There were a lot of strikes both from teachers and for students.. Well, money was always a problem as I come from a poor family, and although there were no tuition fees, still there were expenses in conjunction with studying this particular course. For example I spent a lot in transportation ...Time is also an issue, as we have to go to the hospitals in the morning and to the school in late afternoon, and it is very difficult for me to get a part-time job. Classmates were ok. I did not have any particular problems. Language was a problem at first, because Greek is the third language I speak ...` (A migrant woman in training, Greek Study, p.53)

`A common barrier is the great number of practical placements and moreover, the fact that students face nursing reality a very demanding professional in Greece, which influences a lot of them in a rather negative way` ..... `Migrant women do not have any kind of privilege when it comes to continuing education or life long learning. On the contrary they are underprivileged as they have to compete with their Greek colleagues in order to get on a programme like that` (Training institution, p.44)

Another barrier focused in the Greek study are the very high tuition fees in private secondary education and no student loans and or other financial support available.

## **8.2. Challenges/problems migrant women have to face in employment**

Here again, the Austrian study provides an extensive view of the challenges/problems faced by migrant women at the workplace, stating that `The fields of activity migrant women face in their daily work in health and care are very broad, various and diverse ... For migrant women these fields are further increased with additional challenges...` (p. 55 - 60)

### **8.2.1. Structural and institutional racism, discrimination**

“... I had to wash an older resident – that is one of my responsibilities – that was extreme. He said he wouldn’t let me wash him. I asked him why. He said because I was a foreigner. He told me that to my face. He died and with that the problem was gone!” (Migrant woman, certified nurse working in a seniors’ home) ` (Austrian Study, p.58)

"We won't call her. We can't take notice of her, she can't even write in German." I find it disrespectful that this was so openly said. This is unpleasant because I am myself a foreigner.” (Migrant woman, certified nurse working in a seniors’ home) ` (Austrian Study, p.59)

In Greece: `The migrants who don't hold a green card / work permit, they can only work in the “black market”, and in most cases they look after the elderly at home. The third category is the ones who hold a green card but still they can not work in the public sector as their work permit is valid for a period to three years. However, they are able to get a job in the private sector. Unfortunately there are no special policies in power for the time being which would aim at improving this situation.` (p.42)

`...Moreover, if one is a foreigner it is not always easy to find an old person happy and willing to accept a new presence in the home.` (Italian Study, p.22)

From the Spanish report: `The confusion that is between the functions of the nursemaids of dependent people and workers of the domestic service servant, becomes evident in the conditions of hiring by means of which they tie to the service. This can be observed in the interview of the nurse of the National School of Health: "These people has contracts on watch servant domestic, in which one regulation you know is discriminatory in relation to any other contract of labor type. The regulation of the contract of the service domestic servant has characteristics discriminatory in general in Spain, in relation to another type of labor contract of wage-earning person. To begin, that would be necessary to comment it well, the regime of the service

servant domestic "(E13)` (p. 18) Further on "She must know how to read and to write, to have some type of ability in cares. I believe that immigrant people do not consider they like a work or no. He must do it, he has made that possibility and point. That can be asked to him a professional of elite. But no worker or worker with an average qualification can consider: I like or I do not like the work. It is possible to be raised if he has economic conditions to the margin of that work that allows him not to receive at the end of the month." (E14)` (p. 19)

Bulgarians are only now forming an attitude towards migration: `There is, however, a repeated interest from migrant women to work as home assistants or other home care activities – looking after children, sick people, general homework. Their experience shows though, that even if Bulgarians are tolerant to them, they are not so comfortable with letting them at home and trusting them with their property and well-being. This can be explained with the little experience Bulgarians have with communicating and mixing with foreign people. ` (Bulgarian Study, p.46)

**8.2.2. Care and nursing** (in regard to questions of philosophy of life, the employers`, employees` and clients` perception of care)

“And it’s not only a medical problem, but sometimes a psychiatric problem or social problem as well.” (Migrant woman, certified nurse working in hospital)` (Austria, p.56)

A service provider in Greece: `The greatest challenge is the evolving professional role as mentioned before. Nursing is expanding, there is new technology at our disposal, and perhaps some of the traditional medical roles are now shifting towards nursing... The other challenge is to keep delivering high quality care in a “negative” working environment that is heavy caseload, low staff case-mix.` (Greek Study, p.41)

And also: ` My main reason for following this course is that I love nursing and I want to work as a nurse. I am in the third year of my studies, I am just about to finish the 6<sup>th</sup> semester, and I have passed all the modules so far. Yet, if I don’t finish off this course I will not be able to work as a nurse in this country, as my previous qualifications were not recognized, so I guess choosing to follow this course was a smart thing to do, don’t you agree?` (a migrant woman in training, Greek Study, p, 53)

The Italian study: `In general, what the immigrant women had to cope with, when they began to work in the health sector, is the high level of responsibility involved in this kind of work. Coming in contact with old people and patients needing care is an

arduous challenge, which can only be borne if there is a strong underlying motivation.` (p.22)

`Two of the interviewees stated that work like that in the care field did not exist in their country of origin. For this reason, the expectations that had been created while working in the health sector were completely different. Nevertheless, they continued to work in care because the wish prevailed in them to continue in their chosen direction, animated also by the personal satisfaction that such work offers them. (Italian Study, p.22)

### **8.2.3. Team work**

“You have to prove your competence. Otherwise, they don’t have confidence ... It’s not a matter of course. I had to work hard for it.” (Migrant woman, certified nurse working in homecare)` (Austria, p.57)

The service providers in Italy: `As for the challenges that these professionals have to face in the work place, the one most strongly felt is collaboration within the group and sharing of ideals. In second place is the achievement of an optimisation of diagnoses and the care of the patients.` (p. 27)

### **8.2.4. To be a member of staff**

`During interviews a common theme that came up, was the fact that during their first years of work, these women were assigned to the heaviest tasks. Characteristically the interviewee from Czechoslovakia said that although her degree was recognised as that of tertiary education, on a daily routine, she would work as an auxiliary nurse..` (Greek Study, p.34)

### **8.2.5. Languages**

Greece: `Yet their social profile not regarded as high, in comparison to Greek nurses to similar qualifications and experience, by both superiors and colleagues. Low language skills to seem to be the sole argument against them, as in essence after twenty years of experience, nobody can really challenge their competencies. Often these migrant nurses are called by their country of origin, as a diminishing name. ` (p.33) A migrant woman in the nursing field: `My writing skills were poor for years, I had to learn the hard way, asking all the time, and trying to catch up...` (p.52)

### **8.2.6. Other challenges**

Even migrant women that have relevant nursing education, recognized in Greece, cannot be employed in the public healthcare sector, for only natives or repatriated citizens or EC citizens have access there. There is actually a Greek law which orders that a public servant can only be a native Greek, a repatriate citizen or a EC citizen who has adequate knowledge of the Greek language.

The Italian Study: `The difficulties of the work are indeed numerous: low pay, excessively long shifts and lack of psychological support.` (p. 25)

The German Study is establishing a direct link between low training achievements  
`To give access to qualification and employment the female migrants' qualifications which they have by nature are to be made use of: their language, their cultural background. These are qualifications for which there is a rising demand in the health and care sector and which shall be reacted to with an intercultural opening of such services. Even though in a more and more globalise economy intercultural competence and speaking several languages is becoming more important, apart from competence in one's field of work, this does not play a role in the actual recruitment procedures. Intercultural competence is a multi dimensional concept comprising various skills, attitudes and learning processes.` (German study, p.15)

The interviews with migrant women in Bulgaria showed some reluctance for employment within the health sector on the positions not requesting formal qualification. Part of it is due to the fact that the salaries on these jobs are among the lowest..... ` And also ` Another reason is the fact that with their contacts with the public health and educational spheres most migrant women in Bulgaria face some discrimination and lack of understanding. As a result, employment there is not deliberately sought, in comparison to other sectors. ` (Bulgarian study, p.46) As is mentioned in the report, the market of home caring is now only emerging in Bulgaria and is in process of developing into a thriving marketplace, however still very much within the grey economy and reinforcing precarious working conditions.

More challenges/problems are reflected in the Austrian Study. (p.55-60)

## **9. Recommendations to the curriculum of the pre-qualification training program**

The results from the national studies have culminated in drawing up recommendations to the curriculum of the pre-qualification course.

The **Austrian study** refers to its recommendations as 'tools to strengthen migrant women' positions in the Austrian labour market and in the workplace'.(p. 61) with the intent to cover the areas of Residency and Labour Laws, Unions and work councils, concepts of work and the working world in the health and care sector, structural barriers and discrimination and racism in the workplace.

' In regard to the time schedule of the course the curriculum has to take into account the temporal and financial parameters of the target group. That is to say the duration of the training has to stay within a timeframe that is realistic for the participants or otherwise their means of subsistence have to be covered by financial allowances.' (p. 62)

The content of curriculum focuses on Care in international comparison, The care system in Austria and opportunities for further education and training, Application procedures, Precarious labour conditions, Legal framework, Possibilities of financial subsidies, Exchange of experience with other migrant women, Exploring racism and developing strategies, Possibilities for on the job trainings, Placements for short-term practical trainings and job trainings, 'Healthy languages', Communication, Methods of learning – communication of self-learning skills.

The Study extends with 'an attempt to integrate these statements into recommendations as input for the design of the pre-qualification curriculum'. ' A very essential element from this compilation is the consideration, formulation, awareness raising and enrichment of personal abilities and skills. Further essential elements include experience in specific occupational fields together with practice in communication, cooperation, inclusive conflict management strategies and numerous other areas important to working in the nursing and care fields. Besides the structure of the content, the didactical implementation requires using a method which necessitates the input of the course participants and where that input can be incorporated into the lessons.' (p. 63)

Further on, the Study expands on the Paulo Freire's approach to pedagogics called 'pedagogy of the oppressed' and explains in detail its nature.

'Regarding the contents of the curriculum pertinent to dealing with the topic of health and nursing; the interviews reveal that migrant women themselves consider work experience (including of practical trainings BEFORE entering into training) to be helpful and are recommended by the training directors and nursing supervisors. Furthermore, dealing

with the terms “nursing and care” in a cultural context appears to be of significance; from a personal perspective and within a social context as well as in connection with performing related jobs within public or private facilities. Migrant women already working in such jobs address this explicitly and maintain that by dealing with these issues right in the pre-qualification phase, success and satisfaction in training and work can be positively influenced. ` (p.64)

Highlighting the recommendations to the curriculum, **the German Study** once again grounds them on the population characteristics of German society, the impact of structural barriers and the growth of the care market.

` The preparatory course will include occupations and basic qualifications in health and care sector like nursing/care assistant, unskilled work in the health and care and assistant for homecare and care for elderly. In particular these fields provide employment opportunities for people with varying qualifications which reflects the situation among female migrants and labour market demands in Germany. `

` In this context the project wants to provide a model of how groups of women who are often in informal, illegal employment can be prepared to enter into vocational training and legal employment relationships. A common innovative target is the intercultural orientation in the care and health services. Components of inter cultural orientation and inter cultural training combined with German language classes and the training of key qualifications for working life are included as well. Advice, consultation, support and coaching for vocational orientation, the training of applications and job interviews are further contents of the project.`

`The project results will also be of use in intercultural dialogue to increase understanding of cultural differences and will help to increase intercultural respect and citizenship engagement.` (quotes on p. 24)

`Most of the interviewed women find it helpful to have a direct contact person during the qualification courses, at best a social worker. It is also important to have instructors and lecturers who are open for possible problems, they said.`

`Cultural mediation and intercultural learning should be an explicit component of the curriculum; although a main working field for elderly care nurses who are migrants will be the growing number of old and migrants in need of much care.` (quotes on p.27)

**Italy:** `It being understood that the institution concerned will recognize the new training curriculum, both in terms of professional qualification and of training credits giving access to higher qualifications, the recommendations received from the interviewees can be summarized as follows:

- the training curriculum must be conceived in a flexible manner, so as to be suited to the needs of women, reconciling therefore study with work and family life;
- there must be a balance between theory and practice in the training curriculum;
- the training curriculum must provide a language course on the terminology used in the sector and an introduction to the administrative structure of the social and health services;
- the training curriculum must provide orientation for future professional opportunities, describing the roles and duties of the professional functions existing in the sector;
- the training curriculum must provide elements of intercultural communication and also of psychology to facilitate better interaction with customers using the services as well as with colleagues and Italian society in general.

Finally, for the course to be successful, it is hoped that the participants will receive an economic contribution, in the form of a grant or refund of costs.` (all on p.29)

**The Greek National Study:** `The most common recommendation made by all the interviewees, was that a course in Greek should be offered as a prerequisite for students and nurses working in the field. The content of this course should not only be Greek grammar and vocabulary, but also medical terminology as well. In fact, as the nurse trainers suggested, the scope should be towards medical and surgical nursing, which is thought to be the basis of the profession. They all agreed that the course should be free of charge.

They would also like a course on cultural mediation and intercultural learning, as they thought it would be very helpful for them.

Another suggestion made by policy makers and migrant nurses working in the field, was that they could act as interpreters for patients with a migrant background. This is very important, considering the escalating number of foreigners treated in Greek hospitals.` (all on p.35)

Two more recommendations expressed in interviewing migrant women who dropped out from a training course: ` Basically, I think there should be more information on how you get a job on the public sector as a nurse, and on the private sector as well, with or without

qualifications, because I discovered all these on the way by talking to my schoolmates.` (p.48) And: `I needed more information on how valid is my degree, (or even better) my nursing degree to be, and how easy it would be to work as a nurse. Also I needed more information about the content of the course and exams. Also, I was not informed properly that in order to get my degree I still would have to sit on national exams and compete with my Greek classmates.` (p. 49)

The **Spanish Study** opens its part with recommendations by clarifying the process starting from the theory and flowing to methodology. This process is based on the theory of P. Freire and is given in detail. (p. 20)

`These contents (of curriculum) aim at the necessity to know the context in which the women are going to develop their works. Knowledge that will allow to be subject of rights and duties, to empower itself before a different reality, demanding of her a worthy and egalitarian treatment.` (p.21). The content is concentrated on:

- `preparatory contents for the incorporation to the labor market` focused on the Spanish model in the area of health, knowledge of the different access routes to the employment in the health and care sectors and the labor legislation;
- `psycho-social contents` in terms of self-esteem and `elaboration of the migratory duel`;
- `contents on occupational health`;
- `contents in new sanitary technologies of the information`;
- `levelling of languages`;
- `referred contents to the necessities of the dependent people`;
- `first aid` and `nutrition`

Further on, the Study elaborates on the methodology of the training course, detailing its approach and strategies. Recommendations are given here for the `presence of intercultural mediators or even educative`, `on the practices`, `processes of pursuit`, `percentile classes mainly`, `the schedules`, `the conformation of the groups`, `the financing: gratitude and scholarships`, `strategic alliances and social networks of support: a proposal of sustainability and good practices`. (for more information p.31-36)

‘The **Bulgarian research** estimated that it is difficult to make a direct link between labor demand in the health and care sectors and employment opportunities for migrant women.’ (p.50)

However, ‘..it does indicate that migrants are interested in employment in these sectors and that the sector will continue to evolve and mature, as a result of the ageing Bulgarian population, intensive emigration trends and the access of private healthcare and social care providers.’ (p.50)

In such an environment, and considering the maturing strategies for migrants integration in Bulgaria, the Study recommends that the curricular should have a more varied content, besides the occupational one.

In doing so, the curriculum can comprise several training modules: intensive Bulgarian language training, health and care occupational training module, social orientation module, cultural integration module, children integration module, self-presentation module, ‘self-employment’ module, avoiding precarious situation module. (more information on p. 52-53)

Further on, the Study give recommendations on the structure, trainers and the financial incentives for training. (p.53-54)

It is needed to explain here, that the Partners have not attempted to define – neither in Studies, nor during meetings - issues connected to intercultural learning, intercultural mediation, intercultural communication, cultural mediation... These terms are often used in reference to the recommendations to the curriculum in different studies, but the reader must be careful of the context they are put in and the underlying notion. They do not at all have the same meaning, but rather share subtle difference that demand their clarification among the Partners.

This and all recommendations from the National Studies will be further worked on and given much consideration on the part of the health and care sector experts and migrant women involved in the curriculum development in Phase 2 of project. Expert workshops are to be organized by 4 Project partners and joined efforts and expertise will draw the Partnership nearer the common project goal of developing the curriculum for the pre-qualification course, and in the same time confronting racism and discrimination and promoting empowerment.

## Annex

### PRE-QUALIFICATION FOR MIGRANT WOMEN IN THE HEALTH SECTOR

#### Interview Guide

##### Introduction

##### **General Statements to the method of interview within our project:**

- Our research activities should neither imply nor support any tendency to make the completion of a pre-qualification course compulsory for migrant women.
- All interviews should be conducted by competent persons who have experience in the migration field, especially by those from representatives from the target groups.
- We consider the results of this study to be input for relevant organisations as well as policy and decision makers.
- Some categories, regarding policy makers and trade unions in particular, as well as some questions and the number of interviews within the categories are recommendations. Each partner must decide according to their national situations and contexts.
- The goal of the interviews is to gather information to contribute to the content of the curriculum and not to treat the migrant women as objects of research.

##### **The method**

The qualitative interview is one of the methods we will use to compile the study on the labour demands in the health sector. The study has the final objective to find out the reasons for migrant women to drop out training in the health sector in the countries participating in the Leonardo project. We propose you to use a semi-structured interview.

##### **Categories:**

- The qualitative interview shall be carried out with representatives from the following categories:
- Migrant women in the nursing field
- Migrant women who are currently attending a training course in the health sector
- Migrant women who have dropped out a training course

and/or

- Migrant women wishing to attend a training course in the health sector
- Directors, decision makers or senior trainers in educational/vocational institutions delivering training in the health sector
- Directors, head nurses or management in a health care institution (hospitals, elderly homes, home care,...)
- Policy makers on vocational training (Regional and local government, universities, etc..)
- Representatives of the trade unions.

##### **Practical indications for the interview:**

While doing the qualitative interviews, we recommend you to follow the practical indications listed here below:

- We advise you to interview 1-3 persons per category. The number of interviewees relates to your internal capacity, in terms of manpower, to carry them out. Of course, the more interviews, the

more material we have to work on and to make comparisons with.

Make sure as far as possible that the interview takes place in a setting that is quiet and private.

- Try to use a language that is comprehensible and relevant to the people you are interviewing.
- Your questions should be short and precise. The quality of the answers you receive is based on the assumption that the interviewee clearly understands the intent of the questions you pose.
- Ask only one question at a time and allow silence and pauses to signal that you want to give the interviewee the opportunity to reflect and amplify an answer.
- After the interview, make your own notes about how the interview went, where the interview took place and the setting, any other feelings about the interview. These notes might help you in elaborating the interview results.
- Please decide accordingly to your country regulation if the interview should be anonymous or not. If you decide for the anonymous interview, we recommend you to collect some data for statistical purposes: age, gender, position and function in the institution, number of years involved in the institutions, country of origin, marital status, children, etc.

### ***Interview guide***

The following interview guides will help you in conducting the interview with the different target groups. The semi-structured interview allows you certain flexibility during the interview process. Questions may not follow on exactly in the way outlined on the schedule. Questions that are not included in the guide may be asked as they pick up on things said by the interviewees. But, by and large, all of the questions will be asked and a similar wording will be used from interviewee to interviewee.

### **Recommendations for the interview guidelines concerning:**

#### **Policy makers**

Please, interview policy makers on vocational training (Regional and local government, universities, etc..)

#### Warm-up questions:

1. Presentation of interviewer (role, function etc.)
2. Introduction to Leonardo project specifying objectives and activities. The following key points should be made clear to the interviewee:
  - the data obtained from the interview will be strictly confidential;
  - the data obtained will only be used for the purpose of this study.

#### Interview questions:

3. Which are the vocational training opportunities in the health and care sector that you recognise? Please, specify the level of education (secondary level, university level, professional courses, specializations etc.)
4. Do you believe that your training strategy in the health and care sector is fully answering the services demands and the employment opportunities?
5. Given the prerequisites fixed and the high percentage of migrant women involved in the sector, would you support the implementation of a pre-qualification training course for migrant women? If yes, to what extend? (Financing, recognition, standard pre-qualification, etc...)
6. Considering the high number of migrant persons in the country, what do you think about the possibility to include in all vocational training courses at least a module on cultural mediation and intercultural communication?
7. Considering the high number of migrant women involved in health and care sector, how would you improve their participation in the vocational training system?

## **Training institution**

Please, interview directors, decision makers or senior trainers in educational/vocational institutions delivering training in the health sector.

### Warm-up questions:

1. Presentation of interviewer (role, function etc.)
2. Introduction to Leonardo project specifying objectives and activities. The following key points should be made clear to the interviewee:
  - the data obtained from the interview will be strictly confidential;
  - the data obtained will only be used for the purpose of this study.

### Interview questions:

3. Information about their training courses (length, content, number of student per course, etc.)
4. To what extent does the issue of migration play a role in the content of the current curriculum?
5. Which topics in the curriculum do you think are key to working in this field?
6. Which prerequisites (personal, knowledge, etc.) do you think provide an advantage to students in completing the training course successfully?
7. Which language-oriented requirements do applicants /apprentices have to fulfil in order to work in this sector?
8. What do you think are common barriers for students in completing the training course successfully? In general and for students with a migration background specifically?
9. Pre-qualification and pre-conditions for completing the training course successfully - which reasons for dropout could be reduced with a special pre-qualification?
10. Considering the concept of equal opportunities, do migrant women have "some kind of priority" when it comes to continuing education and life long learning?
11. In your courses do you include module on cultural mediation and intercultural communication? If yes, how many hours? Do you think it is sufficient? If not, what do you think about the possibility to include this module in the courses?

## **Service providers**

Please, interview directors, management or head nurses in a health care institution (hospitals, elderly homes, home care)

### Warm-up questions:

12. Presentation of interviewer (role, function etc.)
13. Introduction to Leonardo project specifying objectives and activities. The following key points should be made clear to the interviewee:
  - the data obtained from the interview will be strictly confidential;
  - the data obtained will only be used for the purpose of this study.

### Interview questions:

14. Please describe the services your institution provides.
15. Please describe the various positions in your institution/ department with regard to qualifications, competencies and responsibilities.
16. According to your experience, are the current competences of your professionals corresponding to the demands of your clients?
17. What challenges do you think professionals are facing with in this field?
18. Which competencies do you think are key to working in this field?

19. Are there any women with a migration background currently working in the nursing field in your institution?

If so, how many and in which positions?

20. Do professionals with migrant background, with similar degrees and language skills, have the same chances in the labour market as a native one? If not, are there any special policies to improve the equity of chances?

21. Considering the high number of professionals and patients/clients with a migrant background, what do you think about the possibility to include in health and care sector vocational training courses at least a module on cultural mediation and intercultural communication?

## **Trade unions**

Please, interview representatives of the trade unions taking care of vocational training and migrant issues.

### Warm-up questions:

22. Presentation of interviewer (role, function etc.)

23. Introduction to Leonardo project specifying objectives and activities. The following key points should be made clear to the interviewee:

- the data obtained from the interview will be strictly confidential;
- the data obtained will only be used for the purpose of this study.

### Interview questions:

24. Please describe the services your office provide to migrants

25. Do professionals with migrant background, with similar degrees and language skills, have the same chances in the labour market as a native one? If not, are there any special policies to improve the equity of chances?

26. Which are the labour and continuing education policies addressed to migrants?

27. Given the prerequisites fixed and the high percentage of migrant women involved in the sector, would you support the implementation of a pre-qualification training course for migrant women?

28. Considering the concept of equal opportunities, and according to your experience, do migrant women have “some kind of priority” when it comes to continuing education and life long learning?

29. Considering the high number of professionals and patients/clients with a migrant background, what do you think about the possibility to include in health and care sector vocational training courses at least a module on cultural mediation and intercultural communication?

## **Migrant women in the nursing field**

Please, interview migrant women working as a nurse

### Warm-up questions:

30. Presentation of interviewer (role, function etc.)

31. Introduction to Leonardo project specifying objectives and activities. The following key points should be made clear to the interviewee:

- the data obtained from the interview will be strictly confidential;
- the data obtained will only be used for the purpose of this study.

### Interview questions:

32. Please describe your position and responsibilities in the service.

33. Where and how did you acquire your competences and work experience to work in this field?

34. What is your motivation to work in the nursing field?

35. Is the work in this field what you expected it to be?

36. What do you think are your personal strengths for working in this field?
37. What do you think are some of the difficulties (in general and personal) in working in this field?
38. Did you find any difficulties in acceding training courses in health sector (language skills, bureaucratic aspects, etc.)?
39. How has your training (in this country/ in home country) contributed to your work in the nursing field?
40. In your opinion which conditions /things would have been helpful to make the training period easier?
41. What additional training, information, competences, experiences would be helpful for you?
42. Considering the high number of professionals and patients/clients with a migrant background, what do you think about the possibility to include in health and care sector vocational training courses at least a module on cultural mediation and intercultural communication?
43. Would you like to participate as a trainer in some parts of the training courses for migrants and be able to share your experience with other migrant women? If so - in which themes/issues/topics can you contribute most?

### **Migrant women who are currently attending a training course in the health sector**

Please, interview migrant women currently attending a training course in the health sector

#### Warm-up questions:

44. Presentation of interviewer (role, function etc.)
45. Introduction to Leonardo project specifying objectives and activities. The following key points should be made clear to the interviewee:
  - the data obtained from the interview will be strictly confidential;
  - the data obtained will only be used for the purpose of this study.

#### Interview questions:

46. Which are your motivations to work in the health and care field?
47. Do you have experience in working in the nursing field? In home country/in this country. If so, what experience do you have?
48. Which are your reasons to following this training course? How far are you into the training?
49. Up until now, has the training been what you expected it to be?
50. Have you experienced any difficulties in the training with regard to conditions (time, finances etc.), content, classmates, trainers, and language?
51. What kind of preparation and which information do you think would have been helpful in preparing you for the training?
52. Considering the high number of professionals and patients/clients with a migrant background, would you consider important to include in health and care sector vocational training courses at least a module on cultural mediation and intercultural communication?

Migrant women who have dropped out a training course in the health sector and /or migrant women wishing to attend a training course

Please, interview migrant women who dropped out a training course in the health sector and/or migrant women wishing to attend a training course in this area.

#### Warm-up questions:

53. Presentation of interviewer (role, function etc.)
54. Introduction to Leonardo project specifying objectives and activities. The following key points should be made clear to the interviewee:
  - the data obtained from the interview will be strictly confidential;

- the data obtained will only be used for the purpose of this study.

Interview questions:

55. What were your motivations to decide to follow this training to work in the nursing field?
56. Did you consider any other training course?
57. Do you have experience in working in this field? Which one?
58. Why did you drop out? How long did it take you to make your decision?
59. What would have helped you to complete the training course?
60. What kind of preparation and which information do you think would have been helpful in preparing you for the training?
61. Can you describe your daily routine - included the resources you need for learning?
62. and /or migrant women wishing to attend a training course
63. Do you have any apprehensions or worries about the training course? If so, which one?
64. What would help you to complete the training course successfully?
65. Would you suggest any changes to the actual training structure/programme/content to facilitate your participation in the training course?