LevFem

WHO CARES?

FEMINISED CARE LABOUR AND THE CRISIS OF SOCIAL REPRODUCTION IN POST-SOCIALIST BULGARIA

WHO CARES?

Feminised care labour and the crisis of social reproduction in post-socialist Bulgaria

Sofia, 2025

Authors: Mariya Ivancheva, Stoyanka Eneva, Stoyo Tetevenski, Neli Konstantinova, Alesandriya Angelova, Darina Kokonova, Kalina Drenska
Scientific editor: Neda Deneva
Expert editor: Nina Bankova
Ethics Approval: University Ethics Committee, University of Strathclyde: UEC24/25 Ivancheva
Translator: Margarita Spasova
Copy-Edit: David O'Kane
Design and layout: Vladimir Vatkov
Cover illustration: Boryana Rossa

We would like to thank everyone outside the editorial team who participated in the process of conducting and transcribing the interviews: Lea Vajsova, Anna Dankova, Valia Marinova, Troyan Mihaylov

We are grateful to all the women who participated in the research and made time for us in their busy, caregiving daily lives.

We also extend our gratitude to the organisations and individuals from the CARE Coalition (Koalitsiya GRIZHA) — Women of Kazanlak, Orion Grid, The Feminist Library, Valia Marinova, Diana Kalaydzhieva, Radka Tuneva, Viktoria Velcheva, Elitsa Kapusheva — with whom we have collaborated closely in recent months on the topic of care work. We believe that our joint efforts will continue in the future!

This report was funded by the Economic Opportunities Fund of the Alliance for Gender Equality in Europe. It is not intended for commercial use, and its sale and/or resale is prohibited. The report does not reflect the views of the funding organisation, which bears no responsibility for its content.

ISBN: 978-619-92174-5-0

TABLE OF CONTENTS

Executive summary 5

Introduction 9

Context 14

Historical context 14

Funding of the sector 15

Inequalities between men and women 17

Shortage of personnel 18

Research methodology 20

Theme 1: Working conditions 23

1.1 Divide between public and private sector workers and informal forms of labour 24

1.2 Irregular working hours and unpaid overtime 26

1.3 Pay: moral fulfilment or material security? 30

Theme 2: Socio-economic vulnerability, migration, and social reproduction 36

2.1 Violence, legal liability and risks at work 38

2.2 Long-term and family vulnerability in the context of migration 41

2.3 Normalising the 'second shift' of care as women's (and Bulgarian) work 42

Theme 3: Workplace relationships 47

3.1 Solidarity, alienation, and collective self-exploitation 47

3.2 Individualising problems and solutions 51

3.3 Disempowerment, shifting context, and diffusion of responsibility 52

Theme 4: Trade unions and self-organisation 54

4.1 Clarity on problems and identifying obstacles to their resolution 55

4.2 Membership in and attitudes towards trade unions 56

4.3 Attitude towards protest actions and other forms of (self)-organisation 59

Conclusion and recommendations 63

Annex: List of interviews 69

References 71

Executive summary

This report on the working conditions, experiences, and struggles of those employed in the care work sector of Bulgaria presents data from a qualitative research project conducted between January and September 2024 across various fields — education, healthcare, and care for the elderly, children, and people with disabilities. A total of 40 women working in these spheres of work were interviewed as part of the research — nurses, midwives, caregivers, kindergarten educators, primary school teachers, personal assistants, social assistants, and social workers. The respondents were working in 17 different locations, from the capital city, Sofia, to large and small towns, as well as in villages. We also interviewed women working as caregivers and personal assistants abroad. The research included both women working in institutions such as hospitals, residential care homes for people with disabilities and the elderly, kindergartens, and schools, as well as women providing what is called domestic care, or care provided in the private homes of those in need.

The research aims to identify some of the key issues characteristic of the care sector, as well as to bring greater public attention to the feminised and 'naturalised' character of the unique labour of female care workers, and to their excessive workload, which is neither rewarded nor valued in accordance with its importance for the maintenance and reproduction of society. We also draw particular attention to certain features of the sector that make mobilisation and the pursuit of collective labour rights for care workers more difficult, yet all the more necessary.

Key highlights from the research:

- **In contrast to other European countries, in Bulgaria there is a lack of understanding of the care sector as a unified field,** except as a set of 'humane professions', where self-denial and even self-sacrifice are implicitly seen as obligatory.
- **Certain working conditions are common across all areas of the care sector.**

These include:

- **Low pay** — in some cases (e.g., personal assistants) wages were below the minimum wage, and were, in other cases (e.g., healthcare workers), positioned low within the hierarchy of their respective segments of the labour market.
- **Personnel shortages —** especially of male workers, who are less willing to engage even in formal and regulated forms of care work due to the high workload and low income. These working conditions push many qualified female care workers to seek employment abroad, while many other women engaged in informal care work within their families become caregivers in Western countries. This results in an increasing burden on a shrinking and ageing group of female care workers in Bulgaria, often themselves in need of care.
- **Unpaid overtime** — the expectation not only to be available, but to actively work 24/7 and take initiative when problems arise and no standard procedures exist.
- **Emigration** as a temporary solution to present-day difficulties, especially due to the lack of labour market opportunities in Bulgaria or household indebtedness, but also as a source of long-term vulnerability: migrant care workers rarely have health and pension insurance abroad and lose access to these in Bulgaria; the outflow of care labour negatively affects their own families and children, who are left in the care of relatives.
- **The normalisation of care work as something that 'belongs' to women** — who are seen as possessing 'natural qualities' that make them more suited to providing care, with 'Bulgarian women', in particular, seen as especially caring, destined to look after other families in the global care chain. Due to the assumption that women instinctively know how to 'tend to others', there is often a lack of institutional support, training, and information for delivering care in complex or specific circumstances and medical conditions.
- **Instead of enjoying a dignified old age, pensioners must continue to work —** due to the lack of adequate, systemic alternatives, the phenomenon of 'elderly caring for the elderly' leads to a situation in Bulgaria where the healthcare system, early education, and the social care system rely on the overtime and over-

burdening of elderly women, many of whom are themselves living with disabilities and facing physical and financial difficulties.
    - **Care workers face violence at work and the threat of legal liability**, including in cases where the work is done 'off the books' or under informal payment arrangements. Risks and responsibilities are borne by the care worker herself, not by the employer or the intermediary agency.
    - **Care workers must deal with a lack of public awareness of the difficulties they face,** and the limited societal recognition of their feminised labour, aside from isolated expressions of gratitude by individual 'users'; the diverse skills and specialised knowledge these female workers possess, as well as their irreplaceable value for our well-being as a society and as individuals who require care at different stages of life, tends to go unrecognized.

- **Working conditions in the public and private sectors vary**, according to workers' levels of qualifications, and with regard to transparency in recruitment and pay. It is, however, difficult to speak of standardisation, as informal labour, particularly common among domestic care workers, is often the only means of quickly securing care for families in need, as well as a livelihood for informal care workers in Bulgaria and abroad, many of whom are unemployed or retired women who lack the resources or time to pursue formal training.
- **Unions: experiences with, and positioning in relation to, trade unions are also diverse**. On the one hand, there are trends towards greater unionisation in the public sector, particularly in education. Active union members describe various ways in which they manage to maintain or sometimes even improve their working conditions through mechanisms for collective bargaining, or through the authority that comes with their position as union representatives. However, the overall picture in the sector is different: many female workers are either indifferent to unions, citing their limited activity and usefulness, or sceptical due to unions' closeness to those in power, especially at the local level. In some places, the experience of organising a strike as a form of union action is associated with personal or collective memories of violence and repression during union self-organisation, which discourages many female workers from pursuing this path.

- **Self-organisation and solidarity among colleagues and across subsectors do exist, but care workers feel isolated, alienated, and powerless** to bring about social change. In rare cases, they manage to improve their working conditions through informal and individualised negotiations with benevolent directors or municipal officials, but without any collective strategy. Apart from trade union structures that cover care workers as a community, there is also an absence of any network or guild for communication or self-organisation among care workers that would enable the sharing of experiences and struggles to improve conditions in the sector.
- **Among the demands for change in the sector, three areas of action stand out:**

    - **Formal and informal pathways for standardising information and sharing resources,** such as care manuals, training programmes, and mobile social care teams. Key conditions identified for achieving these priorities include advocacy at both local and national levels, economic analysis and monitoring of how care work budgets are spent, and also self-organisation in smaller, grassroots mutual aid groups.
    - **Information campaigns and sustained efforts to raise public awareness** about challenges and needs across different areas of the care sector, as well as the importance of care work — and about the pay and recognition that care professionals deserve. Particular attention should be given to migration and the care deficit it creates, and how this deficit can be compensated for in the families of migrant care workers, as well as for Bulgarian society as a whole;
    - **Professional organisation and unionisation of domestic care workers, along with more active cross-sectoral coordination within already unionised fields** such as healthcare, social services, and education, in order to advance common demands and exert pressure.

Introduction

This report examines the working conditions, experiences, and struggles of those employed across various fields within Bulgaria's care work sector — education, healthcare, care for the elderly, children, and people with disabilities. It presents data from a qualitative research project conducted between January and September 2024. The aim of the report is to expand knowledge about the workload, challenges, and unique nature of labour in the Bulgarian care economy, drawing on the experiences of those working within it. This text is part of LevFem's ongoing efforts to increase the visibility of care work and highlight its importance to society as a whole. These efforts also include two previous studies, the first on elderly care (Apostolova, Vajsova & Genova, 2020), and the second on the impact of the shortage of places in municipal nurseries and kindergartens (Vajsova, 2022).

There is little discussion in Bulgaria about care work or the 'care sector'. In order to establish this important framework — well recognised in many European countries, but still relatively unfamiliar in the Bulgarian context — this report examines the working conditions of a wide range of care workers across several professional fields. These fields vary in structure and size, and have diverse origins and histories in relation to their place within the systems of education, social care, and healthcare. There are significant distinctions between care for adults and for minors, for people with intellectual or mental health conditions versus those with physical disabilities, and for people with various illnesses. Differences also exist between care provided in large cities and in smaller towns, and between care delivered at home and that provided in institutions. This diversity is also reflected in the wide range of employment arrangements within the public or private sectors (and through those arranged in informal agreements with employers), as well as in the range of skills and professions among care workers: midwives, nurses, healthcare assistants, rehabilitation therapists, teachers, assistant educators, social workers, educators, psychologists, personal assistants, and social care assistants. Taking these differences into account, and with the clear understanding that each of these groups deserves separate research, the aim of this report is, above all, to identify the common features of the working conditions faced by female workers in different

areas of the care sector. This will allow us to outline possible pathways for joint political action and mutual support.

The use of the term 'female worker' (*rabotnichka*) in this report is a political choice, and a deliberate one especially for the Bulgarian context: it has been central to LevFem's work since our founding. In Bulgaria today, the words *rabotnik* (male worker) and *rabotnichka* (female worker) are often associated with 'low prestige' and 'unskilled' labour. With this report, we aim to take a concrete step toward reclaiming these terms, with the intention of imbuing them once again with a sense of pride, recognition, and dignity. We fully acknowledge and respect that many people working in some spheres of the care sector — such as special needs education and healthcare — prefer to be referred to as 'experts', 'specialists', or 'employees', in order to reflect the personal effort and time invested in gaining knowledge and professional qualifications. However, in Bulgarian and in parts in the English text where a more neutral 'worker' is used for both male and female workers, we intentionally use the collective term 'female workers' to counter certain implicit assumptions: that feminised labour is not valuable or sufficient in itself; that the care these women provide is not to be perceived as labour, but as something taken for granted; and that we must live in a society shaped by hierarchies and competition over scarce resources, rather than by a shared interest in collective well-being. For this reason, we consider it crucial to emphasise that the work involved in caring for other people is neither easy nor a given; it is labour that is demanding, stressful, responsible, and extremely important for our society and economy. In this spirit, we use the feminine form 'female workers' (*rabotnichki*) when referring to the group as a whole, and we also use the feminine form when naming specific professions[1], in order to highlight the fact that the overwhelming majority of kindergarten teachers, personal assistants, social workers, midwives and nurses are women. As our research

[1] Translator's note: In order to preserve the readability of the text, and to avoid overburdening it with gender markers, the names of specific professions (e.g., teacher, assistant, social worker, nurse, etc.) are translated using gender-neutral terms, in line with English-language conventions. This decision reflects the linguistic structure of English, while still acknowledging — through context and analysis in the report — that these roles are overwhelmingly occupied by women, and are shaped by gendered expectations and inequalities.

shows, the gendered stereotypes that surround these professions are a key factor in justifying the overexploitation of labour in these sectors.

Why did we choose to examine these complex areas of labour together?

First, this research begins from the premise that care is essential to the maintenance of society. We understand care for other people as a specific form of labour, whose diverse expressions — emotional, physical, medical, and otherwise — are fundamental to sustaining both life and society. This labour plays a vital role in the raising, recovering, and well-being of all citizens — in other words, it ensures the social reproduction of the population. For this reason, it is of key importance to society as a whole. That is why the term 'social reproduction' is increasingly used in academic and professional literature dedicated to labour when referring to this type of work — a term which, alongside 'care work' and 'care sector', we use throughout this research, and which we aim to introduce more widely into Bulgarian public discourse.

Second, as a result of historically entrenched gender inequalities, both paid and unpaid care work is carried out predominantly by women. They make up the majority of the workforce across all the sectors discussed here, and within the care sector as a whole. According to research by Bulgaria's National Statistical Institute (2024), more than 270,000 women, compared to just over 67,000 men, are employed in these fields. This imbalance directly affects our research, as care work is often masked as 'a woman's natural role', her vocation, or part of her biological nature. This masking obscures the economic value of care, allowing it to be framed 'natural', and contributing to the underestimation (symbolic and financial) of the specific burdens placed on women — before, during, and after their paid working hours. In this report, therefore, we refer to the care sector as 'feminised' — that is, as a sector in which women are the overwhelming majority of workers, but with the additional meaning that the broader exploitation and underpayment faced by women in the labour market are transferred onto the sector as a whole. This is how poor working conditions and low pay across the care sector are normalised and excused.

Third, it is important to note that, in addition to being feminised, in Western developed capitalist countries work in the care sector is predominantly carried out by migrant women (European Parliament, 2015) — in the European Union, these are often women from Europe's periphery, such as Bulgaria, Romania, Ukraine, Georgia, and similar countries. As a result, what is naturalised is not only the 'womanness' of this type of labour, but also its alleged 'Bulgarianness'/ 'Eastern Europeanness'. As a country located on the periphery of Europe — that is, on the margins of the developed capitalist world — Bulgaria occupies an intermediate position in the global care supply chain (Ehrenreich & Hochschild, 2004). The country supplies female care workers to more developed economies and countries which have ageing populations and high levels of female employment: these female workers then look after children and the elderly within the dual-earner family model prevalent in those countries. Because care work is being 'drained' from countries like Bulgaria through migration, this leads to a care deficit that is typically filled either by other members of the migrating woman's family, or by women performing care work beyond standard working hours and labour norms, or by migrant women from even poorer countries. This is the care deficit to which we want to bring attention.

Last but not least, although the care sector is one of the most difficult to organise collectively, some of Bulgaria's most significant social and labour mobilisations of recent decades have taken place precisely within that sector: the teachers' strike of 2007, the protests by mothers of children with disabilities in 2019, the protests and unionisation within the newly formed nurses' union (2019–2020), and the demonstrations by social workers in 2024. Despite the persistently imposed conservative narratives about women's place in society, and the limitation of their socio-economic rights to work and equal pay, the deepening crisis of social reproduction has given rise to ongoing struggles by those working in the care sector, who have boldly brought into the public sphere the problems of their otherwise isolated workplaces, raising demands for improved working conditions. At the same time, as this report shows, as the commodification of care in Bulgaria is following the European model, a new market-oriented language is pressuring female workers to adopt terms such as 'services', 'clients', and 'users' — terms that conceal underlying relations of informality, insecurity, and economic coercion.

This stands in stark contrast to the ethos of the profession: the reframing of care through the logic of the market leads to the erosion of what has kept many women in the sector despite its hardships — the fact that they care.

It was against this backdrop that we at LevFem saw the emergence of this task, that of researching economic violence. For us as an organization, from the time of our founding in 2018 during a country-wide campaign against gender-based violence, it was clear that the task of exposing economic coercion was particularly important. It was vital to explore this phenomenon especially when it came to one of the key feminised sectors of the Bulgarian economy: care work. We were particularly interested in the working conditions within the sector, the differences and similarities between those conditions across various professional fields and different localities, as well as the possibilities for organising and building solidarity among female care workers.

To this end, between January and September 2024, we conducted 40 semi-structured, in-depth interviews with women working in the fields of care work (healthcare, social services, and education), who were from a total of 17 cities, small towns and villages across Bulgaria, with a particular concentration in five settlements of different size located in different regions of the country. We also spoke with women who have histories of migration and care work in five European countries: Spain, Italy, Austria, France, and Belgium. The interviews were transcribed and analysed using qualitative data software, and in this report, they are presented in anonymised form in order to protect the women we spoke with from potential risk to be recognised by employers, colleagues, or clients.

Our report unfolds in the following sections: following the summary and introduction, we provide an overview of the context of care work in the subsectors we studied, followed by a description of the methodology. The findings of the research are presented across four main themes from the interviews: (1) working conditions; (2) social and economic vulnerability, and the role of migration in the sector; (3) workplace relationships; (4) unionisation and tactics of individual and collective solidarity and resistance. In the conclusion, finally, we summarise some of the key issues and recommendations that have emerged from this research.

Context

In Bulgaria, social welfare system plays a crucial role in preventing and addressing the social exclusion of vulnerable groups in society. It provides support that enables these individuals to participate fully in social life, safeguards their rights, and contributes to improving their quality of life. In this report, we examine social activities grouped into two distinct sectors, following the Classification of Economic Activities (CEA, 2025): first, human health and social work, and second, education. We pay particular attention to the so-called social services, which remain less researched and less visible.

Historical context

The transition from socialism to a market economy in Bulgaria brought significant changes to the provision of social care. During the socialist period, Bulgaria pursued a deliberate policy of nationalising care or shifting the responsibility for care work into the hands of state institutions, and away from families, charitable organisations, and the church (Popova, 2019). Due to intensified rural-to-urban migration, driven by rapid industrialisation and the expansion of universal medical care, life expectancy and intergenerational living arrangements changed. This, in turn, created growing demand for institutional care for the elderly. A universal, state-controlled social welfare system was built, offering extensive social care: free healthcare and education, guaranteed employment and pension coverage, and state-funded care for children and elderly people. Existing community- and church-based care organisations were nationalised, and new state-run institutions were opened to serve vulnerable groups such as orphans, elderly people, and people with disabilities. In the case of the elderly, these institutions severed connections between institutional care and existing local social structures, and elderly people were required to work in order to contribute to the maintenance of the institution. Often located in smaller settlements, and bound by heavy state bureaucracy and a medicalised approach to care, these institutions did not challenge social stigma, but rather pushed stigmatised groups out of public view. On the other hand, they did provide professional, institutional care, and served as a source of livelihood for some of the local population in the areas where the facilities were built (Mladenov & Petri, 2020).

With the fall of the socialist regime, the transition to a market economy after 1989, and Bulgaria's accession to the European Union, the country underwent a political and economic transformation, one that has had a profound impact on the organisation of social care. On the one hand, many state institutions were downsized or closed due to financial constraints, and local care homes became the focus of deinstitutionalisation without a clear vision of how care should be organised at the community level. This shift led to the quasi-privatisation of health and social services (such as elder care homes, day centres, and services provided by non-governmental organisations through delegated budgets), or in some cases, to *de facto* privatisation, through the entry into the market of private care providers, agencies hiring caregivers, and others. Rising unemployment among workers laid off from state enterprises and services contributed to increasing poverty and social vulnerability. Combined with privatisation and the rising cost of private services, this has led to sharpening inequalities in access to — and quality of — social care. Amid a growing deficit of institutional support and widespread precarity, care is often shifted back to families or informal networks.

Bulgaria's accession to the European Union in 2007, and access to pre-accession and structural membership funds, were long framed as a triumph of the transition toward a more just and prosperous society. However, the lack of democratic and transparent budget allocation, the decentralisation of social services, and the transfer of responsibilities to municipalities did not eliminate, but dispersed, the responsibility for existing inequalities. Migration became the sole source of income and survival for many, while off-the-books care work long served as a solution for families facing ongoing crisis. The care drain has also resulted in a care deficit for Bulgaria's increasingly ageing population, creating a situation in which a shrinking and ageing group, mainly women, is now left to care for the elderly, children, and people with disabilities.

Funding of the sector

Funding through delegated budgets in the education system and the system of social services is one of the key changes in the care sector. Financial resources allocated for social, health, and educational purposes are redistributed through the relevant ministries and specialised agen-

cies to the final service providers. Their budgets are determined by the state, and are based on fixed per capita rates — rates per pupil, or per care recipient. This funding model privileges larger cities and institutions, which has led to the introduction of certain compensatory mechanisms (such as the classification of some schools and kindergartens as 'protected,' shielding them from closure). However, these measures do not address the significant deficits in the system.

In the case of the so-called **social services**, the recipients and distributors of delegated budgets are the municipalities. The specific amounts they receive are calculated based on the so-called uniform expenditure standards, and depend primarily on the number of care recipients. This model creates serious challenges for the adequate planning, funding, and coverage of actual care needs. Firstly, although municipalities are responsible for different types of social, educational, and health-related activities, they receive only part of the funding needed to carry them out. The remaining funds are secured either through the municipalities' own revenues, which are often insufficient, or through project-based applications and implementation, which offer no guarantee of success, and do not allow for long-term or stable planning. On the other hand, when planning key activities, available funds take priority, often pushing aside the evaluation and analysis of the effectiveness of implemented policies and programmes (UNICEF, 2021). As a result, municipalities receive concrete funding for a concrete service, which becomes the structural determinant of both the quality of the service and the working conditions. Programmes for personal assistants, social assistants, and domestic care are also financed through the state and municipal budgets, and distributed by the municipalities.

The funding of **educational activities**, for its part, has been further decentralised. Under current regulations, each school receives its budget directly, calculated based on the number of pupils. Although at first glance this type of redistribution appears to provide some financial autonomy, enabling decisions on salaries, improvements to facilities, and other expenditures, the disadvantages of the model far outweigh its benefits. The incentive to attract more pupils turns schools into something akin to commercial enterprises. Pupil numbers has become the sole criterion for opportunities related to career development, fair pay,

or upgrades to the school's material infrastructure. Furthermore, this model of funding allocation places schools in municipalities of different sizes in unequal positions (Confederation of Labour Podkrepa, 2015).

The current model of **healthcare** funding has turned the system into a network of commercial enterprises, funded by the National Health Insurance Fund (NHIF). The Health Fund allocates resources based on clinical pathways. The shortcomings of this model have been criticised many times from various angles — for example, the standardisation of clinical pathways fails to account for the specific situation of individual patients and the actual costs incurred by hospitals. Due to systemic underfunding, municipal hospitals are often forced to close departments, or find themselves unable to recruit and retain sufficient staff to ensure the normal functioning of their activities. This funding structure has enabled the emergence of private hospitals that specialise in treatments that are less complex but more 'profitable', further reducing the capacity to subsidise more 'unprofitable' treatments, typically covered by public institutions.

Insufficient funding is a major issue across all sectors related to care provision. A key example that illustrates this is that of the **elder care sector**. Bulgaria is one of the EU member states whose elderly populations are growing at the fastest rates. In 2017, people over the age of 65 made up one fifth of the country's population, and every second elderly person living alone was below the poverty line (Caritas, 2018: 5). Despite this, only 0.05% of the GDP is allocated to elder care, whether residential or home-based, compared to the EU-27 average of 0.41% for 2008 (National Health Strategy, 2020).

Inequalities between men and women

In addition to the chronic underfunding of care-related sectors, another particularly pressing issue (along with the shortage of personnel) for care work in Bulgaria is the inequality between men and women in the labour market. Data show that women make up the majority of the workforce in the sectors under review, while also occupying a disproportionate share of lower-paid positions. These roles are marked not only by low material remuneration, but also by low social prestige.

As of 2023, according to data from the Bulgarian National Statistical Institute (NSI), the gender pay gap in the economic activity category 'Human health and social work' was among the most significant across all sectors. Out of a total of 176,500 employees in the sector, 133,700 are women, meaning that nearly 75% of those working in this field in Bulgaria are women. In the European Union, women make up 88% of the nearly 6.2 million people employed in the care sector (CEDEFOP, 2023). In 2023, the average annual salary for women in regulated positions in this sector was 22,268 Bulgarian Lev (BGN) equivalent to 11,385 EUR, while for men it was 32,663 BGN or the equivalent of 16,701 EUR. This means that, on an annual basis, female incomes are 31.8% lower than those of men. Women's wages thus remain significantly lower than those of men, despite women's overwhelming presence in the Bulgarian care sector.

The education sector in Bulgaria is the most heavily feminised sector, exhibiting not only a predominance of women, but also significant disparities in both pay levels and the positions held by men and women. Of a total of 163,700 people employed in the sector, 134,700 are women, and only 29,000 are men. In particular, the employees in pre-primary and primary education — areas that combine teaching responsibilities with elements of care work — are almost entirely women. Women make up 99.2% of the workforce in pre-primary education and 93.2% in primary education (EIGE, 2022). Wages in this sector are also lower for women, though the gap is smaller than in the healthcare sector: in 2023, women's annual salary was 9.94% lower than that of men.

Shortage of personnel

Another clear and pressing issue in care professions is the shortage of care workers: this is closely tied to the disproportion between men and women, the gender pay gap, and other structural problems in care work, particularly in the healthcare sector. The crisis related to the shortage of personnel in healthcare, and especially the shortage of nurses, continues to deepen. At present, Bulgaria faces a shortage of approximately 31,000 nurses and over 4,000 midwives, a deficit which poses serious challenges to the effective functioning of the healthcare system (Bulgarian Association of Healthcare Professionals, 2024). The nursing profession is marked by low pay, excessive workloads, and poor working

conditions. Meanwhile, the medical profession, more male-dominated and significantly better paid, does not face such acute problems. The divide between these two professional tracks — nursing, composed predominantly of lower-paid women, and medicine, still largely dominated by higher-paid men — is similar to the significant disparities in pay and working conditions prevalent across the care sector.

This issue is not limited to the hierarchies within healthcare professions, but affects society as a whole. The income gap has a significant impact on access to healthcare services. In 2022, 3.1% of low-income households reported unmet healthcare needs, a figure approximately 30 times higher than that of high-income households (0.1%) (OECD and European Observatory on Health Systems and Policies, 2023). The main reasons for this disparity include high direct costs, medical services being not covered by health insurance, restrictions on referrals, and the uneven distribution of financial and human resources across the sector.

Another important aspect in which these hierarchies affect the labour market in Bulgaria, and more broadly shape the parameters of care work within the European Union, is the growing need for qualified care, given the ageing population and its increasing need for care. In the EU, care workers make up 4.7% of the total labour force, but there is a stark disparity between Western European countries, where this figure reaches 9–12% (e.g., Denmark, the Netherlands, Finland, Norway), and the peripheral EU countries such as Greece, Cyprus, and Romania, where care sector employment is 1% or lower (CEDEFOP, 2023: 3). Only 2.1% of the elderly in the EU currently live in institutions, yet the ageing population is projected to account for 65% of the total population by 2030 (CEDEFOP, 2023). This promises a future care deficit, even in more developed countries, and a likely continued care drain of migrant labour from peripheral states such as Bulgaria. Many of the women who migrate to work in the care sector in the West are qualified nurses, and/or have training in other care-related professions.

Although the social welfare system plays a key role in supporting vulnerable groups, long-standing structural problems and inequalities have a significant impact on its functioning. In this section, we examined how the replacement of centralised planning with market-oriented policies

often leads to fragmentation, privatisation, and the individualisation of responsibility for care, without providing an adequate institutional alternative. Funding for the social, health, and education sectors is decentralised, but uneven and insufficient: this particularly affects smaller municipalities and various vulnerable groups. The consequences are felt not only by care recipients, but also by those working in these sectors — the result of persistent underfunding is a chronic shortage of personnel, especially in healthcare, as well as a deepening of social and territorial inequalities in access to care. The issue of gender inequality is especially acute — women dominate the care sector, but are concentrated in that sector's lower-paid and less socially recognised positions.

Research methodology

This report is based on 40 in-depth semi-structured interviews with care workers employed as nurses, caregivers, kindergarten educators, primary school teachers, personal assistants, social assistants, and social workers. The participants were primarily concentrated in five localities of varying sizes situated across different regions of Bulgaria (the capital, Sofia, a regional centre, smaller towns, and rural areas). This research explores the challenges and possibilities these care workers face in relation to the lack of financial support for public services, an ageing population, and the growing trend, among care workers from Bulgaria, of outward migration.

FIELD		
Healthcare	**Education**	**Social work**
8	13	19
PLACE WHERE THEY PROVIDE CARE		
Home-based	**Residential/in an institution**	
13	27	
TYPE OF FUNDING		
Private	**Municipal/state**	
6	34	

Table 1: Employment profile of the 40 interviewed participants

We combined a snowball sampling approach, where respondents referred us to their colleagues, with a targeted stratified sampling strategy. In the latter case, in order to ensure that we captured a variety of lived experiences, we identified and sought out specific profiles based on subsector, work experience, type of employment contract, educational qualifications, locality, ethnic background, age, and migration experience. Most of the workers we interviewed were Bulgarian citizens, and while we made efforts to reach immigrants and people who do not identify as women, all participants who agreed to speak with us self-identified as women, which reflects the demographic reality of this highly feminised sector.

Data collection for this research was based on semi-structured interviews with individuals who were of an age to provide informed consent to participation in interviews about their working conditions. After receiving detailed information about the research and signing a consent form, participants were interviewed. The interviews were recorded and transcribed with their permission. The interviews followed a standard set of questions related to participants' educational and work experience, working and living conditions, and their visions for social change and involvement in labour (self-)organisation. Personal information collected during the interviews was kept to a minimum. After each interview, only the audio files were retained, under coded names, and these were deleted after transcription. The transcriptions were stored in a password-protected digital archive. In the transcripts, participants were fully de-identified: all personal information, geographical locations, names, and any identifying details about employers or institutions were removed. This level of anonymity significantly reduces the risk that participants might be recognised by employers, colleagues, or clients.

To reach the desired sample, we initially relied on connections with allied organisations working in various localities across Bulgaria. These organisations often acted as intermediaries, facilitating the initial contact with participants. Some of them are members of the CARE Coalition — a network we co-founded with other non-governmental organisations and initiatives as part of our broader work in the field of care work. At the end of each interview, participants themselves frequently recommended colleagues or friends who were also working in the care

sector. During each interview, we also collected basic background information about the female workers to ensure that we captured a wide range of educational qualifications, professional experiences, and age differences within our targeted sample.

Each interview began with a general introductory section, followed by questions across four thematic areas. We first asked participants about their backgrounds: their educational and professional experience, the length of time they had spent in the profession, and the position they currently held. We then focused on their working conditions, including: formal working hours and overtime; spatial arrangements (working from home, in an office, commuting, etc.); availability of paid leave and sick leave; organisation of the working day, responsibilities, challenges, individual and collective decision-making by the worker; and the worker's sense of autonomy and recognition at work. The third section of the interview addressed broader questions related to care and emotional and social reproductive labour. These included: whether their income was sufficient to cover the cost of living; their ability to cover major health-related expenses; reliance on remittances from migrant family members, second jobs, or income from a spouse or dependents in the private sector; household indebtedness; and the emotional labour invested in care recipients and their families. Each interview concluded with questions about the participants' vision for social change in the sector. These explored their sense of democratic representation and political empowerment: whether they were members of professional organisations and/or trade unions; and their analysis of what would need to change in their sector or in society more broadly for that change to have a positive impact on their lives.

During transcription, the interviews were coded and analysed using thematic analysis, with the help of a software for qualitative data analysis. In this type of analysis, the frequency of themes and recurring motifs in the interviews is treated as indicative of broader structural constraints and opportunities. At the same time, exceptional individual experiences, insights, and suggestions were not dismissed, but were, rather, contextualised within more general patterns, allowing the analysis to shed light on how unique or widely shared certain experiences revealed in the interviews might be. When writing the analysis presented in this

report, some of the themes were reorganised and grouped into four broader thematic categories, discussed below: (1) working conditions; (2) social and economic vulnerability, migration, and social reproduction; (3) relationships at work; (4) trade unions and self-organisation.

Preliminary findings from the initial analysis of the interviews were shared in the localities where the majority of the interviews were conducted. Meetings were arranged with organisations and female workers in the care sector, and some of the interview participants, along with their relatives or colleagues, also took part in these gatherings. During these discussions, we collected feedback from care workers, tested our initial intuitions and hypotheses, gained deeper insight into local specificities, and reflected collectively on possible demands that could be drawn from participants' experiences and from broader trends in the sector. These meetings were extremely valuable in helping us to make sense of our impressions from the interviews, and in systematising proposals for possible directions for action, which are presented in the conclusion of this report.

Theme 1: Working conditions

When discussing working conditions in the care sector, the female workers we interviewed indicated that the challenges they faced were strongly determined by both the type of labour, shaped by the profile of those receiving care, and the space in which care is delivered. Caring for infants, pre-school children, school-age children, children with disabilities, adults with disabilities, etc., affects levels of physical strain, psychological burdens, required levels of preparation, and after-work responsibilities, and does so in different ways. The location of care — whether a hospital, day centre, kindergarten, or private home — also defines the boundaries between individual and shared responsibility, and between institutionalised models of care: it also shapes more ambiguous expectations around the distinction between working time and 'rest' time.

In this section, we focus in particular on the regulation of the relationship between worker and supervisor/employer, which has a direct im-

pact on the working conditions of our respondents. Some of the key issues that emerge include: the diverse working conditions for those employed in the public and private sectors; the absence of formal, contract-based employment for some workers, especially those caring for sick and elderly people in home settings; the frequent occurrence of irregular working hours and unpaid overtime; and the tension, in care work, between moral fulfilment and material insecurity.

1.1 Divide between public and private sector workers and informal forms of labour

Among those formally employed in care work, a key distinction can be drawn between the private/non-governmental sector and municipal or state-delegated services (some of which are also provided by non-governmental organisations). None of the respondents working in the public or municipal sector reported irregular employment relationships or inconsistent pay**.** The same cannot be said for the private sector. For example, personal assistants employed through private arrangements between individuals often work without a formal employment contract**:** 'Even when I worked privately, I never, never had a contract' (R37, personal assistant) or with only a fictitious contract: '... [And] now they make contracts, but they're for four hours, while the women work 24 hours' (R38, personal assistant). Some of the nurses and midwives we interviewed also reported a lack of transparency in salary determination in private hospitals. 'One month you might get 1,300, another 1,700. Every month different. I received them by bank, but why that amount, I can't say' (R22, midwife in a municipal nursery, speaking about a previous job in a private hospital). Moreover, being insured on the basis of one's actual salary is not possible for everyone.

*'Back in the day, there used to be payroll sheets, now there aren't any, we don't sign anything. At state hospitals, we get payslips. At the private ones, I haven't seen a payslip for three years… At the private ones — I once dared to ask HR — why my salary is the same when there are 100 patients and when there are 300. And they told me that private hospitals are not required to sign the National Framework Agreement.' (***R13, nurse**)

The absence of contracts places female workers in more vulnerable positions, as they are unable to exercise their labour rights, such as paid leave, sick leave, workplace protections, access to trade unions, the labour inspectorate, or protection from violence at work. The lack of formal employment relations means that the employer does not pay health and pension insurance contributions. The women who take up such informal care roles are often among the most vulnerable — poor low-paid or unemployed women, or pensioners who struggle to make ends meet, who are repaying debts, or face other family-related expenses they cannot cover. The large majority of them have no formal qualifications for care work, although they often have solid experience as nannies and carers within their own families. *'The people who take on this work are usually those who have already played the role of caregiver in their personal lives. And this trains them to take on the role professionally. It's usually retired women.'* (R01, social assistant, elder care). In this way, the risks of care work are entirely shifted onto the female workers themselves. They may find themselves in dangerous situations, or remain without health insurance and unemployment benefits if the care arrangement ends, and often, in the long term, find themselves without formal employment records entitling them to a pension.

In this regard, a serious paradox is particularly evident, one that is not only typical for the sector in Bulgaria but is also discussed at the Euro-

pean level (European Parliament, 2015). On the one hand, interviewees often spoke about the need to professionalise the work by introducing standard qualifications for care workers that can be delivered through training courses where care workers can learn or share up-to-date practices and methodologies, which would be particularly useful for people who are more isolated in small communities. The lack of a register of qualified, trained female workers from which relatives can choose people to hire leads to situations where families have to find personal assistants and caregivers themselves, often assigning the tasks of care to an untrained family member. *'They are not regulated, there is no standard, and personal assistants are NOT social workers, they are not trained...'* (R40, nurse). *'One of the things that for me should be placed as important is that people who start working should have the necessary professional training. At least one year... Not taking a course that's just a two-day seminar'* (R07, social worker, municipal service for adults with disabilities).

On the other hand, in this and every other interview where the topic of professionalisation or standardisation of training was raised, respondents also acknowledged that the implementation of such measures is difficult. Unqualified care work is most often taken on by those in greatest need, who lack the resources or time to invest in training, and for whom off-the-books care work is the only quick and effective way to avoid destitution: *'These women don't have a choice, they become caregivers out of need and compulsion, spontaneously and immediately, how are you going to license them?'* (R40, nurse). The lack of qualified knowledge is also acknowledged by those who found themselves in the difficult position of having to seek employment in the care sector without prior training: *'When I started, I was working with a woman who had Alzheimer's. I didn't know anything about the illness back then, everything felt like a fog. I had done all sorts of other jobs, but I had never worked with sick people. While working, I searched for information on the internet.'* (R24, caregiver in a Western country).

1.2 Irregular working hours and unpaid overtime

With regard to the organisation of the working day, respondents in professions with fixed working hours and formal employment relationships confirm that they can and do take the breaks to which they are entitled,

with some limitations related to workload (for example, teachers are not able to leave kindergarten children in the care of just one adult). A similar situation is reported by social workers employed in day centres, who often eat lunch on the go, as they cannot leave the children unattended (R06, social worker, municipal service for children with disabilities). Nurses experience violations of the right to a 48-hour weekly rest period and adequate breaks between 12-hour night shifts: *'Because of staff shortages… I've had to do two- or three-night shifts in a row. I mean, our schedule isn't fixed — it doesn't account for the fact that you're supposed to have a break'* (R27, nurse and patronage care worker). In domestic care, the work rhythm is entirely tailored to the needs of the care recipients. Female care workers describe this work as constant: '*There's no time when I'm not providing care*', (R36, personal assistant), and breaks are only possible in brief windows, for instance, when the person being cared for is asleep (R04, nanny and R37, personal assistant). It is worth noting that workers employed on part-time contracts are entitled to fewer days of paid leave compared to those working full-time in programmes for social assistants or in what in Bulgaria is called 'patronage care services', in which care workers provide home visits to families.

Another issue related to employment contracts concerns the regulation of working hours in domestic care. Programmes for personal assistants provide salaries close to the minimum wage, which is why they are most often taken up by relatives or close family friends of the person receiving care. However, they cover only part of the care work. In one of the cases under study (R23, personal assistant), a family friend was employed as a personal assistant to a child with special educational needs. She has an employment contract with the municipality, but it only covers four to five hours of the child's daily care — as determined by TEMC (Territorial Expert Medical Commission). Since the child's parents are both working full-time, they pay the personal assistant extra in cash, and bear an even greater share of the financial burden. As a result, the assistant's employment record and social security contributions only reflect a portion of her actual working time.

This issue is not limited to personal assistants. In most care professions, working additional hours appears to be expected, and care workers feel pressured to work overtime: *'Here, we were on six-hour shifts, which*

were very rarely respected — I'm one of those people who value their time. Just as I arrive at work on time, I also insist on leaving when the schedule says. And that wasn't viewed favourably. Even when my working hours were extended by two hours, my salary stayed the same' (R14, employed in a private kindergarten).

In municipal kindergartens and schools, additional working hours are also unregulated and often involve administrative tasks and preparation for extracurricular activities. Several respondents shared that their actual working hours are 'much longer' than those stated in their contracts and that employers count the extra hours as 'work experience', but do not compensate them for this time (R09, kindergarten teacher; R14, employed in a private kindergarten). Midwives and teachers have additional responsibilities outside their working hours and job descriptions, such as helping to maintain school infrastructure: *'...When they were replacing the flooring, I went there again, stayed all day. Even if you're not doing anything, you're still there on a Saturday. Sometimes [the headteacher] counts that day as leave, because you're not obliged to be there, but you are there'* (R26, assistant educator in a kindergarten).

In professions that require 24-hour care, overtime is often linked to events outside the scope of daily duties, for example, the death of a patient in a residential care home for elderly people (R08, healthcare assistant in a care home for elderly people). Such homes are frequently understaffed, and at times dozens or even hundreds of patients are left in the care of a single person on night duty, who is physically unable to manage all tasks related to a deceased person. This type of labour is not compensated, unless there is an informal agreement with the employer. Not only is there no financial compensation, but it can also result in serious physical and psychological consequences: *'This lack of sleep that I have to endure, it affects the whole body, especially the cardiovascular system, the nervous system'* (R27, nurse and patronage care worker). Such extreme overwork inevitably affects both the quality of the job and of the care itself: *'I don't know how I keep going, but it's been so long that I don't see it as heroic. It's definitely not normal... They start making mistakes from the overload, they start shouting'* (R13, nurse).

*'...In care homes for elderly people — it's 24/7 — there's no lunch break, because that elderly person, the service user, might need something specific at any time... Especially in the private sector, the focus was on doing my job well — it didn't matter when I took a break.' (***R02, social worker in a municipal service (support for children), speaking about a previous job in a care home for elderly people***)*

The daily rhythm of work is also dictated by the needs of the care recipients: *'...She, for example, has gone outside, the bell rings, and you run. Breaks are scheduled, but it's just not possible — that's the reality.'* (R19, caregiver/personal assistant). The lack of sufficient medical personnel and care workers also leads to workers going without sick leave when needed: 'Having a sore throat, a headache, it doesn't matter, you put on a mask and keep working' (R22, midwife in a municipal nursery). 'There have been times when I've gone to work with a fever. Just because there's no one to cover for me. I take a load of pills and keep working' (R27, nurse and patronage care worker). The shortage of personnel is also narrated as a personal responsibility arising from the nature of the work: 'Me personally, I want to take sick leave, but the work sometimes... just has to be done. The documents have to be processed. Things have to be sorted out. Otherwise, when we have no problems, we can take sick leave' (R07, social worker in a municipal service for adults with disabilities).

Many of our respondents linked the right to sick leave with the idea that one should not 'overuse' it, and that it should be taken only when necessary. However, the cases of 'overuse' they referred to were solely related to providing additional care for ill family members, which quickly exhausts the limited number of allowed days. At the same time, mu-

nicipalities do not have workers who can substitute for personal assistants — often providing care for their parents — in cases of temporary incapacity for work. This means that those engaged in paid or unpaid care for their relatives have, effectively, only limited access to sick leave, and is forced to provide care while ill, risking both their own health and that of others.

Thus, workers across different areas of the care sector are expected to perform overtime work, often framed as supplementary or preparatory to their core caregiving duties. This is a particular issue in informal care work, where the terms agreed between employer and care worker are not subject to labour regulation and protection. Where contractual relations exist, certain violations (such as being insured for a lower wage or a shorter working day) still occur, as a result of the overall low pay in the sector. This forces female workers to 'choose' between higher immediate income, or accumulating formal work experience that counts towards a pension.

1.3 Pay: moral fulfilment or material security?

Care work is often taken for granted, and it is neither highly valued nor well paid, even when formalised and regulated. The issue most frequently mentioned by respondents in the sector is the inadequate pay received for their labour. Low wages are cited as one of the main reasons for the shortage of personnel and the lack of motivation to fill vacant positions: *'I'm happy with my job, I'm used to it, I've been doing it for so many years. That's it. It's just the pay...'* (R35, assistant educator in a kindergarten). '*The salaries need to change. I just think about the work I do, I think my pay is far too low'* (R07, social worker in a municipal service for adults with disabilities). *'If I could change something in the sector... Higher pay, so that people are more motivated. So, they stay to work and don't leave the field'* (R09, kindergarten teacher). Low pay and high living costs often force female workers to take on more than one job, even when one or both involve 12-hour shifts and/or overtime: *'It's not because things are good that I work two jobs'* (R27, nurse and patronage care worker). But even with standard shifts and compliance with regulations, working multiple jobs is normalised, especially in the healthcare sector, which inevitably leads to excessive workload.

The moral undervaluation of care work often goes hand in hand with its material undervaluation. As many of the interviewees pointed out, the issue is not only about increasing wages, but also about reducing inequalities within the sector itself. Hierarchies of labour and pay, particularly in the field of healthcare, as well as between higher-level and ordinary workers, are perceived as unjust, especially because they are combined with a sense that the labour of the latter is not valued as it deserves to be.

*'These are the two things — valuing the work and normal pay. When you give a nurse 700–800 leva, or fine, now it's 1,500 by law, but you still see hospital directors or department heads focused only on how to steal money through the clinical pathways, while the nurse is left to manage on her own, doing 36-hour shifts, right, there's not going to be an influx [of staff], only an exodus.' (***R31, nurse and patronage care worker***)*

In other parts of the sector, including regulated fields such as education, however, there is also a perception of critically low pay: '*This thing with the salaries — it would be good to regulate that too. At least to have smaller gaps, a set range from [one pay level] to [another pay level]*' (R14, employed in a private kindergarten). '*I take home 1,500 BGN (750 EUR). It works for me because I don't have a child to look after, I don't pay rent, I live with my boyfriend and we split the bills. But I have colleagues earning the same, some even less, and they have one or two children and pay rent.*' (R29, nursery teacher).

The problem of low pay contributes to the shortage of care workers. *'Who's going to enrol to study this, knowing that it is an unappreciated and low-paid profession?*' (R27, nurse and patronage care worker). After

underfunding and low pay are driven by the feminisation of care, labour shortages are addressed through the same mechanisms that naturalise care as an inherent trait of women — the requirement for additional work and caregiving as an extension of their 'biological' role. This is why, in the accounts of various respondents, entering and remaining in a care profession is described as a calling, which always involves dedication 'to the people', albeit expressed in different forms: '*To work with people, it has to come from within. To be able to stay on these low wages and do that, you have to like it*' (R02, social worker in a municipal service, providing support for children).

The physical dependency of care recipients requires care workers to provide additional support, which they understand both as a consequence of the lack of workers and as part of the nature of the work, a marker of its special role in society. When we talk about motivation for the profession, however, it is presented as a calling, as an inner need to help other people. '*I love working with people, in the helping professions, and that's what drew me to it*' (R33, social worker). '*This is my education, I like social work — being there to support, to help someone*' (R05, social worker in a municipal service, support for children).

*'Well, to help people, to know that I'll be useful. Being a nurse and a teacher — these are professions that are humane.' (***R11, patronage care worker***)*

Moreover, work in the care sector is strongly influenced by a sense of duty and responsibility. This manifests at several interlinked levels: care workers speak of their commitment to the profession as a matter of responsibility to their own conscience, to the people they care for, and to their workplace/the sector as a whole: '*There's no way around it, you have to work. There's no one else*' (R17, caregiver in a Western European country). *'You can't just throw them away like a dog; and even if it were*

a dog, you'd still feel pity for it' (R39, personal assistant). It is clear, however, that this sense of individual responsibility, which goes beyond the capabilities of some people in such situations, is not just a matter of principles and values, but also a consequence of the lack of real alternatives and a sense of hopelessness: *'I'm persisting, what can I do, I have no choice and that's how I feel. […] I can't imagine even for a moment that I could move her somewhere else.*' (R19, caregiver/personal assistant). 'It's just hard for me [her voice trembles] ... And it wouldn't sit right with me to put the old man in a care home, because there he'd last a month at most, not even that… That's why I'm forced to do this. I keep thinking: what if he goes there and dies within a month? My conscience would eat me alive' (R39, personal assistant).

This motivation often serves as an explanation for staying in the sector, as neither career opportunities, nor good working conditions/pay, nor the prestige of these professions are cited as motivating factors by practitioners. In fact, among our respondents, sensitivity is seen as a necessary part of the job, not as the opposite of professionalism: *'I don't believe that someone who is in this profession and who truly loves their job would not become emotionally involved with the children. For me, it just means that they're... how can I put it, fake. You inevitably become attached to the children, even if you only work with them for two or three years, and then it's hard to part with them. Because I can't like one child and humiliate another'* (R25, kindergarten teacher). What is more, this perception persists even when the respondent reflects on herself through the view of attachment as an 'obstacle'. '*I generally perceive myself as having difficulty setting boundaries — especially with children — which I realise is an obstacle. But I haven't had any problems with the children. Apparently, this is my approach, and for now, it works*' (R32, teacher).

It is interesting to note the contradiction: while in the standard logic of capitalist production emotions are perceived as 'unproductive', because they interfere with the rational nature of production (for example, it is not 'professional' to cry in the office, because it 'disrupts' the work process), in the case of care work, emotions — concern, attachment, closeness — actually generate more added value that can be extracted from the labour performed. If poor working conditions and low pay are the 'stick', then the emotional connection and moral sense of duty in the

caregiver-care recipient relationship are the 'carrot' that compels care workers to contribute (even more) labour.

The interviews showed that professional and personal satisfaction is particularly important for women working in the care sector. The specific nature of this type of work involves establishing an emotional connection between workers and the people they care for, treat, provide resources to, or educate. In this way, care workers' self-assessment of their labour and their sense of fulfilment are closely tied to how that labour is recognised by the recipients of care: *'You can tell when you see people outside of work — on the street, in the shop. The attitude of the children and their parents gives you a clear sense of the place you hold in their lives. To my great joy, both the parents and the children are happy to see me outside of work and that really warms my heart'* (R25, kindergarten teacher). *'In my previous job, even though it was well-paid, it didn't bring me moral satisfaction, whereas here, caring for the children and what you get in return — their genuine emotions — is extremely important and energising for me'* (R32, teacher).

At the same time, personal fulfilment and individual expressions of gratitude do not always resonate with how care work is valued by employers or by society at large**.** There is an interesting contrast between the recognition, in theory, of the value of care as a profession, and the reality of how care workers are actually treated in practice. As one of the respondents said:

> *'In Bulgaria, there's this other word — "gledane" [tending to], but "care" is something else! In our society, there is no respect for care.' (***R40, nurse***)*

When asked whether their labour is sufficiently valued, respondents replied: *'Well, no. It's as [...] if you owe something to someone and you're obliged to do something and respond immediately, and that's that...'* (R30,

primary school teacher). *'When you work with people and provide care for someone else, people take it for granted — "since you chose this job, I have no reason to thank you". This happens even if you're a doctor... when you work with people, gratitude is missing… And is my labour valued? No. Not by the parents. By society — yes, but here it's funny again, because when you tell someone you're a teacher, they praise you and act like you're a superhero — "how do you manage, I don't envy you" — but when it comes to the parents, they often look at me like I couldn't do anything else with my life, so I became a teacher... not even a simple thank you'* (R29, nursery teacher). *'There's a lot of talk in the media about violence by teachers, and they try to erode the respect for teachers in general. For sure, the profession is not as respected as it used to be in the past'* (R09, kindergarten teacher).

For migrant workers, even more effort is required by the tasks of proving themselves in the labour market, and establishing a place in that market. In Western European countries, care work has been pushed out of the everyday lives of nuclear families, as women who were previously engaged in domestic labour have entered paid employment. The responsibilities for the home, children, and elderly have been transferred to migrant women hired specifically for this purpose, making the symbolic value of this labour even lower. As a result, female workers must put in even greater effort to earn both personal respect and recognition for their labour, making an already complex and demanding job even more intense: *'There's a similar attitude in France, but I've come to realise that when you earn people's trust, when you are reliable, when you give it your all and the people on the other side start believing in you, then the attitude toward your work changes. [...] So, I dare say that in France I've earned the right to carry out with dignity a profession that is generally not taken seriously'* (R18, domestic care worker in a Western country).

It is important to note here how the respondents' emotional investment and professional responsibility, as well as the sense of moral fulfilment they report, discussed earlier, contrasts with the underappreciation and underpayment of the type of work they perform. As noted, care work is sometimes perceived as a duty and a calling, which serves to normalise the harsh working conditions of self-sacrifice and exploitation. Emotional labour and psychological strain are an additional burden that results from the inherently social nature of caring for others.

Many respondents repeatedly stated, in one way or another, that their work extends beyond the specific tasks inherent to their respective profession, and requires them to take on more than one or two roles. Personal assistants providing domestic care, for example, often perform the functions of nurses (e.g., measuring blood pressure, administering medication, changing catheters, treating wounds), as well as those of rehabilitation therapists, psychologists, and administrators. In addition to the mandatory reporting required of personal assistants, they also take on tasks such as collecting the pensions of the people they care for, and filling out their paperwork. In institutional settings, a similar taking on of additional responsibilities also occurs, though to a lesser extent than in domestic care: nurses often take on the role of caregivers or even educators when there are new young members joining the team (R27, nurse and patronage care worker).

Assistant educators take on the role of resource teachers, and have to educate themselves on appropriate approaches to children with special needs (R26, assistant educator in a kindergarten), without this being reflected in their job description or pay. In other circumstances, each of these roles could be carried out by a separate person with expertise in the specific tasks, as some respondents working abroad (R18, domestic care worker in a Western country, and R24, caregiver in a Western country) reported is the case where they work. In the local context, we see that these professions involve a wide range of activities, requiring a broad set of diverse skills and a lot of specific knowledge. This only further exacerbates the injustice of the low pay they receive and once again illustrates how undervalued this labour is in Bulgaria — it is undervalued both socially and economically.

Theme 2: Socio-economic vulnerability, migration, and social reproduction

Our research revealed certain conditions that place female workers in diverse situations of vulnerability related to violence at work, to their migration status, and to their family situations. In this section, we highlight some of the mechanisms of these vulnerabilities, focusing on is-

sues related to the specific nature of the work, violence and legal responsibility in the workplace, migration, and the expectations placed on workers as women (and as Bulgarians). Many of these conditions are structural — shaped by the economic context in which not only the Bulgarian care sector but also Bulgaria's wider labour market functions, as well as by the country's position in a global system driven by the market logic of profit at all costs. This logic also applies to the care sector, where the fact that care is informal, unregulated, spills over from the work into the personal sphere and from the local context into migration processes, means that people working in this sector often face different, intertwined forms of risk, physical and psychological violence, harassment, and legal liability. Very often, this means not only immediate personal vulnerability, but also vulnerability projected into the economically precarious future of the care worker herself and of her loved ones. The normalisation of care work as 'women's work', and as something that Bulgarian women do particularly well, imposes it as a duty and blurs the boundaries between labour rights and moral obligations.

About 15% of our respondents are retired women, most of whom care for other elderly or ill people. In 2023, the chairwoman of the Association of Health Care Professionals reported that 63% of medical personnel in Bulgaria are of retirement age (BTA, 2023). In 2024, the Education Trade Union at the Confederation of Labour Podkrepa announced that 10% of teachers are of retirement age and that, among kindergarten teachers specifically, the figure is over 15% (BTA, 2024). In most cases, retired women continue working out of necessity: *'Because pensions are very low... Do you think that were I to have a decent pension, I would still be working at 74!? I also need rest. I have worked my whole life'* (R38, personal assistant). Instead of enjoying a dignified old age, retired women in Bulgaria are exploited to fill the gaps in sectors that young people are largely unwilling to enter, and from which they cannot make a living. In addition to the shortage of personnel in these spheres, respondents reasoned that the high number of retirees was related to the low wages, explaining that this is how they supplement their pensions: *'Most of us are pensioners, because no young person would go work for 400 or 500 BGN* (200-250 EUR)*'* (R11, patronage care worker). The same goes for declaring a lower salary for social security purposes — a widespread practice, especially in private hospitals: *'They're very convenient*

for them, because they don't pay their social security contributions... it works for them, but for younger people, it's not okay' (R13, nurse).

2.1 Violence, legal liability and risks at work

In some of the collective labour agreements, particularly in the health-care and education sectors, there are clauses addressing violence at work. These provisions are the result of Bulgarian trade unions' recognition of the risk of violence as a significant issue in the context of work. Their position is expressed both nationally — through calls for the ratification of ILO Convention 190, which addresses gender-based violence occurring in the course of work — and internationally, through cooperation with the European Trade Union Confederation and the publication of translated studies and reports. Despite this, and taking into account all the examples from our interviews, we did not find any evidence of effective measures to address the specific vulnerability to violence at work — particularly in domestic care settings — either through the organisation of labour, or through the recognition of this risk in pay or employment status.

As we have seen, the relationships between care workers and care recipients require not only physical but also emotional labour, involving the building of trust and mutual responsibility, and, in many cases, developing into personal attachment. However, the experiences of female workers also reveal how these relationships can take the opposite turn. First, out of concern for the people they care for, some interviewees described how some specific vulnerabilities — especially in cases involving elderly people with severe physical and mental illnesses — places care recipients at risk of violence: '*There is a lot of abuse there, because someone who is ill or bedridden or has dementia can't speak or tell anyone. And these people are at risk of violence and neglect... and this happens all the time, but there are no witnesses, no one to say anything'* (R28, personal assistant).

From the interviewees' perspective, they often share stories of aggression from the people they care for and their families. Here, we observed a distinction between female workers employed in various types of institutions and those providing care in private homes. The former can

rely on pre-developed and tested mechanisms for addressing conflict, as well as on training they have undergone: *'The children are quite aggressive. But I have defended a thesis on aggression in children, and I manage to cope. We've had issues with an aggressive parent — I've been the teacher on duty. But we've managed the situation, we've never let it escalate. It has never come to fighting, we haven't allowed it to'* (R10, teacher). In contrast, a significantly greater vulnerability is observed in domestic care settings, and crisis situations must be resolved based on the specifics of each case and the personal relationships involved. In addition to the frequent blurring of boundaries between working and personal time that occurs when the home is the workplace, a key feature is the invisibility of working conditions: in many cases this creates further vulnerability to inappropriate treatment or even harassment by employers.

*'[At that job] I was a prisoner, not an assistant but a prisoner. They wouldn't let me go outside, because I would press the elevator button, touch the door handle — it was during COVID… The daughter and son-in-law [of the sick person] bought me everything and brought it to me. I didn't struggle for food… But it was some kind of obsession. Even when I let in the water company worker — the woman had come to take a meter reading, and I let her in — they caused a huge scene.' (***R38, personal assistant***)*

Domestic care work is linked to additional legal liability. Some of our respondents have faced legal prosecution and/or accusations of committing a crime in connection with their professional duties, leading to various problems, including the loss of employment. This is especially true for female workers abroad, where there is often no guarantee whatsoever from the company that facilitates the contact between the caregiver and her patients: *'I don't have any protection whatsoever from*

anyone. The agency throws you to the wolves, the family looks after their own interests. And you are completely left to the mercy of fate — you have to go through court cases, nothing' (R24, caregiver in a Western country).

The respondents working in migration are even more vulnerable in terms of working conditions, exposure to harassment and violence at work, and racist discrimination based on their origin: *'In the previous household, there was a lady who was extremely domineering and even subtly sadistic. She liked to play games with you, to humiliate you with certain remarks, I was even asked if we had colour TVs in Bulgaria, things like that. [Also,] the man would periodically become aggressive toward me. And regarding the duties, she would just sadistically play games with me, including measuring how thinly I had sliced the carrots... You come from Eastern Europe... it's not obvious at first, but you begin to feel it over the years. They try — even at this address, even though the people aren't as nasty or cruel as the previous ones — they try to manipulate you into feeling as though you should be constantly in active work mode, as if you should feel guilty if you decide to rest, to go out... A woman, if she's already been crushed by awful employers in Bulgaria, she's mentally broken, she has no strength or energy to fight back... she doesn't insist on what is rightfully hers'* (R17, caregiver in a Western country).

Most of the female workers interviewed did not feel threatened by potential legal liabilities arising from their professional duties. Nevertheless, while discussing the topic, they pointed to certain specific things that create situations of vulnerability in the workplace. For example, frequent complaints and threats (if not actual lawsuits) come from parents in kindergartens. According to the teachers we interviewed, the reasons behind such situations are mainly due to parents' lack of information or knowledge about the caring labour which the teachers' work entails. As a result, part of their job involves providing clarification and reassurance to the parents. There are no official procedures for dealing with aggressive or confrontational parents, but most teachers believe that they would receive support from school management in the event of a real threat or legal action. In one case, cited by a respondent, the school had introduced a procedure that prohibited parents from entering the grounds of the secondary school where she worked, which helped avoid the 'chaos' of unrestricted access (R21, teacher).

2.2 Long-term and family vulnerability in the context of migration

Migration appears in the narratives of women working in Bulgaria as a distant or more immediate possibility — sometimes because their spouse already works abroad, often out of necessity due to mounting household debts, loans, or the need to support children: *'[I haven't migrated], but I wanted to, back when we were living on credit, on loans... even if you don't want to, you wonder what to do to improve your situation'* (R25, kindergarten teacher).

> *'I took up this profession [personal assistant] out of necessity, because I had to go somewhere to help my children. I've been on my own since 1983, and I had to — my children are good, but the money isn't enough. We had a university student, we had to get her through her studies, so I left... I've worked 24-hour shifts... Every woman who goes abroad to work as an assistant is trying to help her children. We're like that, we Bulgarian women — we help our children as long as we live.' (***R38, personal assistant***)*

It is well documented that, at the European level, more than one-third of women employed as domestic workers have no right to maternity leave, related benefits, or allowances, and in some EU countries, care workers are not entitled to unemployment benefits (European Parliament, 2015). While they are of working age, workers see Western countries as providing the opportunity to earn higher incomes (we did not encounter any other type of motivation among the care workers from abroad that we interviewed): with the advance of age, workers come to perceive returning to Bulgaria as the safer option: *'And I came back, because I'm getting older and I was worried that something might hap-*

pen to me abroad and my children wouldn't be able to bring me back' (R38, personal assistant). Thus, working abroad is seen as an activity in service of the family (or, in some cases, of personal development), but it does not provide opportunities for a fulfilling social and cultural life, or for building lasting relationships with the host country. This model is extremely advantageous for the countries in which the women work, as they benefit from the labour of women who typically arrive alone, have little choice but to focus their lives almost entirely on work, and leave once they are no longer of working age.

An interesting aspect of social workers' activities is the impact of migration processes on the people they work with. At various points in the narratives of some respondents, a certain key topic emerged: that of migration by people of working age, whose children or elderly parents ended up in the social care system due to the absence of family support — or, in the case of children, due to neglect. Previous research has also documented cases in which, following migration, the middle generation is pressured to care both for their grandchildren abroad and for elderly relatives back in Bulgaria (Deneva, 2012). This brings into focus the issue of so-called care chains, in which female workers from Eastern European countries migrate to provide care work in households in Western countries, while the same type of care at home is taken up by relatives or, alternatively, further deepens the sense of crisis in the social care system. Moving from one country to another, shifting between different types of care work, or combining two or more types of that work, leads to an accumulation of care labour, which shapes care as a career path — albeit one that, in many cases, is not freely chosen. In the same way, it normalises care as women's work, since women have already been providing care for their family members in one form or another.

2.3 Normalising the 'second shift' of care as women's (and Bulgarian) work

The biographical narratives of the respondents point to a variety of life trajectories leading to professions in the care sectors. Some entered by chance, following a friend's recommendation or due to an available position: others were drawn by relatively decent working conditions (a state job, regular hours, paid leave); another source of attraction, for

some, was the deep sense of fulfilment that comes from working with people; still others came from families of teachers or doctors; and a fifth group consider their profession a calling they have always aspired to. Others initially decided to temporarily 'give it a try', but ended up staying. For some, the need to care for a family member ultimately shaped their professional path. For female workers abroad, however, care work is perceived as the only available option — they go abroad with the expectation that they will become caregivers. The lack of opportunities in Bulgaria for securing their family's financial stability and the future of their children, due to low pay, is for most respondents, the reason why migration is undertaken or seriously considered.

Given the predisposition to working with people, the sector often sees 'transitions' between different care professions, especially in the case of more specialised female care workers (for example, those with a university degree in the field). During the research, we observed that when changing jobs, many of the women interviewed remained working within the feminised care sectors even if they changed the field of labour within it, partly because of the socialised tendency to do work by tending to others, but also because of the constant shortage of workers, personal motivation, and the meaningfulness of the work. This type of continuity is also observed among migrant female workers and those who have returned from abroad, many of whom continue to engage in care work in Bulgaria as well.

On the other hand, the naturalised notion of 'women's work' sometimes means, also, recognition of accumulated 'experience' within the domestic sphere as something women can do — and therefore use as a resource to realise their labour power. In the cases of migration particularly, the process appears to be one of almost 'natural' demand for women, who in turn, are already aware of their potential to work in something they are assumed to be good at: *'When I went, I knew I'd have to look for a job in the service sector — in private homes, caring for elderly people, for children. So, it was completely clear to me where I was going and why'* (R18, domestic care worker in a Western country).

However, it is precisely the recognition of domestic work as work that poses a problem in cases where there is a conflict between family re-

sponsibilities and 'roles' and career development. Sometimes the family serves as a unit in which labour is redistributed to care for its members in need, and this activity involves children, spouses and parents. *'Even before I started working on a contract, I helped a lot with this when I was at home because I was studying in another city before. So, I can't say that I separate it. It's something I'm used to doing and it's part of my family duty'* (R20, caregiver/personal assistant).

The life path of the women respondents in the sector is often shaped by the need to care for relatives rather than a choice of profession. The feminisation of certain professions (midwifery, for example) is normatively determined. In other professions (such as nursing), there are quotas for men in university programmes, but these are rarely filled, as our respondents pointed out. In others — such as education — more men are present, but the sector remains strongly feminised. In yet another case, when a woman care worker is a personal assistant to a family member, it is often she and other female relatives who take on the responsibility of caring for children, the ill, and the elderly. Through the 'Personal Assistant' programme, one of the relatives receives funds to live on while providing care, but the family continues to function as a single household with a shared market, budget, and division of responsibilities among the women in the home — often with additional financial support from other relatives, as the remuneration is low.

Some of the respondents attribute the difference in the ratio between men and women to the expectations placed on them. The impression is that even when men are employed in care work, the gendered division of labour persists, with tasks split into 'men's work' and 'women's work'. *'There are men candidates in the sector, but they always awkwardly ask: "will I have to change nappies, will you assign me to care for women?" He does what he does for a month or two, then quits'* (R40, nurse). According to R07, a social worker in a municipal service for adults with disabilities, this happens because of the stigma passed down through generations that women are more sensitive, more empathy-driven, and more likely to 'attach' to those they care for. There is also a perception that men would not engage in work as personal assistants: *'I don't know, we women are more resilient. We're more resilient, and we Bulgarian women in particular — nothing scares us'* (R38, personal assistant). Thus, the care

sector often naturalises not only the 'womanness' of care work, but also to what extent women's care is seen as an inherently Bulgarian or Eastern European 'trait'.

*'My friend from Poland and I both fit into this — into the little box of what kind of work an Eastern European woman does in the UK. Even though we're there for higher education… You work for two weeks and then rest for two weeks. Which means that many women, pensioners, come, do their two-week shift, and go back to South Africa or Eastern Europe and live a double life.' (***R01, social assistant, elder care, referring to her previous job abroad***)*

Such symbolic and practical normalisation of the place of Eastern European women — and women from Bulgaria in particular — as confined to a specific service role in the global care chain positions them as givers, but not as deserving or receiving care. This situation places Bulgarian society in an economically disadvantaged position. To reverse such a logic, Raya Apostolova, a sociologist at the Bulgarian Academy of Sciences, recalls the work of her colleague from the socialist period, Minko Minkov, who calculated the damage caused to developing countries by the draining of labour through migration — even within solidarity-based socialist programmes — and proposed a kind of tax on migrant labour to be paid to the societies from which migrants emigrate, in order to compensate for the loss of their labour (Apostolova, 2023). In this sense, we join Apostolova in calling (as she did in a lecture she gave in Georgia in 2023 to activists and trade unionists, including LevFem members) for such a tax to be applied specifically to care labour. As a starting point, such a policy could be introduced within the EU context and then piloted globally.

The normalisation of care, however, does not only take place at the international level — it also occurs on an interpersonal level. When we talk about unpaid care within the family, it is most often carried out by women. On the one hand, this care includes household maintenance — caring for children, cooking, cleaning, doing laundry, and providing emotional support to other family members. Many of our respondents reported that there is some degree of shared responsibility between them and their spouses. Nevertheless, their responses often include phrasing around how much their husband 'helps' with household work. In any case, in certain areas such as childcare, it seems that this work is predominantly performed by the female workers interviewed after the end of their formal working day. This labour is also passed down across generations. *'Free time is… when I go to sleep... The rest of the time, I'm running on "adrenaline", because I'm constantly looking after the grandchildren'* (R06, social worker). *'My husband is in a particular state of health. My day basically starts in the morning with caring for him; during the day he manages on his own, after I've prepared everything he'll need, and in the evening, when I return home, we start again — with hygiene routines, dinner, medication, insulin. To start my working day at 8:30, I get up at 5:30, so I can manage everything before I leave. And so, instead of going to bed at 9, we go to bed at 10:30, just to successfully get through the day'* (R18, domestic care worker in a Western country).

On the other hand, when there is a person in the family who needs constant care, they are entitled to a personal assistant. In most cases, personal assistants are women family members — mothers, sisters, daughters, or granddaughters. Their minimally paid care does not stop at the end of the working day; they continue to perform the primary caregiving role after working hours, without this being recognised as care work. Some of our respondents who work as personal assistants to a family member hire an additional person to replace them in caring for the ill relative during their off-hours (at a rate higher than that they themselves receive as assistants), so that they can work overtime elsewhere and earn additional income to cope with extra costs arising from their relative's health condition. Rest is impossible, as municipalities cannot provide substitute care workers to cover for personal assistants during illness, leave, etc. Others work full-time as care workers and also care for ill spouses, siblings, or parents before and after work: they remain engaged in care labour from morning until night.

Theme 3: Workplace relationships

As we have already pointed out, identifying the main problems in the sector is not difficult for care workers: low pay, poor infrastructure, excessive workloads, unclear distributions of responsibilities and duties, and the lack of appreciation of care work are frequently mentioned in the interviews, and are clearly and concretely recognised and articulated. At the same time, pointing out these problems is often accompanied either by the identification of individuals as responsible for addressing them, or by accounts of individual or collective coping strategies adopted in situations that female workers should not have to face or resolve on their own or through informal means: or by a sense of disempowerment and, at times, uncertainty about identifying the actors or avenues for change, often linked to the volatile political and economic context and the diffusion of responsibility within the sector. In this section, we elaborate on how the respondents frame these problems, and how they imagine possible solutions through the lens of broader structural change. The key question here is not only what the sector needs, but also to what extent the female workers themselves feel empowered, and how they envisage mobilisation to achieve better labour conditions.

3.1 Solidarity, alienation, and collective self-exploitation

In addition to labour relations with employers and care recipients, another important element shapes the working environment: relationships with colleagues. The interview data outlined three trends in this regard: the formation of stable and solidaristic relationships; lack of contact; and, lastly, avoidance of, and hostility towards, colleagues.

Firstly, those working in formal contexts with a clear contract, employer, and a community of colleagues often manage to build relationships based on support, taking time to listen, mutual understanding, and the offering of help. Relationships of this type not only provide interpersonal comfort and peace of mind in the workplace, but also ensure the effective performance of the job: *'We share everything. We're very close, because there are few of us, we suffer from the same issues — it's inevitable'* (R29, nursery teacher). *'Exactly because we understand each other, and that's the*

most important thing — for colleagues to step in when it's hard. The two teachers working together need to coordinate. If one slacks off, the group doesn't function. Even the assistant, even the teacher — if one slips up, it's over, it doesn't work' (R26, assistant educator in a kindergarten).

As mentioned above, the shortage of personnel, the sometimes unregulated nature of duties and breaks, as well as the project-based nature of some jobs, leads to the emergence of responsibilities that go far beyond the job description. In such situations, to complete a given task, workers rely on self-organisation, initiative, and coordination — even when this means performing entirely different work, skipping breaks, and not taking sick leave: *'Well, just like I sometimes do the general worker's job — it's happened quite often that I mow the lawn or dig holes — because we currently have a project to green the kindergarten, in which my teachers are participating. And I just have to help out, there's no other way, so I dig holes and that's that!'* (R26, assistant educator in a kindergarten).

Some of the respondents link this cooperation to the nature of the work they do. Empathy, care, and responsibility as central elements of the profession and of the relationship with care recipients are extended to their colleagues as well. '*Well, they helped me a lot. I survived thanks to my colleagues: they really put up with me, and when needed, they even changed their holidays... That's the informal support they gave me'* (R28, personal assistant).

In other cases, however, responsibility toward colleagues and the workplace can lead not only to self-exploitation, as we saw earlier, but also to neglect of one's own health and the normalisation of violations of labour rights.

*'I had to go to the doctor on a Monday — I had been coming to work sick with a cough for a week because there was no one to cover for me. The headteacher was also on leave. I couldn't go to the doctor, I didn't want to leave my colleagues to work alone... Sick leave is harder. They don't say it directly, but unless you're bedridden, don't take sick leave.' (***R29, nursery teacher***)*

The second trend, most visible in the case of domestic care workers and those working privately with individual clients, is the absence of contact with colleagues. Isolation within the individualised relationship between care worker and care recipient most often confined to the latter's domestic setting creates serious difficulties in connecting with and maintaining relationships with other female workers in similar situations. With a few exceptions among migrant workers that we discuss in the next section, respondents shared that they had no contact with colleagues or that such contact was very limited: *'I have no colleagues. I used to share things, and still do, with the family I worked for. With the mother and father, but I have no colleagues... I don't personally know any other nannies. That's why it's hard for me to answer this question [about collective action for better working conditions], because I don't have a single person in my circle who does the same work I do'* (R04, nanny). *'I only see other assistants at the beginning of the month when we go to submit those reports to the municipality'* (R20, caregiver/personal assistant).

The third trend that emerged from the interviews is the presence of a degree of mistrust, avoidance, or even hostility between colleagues. Beyond the interpersonal relations and conflicts that can arise in any workplace, what is interesting is the link between the closure and fragmentation of public services and the deepening distance between different profiles of care workers remaining on the ground. In this context, their relationships show a retreat into their own professional silos and

a certain level of competition for resources, as well as an increased responsibility for a larger number of users of social and health services. A particularly telling point is the breakdown of connections between social and medical workers in cases where individuals require both types of care. The shortage or reduction of a specific type of essential care often leads to situations of conflict.

In the healthcare sector, strained relationships are also linked to a sense of internal hierarchies. These are particularly evident between nurses and doctors and reflect the feminisation of the nursing profession and the pay gap: *'[A]mong us, healthcare workers, the institution we're affiliated with is meaningless. That is, we don't have the right to go and request a referral… GPs think we're taking away their livelihood. [The patients], when I or another nurse go out, they start whining and complaining. But the moment the doctor comes out (excitedly), "Oh, doctor! I'm so glad to see you!" And there's not a single complaint… As for the doctors, I haven't personally felt this… but listening to the other nurses — there's disrespect, condescension, at times even mockery [towards the nurses]'* (R31, nurse and patronage care worker).

The role that migration processes play in overcoming distance, and addressing the barriers to connecting with colleagues, is interesting. Those who work and/or have worked abroad, providing care in the homes of their clients, told us that they actively seek contact with female colleagues and/or fellow countrywomen who are able not only to guide them through the specific cultural characteristics and working conditions of the country in which they live, but with whom, also, they can share problems at work or violations of labour rights. At the same time, recruitment agencies — acting as intermediaries between individual employers and workers — disapprove of or even openly oppose such contact on the pretext that it might create a conflictual work environment: *'There's this kind of dynamic here — [the agencies] try hard to prevent us from having contact with one another, but of course they can't ban or prevent it altogether, because it leads to conflicts, gossip… But otherwise, the women do meet up. There are colleagues who drive, they pick up three or four others, those they keep in touch with, and they go somewhere'* (R17, caregiver in a Western country*). 'I don't think that if there were unions, things would improve. It's just that the system is set up*

so that the agency has control over whether you have work or not' (R24, caregiver in a Western country). Thus, while female workers sometimes maintain friendships with fellow countrywomen, sharing experience, advice, and job offers, the power held by employers and agencies over their individual labour prevents their shared experience and established relationships from transforming into a social movement.

3.2 Individualising problems and solutions

Apart from the increase in remuneration, unanimously identified as the main change that needs to be implemented, the problems named by the respondents fall into two main groups: on the one hand, specific issues related to their individual workplaces and ideas for resolving them are identified: on the other hand, structural problems and social actors/agents that could influence them are outlined.

In the first category, demands include improvements to infrastructure, equipment, the personnel situation (i.e., they urge the hiring of more personnel), and the simplification of administrative procedures. In these cases, the change is understood as a solution to concrete problems — material, communicational, logistical, or related to the redistribution of responsibilities. In this sense, as also described in the section 'Trade unions and self-organisation' below, the preferred method for improving working conditions in many instances involves personal, direct contact between the worker and the manager, including the making of requests, the outlining of problems, and the proposing of solutions.

In line with this, care workers we interviewed tend to seek solutions to problems at their workplace independently, preferring to address management directly (alone or together with colleagues) rather than through the trade union: *'I mostly speak with the senior management, especially with the headteacher, not so much with the deputy headteacher'* (R12, teacher). *'In principle, the manager is the one in the respective unit whom we should turn to… the manager is the one who makes decisions at the local level'* (R07, social worker in a municipal service for adults with disabilities).

*'For any problem of any kind, I would turn to the director. Even if she can't help personally, she would set things in motion, direct me to someone. Maybe it's possible to seek help elsewhere, like from a union, but right now I work in a place where I would turn to the director.' (***R22, midwife in a municipal nursery***)*

The effective resolution of problems by a manager is often attributed to their moral and personal qualities, as well as to communication skills they might possess: *'If we have a problem at work or are unhappy with the conditions, we talk to the director and the dispatcher, who are responsible. The director in particular is a very conscientious woman who knows about everyone's situation, finds time to talk to us all — she inquires how the service users are, how the patients are. She always reacts promptly, very kind woman, cares about the staff'* (R11, patronage care worker). In the private sector, the role of the manager as the one who defines the working conditions and any potential changes in response to staff discontent is even more notable: *'Who is responsible for changing these things? [It's] the management itself, which is one person. We work according to his model. Because when you open a private kindergarten, you have a clear idea of how things should be done, you have your brand, your working method, this is what's promoted to the parents.'* (R29, nursery teacher).

3.3 Disempowerment, shifting context, and diffusion of responsibility

The articulation of these problems is accompanied by a sense of disempowerment and, at times, uncertainty about who the relevant actors are or how change might occur: *'If I could change something at work: more tolerance and respect... But I don't know how these things can happen. Those at the top don't do anything, so I don't know who would change it'* (R03, kindergarten assistant educator). This feeling of political power-

lessness and lack of motivation to engage in mobilisation is explained by examples of past/recent failures of collective organisation.

> *'This injustice that has taken root here — this disorder, lawlessness, the lack of respect for laws, for public order. But I've come to the conclusion that it doesn't depend on me alone — not that it doesn't depend on me, maybe I'm to blame for not participating in such protests.... but such protests don't lead to any meaningful result either. Everything passes, is forgotten, and repeats again. There is no order in our country.' (***R36, personal assistant***)*

The unstable and unpredictable political situation in Bulgaria also contributes to a sense of insecurity and difficulty in orienting toward change, an inability to plan for the long term, and challenges in establishing contact with institutions or working together toward a specific goal for change. *'Either something drastic has to change — I don't see how that will happen [in this] uncertain environment: there's no political stability. If there were stability, there would be change, but with these constant changes of ministers and here in the regional inspectorate — one starts to make changes, another comes and stops them. If there were stability, some things could be done'* (R12, teacher). *'We need to get in touch with the people in charge. The bad thing is that they change like the weather here. Today someone is a minister, tomorrow they're not. Organisations can't establish lasting cooperation with these people, but long-term work in this direction is what's needed'* (R37, personal assistant).

Some of the respondents do identify the authority to whom demands can be addressed, but more in the sense of an institution that could take steps toward change and from which initiative is expected, rather than one that female workers in the sector could approach with

demands. Some respondents clearly align themselves with this top-down approach to change, which stems from an understanding that responsibility for improvements lies with institutions and the government: *'[The] change depends on the Ministry of Social Work'* (R33, social worker). *'[It depends] on the state, the Minister of Health, the [Health Insurance] Fund, Parliament. It all depends on those at the top. These are the institutions that are supposed to work for the people. Again, I mention the unions — in our case, you can't raise your head, because you'll be fired'* (R37, personal assistant). *'Where should it start? Well, again, it has to come from above. Someone who has the will. Not just writing... you know, laws and scratching things out... Because in this law, many of the things that were laid out got changed, but... I don't know. I don't know who writes them. Whether the one writing them has ever even gone out into the field. Because if it doesn't come from the lawmakers, it'll be hard for anyone to accept it. You can't do anything if you know there'll be an inspection from the agency that's been set up to carry out checks. And when they come, they demand this and this and this'* (R06, social worker in a municipal child support service).

Theme 4: Trade unions and self-organisation

Another specific point we discuss in this final section of the report is the difference in the type of work in the care sector and, in particular, the place where it is performed, which makes it more difficult for some workers to unionise and/or organise than others, affecting their working conditions and levels of vulnerability, described above. Respondents who identified themselves as union members are mainly employed in state and/or municipal institutions such as schools, kindergartens, care homes for elderly people, hospitals, and social services, while non-unionised workers mainly work as nannies/caregivers, personal assistants, patronage care workers, or are employed in private kindergartens and schools. All of them identify the problems very directly, and often see those in power (government, ministry, employers) as the main problem in the sector. However, with the exception of union leaders, who prefer consensus, compromise solutions, and the avoidance of conflict, they do not feel empowered to change anything about their working conditions and vulnerability.

4.1 Clarity on problems and identifying obstacles to their resolution

With regard to the possibility of identifying problems and articulating potential ways of mobilisation to address them, the most noteworthy responses of our research participants were those that revealed the contradiction between a lack of power in practice, on the one hand, and an awareness of the power of the majority, invoking the image of solidarity and mass action, but as an abstract idea and/or ideal, on the other. *'We all need to rise up, but in Bulgaria there is no one to hear us... and anyway, we can't do anything, ten people — we're a drop in the ocean'* (R36, personal assistant). '*There should be complaints, riots, protests, petitions about pay and social security... but I haven't heard of any willingness among nannies to revolt. On this issue I think that it would not come from themselves*' (R04, nanny).

It is important here to note the different possibilities for collective mobilisation across the various sectors of care work, as well as the variation in public sensitivity to, and potential support for, collective demands. The high level of unionisation in the public sector not only facilitates periodic pay increases through collective bargaining mechanisms, but also fosters a readiness to mobilise when needed. Sector-specific factors such as the profession's public prestige, opportunities for contact and support, the ability to organise horizontally among colleagues, and the potential to initiate protest actions — these all strongly influence how female workers articulate and address their professional problems, and how they perceive their own role and capacity to impact their resolution. In this regard, the most disadvantaged women are those providing care in private homes and those working abroad, since the isolation of their workplaces is compounded by personal, legal and financial insecurity arising from the migration process.

Many of the women are well aware of the long and difficult processes that are unlikely to lead to unanimous and simple solutions, and that those in power would block any such solution.

*'It is an old tested truth that those who hold money and power will not voluntarily make concessions to the people who have to work for them or provide services to the relevant sectors. Without a struggle, nothing will happen!' (***R17, caregiver in a Western country***).*

A sense of disenfranchisement and disempowerment prevailed over most narratives about the possibility for social change: *'Protests against certain government policies, the arrogance of politicians, the disregard, and ridicule. That's why I don't see it, although I personally believe that at some point, perhaps, people should take up arms and make some kind of impact'* (R31, nurse and patronage care worker). *'But it's also a game... an economic game between NGOs, state structures, and so on. A political game, and a governmental one. And somewhere among these secondary interests and benefits... sometimes, you know, we say to ourselves, "This person actually has his own personal interests and he's using me"'* (R28, personal assistant).

4.2 Membership in and attitudes towards trade unions

For most of the unionised respondents, joining a union that can exert pressure — through strikes or other means — has secured better working conditions and provided a sense of protection for female workers: *'[The teachers' strike] changed so much. After it, our salaries increased significantly. Before that, there were times when we went three to four months without pay, but following the strike these budgets were introduced for each school, and that's wonderful'* (R09, kindergarten teacher). '*If something happens and my employer wants to sack me, I go to the union and say, for example, that I don't think it's fair for them to fire me. And I have protection from there'* (R26, assistant educator in a kindergarten).

Among those who are union members, however, there was a marked divide between active participants and those who feel their membership is merely pro forma, yielding only limited benefits such as extra leave days: *'[Most of] us join for the eight days of extra leave we get'* (R35, assistant educator in a kindergarten). Not everyone, however, takes advantage of these or other membership perks: *'Well, it's not that membership is pointless. I know there are extra days of leave you can take, but that's it. I've never needed additional leave… which is why I've never bothered with the union'* (R03, kindergarten assistant educator).

A lack of trust in trade unions also became clear in respondents' statements, as they are often not seen as the primary defenders of labour rights and champions of improved working conditions: *'In every school, the union leader is a person of the boss. There isn't a single institution where it isn't that way. This role of the unions has existed since time immemorial — historically they defend the chairperson and the union leader, but not the worker'* (R21, teacher). This attitude is frequently linked to passive membership among ordinary members, where female workers have no direct relationships or interactions with union structures and have not developed a reflex for collective action.

These union-member workers, in choosing to assert their rights more through direct, individual appeals than through collective action, do not differ significantly from their non-unionised peers: *'My small victory was against the municipality: I started submitting written requests for leave, or to be paid under article — whatever it was. I mean, I immediately learned my labour rights'* (R28, personal assistant).

'First, I would seek support from my colleagues, and only then would I turn to management' (**R32, teacher**).

Respondents who speak positively about their unions, and consider them genuinely effective, are often the most active members, includ-

ing those holding leadership roles — local union representatives, for example. In these roles, they engage directly with union structures and understand the mechanisms used to exert pressure on employers: *'I'm very satisfied with them [the union] in terms of support, attitude, everything. Every time I've turned to the union, their lawyer drafts everything and does everything. Even if there's something I want from my employer, I just tell him… When it's something major, it comes from the union, and in some cases I tell them to assign it to me — when they see me, they get even more scared'* (R02, social worker).

In this respect, however, these respondents do not see the unions' strength primarily in their capacity for confrontation with either employers or the authorities (for example, through strikes), but rather in the established mechanisms for bargaining at local and national levels. Yet these mechanisms can often operate informally and thus depend on personal relationships between union representatives and institutional directors or managers. *'If there are any issues — say, with the manager — then, in her capacity as the union chair, she has the right to arrange a work meeting between the employer and the union. A statement is then issued, the director says what is feasible and what is not within her competence. Then some agreements are made and consensus is reached, that's it… once we sit down to negotiate, she [the director] commits herself. It never escalates into serious conflict'* (R08, healthcare assistant in a care home for elderly people).

On the other hand, union experience gained in another country can strengthen a female worker's sense of empowerment in asserting her rights, even in situations of heightened vulnerability and the absence of collective protection structures and mechanisms. One caregiver in a Western country, for example, shared that it was precisely her union experience in Bulgaria that motivated her to more thoroughly study her contract and rights abroad, and to defend those rights: *'The fear of being in an unfamiliar place, my experience in Bulgaria — I was a member of [the Confederation of Labour] Podkrepa; I had connections, acquaintances, and friendships with left-leaning people, trade-union activists, who during the years of our great democracy… [G]ood things don't descend from the sky; you're in a dynamic where you constantly have to stand up for them yourself'* (R17, caregiver in a Western country).

Other respondents draw a direct link between labour and civil rights for those working abroad, illustrating how discrimination based on origin has an impact on labour rights and on the role of unions for migrants: *'The rights of women coming from Eastern Europe simply need to be made equal to the rights of people here... When people here know that we have equal rights to them, you can always turn to a union. And when they are afraid that you will turn to a union, they will not abuse you. Just as they do not abuse their own people'* (R24, caregiver in a Western country).

Unionisation is also important for fostering solidarity across different sectors and enhancing the mobilisation potential of female workers, since membership and accumulated experience in a union can lead to a 'broadening of one's worldview' (R07, social worker) and an increased sensitivity to issues not only in their own sub-sector but, also, in other, related, areas of care work: '*[People] see that they are not alone. It's just that the union... brings together people from different sectors'* (P07, social worker).

Often, however, the lack of interest in unionisation also reflects how the female workers perceive the labour they perform — at home, on an individual and informal basis, and often for relatives. Some of these women are pensioners and see this work as a way to earn a little 'extra' and maintain a more active social life: '*Since we're pensioners, we feel that... the important thing is not to stay at home'* (R11, patronage care worker). Others view their working conditions as a matter of personal organisation, since they carry out the work in their own home or that of a family member: '*How can I assess my working conditions — they're whatever I make them'* (R36, personal assistant). In this sense, some respondents do not perceive unions, unionisation, or collective defence of labour rights as relevant to them, and so they often do not seek out information — *'to be honest, no — I had never even thought about it'* (R20, caregiver/personal assistant); *'it just never occurred to me as an idea'* (R23, personal assistant).

4.3 Attitude towards protest actions and other forms of (self)-organisation

Effective strike actions are rare even in the most unionised segments of the care workforce, such as among teachers, with many respondents citing only the 2007 teachers' strike as an example. More often, unions organise sym-

bolic strike actions. Ordinary members typically do not participate in organising these actions (nor in the decision to call them), but are expected to 'respond' and 'join in' activities that are generally organised in a centralised, hierarchical manner: *'We join in when there's something. We're ready to react. They give us a shout, and we're there'* (R07, social worker in a municipal service for adults with disabilities). These — and other attempts such as submitting letters, petitions, or complaints — do not always achieve a successful or immediate outcome. In the case of social workers, an increase in annual paid leave has been agreed, to take effect from July 2025, but at the time of the interviews this remained unclear: '*We, the social workers affiliated with [the Confederation of Labour] Podkrepa, held a meeting in the regional centre. We made a draft proposal for the paid leave and sent it. No result. Nothing'* (R06, social worker in a municipal service for children with disabilities). Even where the desired outcome is not achieved, some respondents hold a positive view of protest actions: *'At the very least, it gives courage to the rest of the personnel to stand up for our positions, which to me is a major step. Not to endure the situation we're in. And so, making more noise until we win what we want'* (R27, nurse and patronage care worker).

Alongside scepticism about the effectiveness, in their own sector, of trade unions and strike action in general, unionised respondents tend to share examples of participation in other solidarity activities and actions, such as participation in, or support for, protests and petitions by female workers in other sectors, often at the initiative of the union: '*We supported the social assistance workers when they were protesting. Recently we organised a petition for the nurses. We've gone to protests, our representatives in Sofia, but again it was through the unions'* (R06, social worker). '*That's the point — when one person needs something, everyone mobilises'* (R02, social worker).

*'Whenever there's a petition, I sign it… I would always support [others' protests] when it's about having their work valued properly. Every form of work should be valued properly, and everyone deserves to earn a high salary. Overall, pay in Bulgaria is very low.' (***R09, kindergarten teacher***)*

On the other hand, the interviews show that non-unionised women — often performing care work in the individualising and isolating conditions of private homes — are generally less inclined to take part in collective solidarity or protest actions, especially on issues related to working conditions. The reasons most frequently cited are the lack of time *'I'm busy enough'* (R36, personal assistant), lack of information — '*There has never been an organised protest by workers in the sector, or at least I haven't heard of one'* (R04, nanny), and distrust of political processes in general — '*Politics is very complicated and, no matter how simplistic it may seem on the surface, there are big games being played and big money involved. I have participated in some protests and was disappointed afterwards*' (R28, personal assistant).

Unionisation as well as the participation in more confrontational actions such as strikes, for example, also carry significant risks of repressions, pressure, and dismissals. This makes extending union protection within care sectors by organising more of their workforce particularly difficult: *'They even formed a union in opposition — at Aleksandrovska University Hospital — some wonderful colleagues set it up to defend us and address all these issues we're talking about. But the moment they called a protest at the hospital entrance, all [the] managers passed by and said, 'If you dare to go out to picket tomorrow, you're fired…' And now, after all that, we've all signed a document stating that we are strictly forbidden to talk about what happens in the hospital while we work there'* (R13, nurse). Repression does not always lead to solidarity and empathy, but sometimes it also generates negative attitudes among those who do not resort to protest as a way to express their discontent or fight for their rights: '*The nurses who walked out to protests… gave the profession a bad name'* (R40, nurse)

This risk is particularly acute in the private sector: *'I used to work in a private factory in a small town. We had a union representative who was very protective of the workers. She was warned two or three times that she would be fired. And she was fired. They found a loophole and got rid of her... That's why I didn't get involved'* (R37, personal assistant). '*They can't fire you for going on strike, but they find excuses, I don't know how they justify it'* (R13, nurse).

Correspondingly, unionisation, and awareness of unions and their activities, are both lower in the private sector: *'Well, no, we don't have [a union], because we are a private school and I don't know... we have tried to set one up over the years, but without success so far'* (R30, primary school teacher). *'I have never heard of one, nor do I know anyone who is involved or a member'* (R14, employed in a private kindergarten). In the public sector, however, union density is uneven: in highly fragmented subsectors such as social services the task of organizing workers also faces challenges and often lacks coherence, making it difficult to mobilise the entire sector at a national level. This, in turn, leads to varying working conditions across different municipalities: '*The problem is that the services themselves are not yet organised. In every town, each goat looks after its own patch. Many municipalities aren't connected to the union, so there's no way to organise'* (R06, social worker).

Last but not least, interviewees often expressed views on what could be changed in their work environment. On the one hand, the demands mentioned in the 'Working conditions' section were linked to professionalisation, qualifications, and the sharing of best practices. Beyond formal education, suggested ideas included care manuals and mutual-aid groups for exchanging information, since such information is often missing: *'Otherwise I search online, but I'm not satisfied — I definitely haven't found anything that's helped me; the information is simply scarce'* (R19, caregiver/personal assistant). Some respondents also proposed mobile social-care teams, particularly for smaller, infrastructure-isolated localities where substitute carers are unavailable. On the other hand, there were calls for broader public awareness of care and care work through national discussions, round tables, and media reports. While there was frequent talk of putting pressure on institutions through economic analyses of the sector and lobbying politicians at local and national levels — especially around budget planning — the respondents also embraced the term 'care work' itself, and expressed a desire to see it discussed in the public sphere, not only in times of crisis: *'We need publicity about care work! During the pandemic, journalists were on our doorstep; now they're nowhere to be seen. Journalists must engage with care as a topic and tell concrete stories…'* (R40, nurse).

Conclusion and recommendations

This report presented the findings of a qualitative study involving 40 female workers in the care sector, including healthcare, education, and care for elderly, children, and people with disabilities, across various locations in Bulgaria. The respondents were interviewed by members of the LevFem team between January and September 2024, with questions focusing on their working conditions, lived experiences, and struggles within the sector. As a continuation and expansion of LevFem's previous study, Care as Commodity, this research identifies similar trends in the care sector: extended working hours; unacceptable labour conditions; a lack of pay transparency, particularly in the private sector; and a heavy reliance on informal work arrangements (Apostolova, Vajsova & Genova, 2019).

The present report also identifies additional challenges specific to this sector, including various forms of vulnerability and violence, and the fact that many women are driven into care work and labour migration because of the lack of other means of earning a living. Beyond examining working conditions, the research draws attention to the degree to which it is expected that care work is to be performed with irregular and overtime hours, and by women who also shoulder care responsibilities in their personal lives. It identifies existing forms of solidarity and unionisation, and captures what the female workers themselves wish to change, as well as the factors that help or hinder those efforts.

In view of these identified characteristics of care work, the report aims to raise public awareness about some of the central issues and demands in this sector. We have paid particular attention to certain sector-specific factors that make it more difficult, but also very necessary, to mobilise and demand common labour rights for those working in that sector. The most significant trends and corresponding demands for change identified by the research fall into the following areas:

Lack of public discussion on care work, the care sector, and the care deficit

Unlike in other European countries where this discourse is well established in both the public sphere and the institutional and union representation of care workers (for example, the UK's Care Workers Union, CWU), in Bulgaria there is no collective understanding of the care sector, except as 'humane professions' in which self-denial or even self-sacrifice is taken for granted. Equally absent is a shared public recognition of care as a human right and as a public good/interest.

⇔ There is a need for an information campaign on the challenges faced by care workers, which should address care work, the care sector, and the care deficit, and make demands for financial remuneration and public recognition of work in this field.

⇔ Public discussion is required to link the right to care and its fulfilment with the provision of decent working conditions and pay at both national and international level.

Low pay and lack of personnel

Low pay was cited by the majority of respondents as the main problem in the care sector. At the same time, national statistics show that care sector wages are not only low, but also subject to a significant gender pay gap. Income differences vary between professions and positions, and the available data is at the level of economic sectors: women's wages are 9.94% lower in education and as much as 31.8% lower in health and social work. This leads to a significant shortage of workers willing to engage even in formal and regulated forms of care work due to high workloads, low incomes, and forms of violence and harassment at work. This shortage is pushing many workers in this sector abroad, at least temporarily, but it also means an increasingly heavy workload for an increasingly small and ageing group of female care workers in Bulgaria, with varying qualifications and levels of transparency in recruitment and pay.

⇔ It is necessary to increase the pay of care workers as a whole, but also to reduce the differences between the private and public sectors and the differences in job hierarchies in certain sectors, particularly healthcare.

Lack of uniform standards for contracts, education, and qualification requirements in the domestic care sector.

Significant differences were found between the requirements for professional qualifications, job descriptions, and the availability of training and supervision, especially in domestic care. However, standardisation is difficult to achieve because informal work is the only way to quickly find care workers for families in need of assistance, but also a source of livelihood for women seeking urgently work in Bulgaria and abroad, often unemployed or retired, who do not have the means or time to obtain additional qualifications. Efforts to standardise professional qualifications and licenses for practicing care work should not be at the expense of the workers themselves.

⇔ There is a need for advocacy for state subsidies for care training and professionalisation of care professions, especially in the domestic care setting (European Parliament, 2015). This must go hand in hand with mobilisation and advocacy for improved working conditions, pensions, and health insurance for those who perform this work.

The normalisation of care as women's work: widespread beliefs that frame care work as something that 'belongs' to women.

Women are seen as possessing 'natural qualities' that make them more suited to providing care. These notions are not just prejudices, but have an impact on the material conditions of care work in both the workplace and the home. The result is, on the one hand, the feminisation of care professions and a shortage of male workers, and on the other hand, low pay and low status, as well as poor working conditions in these sectors, and, last but not least, the unequal distribution of care work at home, which is mainly performed by women.

⇔ There is a need to shed light on gender inequalities in care work through better data collection and reporting, broad public debate, and involvement from the media, feminist organisations, professional care worker organisations, and unions.

⇔ There is also a need for effective policies to break down stereotypes, legitimise care as work of particular importance to society, and provide adequate pay and decent working conditions, policies that should be agreed upon by those working in the sector and their representative associations, and aimed at tackling discrimination based on gender, age, ethnicity, etc.

A care deficit in developed countries with aging populations, which pushes many female workers into migration and creates a care deficit for their families in Bulgaria, normalising care not only as women's work but also as migrants' work.

Migration offers a solution to individual economic difficulties in the present, especially with the lack of work in other sectors or household debt, but it is also a source of vulnerability in the long term: female migrant workers do not always have guaranteed health and pension insurance abroad and lose those in Bulgaria; the care drain affects their own families and children, who are left in the care of relatives; the position of the 'Bulgarian woman' as a particularly caring woman who is expected to take care of foreign families in the global care chain is normalised.

⇔ There is a need for broad public discussion and action to address the care deficit in Bulgaria. The normalisation of care as 'belonging' to Bulgarian women in the global care chain must be questioned and seriously criticised.

⇔ There is a need for a solidarity care tax paid by richer countries attracting care workers to poorer countries like Bulgaria sending them to close the care work gap. Such a campaign should be especially carried out within the European Union, where Bulgarian trade unions, NGOs, and politicians have the opportunity to make this issue central to their mobilisation and lobbying efforts.

Lack of cross-sectoral dialogue, solidarity-building, and joint demands across the care sector as a whole, as well as limited unionisation in parts of the sector — particularly among domestic care workers.

Although some professional fields are unionised and represented by guilds (particularly in education and healthcare), in the rest of the domestic care sector there is a marked absence of union or other professional representation, especially among domestic care workers and those in the private sector. Even in the unionised spheres of public services, many of the respondents we interviewed expressed a sense of powerlessness, and were either indifferent towards the unions due to their limited activity and effectiveness, or were sceptical of unions due to their perceived proximity to those in power at the local level. In some places, experiences with union activity are associated with personal or collective memories of violence and repression in response to union self-organisation, which deters many workers from following that path. Beyond the existing intra-sectoral forms of representation, active coordination across care sectors (healthcare, social work, education) to formulate and advocate for common demands is largely absent.

- ⇔ For domestic care workers, and particularly for caregivers, it is necessary to establish a network or guild with its own union and/or integration into an existing trade union body. Such a structure would enable the development of formal and institutionalised channels for standardising information and sharing resources such as care manuals, training programmes, and mobile social work teams. This organisational body, in cooperation with NGOs, trade unions, researchers, and the media, would be well-positioned to coordinate such activities — potentially in partnership with the non-governmental sector and especially with organisations like LevFem and cross-organisational formations such as the CARE Coalition.

- ⇔ In the care sector as a whole, existing trade unions and representative organisations need to encourage worker mobilisation and cross-sectoral coordination for advocacy at both local and national levels. To strengthen advocacy efforts with solid arguments, economic analyses of labour in the sector as a whole

are needed, along with monitoring of where and how structural funds and care-related budgets are allocated and spent.

⇔ Alongside these measures, it is important to organise information campaigns to raise public awareness of the difficulties and needs present in the various areas of the care sector, and to lobby for the pay and recognition that care workers deserve.

Annex: List of interviews

Before writing the report, the names and locations of the women we interviewed were anonymised to ensure their safety. Below is a brief description of the respondents:

- R01 — Social assistant (elder care) in the capital, Sofia;
- R02 — Social worker in a municipal service (support for children), big regional city;
- R03 — Assistant educator in a kindergarten, medium-sized regional city;
- R04 — Child carer in the capital;
- R05 — Social worker in a municipal service (support for children), big regional city;
- R06 — Social worker in a municipal service (children with disabilities), big regional city;
- R07 — Social worker in a municipal service (adults with disabilities), big regional city;
- R08 — Healthcare assistant in a care home for the elderly, small town;
- R09 — Kindergarten teacher, medium-sized non-regional town;
- R10 — School teacher, medium-sized non-regional town;
- R11 — Patronage care worker, medium-sized non-regional town;
- R12 — School teacher, medium-sized non-regional town;
- R13 — Nurse in the capital;
- R14 — Kindergarten teacher (private kindergarten), capital city;
- R15 — Teacher in the capital, former domestic care worker in a Western country;
- R16 — University lecturer, founder of a care workers' training programme, large regional city;
- R17 — Caregiver in a Western country;

- R18 — Domestic care worker in a Western country;
- R19 — Caregiver/personal assistant near a big city;
- R20 — Caregiver/personal assistant, small town;
- R21 — Secondary school teacher, small town;
- R22 — Midwife in a municipal nursery, big regional city;
- R23 — Personal assistant, big non-regional town;
- R24 — Caregiver in a Western country;
- R25 — Kindergarten teacher, village;
- R26 — Assistant educator in a kindergarten in the capital;
- R27 — Nurse and patronage care worker in the capital;
- R28 — Personal assistant in the capital;
- R29 — Nursery teacher in the capital;
- R30 — Primary school teacher, big regional city;
- R31 — Nurse and patronage care worker in the Roma neighbourhood of a big regional city;
- R32 — Teacher, big regional city;
- R33 — Social worker, small town;
- R34 — Chairwoman of the Union of People with Disabilities, medium-sized regional city;
- R35 — Assistant educator in a kindergarten, village;
- R36 — Personal assistant, village;
- R37 — Personal assistant, village;
- R38 — Personal assistant, medium-sized regional city;
- R39 — Personal assistant, village;
- R40 — Nurse in a care home for the elderly, big regional city.

References

In Bulgarian:

Apostolova, A., Vajsova, L., & Genova, N. (2020). *Грижата като стока: Проблеми на грижовния труд в България* [Care as a Commodity: Problems of Care Work in Bulgaria]. Sofia: LevFem.

Association of Healthcare Professionals, Bulgaria (2024). *Недостигът на медицински сестри, акушерки и други медицински специалисти е един от най-сериозните проблеми на българското здравеопазване, нужни са спешни мерки* [The shortage of nurses, midwives, and other medical specialists is one of the most serious problems in Bulgarian healthcare; urgent measures are needed]. https://nursing-bg.com/%D0%B0%D0%BA%D1%82%D1%83%D0%B0%D0%BB%D0%BD%D0%BE-%D0%BE%D1%82-%D0%B1%D0%B0%D0%BF%D0%B7%D0%B3/%D1%83%D1%87%D0%B0%D1%81%D1%82%D0%BD%D0%B8%D1%86%D0%B8%D1%82%D0%B5-%D0%B2-%D0%BD%D0%B0%D1%86%D0%B8%D0%BE%D0%BD%D0%B0%D0%BB%D0%BD%D0%B0%D1%82%D0%B0-%D0%BA%D0%BE%D0%BD%D1%84%D0%B5%D1%80%D0%B5%D0%BD/

BTA (2023). *Около 63% от медицинските сестри в България са на възраст над 63 години, заяви председателят на Асоциацията на професионалистите по здравни грижи* [Around 63% of nurses in Bulgaria are over the age of 63, stated the Chair of the Association of Healthcare Professionals]. https://www.bta.bg/bg/news/bulgaria/422393-okolo-63-ot-meditsinskite-sestri-v-balgariya-sa-na-vazrast-nad-63-godini-zayav

BTA (2024). *От работещите във всички видове училища учители почти 10 процента са пенсионери или са в пенсионна възраст според Синдиката „Образование'* [Nearly 10 percent of teachers working in all types of schools are retirees or of retirement age, according to the 'Education' Trade Union]. https://www.bta.bg/bg/news/bulgaria/626420-ot-raboteshtite-vav-vsichki-vidove-uchilishta-uchiteli-pochti-10-protsenta-sa-pe

Caritas Bulgaria (2018). *Домашни грижи за възрастните хора* [Domestic Care for Elderly People]. https://caritas.bg/cms/wp-content/uploads/2018/11/Domashni-grigui_BG_2018.pdf?x48025

Confederation of Labour Podkrepa (2015). *С делегирани бюджети към приоритет* [With delegated budgets to priority]. https://www.podkrepa-obrazovanie.com/en/component/content/article?id=1067:%D1%81-%D0%B4%D0%B5%D0%BB%D0%B5%D0%B3%D0%B8%D1%80%D0%B0%D0%BD%D0%B8-%D0%B1%D1%8E%D0%B4%D0%B6%D0%B5%D1%82%D0%B8-%D0%BA%D1%8A%D0%BC-%D0%BF%D1%80%D0%B8%D0%BE%D1%80%D0%B8%D1%82%D0%B5%D1%82

Council of Ministers (2018). *Национална стратегия за дългосрочна грижа* [National Strategy for Long-Term Care. https://www.mlsp.government.bg/deinstitutsionalizatsiya-na-grizhata-za-vzrastni-khora-i-khora-s-uvrezhdaniya

Deneva, N., Petrov, R. (2016). Деинституционализацията е СКЪПА, но нищо не СТРУВА! [Deinstitutionalisation is EXPENSIVE, but not WORTH anything!]. Centre for Independent Living. https://cil.bg/wp-content/uploads/2020/03/Report-DI-Final.pdf

European Parliament (2015). *Резолюция на Европейския парламент от 28 април 2016 г. относно жените домашни помощници и полагащи грижи лица в ЕС (2015/2094(INI))* [European Parliament resolution of 28 April 2016 on women domestic workers and carers in the EU (2015/2094(INI))] Official Journal of the European Union. https://eur-lex.europa.eu/legal-content/BG/TXT/HTML/?uri=CELEX:52016IP0203

Maslarova, E., Georgieva, T., & Krastev, I. (2020). *Развитие на дългосрочна грижа за зависими членове от семейството/домакинството* [Development of long-term care for dependent members of the family/household]. Friedrich Ebert Foundation — Bulgaria. https://bulgaria.fes.de/fileadmin/user_upload/documents/publications/Dalgosrochna_grija_BG_WEB.pdf

Mihalkova, E. (2021). *Проблеми на социалните и грижовните работници в Чехия и възможни решения чрез синдикализация в*

сектора [Problems of social and care workers in the Czech Republic and possible solutions through unionisation in the sector]. In: S. Tetevenski, M. Ivancheva, S. Eneva, N. Konstantinova, & K. Drenska (Eds.), *Пандемията: Феминистки фронтове* [The Pandemic: Feminist Fronts] (pp. 47–57). Sofia: LevFem.

Ministry of Labour and Social Policy (2019). *Деинституционализация на грижата за деца* [Deinstitutionalisation of child care]. https://www.mlsp.government.bg/deinstitutsionalizatsiya-na-grizhata-za-detsa

NSI (2024). *Заети лица и коефициенти на заетост — национално ниво; статистически райони; области* [Employed persons and employment rates — national level; statistical regions; districts]. https://www.nsi.bg/bg/content/4009/%D0%B7%D0%B0%D0%B5%D1%82%D0%B8-%D0%BB%D0%B8%D1%86%D0%B0-%D0%B8-%D0%BA%D0%BE%D0%B5%D1%84%D0%B8%D1%86%D0%B8%D0%B5%D0%BD%D1%82%D0%B8-%D0%BD%D0%B0-%D0%B7%D0%B0%D0%B5%D1%82%D0%BE%D1%81%D1%82-%D0%BD%D0%B0%D1%86%D0%B8%D0%BE%D0%BD%D0%B0%D0%BB%D0%BD%D0%BE-%D0%B-D%D0%B8%D1%81%D1%82%D0%B8%D1%87%D0%B5%D1%81%D0%BA%D0%B8-%D1%80%D0%B0%D0%B9%D0%BE%D0%BD%D0%B8-%D0%BE%D0%B1%D0%BB%D0%B0%D1%81%D1%82%D0%B8

OECD, European Observatory on Health Systems and Policies (2023). *State of Health in the EU. Bulgaria: Country Health Profile 2023* [State of Health in the EU. България. Здравен профил на страната 2023]. https://health.ec.europa.eu/system/files/2024-01/2023_chp_bg_bulgarian.pdf

Popova, K. (2019). *Домовете за възрастни хора в първите години на социализма в България* [Homes for the Elderly in the Early Years of Socialism in Bulgaria]. In: Koleva, D. (ed.), *Възрастта при социализма: поколения в семейството и обществото* [Age under Socialism: Generations in the Family and Society] (pp. 34–60). Sofia: Centre for Advanced Studies.

Vajsova, L. (2022). *Грижа и социални неравенства: Изследване за влиянието на недостига на места в общинските ясли и детски*

градини в град София върху живота на жените 2021 — 2022 г. [Care and Social Inequalities: A Study on the Impact of the Shortage of Places in Municipal Nurseries and Kindergartens in the City of Sofia on Women's Lives, 2021–2022]. Sofia: LevFem

UNICEF Bulgaria (2021). *Ситуационен анализ на управлението на публичните финанси с фокус върху децата в България* [Situational Analysis of Public Finance Management with a Focus on Children in Bulgaria]. https://www.unicef.org/bulgaria/media/12606/file/BGR-Sit-An-Public-Resources-Management.pdf

In English:

Apostolova, R. (2023). *Theory and Process of Socialist Migration: Local Enmities and International Friendships in the Vietnam — Bulgaria Relations (1975-1985).* Labor History 64, no. 4: 406–24. https://doi.org/10.1080/0023656X.2023.2171376.

CEDEFOP (2023). *Handling change with care*. European Centre for the Development of Vocational Training https://www.cedefop.europa.eu/en/publications/9185

Deneva, N. (2012). *Transnational Aging Carers: On Transformation of Kinship and Citizenship in the Context of Migration among Bulgarian Muslims in Spain*. Social Politics: International Studies in Gender, State & Society, 19(1), 105–128. https://doi.org/10.1093/sp/jxr027

EEG (2012). *Common European Guidelines on the Transition from Institutional to Community-based Care*. European Expert Group on the Transition from Institutional to Community-based Care. https://deinstitutionalisation.com/wp-content/uploads/2017/07/guidelines-final-english.pdf

Ehrenreich, B., Hochschild, A.R. (Eds). (2003). Global Woman: Nannies, Maids, and Sex Workers in the New Economy. New York: Metropolitan books

EIGE (2022). *Gender Statistics Database. Classroom teachers and academic staff by education level, programme orientation, sex, type of institution and employment status*. https://eige.europa.eu/gender-statistics/dgs/indicator/ta_wrklab_lab_employ_selected_educ__educ_uoe_perp02/bar/year:2022/geo:BG/isced11:ED1/sector:TOT_SEC/sex:M,W/unit:NR/worktime:TOTAL

Mladenov, T., Petri, G. (2020). *Critique of deinstitutionalization in post socialist Central and Eastern Europe*. Disability & Society, *35*(8), 1203–1226. https://doi.org/10.1080/09687599.2019.1680341

Nenova, G., Antonova, R. (2023). *Children's rights in Bulgaria between theory and practice: The case of the deinstitutionalization reform*. Intersections. East European Journal of Society and Politics, 9(2), Article 2. https://doi.org/10.17356/ieejsp.v9i2.1126

‘The report addresses an extremely important and under-researched topic — care work in Bulgaria. In doing so, it makes a significant contribution both to advancing academic knowledge in this field and to raising awareness of the urgent need to improve the working conditions of care workers. Particularly valuable is the fact that the study spans several sectors at once, and that it attempts to identify common problems and draw parallels between them.’

Neda Deneva, anthropologist and sociologist

‘I am impressed by the professional approach to conducting the interviews and the thoroughness with which the problems in the care sector are identified and supported by the respondents’ narratives — problems I too have encountered, and stories very similar to those I’ve heard from care workers in my own practice. This report will be of use to every manager in the education, healthcare and social sectors… to the heads of licensed social service providers, private educational and healthcare institutions… to trade unions, and above all to experts in the relevant ministries and parliamentary committees, so that the measures outlined in its conclusion can be implemented.’

Nina Bankova, social policy expert