Pharmaceutical Redemption: Reconfigurations of Care in Austerity-Laden Athens

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Acronyms

ANEL Party of Independent Greeks
DIMAR Democratic Left Party
EC European Commission
ECB European Central Bank
EOF (Ethnikòs Organismòs Farmàkon) National Organisation for Medicines
EOPYY Greek National Health Service Organisation
IKA Institute for Social Insurance
IMF International Monetary Fund
ISA (Iatrikos Syllogos Athenon) Medical Organisation of Athens
KIA (Koinonìkò Iatreìo Allileggiì) Social clinic of Solidarity
KKE Greek Communist Party


PFS (Panellinikos Farmakevtikos Sillogos) Panhellenic Pharmaceutical Organisation

SEEF Hellenic Association of Pharmaceutical Companies

SYRIZA, Coalition of the Radical Left. A parliamentary coalition of Euro-communist, socialist, and radical left groups.

TROIKA, Triumvirate representing the European Union in its foreign relations: the European Commission, the European Central Bank and the International Monetary Fund

XA Golden Dawn (Far Right Party)
Abstract

This thesis draws on ethnographic fieldwork that I carried out in Athens between September 2015 and January 2017. It focuses on how the practices and practicalities of care have been reconfigured during nearly a decade of economic austerity, and suggests that new modes of medicalisation of care have arisen at the convergence of the neoliberal restructuring of the state and the emergence of solidarity initiatives. Since 2010, an increasing number of solidarity and grassroots initiatives have monopolised the Greek medical landscape. In the aftermath of the first round of structural adjustments linked to the memorandum proposed by the Troika [ECB, EC, and IMF] in May 2010, almost three million Greek citizens have increasingly found their medical needs unmet; funds for the public healthcare system were severely reduced, and access to healthcare resources was made conditional on either insurance or individual economic capacity. As a consequence, the number of Greek nationals admitted, cared for and cured outside the official locations of care increased dramatically. At the time of my fieldwork, 28 social clinics of solidarity were located in Athens, working to provide uninsured citizens with basic medical care and primary healthcare services. Building on the ethnographic material I collected in one of these social clinics of solidarity, located on the southern outskirts of Athens, I describe how the clinic worked at the border of state institutions and kinship, and often unintentionally served as a catalyst for patients’ complaints and contestations towards state institutions. In particular, this thesis proceeds by tracing social trajectories, political meanings and local understandings of pharmaceuticals, and their role in shaping new subjects of care, and new modes of economic, social and medical dependency. As I will demonstrate, different modes of care were reconfigured around pharmaceuticals.
Declaration

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This thesis is dedicated to my mum who has always cared more than anyone else.
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Timetable of the Greek Crisis (2009-2015)

04 October 2009 The centre left-PASOK wins the Greek legislative elections. The party received 43.92% of the popular vote, obtaining 160 of 300 parliamentary seats.

20 October 2009 Greece’s budget deficit is expected to reach 12.5% of GDP, according to the Minister of Finance George Papaconstantinou. This deficit exceeds a threshold of 3% of GDP, as it was set in the Stability and Growth Pact for all Eurozone member states.

22 October 2009 Greece’s credit rating is downgraded by Fitch (one of the Big Three credit rating agencies) from A to A-.

8 December 2009 Greece’s credit rating is further downgraded by Fitch from A- to BBB+.

16 December 2009 Standard and Poor’s (another of the Big Three credit rating agencies) downgrades Greece’s credit rating.

23 December 2009 Moody’s (the third of the Big Three credit rating agencies) downgrades Greece’s credit rating from A1 to A2.

9 January 2010 The Greek-German 10-year debt yield spread surpasses 300 basis points.

9 February 2010 The first austerity package is passed by the Greek parliament. Measures include a freeze on all government employee salaries, 10% cut in bonuses, and cut in overtime workers.

3 March 2010 A second austerity package is passed by the Greek parliament. Measures include a freeze in pensions, an increase in VAT from 19% to 21%, rise in taxes on fuel, cigarettes and alcohol, rise in taxes on luxury goods, and cuts in public sector pay.

23 April 2010 Prime Minister George Papandreou formally requests an international bailout for Greece. The European Union, European Central Bank and International Monetary Fund (IMF) agree to participate in the bailout.
2 May 2010 The IMF, the Greek Prime Minister and other Eurozone leaders agree to the first bailout package for 110 billion euros over 3 years. The third austerity package is announced by the Greek government.

5 May 2010 Nationwide riots and popular revolt ensue. There is a 48-hour nationwide strike and demonstrations in major cities.

6 May 2010 The third austerity package is passed by the Greek parliament.

7 July 2010 The Greek parliament passes pension reforms (N.B. a key requirement of the EU and IMF). Measures include: increasing the retirement age from 60 to 65 for women, a cut in payments from 25% of GDP by 2050, and additional pension reforms expected in November 2012.

15 December 2010 The Greek parliament passes a new law regarding state-owned companies. The law caps monthly wages and introduces a 10% cut on salaries above 1,800 euros.

23 December 2010 The Greek parliament approves the austerity budget for 2011.

25 May 2011 The Square Movement (Greek Indignant Citizens Movement) starts daily protests.

29 June 2011 The fourth austerity package is passed by the Greek parliament despite protests spreading through the country. The austerity measures included new taxes and new cuts in workers’ wages.

11 September 2011 The Greek parliament imposes a new property tax to be collected through the electricity bill.

20 October 2011 The fifth austerity package is passed by the Greek parliament amid protests and violent riots outside Parliament.

31 October 2011 Prime Minister Papandreou calls for a confidence vote and a referendum to approve the
EU summit deal about the Greek debt cut

4 November 2011 Papandreou wins the confidence vote, but resigns two days later.

10 November 2011 Lucas Papademos becomes the new prime minister of Greece, as the leader of a coalition government consisting of the PASOK, New Democracy and Popular Orthodox Rally (LAOS) parties.

12 February 2012 The fifth austerity package is passed by the Greek parliament amid violent protests.

21 February 2012 The second bailout package is finalised. It brings the total amount of Eurozone and IMF bailouts to 246 billion euros by 2016.

3 April 2012 A retired pharmacist commits suicide nearby Parliament in protest against the austerity measures. He soon becomes a symbol for groups opposing the austerity measures. Violent clashes between police and demonstrators erupt in Athens.

6 May 2012 New Democracy party wins the elections, but with a smaller share of the popular vote. The governing PASOK party collapses, while more votes go the left-wing parties (Coalition of the Radical Left [SYRIZA], Communist Party of Greece [KKE] and Dimokratiki Aristera [DIMAR]) and right parties (Independent Greeks [ANEL], Golden Dawn [XA]).

16 May 2012 No coalition is formed and Panagiotis Pikramenos assumes the position of caretaker Prime Minister. Early elections are called for the 17th of June.

17 June 2012 Early elections are held. The New Democracy party wins with 29.7% of the popular vote, although it does not win the majority of seats in parliament. Four days later, a coalition government is formed between New Democracy, PASOK and DIMAR. Antonis Samaras (ND) becomes the new Prime Minister.

6 November 2012 The sixth austerity package is adopted by the Greek parliament. The austerity measures are required for Greece to receive the next instalment, the second economic bailout of 31.5 billion euros. Austerity measures include: public...
pension cuts between 5% and 15% through the removal of two seasonal bonuses, an increase in the retirement age from 65 to 67, additional wage cuts for civil servants up to 20%, and public salary wage cuts up to 30%.

11 November 2012 The Greek parliament passes the 2013 austerity budget.

28 April 2013 The Greek parliament approves a reform bill, abolishing 15,000 state jobs by the end of 2014 (4,000 jobs in 2013). It makes it easier to fire civil servants and increases the working hours for teachers. Property tax is cut by 15%.

11 June 2013 The Greek parliament shuts down the country’s public broadcasting service (ERT).

21 June 2013 The Democratic Left party withdraws from the Greek coalition government, which retains a razor thin majority in parliament.

17 June 2013 Prime Minister Samaras reshuffles his cabinet.

17 July 2013 The seventh austerity package is passed by the Greek parliament. Measures include: a contentious plan for thousands of layoffs, and wage cuts for civil servants.

21 December 2013 A bill on the Single Property Tax and the auction of houses is approved by a majority of 152 deputies in the 300-seat chamber.

30 March 2014 The Greek parliament passes a new multi-bill which is needed to receive the next bailout payment.


9 May 2014 The cabinet is reshuffled. Gikas Hardouvelis assumes the position of Minister of
Finance.

25 January 2015  The Greek legislative election is held. Syriza wins a historic victory.

26 January 2015  Syriza and the Independent Greeks join to form a new coalition government. Alexis Tsipras is sworn in as the new Prime Minister.

20 February  The Eurogroup brokers an agreement between Greece and the Eurozone for a 4-month loan extension.

4 June 2015  Greece asks the IMF to postpone the 5\textsuperscript{th} of June instalment until the end of the month.

27 June 2015  Prime Minister Tsipras announces a referendum on a bailout agreement, to be held on the 5\textsuperscript{th} of July.

28 June 2015  The Greek parliament approves the referendum. Tsipras announces the closure of banks and the imposition of capital control (withdrawal limit set at 60 euros per day; foreign transfers banned).

30 June 2015  Greece misses a payment on an IMF loan.

1-3 July 2015 One thousand bank branches open to allow pensioners to withdraw 120 euros for the week.

5 July 2015  The Greek Bailout Referendum is held. Over 61\% vote against the proposed measures imposed by the Juncker Commission, the ECB and the IMF.

6 July 2015  Finance Minister Varoufakis resigns and is replaced by Euclid Tsakalotos.

11 July 2015  The Greek parliament approves the government’s proposed bailout plan.

13 July 2015  Greece and European creditors strike a deal for an 86 billion euro bailout over three years, though it must be approved by the parliament.

16 July 2015  The Greek parliament votes through
measures required by the creditors, including changes to pensions and taxes.

17 July 2015 The cabinet is reshuffled. The left-wing deputies who voted against the new bailout agreement are sacked from the government. German parliament approves the Greek bailout.

Foreword

A man goes to the doctor. The doctor asks the man what his symptoms are. The man explains to the doctor how he feels, and the doctor gives him a diagnosis. The man is perplexed by the doctor’s diagnosis and remains silent for a few seconds. Then he shouts out, ‘No Yannis! Yannakis’ [Oxi Yannis! Yannakis].

Two of my dearest friends and most talkative informants at the social clinic, Basileia and Martha, argued that in Greece, not only do people distrust doctors, but they actually go to see a doctor just to confirm their distrust towards them. Doctors are often described as grumpy, greedy and careless individuals who do not have any interest in helping people. Doctors are just after the money, Martha and Basileia often told me, and never refrain from asking or accepting fakelakia, (a bribe) from the patients they are supposed to take care of.

Yannis, of which Yannakis is the diminutive, is one of the most common male names in Greece, so much so that it was often jokingly suggested that I should just call for ‘Yannis’ if I was unsure about the name of the person I was looking for. The doctor [o giatros] is the doctor whose name is just an accessory to his title and the authority it conveys. Although what Martha and
Basileia recounted was just a joke, it actually speaks of the limits of medical authority and suggests how sociality mediates medical knowledge: Yannakis’ lay medical knowledge contests and contrasts with the doctor’s authority, and hints at the potentials for care beyond biomedicine, in a time where the latter has increasingly been tied to technology, and practices of healthcare have instead spilled out beyond the merely biomedical environment.

This thesis is a journey into forms of sociality which prove stronger than medical authority, and is an exploration of how, in the aftermath of the 2008 economic crisis, biomedicine retains potentials beyond merely biomedical ones. It is an exploration of how new economic and social dynamics have destabilised and reshuffled the terms and conditions of social and biomedical inclusions and exclusions, while changing the meaning and the experience of care and abandonment.

‘Illness is the night-side of life, a more onerous citizenship’ claims Susan Sontag in her book *Illness as metaphor* (1978: 3). ‘Everyone is born holding dual citizenship in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place’ (1978: 3). To follow on from Sontag, this project charts the differential experiences of health and sickness of Athenians in a moment when state institutions vacillated under the strain of austerity measures and a mounting social discontent. This work aims to investigate how new practices of care have flourished upon bureaucratic and biomedical knowledge. Within and against the unstable and opaque categories of health and disease, this ethnography explores how multiple trajectories of sociality and belonging are negotiated, made and unmade, in places other than the state and the household.
Introduction

I was drawn to Athens to explore the political potential of community-based healthcare practices which have, since 2010, been known as Social Clinics of Solidarity [Koinonika Iatreia Allileggi, henceforth KIA]. In my decision to pursue this project, the intellectual legacy of the Italian psychiatrist Franco Basaglia\(^1\) played a crucial role: his idea of healthcare as a community concern and a collective practice towards the demedicalisation of illness, and his critique of biomedicine as a disciplinary power oriented my interests towards these grassroots medical initiatives. I was especially intrigued by how those social clinics had managed to organise an efficient system of healthcare provision on a strictly voluntary basis, and presumably worked independently from any medical institutions. In my mind, this implied forms of mutualism and reciprocity, horizontality and a division of labour which could transcend the traditional distinction between women caring and men curing. At the same time, the poignant critique that these self-organised medical facilities seemed to direct towards diverse state institutions captured my interests. Also particularly intriguing were those aspects related to the improvisation of biomedicine in terms of both poor medical technologies and infrastructures: most of the social clinics were in fact located in flats, the basements of buildings, and workshops that were rearranged into spaces where minimal

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\(^1\) Franco Basaglia (1924-1980) was an Italian psychiatrist. He worked to dismantle psychiatric hospitals, pioneering the modern concept of mental health.
privacy and low levels of hygiene were ensured. As most of these social clinics sustained their activities through donations of medications and the work of volunteers, their presence in the medical landscape of Greece seemed to offer a challenging ethnographic opportunity to rethink some of the terms of the debate in medical anthropology relative to local understandings, pursuit and configurations of biomedicine.

At the time of my fieldwork in Athens, between July 2015 and January 2017, and after six years of economic crisis, there were twenty-eight KIAs spread across the city, which together formed an actual shadow healthcare system, in which uninsured Greek citizens and non-citizens received primary healthcare, medical examinations and medications for free. Amongst them, the social clinic located in the southern outskirts of Athens particularly caught my ethnographic curiosity: the birth of this social clinic was in fact linked not just to the outbreak of the economic crisis and its debilitating effects on people’s capacity to seek care, but also to the vicissitudes of the entire neighbourhood in which it was located. In fact, this self-organised medical practice grew and expanded its services, building on the local residents’ commitment to fighting against austerity measures on the ground. Through the local assembly, diverse social welfare projects were initiated to ensure, for instance, the provisioning of food to the poorest local residents, after-school activities for children from low-income families, and technical support to reconnect the electricity and water supplies to those houses that had been cut off. Furthermore, under Samaras’ government, nearby beaches and public spaces had been sold to the Greek-Swiss entrepreneur Spyros Latzis, who planned to build private luxury resorts to incentivise tourism, thus contributing to the economic growth of the area. To accomplish the development of the neighbourhood, however, evictions of insolvent house owners and rampant privatisation of public spaces were feared, and expected to happen from one moment to another. Supported by the local municipality and many SYRIZA MPs, the people of the neighbourhood proudly declared

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2 Antonis Samaras (Nea Demokratia) served as Prime Minister of Greece between the 20th of June 2012 and the 26th of January 2015.
that they were resisting the crisis, while experimenting with alternative ways of sociality and provisioning.

Upon my arrival in Athens in July 2015, my research project was foremost meant to explore people’s experiences of the crisis, and the social dimension of illness and care in improvised medical settings. By looking at the nexus of resistance-solidarity, I intended to explore how the economic crisis as a social experience overlapped with individual medical crises in a moment when the public healthcare system was on the verge of collapse, and healthcare resources were shrinking under the strain of austerity measures. Recent anthropological literature about Greece has extensively discussed the work of grassroots initiatives in terms of alternative modes of provision while enacting forms of resistance to the state. According to this approach, the wide net of KIAs was supposedly playing its crucial part in the barrage of resistance against the state. Crucially, though, my Athenian informants kept repeating that ‘there’s no state in Greece.’ If there is not a state, how can they resist it? This question became ethnographically generative of other questions that ultimately led me to locate the work of the KIA elsewhere than against the state, and to situate its existence beyond resistance. As this work will demonstrate ethnographically, I position the existence of this social clinic within a broader process of the reconfiguration of the medical landscape whereby the social clinic of southern Athens has worked in continuity with the state, rather than in opposition to it. Also, in a diachronic perspective, the birth of the KIA encompasses, but definitely exceeds, the trajectory and the reasons for the economic crisis.

**Crafting the crisis into an ethnographic object**

On the 4th of April 2012, the retired pharmacist Dimitris Chrisoula committed suicide outside the Greek parliament in Syntagma Square. In a note he wrote before his suicide, the 77-year-old pensioner declared that the state had stripped him of his dignity by dramatically curtailing his retirement pension, although he had paid taxes to the state for more than 35 years, during which he had worked honestly and lived in a dignified way. He concluded his note saying that committing suicide was the ultimate act of dignity over the
possibility of finding himself scavenging through rubbish bins to survive. His suicide further inflamed anger and resentment amongst the Greeks: only a few weeks before, on the 21st of February, the government had approved the second bailout package which meant the introduction of new austerity measures in order to slash Greece’s debt from 160% to 120.5% of GDP within eight years. Protests and riots followed the death of Mr. Chrisoula and shook Athens, as well as other Greek cities, for days. In the suicide note, Mr. Chrisoula also wrote that he could not see any future for the young in Greece unless they took arms and fought, as his generation had fought against fascism, both in Italy and Greece. His suicide shook public opinion deeply, while national and international newspapers spelled out the relationship between Mr. Chrisoula’s suicide and the devastating effects of the economic crisis. The economic crisis not only triggered suicidal tendencies amongst the population, but also posed severe threats to people’s mental health: major depression, anxiety and alcohol abuse were reported as ‘omens of the Greek tragedy’ (Kentikelenis et al. 2011).

American anthropologist Elisabeth A. Davis (2015) offered a compelling and critical reading of what, in the media coverage of the time, was reported as ‘suicide epidemics’ plaguing Greece. In fact, a clear correlation was increasingly being drawn between the onset of the economic crisis and the increase in suicide and rising rates of severe mental conditions. For instance, Andrea Muehlebach (2014) observes a similar trend in Italy, and describes the epidemics of ‘economic suicides’ that plagued the country as acts of self-immolation: ‘the individual dead bodies’, she comments, ‘take on a political life on their own’ as, in a time of crisis and economic recession, suicide represents the answer to the inability to survive. Muehlebach suggests that suicide needs to be tied to the larger social malaise that the economic crisis has provoked. In Italy as well as in Greece, the economic crisis was not only seen as pathogenic, but actually rendered the social environment morbid (Kermeliotis 2012).

In light of her long-standing anthropological and ethnographic interests in Greek psychiatric institutions (see Davis 2012), Davis problematises the
correlation between the economic crisis and suicide, and suggests that ‘since the crisis, suicide has been mediated by a peculiar kind of publicity that has introduced a way for people in despair to imagine themselves, and be imagined by others, as political actors, at a moment where other forms of political actions may seem exhausted or futile’ (2015: 1029).

Davis critically relocates the role of the crisis in the current debate on suicide, and clarifies that the economic crisis in fact signified an important change in many people’s lives and livelihoods, while it also affected the ways Greeks understood and talked about these changes. However, the only correlation that can be drawn between the crisis and suicide is in how the ‘crisis has made suicide historical’ (Davis 2015: 1030). In this, Davis follows Janet Roitman’s understanding of ‘the crisis as a blind spot [that] enables the production of knowledge’ (Roitman 2014: 39): any invocation of the crisis allows the production of certain knowledge, and is generative of narratives where events, changes and ruptures are embedded in the trope of the crisis. While exploring the market meltdown in the US, Roitman contends that the concept of ‘crisis’ is often described as a temporal breach where the past and the future both collapse on the present: the crisis is experienced as a temporary condition of deviancy from normality. As an anomalous suspension of normality, the crisis demands re-articulations and enforcements of certain norms in order to allow a return to normality. Rather than being a state, Roitman contends that any crisis is actually a process, and can be better described if anthropologists consider people’s lived experience of the crisis, rather than locating the crisis in the realms of the market, or finance.

From a different perspective which ultimately focuses on the visuals of the Greek crisis, Kostantinos Kalantzis problematises the relationship between

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3 Davis develops her analysis along three comparative axes: the historical axis allows us to individuate ‘historical differences as defined by the economic crisis in relation to the time before it’ (Davis 2015: 1009). The second is the ‘axis of locale’: Davis compares the public sphere of media coverage and consumption with data gathered in Thrace, a ‘region distinguished by its purportedly suicido-genic cultural and economic features’ (2015: 1009). The third axis that Davis individuates is that of evidence: media reports and published medical research analysed through a comparison with the clinical ethnography data Davis had yielded during her fieldwork in a psychiatric hospital in Thrace in the 1990s.
the economic crisis, the knowledge produced about the crisis, and the circulation of certain images that seem to reinforce it. In his introduction to *Uncertain vision: crisis, ambiguity and visual culture in Greece* (2016), the Greek visual anthropologist asks whether the crisis actually appears as something, and contends that the Greek economic crisis has been rendered perceivable and tangible through an obsessive aestheticisation of destitution and dissent. Accordingly, poverty and protest have become not just symbols and metonyms of something more serious but, Kalantzis argues, they offer a strong visual support to what cannot be expressed in words: the Greek economic crisis has ultimately become visible through these deeply polarised images of the crisis itself.

Likewise, much of the recent anthropological literature has initially centred on either the dissent and destitution (i.e., Vradis and Dalakoglou 2011; Faubion, Georges and Van Steen 2016; Papagaroufali 2016), and resistance and solidarity (see for example Dalakoglou 2011; Rakopoulos 2013, 2014a, 2014b; Theossodopoulos 2014b). More recent anthropological inquiries (Cabot 2016a; Papatxaarchis 2016b; Rakopoulos 2016; Rozakou 2016a; Theossodopoulos 2016) have offered more nuanced perspectives on the crisis-solidarity nexus. Rakopoulos argues that solidarity should be considered as a ‘bridge concept’ that ‘capture[s] loosely and yet in tension diverse modes of practice, forms of sociality and mechanisms of envisioning future prospects in people lives’ (2016: 142). Heath Cabot (2016a) interprets solidarity as ‘the other side of the crisis’ by tying the emergence of solidarity clinics in Athens to the outbreak of the crisis and the enforcement of austerity measures, which ultimately resulted in the retreat of the state from the provision of medical care. Loyal to the principles of solidarity, Cabot’s informants appear somewhat aware of the ambiguities of solidarity as a possibility of being complicit in neoliberalism, meaning that their participation in solidarity initiatives would just fill the gaps left open by the rolling back of the state, and would lose their antagonistic nature accordingly. Similarly, Greek anthropologist Dimitrios Theossodopoulos (2016) discusses with his informants from Patras the limits and ambiguities of solidarity which, in practice, does not differ substantially from charity. However, in the
urgency of the present and the imperative to help, Theossodopoulos’ informants continue their solidarity activities of provisioning food. In the face of the urgency of providing medications and care to those people in need, my informants often put forward the same arguments, whereby the limits and ambiguities of their practices of solidarity were outweighed by the necessity to provide a quick and effective response to the effects that the economic crisis had on people’s ability to access healthcare resources.

As a therapeutic as well as a social response to the individual experience of disease, the emergence of KIAs in the Greek medical landscape was reported as being tied to the outbreak of the 2009 economic crisis (ikonomiki krisi). These initiatives were in fact responding to what has frequently been described as ‘the Greek healthcare tragedy’ (Kentikelenis et al. 2014): on the one hand, the economic crisis meant the progressive dismantlement of public healthcare services, while also dramatically impacting on people’s health and mental health (i.e. Stylianidis and Souliotis 2018). On the other hand, the crisis also opened up and prepared a new political terrain over which unrest and mobilisation first emerged, and grassroots initiatives of solidarity later flourished.

In his attempt to argue against the exceptionality of the Greek crisis, Rakopoulos (2015a) contends that in the Greek crisis, what stood out as exceptional were the responses to the crisis, not the crisis per se: while the economic crisis as it unfolded in Greece is organic to capitalism and does not show any exceptional form, the solidarity initiatives in response to it are indeed exceptional and peculiar to the Greek social and political landscape. This landscape, Eythimios Papataxiarchis (2016b) suggests, has traditionally been characterised by a myriad of segmentary practices, and today’s flourishing of many grassroots initiatives can be traced back to them. Whereas many arguments about the exceptionality of the Greek crisis have been made (i.e., Brekke et al. 2014; Kyriakopoulos 2011;) and critiqued (Laksos and Tsakalokous 2014; Rakopoulos 2015a, b), solidarity has nevertheless continued to be perceived as ‘the face of Greece’ and ‘as [a]
positive image’ (Papataxiarchis 2016b: 208) of a country which has long been seen as the scapegoat of Europe.

Looking more closely, it appears that references to solidarity often worked as a shield behind which wrong-doings, ambiguities and contradictions were reconciled in the urgency to provide quick and effective responses to the disastrous effects of the austerity measures on the livelihoods of many Greeks (Chapter 1). In this sense, the crisis was not only an ‘affect-generating idiom’ (Roitman 2014) but an overarching narrative that, in turn, became generative of certain practices of provisioning which later came to be labelled as solidarity. I argue that the concept of solidarity as predicated on reciprocity (Rakopoulos 2016) flattens the relationships of vertical dependency, which very much characterised my fieldsite, and fails to fully acknowledge the social and economic inequalities on which solidarity is premised. In this line of criticism, Andreas Streinzer (2018) suggests that the scholarly and media focus on crisis and solidarity has contributed to a general disregard for other configurations of moralities, ideological preferences and normative practice. In contrast, Streinzer offers a compelling overview of how some of his informants from Volos demonstrate support and appreciation for the Troika: the structural adjustments are described as a just punishment for Greek economic malpractice, and as an occasion to finally render Greece modern, European and competitive in the market. Following a similar line of inquiry, Phaedra Douzina-Bakalaki (2017a, b) argues that her female interlocutors involved in diverse voluntary activities in Xanthi were not only reacting to the crisis through ‘familiar frames of references’ (2017b: 38), but they also appeared quite ‘determined to reproduce the past and, with it, to reproduce the positionalities, relationalities and socialities of the provisioning routes they replaced: that is, the household, the (labour) market, and the state’ (2017b: 29). By drawing on my ethnographic fieldwork, I instead describe the practices of alternative provision generated by the crisis and enacted in the social clinic as practices of care, rather than solidarity.

Elana D. Buch contends that care is ‘a shifting and unstable concept - alternatively referring to everyday practices, engagements with biomedicine,
biopolitics, affective states, forms of moral experience and obligation, structures of exploitation, and the relations between these various things’ (2015: 278). Throughout this thesis, I understand care in its double meaning of activities and services (caring for) and social relations, emotions and affects (caring about) that differently involve forms of unpaid labour (Federici 1975), kinship obligations (Alber 2015) and forms of relatedness (Carsten 2000).

By focusing on care as an organising principle of the social clinic and as a mode of community building where care is configured as a collective endeavour, and ‘persistent tinkering in a world full of complex ambivalence and shifting tensions’ (Mol et al. 2010: 14), I follow Tatjana Thelen’s (2015) argument about the importance of care for the ‘(re)production of significant ties in situations of mobility (transnational migration) and change (economic/political reforms)’ (2015: 500). Thelen argues that the process of neoliberal restructuring that many European countries have gone through ultimately resulted in a renewed debate on the division of responsibilities to care between the public (the state) and the private (the market): bringing care to the forefront of anthropological investigations allows us to overcome the ‘established dichotomy such as private-public, good-bad, modern-traditional, micro-macro’ (2015: 498).

Susana Narotzky and Nico Besnier (2014) argue that ‘the practice of care involves a constellation of agents that operates in domestic, market, state, and voluntary sectors […]. The interdependence of these various agents means that changes in care practices in one sector (i.e., the household) are often related to changes in another sector (i.e. the state services)’ (2014: 7). Accordingly, a focus on practices of care allows me to locate and understand the work of KIA beyond the concept of resistance to the state. Rather, it allows me to focus on the links between the private (the household), the public (the state) and the voluntary sector. As the proliferation of many solidarity clinics across Greece seems to confirm, a considerable portion of the provision of healthcare has been outsourced to the voluntary sector. Therefore, an ethnographic focus on care also offers a challenging point of
departure to also understand ‘emerging forms of governance’ (Buch 2015: 279) in contexts of sustained social and economic changes, like today’s Greece. At the same time, considering care as politically embedded in larger social structures (Thelen 2015) allows me to break down the relationship between care and kinship as posed by some anthropological literature: when dislodged from the private sphere of the household and relocated to ‘the social’, care becomes generative of meaningful relations and sustained ties which ‘(re)produce stability but also shape change’ (Thelen 2015: 500). In this sense, care is no longer generated by kinship ties: rather it becomes generative of ties that might become similar to kinship (i.e., Carsten 2000; Drotbohm 2015). However, anthropological literature on care has extensively pointed out how care as a resource and a relational practice can also be tied to situations of coercion, specific modes of gendered socialisation, as well as of social inequalities (Biehl 2012; Burch 2015). In this regard, studies on humanitarianism have offered crucial perspectives on how access to healthcare resources is often negotiated on an individual rather than a societal basis (Thelen 2015): care figures as a response to an individual trauma (Fassin 2011; Tickin 2011) rather than as structural and collective responses to injustice (Tickin 2011).

Following on these considerations, I suggest that reframing the system of provisioning that the KIA enacted in terms of practices of care rather than in terms of solidarity also favours a better ethnographic exploration and contextualisation of the tensions, conflicts and modes of dependency that arose at the KIA. It seems to me that the reliance on solidarity as an interpretative lens tends to reduce those tensions, contradictions and conflicts to mere moral dilemmas that, for instance, Cabot’s (2016a, b) and Theossodopoulos’ (2014b, 2016) informants voiced when asked to explain their involvement in diverse solidarity initiatives. As Chapters 2 and 4 demonstrate, shifting to care helps take into account how conflicts, contradictions and tensions become ethnographically relevant as they may result in differential access to medical resources, the creation of exclusionary mechanisms, and in diverse modes of relationality between the volunteers at the KIA and the people attending the medical facility.
'We are not the state!' What the state should be, but is not. What the state should do, but does not.

As briefly mentioned in the previous section, the KIA was part of a broader net of grassroots initiatives which had sprung up and spread through Greece following the onset of the 2009 crisis. Much of the anthropological literature on contemporary Greece has centred on how these ‘initiatives of solidarity’ (Papataxiarchis 2016b) represent, or try to enact, forms of resistance to the state by experimenting with novel forms of direct democracy (Sotirakopoulos and Sotiropoulos 2013), spontaneous practices (Dalakoglou 2013; Leontidou 2012), revolt (Kaplanis 2011; Dalakoglou and Vradis 2011), alternative provisioning systems (Cabot 2016 a, b; Rakopoulos 2013, 2014b), as filling infrastructural gaps (Dalakoglou, 2016) and as providing novel terrains for the emergence of resistance and politicised subjectivity (Hadjimichalis 2013; Gavriilidis 2014; Kallianos 2011). In particular, the attention with which the antagonistic character of many grassroots initiatives has been considered (i.e. see: Rakopolous 2015a; Vaiou and Kalandides 2015, 2017S) relates to what Stef Jansen (2014) identifies as the ‘libertarian paradigm.’ The libertarian paradigm pays analytical attention to people’s efforts to evade or resist the state (see, for example: Graeber 2007; Scott 2009). In an attempt to probe the ethnographic limits of the libertarian paradigm which posits ‘the state predominantly as an imposed externality’ (Jansen 2014: 239) that people strive to evade, Jansen suggests looking instead at people’s non-evasion or, to put it otherwise, at people’s hopes for the state. Departing from the ethnographic exploration of a self-organised school in Dobrinja, a peripheral apartment complex in besieged Sarajevo, Jansen identifies the persistence of ‘gridding practices’ through which his informants not only tried to restore ‘normal life’ but implicitly expressed their hope for a functioning state. In departing from Scott’s formulation of state-making as a contested gridding process (Scott 2009), Jansen twists the concept of gridding to capture people’s hope for the state: the transferring of practices from institutions to self-organised initiatives should in fact alert the anthropologist to people’s desires and hopes for a functioning state.
In this sense, my ethnographic material responds to Jansen’s suggestion to look at how people affectively and practically invest in ‘ordering statecraft’ (Jansen 2014). In particular, the travelling and transferring of bureaucratic papers back and forth between state institutions and the KIA offered an important entry point to productively reflect on how state-like bureaucracy infiltrated the KIA structurally. In the presence of such a bureaucratic apparatus, I have not only asked whether the state was being reproduced rather than actually resisted, but also whether the presence of such bureaucracy could actually alert me to people’s imagination and perception of the state. Chapter 2, in particular, looks at how the persistence of bureaucratic documents provided a powerful ethnographic cue to investigate the relationship between initiatives of solidarity and the state.

Throughout this thesis, I describe the state according to the emic understanding of it: as an aggregate of institutions which became apparent through the documents they issued, the welfare services those same institutions were meant to provide, and the possibilities for accessing those services that they upheld and upended. My Athenian informants’ utterances of ‘we don’t have a state’ pointed to the absence of a functional and inclusive welfare system, the inability of the institutions to manage the economic crisis, and the presence of a dysfunctional bureaucratic apparatus which differently impacted upon and regulated Greek citizens’ and non-citizens’ lives.4

Specific to the context of the KIA, ‘we don’t have a state’ (den exoume kratos) was predicated on different understandings and experiences of the state along class, gender and ethnic lines: for the volunteers, this statement was often followed by the sentence ‘we are not the state here’ (den eimaste kratos edo), as if an implicit linking and overlapping was perceived to exist between the absence of the state and the presence of the KIA. Furthermore, ‘we are not the state here’ as uttered by the volunteers was a discursive

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4 Between 2015 and 2016, Greece faced what later become known as the ‘refugee crisis’. The social clinic of solidarity where I conducted my fieldwork took part in the provision of food, clothes and pharmaceuticals that a net of solidarity initiatives in Athens initiated. Doctors from the KIA occasionally visited the refugee camps that had meanwhile been set up in the disused airport of Elliniko. Refugees and migrants in general are methodologically absent from this work as much they were absent from the KIA, whose primary concern was to provide care to Greek nationals or long-term residence migrants.
strategy by which the KIA distanced itself from the state, restated its formal opposition to it, and managed patients’ complaints about the KIA’s disservices and regulations. As the provision of healthcare services was not only free, but was also operated on a voluntary basis, the people approaching the KIA were expected to comply with the KIA’s bureaucratic rules and regulations, modes of care and delivery of healthcare services (Chapter 1). Complaints and claims were perceived as an offense against the volunteers’ hard but unpaid work and as a lack of gratitude towards them; the KIA was not only fulfilling the biopolitical obligations that the state institutions should, but was actually taking care of those people that the state had left behind. Nonetheless, as I will also explore further in Chapter 2, those who approached the KIA in search of health care felt that the KIA was somehow working in continuation with the state in the provision of the healthcare services that the state was no longer able to guarantee. I suggest that the perceived continuity between the KIA and the state was triggered by the presence of both bureaucratic documents and biomedicine as a set of standardised practices and scientific knowledge owned and managed by medical doctors.

In order to understand the perceived continuity between state institutions and the clinic, I follow on from Aradhma Sharma and Akhil Gupta’s (2006) consideration of localised images and experiences of the state as being crucial to people’s imagination of the state and to its discursive production (2006: 19). By closely looking at the work of the social clinic, it emerged how, on the one hand, the administration of biomedicine and care was heavily regulated through and by documents which travelled from state institutions to the KIA, as medical doctors also did. Furthermore, amongst my informants, doctors were perceived as deeply embedded in the state: from their education to the job positions they occupied in the public healthcare system, the salary they received from the state and their actual participation the bio-political projects of the state. Chapters 4 and 5 of this thesis are devoted to analysing how, along with the presence of bureaucratic documents, the increasing pharmaceuticalisation of care represented another important strand by which a continuity between the KIA and the state was perceived.
As mentioned above, my informants clearly related the presence of the KIA to the absence of the state: ‘had there been a state, we would not have had to open this clinic.’ However, the absence of the state, as voiced by my informants, actually alerted me to its presence in my informants’ lives. Accordingly, I follow Michelle Obeid’s suggestion to attend to people’s ‘simultaneous experience of the state absence and presence’ in order to better understand how ‘these contradictory features of the state produce concurrent conflicting affects of desire and contempt for it’ (2015: 437). These, in turn, rely on and reveal people’s diverse ‘imaginations and aspirations’ (Obeid 2015: 446) for the state: in the case of post-war Lebanon, Obeid contends that the absence of the state has recently become synonymous with the state’s failure to perform its duties. While this situation was somehow accepted on the assumption that a functioning state could not exist during war time, in the aftermath of the war Lebanese people expected the reappearance of the state (2015). On a similar note, Jansen elaborates on how his informants in Sarajevo enact their hope for, rather than against the state (2014), and suggests maintaining an analytical separation between statehood and statecraft in order to better understand the central place his informants in Bosnia Herzegovina attribute to the state in the aftermath of the Dayton agreement (2015). Accordingly, he proposes that questions pertinent to ‘what the state is, claims to be, and should be’ (2015: 12) are thought of in terms of statehood, and those relative to ‘what the state does, claims to do and should do’ in terms of statecraft (2015: 12).

Through these questions and by attending to people’s desires, complaints and claims on the state, this ethnographic work aligns with Obeid’s and Jansen’s line of ethnographic inquiries, and explores how biomedicine has become central to post-crisis statecraft in places other than the state institutions. In so doing, I attended to how volunteers at the KIA talked about, imagined and complained about the state, how they thought the KIA was actually contributing to the structuring of a more functional healthcare system, and how the volunteers, perhaps unintentionally, ended up reproducing the state in a place where it was least expected. Indeed, as Michael Herzfeld aptly points out:
‘even citizens who claim to oppose the state invoke it - simply by talking of it in that way - as the explanation of their failures and miseries, or accuse it of betraying the national interests of which it claims to be both expression and guardian. In the process, however, they all contribute, through these little acts of essentialising, to making it a permanent fixture in their life’ (2005: 2).

‘You’ve become the state.’ The bureaucratisation of care

In an effort to manage an ever increasingly flow of patients, access to the KIA was progressively rationalised through and by bureaucratic documents which served to ensure a fair distribution and management of health care resources. The volunteers’ understanding of these documents actually collided with the patients’ experiences with them. The expired insurance card, the proof of unemployment and medical certifications related to medical conditions and chronic diseases in particular, were no longer valid to access the public healthcare system, but acquired value as they ensured access to the KIA. In this sense, those bureaucratic papers that certified one’s status as uninsured and unemployed, as well as the medical diagnoses and medical prescriptions, served as proof of one’s entitlement to access the medical resources that were made available by the KIA. However, the relation between one’s ‘social’ and ‘medical’ status was somewhat hierarchically organised: medical evidence proved one’s deservingness as predicated on a medical condition or medical needs, but was not always sufficient on its own to access the KIA. Entitlement to the KIA services was rather ascertained by bureaucratic documents that could prove one’s status of being unemployed and uninsured. Being poor, more than being sick, was crucial to ensuring access to the KIA healthcare services. Interestingly, in a moment when the state was alleged to create discrimination and marginality amongst its citizens by increasingly tying access to healthcare services to insurance (and thus employment), the KIA seemed to reproduce the same exclusionary mechanisms by asking the patients to provide those same documents that had previously been issued by the state. In light of these considerations, I have looked at how bureaucratic papers and medical diagnoses offered people unexpected grounds for
negotiations and contentions. In fact, although bureaucratically regulated, access to the KIA services was often allowed by the discretion al process of decision making of the volunteers. Heath Cabot (2013) describes in terms of ‘social aesthetics of eligibility’ the process by which refugees and migrants were granted legal support in an NGO in central Athens. She highlights how aid candidates work to produce and reshape the criteria through which their eligibility is assessed, and aptly shows how these criteria build on, but exceed, bureaucratic categories. In this context, Cabot argues, the intersubjective dynamics and the dialogical engagements by which aid workers and aid candidates coproduce anew ‘dominant images of deservingness, victimhood and vulnerability from within the systems of aid distribution’ are crucial (2013: 453).

While Cabot looks at how bureaucratic procedures act to open up unexpected spaces for asylum seekers to negotiate the terms of their entitlement to both the NGO pro bono legal aid and to protection, I look at how eligibility and entitlement to the KIA medical services are similarly negotiated through illness narratives. With these, those who approached the KIA aim to entice the volunteers to grant them access to the medical aid when their documents do not meet the bureaucratic requirements. I consider how illness narratives may retain the potential for making claims to entitlement to care by following Adriana Petryna. (2013a). In her ethnographic exploration of how the survivors of the Chernobyl nuclear disaster made health and its loss a negotiable realm of entitlement to biomedical resources and social welfare, Petryna (2013) shows how medical diagnoses uphold potentials for redefining the boundaries of the state, and the terms of social inclusion and exclusion. In so doing, Petryna offers a compelling ethnography of how medical and biological conditions can unexpectedly constitute forms of legitimisation and entitlement to make claims on the state. The emergence of what Petryna describes as ‘biological citizenship’ rests on the entanglements of diverse rationalities and bureaucracies and the lived experienced of medical conditions. By tracing how scientific and social knowledge about radiation-related illness transverses the private and public spheres, Petryna argues that
‘how people expressed their grief, how the demands of institutional setting shaped their discourse and body language, and how they elicited the responses the needed from technocrats (and their choices of words or silences) all found their place in the political and scientific regime that defined everyday life. People’s actions, politics, and sensibilities were encoded in and restricted by the professional and legal discourses of this rational-technical domain’ (2013: 20).

Whereas my ethnographic material neither speaks directly to issues of citizenship nor to forms of compensation, the presence of diverse rationalities, medical and bureaucratic, and how they differentially regulate the distribution of healthcare services at the KIA, became a crucial ethnographic thread that I explore in Chapter 2. By attending to how the coexistence of medical and bureaucratic rationalities was productive of contentions between patients and volunteers, I examine what experiences of illness documents revealed or concealed, and how documents came to offer unexpected margins of contestations through which access to the KIA services were renegotiated. At the same time, I ethnographically attended to the ways in which people who wished to be registered as patients made leverage on the volunteers’ lack of medical knowledge to favour their inclusion in the clinic’s distribution of medical care.

Documents have long been considered as a technology of visibility (Street 2012) and legibility (Das 2006), as modes of governance through which populations are rendered visible and legible, and thus governable to the state. In order to tease out how patients’ sense of deservingness as deriving from their medical conditions and volunteers’ reliance on documents as proof of a patient’s entitlement conflated, I follow Alice Street’s (2012) understanding of how people use documents to render themselves visible to state institutions. In her ethnographic work on healthcare practices and bureaucracy in a hospital in Papua New Guinea, Street considers how bureaucratic documents became
‘technologies of visibility within the institutional crevices of a weak state. […] The desire for the state is not only expressed in discursive constructions and representations, but is materialised in routine and bureaucratic and medical work. Within this ambiguous space, where the state cannot see but people nonetheless imagine the state, bureaucratic technologies of visibility conventionally associated with rational forms of governance take unexpected trajectories’ (2012: 1).

As the KIA was perceived to work in continuation with the state institutions and hospitals, it became a place where people thought they could become visible to the state just by being registered as patients at the social clinic. I examine what visibility actually consisted of, and what the role the KIA played in people’s struggle to render themselves visible to the state. Chapter 2 delves into how the social clinic actually made some patients visible to the state by granting them preferential access to public healthcare resources from which they had previously been excluded. Accordingly, the chapter ethnographically follows how people’s attempts to be registered as patients spoke of their desire and need to be included in the meagre left-overs of the public healthcare system. On a similar line of inquiry, Chapter 4 and Chapter 5 explore how pharmaceuticals offered a particularly favourable terrain through which people strove to become visible to the state. By offering an ethnographically informed account of what compliance and chronicity look like at a time of pharmaceutical shortage and difficulty in access to biomedical resources, I have looked at how many informants translated their experience of the economic crisis into an experience of illness. By paying attention to the diverse registers through which people accounted for the relations between their health condition, their experience of disease and their livelihood at a moment of crisis, my analysis moves back and forth between the social and the medical, the collective and the individual. In so doing, this work offers an ethnographic account of both the process of rapid social and economic changes that the economic crisis boosted, and the subjective experience of it.
Biomedical redemption: the pharmaceutical conundrum

In her article ‘Biotechnical embrace’ (2001), Mary Jo Del Vecchio Good charts how biomedical technologies, and the hopes they retain, travel globally and come to locally constitute what she describes as the biotechnical embrace; ‘the affective and imaginative dimensions of biomedicine and biotechnology [that] envelop physicians, patients, and the public’ (2001: 397). However, she argues, enthusiasm for medicine’s possibilities arises not necessarily from the material products with therapeutic efficacy, but through the production of ideas with potential, although not yet proven, efficacy. Around these possibilities, new tangles of power emerge, and relations of dependency, desires, hopes and needs are also created.

The biomedical technologies this thesis looks at include pharmaceuticals, branded drugs and generics. In a moment where the public healthcare system was on the verge of structural collapse, pharmaceuticals seemed to offer a quick fix to meet many people’s medical needs. At the same time, however, many Greeks became increasingly unable to economically afford pharmaceuticals as a consequence of the drastic declines in salaries and pensions, and the reduction in the health insurance coverage. The free provisioning of medications, as was operated by the social clinic in southern Athens, can be contextualised in this socio-economic panorama, while it also spoke of the entanglement of state policies in matters of pharmaceuticals, home-based practices of care, and the expectations and imaginations of care that my informants increasingly tied to pharmaceuticals.

In exploring the relations between medicines and marginality with a special ethnographic focus on antidepressant drugs in India, Stefan Ecks (2005) describes how depressed people are perceived as marginal, wherein their marginality mainly corresponds to the condition of ‘being deprived of medication’ (2005: 239). Generally associated with a form of social inequality and a state of injustice, marginality in healthcare means being cut off from the circulation of biomedical substances (2005: 240). In Kolkata, Ecks argues, the biomedical promise of effective treatments that the
antidepressant drugs bring about comes with a notion of pharmaceutical citizenship. Ecks describes pharmaceutical citizenship in relation to ‘the biomedical promise of demarginalization’ (2005: 241) and asks whether legal citizenship determines the right of access to pharmaceuticals, meaning that ‘equality between citizens implies equal entitlement to receive drugs.’ Ecks also questions whether one’s status as a citizen might change when one is granted access to therapeutic resources, and concludes that ‘pharmaceutical citizenship entails a similar friction, between the citizen-as-patient who is entitled to medicines because he or she is already a full citizen, and the not-yet-citizen patient, for whom taking medicines is a practice of becoming full citizen’ (2005: 241).

Departing from Ecks’ consideration of the promise of demarginalisation that pharmaceuticals retained in a context of uneven access to biomedical technology, this thesis explores how the free distribution of pharmaceuticals as operated by the KIA retained the promise of care more than health for those Greeks who could no longer access public healthcare resources. By shifting the ethnographic focus from social marginality to individual pathology, I have explored how pharmaceuticals travelled across different spheres of social life and how, in each of them, they acquired different meanings, while also responding to different needs. Accordingly, Chapters 4 and 5 explore how the availability of new medical technologies have transformed people’s need for care and the practices of care themselves. Therefore, I have examined how pharmaceuticals moved across state-licensed pharmacies and hospital dispensaries, entered the households and later the social clinics, to which leftovers of pharmaceuticals were donated by private citizens and redistributed to those citizens in need of medications. Crucially, I argue, the free distribution of pharmaceuticals was made possible by some state policies which, in the year prior the 2008 crisis, favoured people’s access to pharmaceuticals. At the same time, ‘floating prescriptions’ (Ecks and Basu 2009), over-prescriptions, greater availability of over-the-counter

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5 Ecks explains that the concept of ‘pharmaceutical citizenship’ develops from Adriana Petryna’s theorisation of biological citizenship as a project of citizenship that ‘centres on biomedicine and new forms of biotechnology’ (2005: 241).
medications and quite a loose positive list facilitated the accumulation of pharmaceuticals within Greek households.

In this regard, I suggest a consideration of the household as the crucial linkage between the state (namely licensed pharmacies), and the social clinics: a site of mediation where medications were charged with different understandings of care and different experiences of illness. As Chapter 4 explores in detail, the abundance of pharmaceuticals over which home-based care practices flourished (these were later transferred into the social clinic) signalled changes occurring at the state level. I argue that, in Athens, the widespread reliance on pharmaceuticals as a means of care represented a ‘practical response to a pattern of intensified disengagement of social and medical services’ (Garcia 2010: 65). Angela Garcia (2010) ethnographically unravels the relations between poor medical infrastructures and the consumption of pharmaceuticals (see also Biehl, 2005), and aptly shows how, in the Espanola Valley, an economically deprived area of New Mexico, ‘the paucity of local services, the endless waiting lists for the few that exist, and the provision of suboptimal care have forced families to perform a kind of social and medical triage’ (Garcia 2010: 65). Sharing medical or even illegal drugs amongst kin and neighbours, she argues, signals a moral and practical effort to recuperate and reconstitute social relations. Garcia highlights how drugs - either prescribed or not - become synonymous with care, although the distinction between curative and destructive medications blurs dramatically. On a similar note, Clara Han (2012a, 2013) observes that the circulation of pharmaceuticals across households in a poor neighbourhood of Santiago, Chile, is indicative of how governmental mental health programmes have been absorbed into domestic relations.

Departing from these premises, Chapters 1 and 3 describe how the social clinic collected, checked, repaired, stored and redistributed for free large amounts of medications, which had mainly been donated by private citizens and Greek expats. These chapters ethnographically attend to the ways in which pharmaceuticals were handled and thought of by volunteers and patients. These chapters also problematise how pharmaceuticals were
considered particularly apt resources to solve the medical crisis that many Athenians had been experiencing since the onset of the economic crisis. As long as medications were seen as particularly apt tools to resolve the crises, both biomedical and economic, I have asked how, through references to pharmaceuticals, people *emplotted* their experience of the crisis beyond their medical stories, and how the KIA constituted itself as a reliable healthcare provider in the fragmented medical landscape of Athens in a moment when medications became increasingly unaffordable for a large number of Greeks. In unravelling what I have described as the pharmaceuticalisation of care, I also show how pharmaceuticals are ‘not only to think with’ (Levi Strauss 1962) but also to ‘claim with’. Chapter 4 sets out to problematise the relations between state policies concerning pharmaceuticals and people’s claims for them, by looking at how the restricted access to pharmaceuticals was a consequence of the introduction of stricter controlling mechanisms by which the state tried to cut public expenditure. In this sense, I have inquired into how people’s claims for state care, and for pharmaceutical care in particular, help me to rethink questions of statecraft and statehood, while offering a challenging entry point to ethnographically amending earlier theorisations of medicalisation as a form of medical domination.

In developing my analysis of pharmaceuticals, I have not engaged with any literature relative to gift economy, commodity and value. Whereas I understand the economic aspect to be crucial to the donation and distribution of medications, I am not interested in analysing this process per se, which has variously been described in terms of ‘redemptive economies’ and ‘value conversions’ (Halvorson 2012). Rather, departing from the consideration of pharmaceuticals as objects that generate care, I contest the hypothesis of ‘care as gift’ (i.e. Kleinman 2012) and draw from feminist scholarship that sees care as a form of affective labour. I argue that in austerity-laden Athens, modes and patterns of care are redrawn by the contextual availability or shortage of pharmaceuticals, and suggest that domestic modes of care were transferred into the social clinic, in particular in the social pharmacy where I myself volunteered for fourteen months. I describe the sorting process that the female volunteers engaged with in the KIA as a labour of care which also
entails a process of re-signification by which discarded medical materials were reactivated and rendered suitable for being donated again (Halvorson 2012). On this note, I have particularly focused on how pharmaceuticals were generative of relations of care and dependency across different scales, rather than on their potential to generate diverse values (also in Chapter 5).

In this vein, I offer an ethnographic exploration of social reproduction as the capacity to sustain and maintain meaningful relations (i.e., Narotzky and Besnier 2014; Thelen 2015; Fraser 2016), and how this was being reconfigured in the context of the KIA. I look at the female labour of care and women’s engagement with practices of care: these, I argue, spill over the boundaries of the households and transcend the traditional idea of care as either a moral experience (Kleinman 2013), as motivated by love and kinship (Thelen 2015), or as a privately paid for activity. As the following section will extensively explore, the women engaged in the KIA’s activities considered their caring skills as a female attribute, and effectively capitalised on them in maintaining and sustaining meaningful ties and relations of care with people who are not kin, and are outside their households.

The state of women and their ethnographic (ir)relevance: the labour of care beyond kinship and the state

Departing from these considerations, this thesis offers an ethnographic exploration into the gendered experience of the crisis by looking at both the engagement of female volunteers with the work of the KIA, and at how the access to healthcare resources was mainly pursued by women. In particular, I explore how the participation of many women in the provision of care at the KIA was generative of new forms of sociality and, at the same time, of new configurations of care at a moment of rapid socio-economic changes. As I will show ethnographically, novel yet contradictory understandings of women’s responsibilities towards their kin and wider society emerged, and were voiced by my informants as signalling gendered modes of engagement with the consequences of the economic crisis. I want to clarify that the perspectives of the female volunteers at the KIA that informed my chapters account for only a partial picture of how Greek women experienced the crisis.
For the female volunteers it was an opportunity to break from their domestic duties and reinstate themselves as modern and independent women. They all came from a middle-class and wealthy background, and were aged between their late 40s to 75 years old. They were married, and apparently well-off housewives (*nikokiries*). By capitalising on their experience as skilled housewives, they organised the space of the social pharmacy. As Chapter 3 will extensively describe, the space of the social pharmacy was domesticated in ways that resembled the domestic spaces where care was mainly enacted along kinship lines. Amongst these women, references to kinship were as common as they were controversial: even if kinship relations granted women a status in society, these same relations locked them into obligations and care relations that were often described as suffocating, demanding, or frustrating, or as confining them within the realm of the household.

According to much of the literature on Greece, women have been described as being relegated to the private, domestic sphere. Furthermore, within the sphere of the private, the experience of womanhood seemingly cannot be disjointed from that of motherhood. Such an assumption applies to both the rural context (du Boulay 1986; Loizos and Papataxiarchis 1991), where motherhood offers women social recognition (Salamone and Stanton 1986), and urban contexts (Paxson 2004), where the experience of motherhood comes to be identified with a personal choice (Paxson 2004) rather than with destiny (du Boulay 1986). Resting on this premise, much of the anthropological scholarship on and of Greece has, until now, offered only rare and sporadic incursions into the realm of female politics. Indeed, women have mostly been thought of in relation to the realm of the household and to the margins of the freedom and power they experience within its premise. Jane Cowan offers the first ethnographic glimpses of female sociality outside the realm of the household, and aptly describes how the cafeteria in a Northern Greek town offered the discursive space ‘in which dominant definitions of female personhood are made explicit and sometimes contested’ (1991: 182).

Nevertheless, until recently, anthropological exploration of womanhood and gender roles have mainly centred on rural society’s most traditional aspects,
that were seen as being preserved by women’s work. Focusing more on those aspects of social reproduction, much scholarly work has described women as inherently linked to the domestic sphere (among others: du Boulay 1974; Seremetakis 1991; Sutton 2001). Jill Dubisch (1991) contends that the erasure of women from ethnographies of Greece may ultimately be attributed to women’s absence from the political scene as active citizens, as well as to the discretion and reticence of women in participating in public initiatives. Therefore, assuming a general unfamiliarity and diffused disinterest amongst women towards politics as played out in the public sphere, ethnographers’ attention has long been focused on women and the gendered experienced of social reproduction and kinship relations. However, the assumed separation between the private (as the realm of the domestic) and the public (as the male arena of politics) has not only been contested by some feminist scholars for whom ‘the personal is political’, but has also shown a certain epistemological fragility.

For instance, Henrietta Moore (2013) observes that, in social anthropology, the public versus the domestic has been, and still is, a useful frame to elucidate culturally-situated meanings of womanhood in relation to the activities women engage with in society. Some Greek anthropology, notably Michael Herzfeld’s (1986; 1988) work, has long emphasised how the public-private dichotomy reverberates in gender roles: while women occupy the domestic sphere, men inhabit the political and public domain where they pursue the interests of the household. However, in critiquing the analytical separation between public and domestic, much feminist work has pointed out that this dichotomy not only implies a hierarchical, sexualised and gendered binary order, but it actually reproduces the dichotomous thinking that it attempts to overcome. Likewise, the public-private frame has been challenged, especially as to whether it actually retains any heuristic potential for analysing structures of power, although it still offers ‘a way of ordering ethnographic data, and of marking out a clear domain for women within the material presented’ (Moore 2013: 21).

In an article from 1986, Michael Herzfeld argues that the absence of Greek
women in ethnographic and anthropological works relates to both a rural-urban divide, which informed much of the previous literature on Greece, and to an oft-assumed dichotomy between the domestic as a female realm and the public as a male realm. In suggesting the problematisation of ‘the category of female’ (1986: 215), Herzfeld argues that the boundaries between the public and the domestic as distinct realms of men and women are likely to blur once the ethnographer becomes aware of the *disemia* informing Greek social life (2005). This becomes possible when the ethnographer gains full acceptance amongst the people they work with. The social transition from the position of *outsider* to that of *insider* seems to mirror the ethnographic shift which is associated with moving from the public to the domestic. Once the domestic is made available to the ethnographer, Herzfeld seems to imply, they would finally be able to witness how power is differentially exercised by women, who have long been described only as submissive and subjugated to male authority. Herzfeld not only attempts to (re)valourise the private/domestic as the realm where gender and power imbalances are levelled off: he also tries to restore ethnographic visibility to women by claiming a privileged ethnographic access to the realm of the domestic. However, he does not in any way challenge the prominent analytical framework whereby women and men inhabit different fields - rather he limits his contribution to adding ethnographic evidence to probe women’s position of power within the household.

For instance, Greek anthropologist Alexandra Bakalaki (1994) poignantly critiques Herzfeld’s ethnographic assumption that the rural lifestyle of the 19th century survived until his ethnographic fieldwork in the late 1970s and, in her studies of women’s education in the 19th century, she also suggests that Greece had been ‘European’ long before joining the EU in 1981. On a similar note, Maria Couroucli (2007) offers a different perspective to look at the production of anthropological works relating to Greece. She suggests that the political conditions in Greece had long been unfavourable, ‘not optimum conditions of democratic rule’ (2007: 74), as was the case during the Colonels’ dictatorship (1967-1974): as fieldwork conditions are dependent upon larger political configurations, Greece remained ‘terra incognita
anthropologically’ for a long time (Cowan 2003: 309) and, until the 1980s, anthropology was ‘very much a rural practice, so that the anthropologist was more urban and learned than the village people he or she studied’ (Couroucli 2007: 76).

More recently, anthropological works have not only followed, but also challenged both the urban-rural and private-public divide that had long informed previous anthropological studies (see, for instance: Cowan 1991; Paxson 2004). Along these lines, Elisabeth Kirtsoglou (2003) offers a compelling ethnographic account of how gender for women is not realised exclusively through kinship and in the domestic sphere. Although Kirtsoglou acknowledges that there exist ‘contexts alternative to kinship that play an important role in the production of gender and sexual identity’ (Kirtsoglou 2003: 21; also: Loizos and Papataxiarchis 1991), these alternative contexts ‘depend on familiar cultural idioms of masculinity and femininity’ (Kirtsoglou 2003: 23-24). What stands out particularly from Kirtsoglou’s ethnography is the novel focus on a female parea (group of friends), a previously unexplored realm of gendered sociality, and the epistemological shift it implies. By describing the social life of a group of women outside the household and their entrance into ‘the public’ (materially, represented by a bar in a town outside Athens), she breaks from the assumption that the private and the public sphere were distinct yet complementary realms of men and women (Cowan 1991; Dubisch 1986; Herzfeld 1986; Loizos and Papataxiarchis 1991; Salamone and Stanton 1986). At the same time, Kirtsoglou claims that friendship ties among women are likely to resemble kinship ties wherein affection, economic, and emotional support are strengthened through dancing, drinking and eating together, activities that have long been considered to describe male sociality (Cowan 1991; Papataxiarchis 1991).

While Kirtsoglou’s exploration of female friendship outside the household offers an original insight into gendered forms of sociality, my work follows on from this, offering an ethnographic exploration of female sociality in the liminal space offered by the social pharmacy attached to KIA and, in doing
so, describes how relatedness and friendship were generated by and through care: for relatedness, friendship and care, ‘kinship provides an idiom’ (Obeid 2010: 94). In particular, I explore how these relationships amongst women contributed to blurring the boundaries between the public and the private through a process of production and reproduction of models of womanhood and ideals of care. In this sense, my ethnographic work aligns with Kirtsoglou’s interest in exploring gendered sociality outside the private realms of households, and follows on Dina Vaiou’s (2014) invitation to trace the more gendered aspects of the Greek crisis. Vaiou urges a consideration of how the position of women has changed over nearly a decade of austerity, and to look at their experiences in maintaining and sustaining social reproduction.

Narotzky and Besnier (2014: 8) describe the 2008 financial crisis by pointing out that

‘[i]t has produced uncertainty of both an economic nature (shrinking resources, decreasing employment opportunities, precarious job structure, failing credit, higher indirect taxation, reduced state benefits) and a political nature (disempowerment, loss of entitlement, technical governments, democratic deficit) in the old centres of Western capitalism, a situation that was long present in other spaces of capitalism. This uncertainty affects people’s ability to reproduce materially and emotionally, creating difficulties in forming new families, maintaining existing ones, forming caring relations and feeling respected.’

Crisis, Narotzky and Besnier continue, signals a rupture in social reproduction and urges people to produce new ‘expectations and obligations and different reconfiguration of opportunities and resources’ (2014: 7). Chapter 3 is therefore dedicated to analysing the relations between the voluntary work my informants engaged with, the labour of care they performed, and the ideals of womanhood they tried to live up in a historical moment when the crisis reconfigured the relations between private and
public, namely the household and the state, and the market and the voluntary sector. As a thematic thread running through the five chapters, I discuss women’s experiences of the crisis and their struggle to access healthcare resources. As I will explain in the methodological section of this introduction, the prominence I give to women’s voices is mainly motivated by the material conditions and limitations of my fieldwork. However, these also resonate with already existing bodies of literature according to which women are, often superficially, described as gatekeepers for healthcare resources, and as care-seekers, for themselves and their relatives.

Particular ethnographic attention is paid to the crucial role that pharmaceuticals played in establishing and restoring relatedness and relations of care, and in structuring its provision. As mentioned above in the previous section, pharmaceuticals as objects of care had long been circulated and shared across households where they informed certain practices of care. I argue that these home-based practices of care were later reproduced in the social clinic: in the process of sorting pharmaceuticals, new modes of relatedness were created outside the households, while ‘old’ modes of pharmaceutical care were extracted and transferred from the household into the social clinic. In describing my informants’ activity of sorting pharmaceuticals and the circuit of donations and distributions, I mainly rely on Sjaak Van der Geest, Susan Reynolds Whyte and Anita Hardon’s (2002) understanding of medicines as travelling across diverse routes and venues crisscrossing, for instance, folk and institutional settings, and the public and private spheres. By looking at the ‘careers’ of various medicines, Van der Geest, Whyte and Hardon draw on Arjun Appadurai’s work (1986) to trace the social lives of medicines, their unlicensed lives (Ecks and Basu 2009), and how they are adapted and used in different cultural and social contexts.

**Care as an ethnographic category and as a methodological approach**

Upon my arrival in Athens, as well as attending a six-month language course, I began to explore possibilities and strategies for approaching the social clinic that I had previously selected as my preferred field-site. After five months of
relentless and intense negotiations with some of the organisers of the KIA, I was granted access to the facility as a volunteer and as a researcher; once I was there, the reality with which I was faced was rather different from what reports from Greece had described. The KIA was indeed providing free healthcare to almost 1,000 patients per year, nevertheless its proclamations about being founded upon a less medicalised approach to health and illness seemed to have succumbed to the urgency of distributing primary healthcare and medicines to an ever increasing number of patients. The tense and often contradictory ways in which healthcare was administrated by this self-organised healthcare facility constitute one of the main ethnographic threads of this work.

Thanasis, a very kind and friendly man that the mother of a friend introduced me to, acted as a gatekeeper at the KIA, advocating on my behalf with the woman in charge of organising the volunteers’ shifts and helping me to go through the bureaucratic papers that the KIA required me to fill in. As a foreigner, I was not able to provide my IKA (national insurance number), and my landlady never drew up the tenancy contract because she said that with the crisis, she would have to pay a lot of taxes on the flat she was renting to me and she could not really afford it. Interestingly, my passport actually proved nothing about who I was: I was just an Italian woman, 33 years old, alone in Athens with no one who could socially vouch for me. I was no one’s daughter (kori), no one’s friend (fili) and no one’s acquaintance (gnosti). Athenians used to say ‘the world is small’ in reference to the city (einaí mikros o kosmos) where ‘any neighbourhood is a small village’ (kathe geitonia einai ena mikro xorio). Often said as a complaint and often as a pledge, for many Athenians references to village life are a measure of Athens’ backwardness, or its greatest virtue. In Athens, as in a village, tight social relationships were built mainly on kin ties and these ensured safety, protection and connection to its dwellers. As a foreigner (xeni), obviously I was not part of any of this - I did not have a village where I came from, and I often found myself begging for help from those people who showed some interest or concern towards me. Thanasis was one of those people.
With no useful documents to hand, Thanasis suggested that I should provide the KIA with a letter proving my affiliation to the department of social anthropology at Panteion University so that ‘they understand that someone knows you.’ He also thought that providing my insurance status and proof that I was a PhD student at the University of Manchester was a good strategy, so that ‘they don’t think they will have to pay you, and if something happens to you, the clinic is not responsible for you.’ A few copies of my research project outline, correlated with the ethical statements, helped ‘make it official.’ Thanasis patiently helped me to fill in the forms and gave me suggestions about how to better phrase my commitment to the solidarity principles and prove how strong my will to become a volunteer was. When I advanced the idea that the outcomes of my research could potentially be of some use to the clinic, he bluntly replied ‘it doesn’t matter. No one cares.’

Through my own experience with the series of papers I had to sign, the documents I had to provide and the people I had to contact, the bureaucratic apparatus of the KIA became progressively apparent to me. I spent days making phone calls and being put on hold, only to be told later that the person I was looking for was not available at the moment. When I showed up at the KIA to make my case, the people at the front desk (grammateio) confusingly suggested that I should talk to Maria, Costas, Yannis, or Vasiliki. When I asked whether and when it was possible to make an appointment with any of them, I was told that ‘because of the crisis’ their presence at the clinic was rather unpredictable. Funnily enough, there were at least seven women called Maria working at the same pharmacy, and as many named Vasiliki volunteering at the social clinic. For further clarity, Vasiliki is the diminutive of Vasileia and I met at least four more Vasileia during my fieldwork at the KIA.

While struggling to establish access to my field-site, what I later describe as the reproduction of a state-like bureaucracy and the bureaucratisation of solidarity immediately emerged as an intriguing ethnographic thread. It was neither the bureaucratic apparatus per se that made the case challenging, nor what Michael Herzfeld (1993) would define as ‘the social production of
indifference.’ Rather it was the persistence of two apparently incompatible organising principles undergirding the structure of the social clinic: solidarity as premised on horizontality, spontaneity and mutuality, and bureaucracy as an actual mode of governmentality, through which volunteers and patients alike were identified, recognised, and entitled to respectively provide or receive healthcare services. Papers, documents, notes and advice, leaflets for translations and receipts for the donations received, books on international pharmacology, the huge black book of the registered patients and their personal files, the lists of medications available and those needed: these became crucially important material cues to explore how medical resources were administrated and healthcare delivered. At the same time, the material presence of these documents and papers seemed to account for, and make sense of, the crisis along trajectories other than those narrated through the lens of solidarity.

Once I was granted the status of volunteer, I was delegated to work in the social pharmacy, a self-organised and incredibly efficient dispensary. The general manager of the pharmacy, Aliki, cut short my hope to work at the front desk, saying that my Greek was not yet good enough to deal with patients: and so it was in the pharmacy that I started and concluded my fieldwork, with frequent incursions to the front desk of the KIA and the outside world of the social clinic. The ethnographic material that I collected in the clinic represents the core of this work, although lateral explorations and sporadic incursions into other medical institutions and organisations across Athens helped to produce a more complete picture of the medical landscape of the city. Of utmost importance were the conversations with people I met casually, as well as the longer, intense conversations with friends: they helped me greatly to make sense of my sense of estrangement from my fieldwork, occasionally my life, and from much of the anthropological literature on Greece my head was filled with. Doing fieldwork in a licenced pharmacy definitely helped to add texture and perspective on how pharmaceuticals circulated across society. From Viktoria’s pharmacy, I could better understand how state policies impacted on people’s access to pharmaceuticals. All those considerations, conversations and encounters are
part of my field-notes, in the form of both written texts and illustrations. While my written field-notes have been reworked into chapters, some of my illustrations, raw and untouched, are included in the chapters.

In the social pharmacy, it was mostly women who worked to check, sort, label, repair and order the vast amount of medications that were donated almost daily to the KIA. Given the quite wide generational gap between myself and my fellow volunteers, these women started taking care of me in a way that was motherly and affectionate, when not patronising and condescending. Their attitude towards me was a form of care and protection, and worked as a connection with the wider structure of the clinic. It was also a source of legitimisation in front of the other volunteers to whom I was introduced as ‘our little Italian girl’ (*i mikri Italida mas*). Their proximity and the affectionate care they showed to me constitute the departing point for me to explore different ideas and practices of care and how they linked to certain gender expectations, kinship practices, and situated understandings of what be(com)ing a good woman looked like. I considered these aspects particularly relevant for two reasons.

First, all together they showed how the economic crisis contributed to blurring the lines between labour and volunteerism, while they also spoke to how changes in the labour market impacted men and women differently. Andrea Muehlebach’s (2012, 2013) appraisal of the relations between volunteerism and neoliberalism in Italy offered an initial departure to reconsider the emergence of the voluntary sector in Greece, beyond the dichotomy of crisis and solidarity as a form of resistance towards the state.

I believe that analyses of the Greek grassroots initiatives have often overlooked a thoughtful consideration of the relations between these initiatives and state institutions, and how the state increasingly outsourced the provision of welfare services to the voluntary sector. In the case of grassroots healthcare, for instance, how these grassroots relate and position themselves towards both the existing healthcare system and the regulations about the distribution of pharmaceuticals and medical services has not been sufficiently
problematised. For instance, Cabot (2016a; 2016b) claims that these clinics promote a reconfiguration of care and citizenship; in fact, the majority of those clinics reproduce the same modes of care by means of pharmaceuticals along the same citizenship lines as had happened at the state level. I suggest that what is being reconfigured is only the medical landscape, wherein the social clinics have come to represent a third healthcare provider, alongside the public and the private healthcare systems. This reconfiguration occurred at the convergence of state-backed appeals to the magnitude of the economic crisis, that was assuming a humanitarian dimension and required solidarity responses from people (as detailed in Chapter 1; see also Theossodopoulos 2013: 206). The anxiety of an imminent humanitarian crisis coupled with the political rhetoric of active citizenship; this latter became synonymous of modernity (Rozakou 2016b), while solidarity (alileggii), together with hospitality (filoxenia), started figuring as a Greek national feature (Papataxiarchis 2016b).

A second aspect that I believe to be worth exploring relates to gender expectations and practices of care, and how those were being reconfigured in a moment of rapid socio-economic change. The precariousness of labour regimes, the curtailment of living salaries, and the progressive retrenchment of the state from the provision of welfare services have not only impacted on women and men differently (Vaiou 2014, 2016), but have also contributed to reshuffling the terms and meanings of care, whose burden has been increasingly shouldered by women (Vaiou 2014, 2016). Greek urban geographer Dina Vaiou (2016) offers a compelling account of the most gendered aspects of the crisis. In particular, she describes how its macro-economic aspects translated into people’s everyday lives and personal projects, and argues that

‘care and its dismantling is an underlying thread that re-organises everyday lives and mobilises tensions at many levels, have to do with gender relations among mother and daughter, local and migrant women, women and men, as well with the ways in which they envisage their prospects on a day-to-day basis and in the immediate and longer-term future’ (2016: 227).
During the fourteen months I spent in the social pharmacy, I actively participated in the work of the volunteers with whom I also shared large amounts of time and intimate chats. Those chats and their stories constitute the ethnographic spine of this research. I did not officially interview any of the volunteers, nor did I record any of our conversations. I spent between six and eight hours every Friday and four hours every Tuesday with them, and worked side by side with them. It was especially during our frequent breaks from work that I could ask more precise questions about the KIA. During our shift, they strove to make me feel part of the group and to include me in their conversations about everyday issues, like family and care for their kin. Aware of my position as a researcher, they never refrained from answering my questions, repeating or explaining words, concepts and sentences again to me. They often slowed down the pace of their conversations to allow me to write my notes when they saw me intent on scribbling down words, chunks of conversations or explanations they gave me about what they consciously described as the Greek mentality (see for instance Faubion 1993). Most of this ethnographic data actually came out of the questions they asked me (Chapter 3), and not from those that I asked them. Insights and considerations on womanhood and care stemmed from the observation of what I considered an embodied knowledge of how to conduct themselves as proper women.

Despite the great deal of energy that my fellow female volunteers employed to make me part of the social clinic, my presence at the KIA was generally looked upon suspiciously. My questions were often met either with indifference or dismissed with condescension and patronising kindness. Men, doctors and volunteers alike, proved to be unreachable: they gave me as many appointments as they cancelled. In the face of my frustration over any appointment that was cancelled, my fellow female volunteers were keen to remind me that the doctors were very busy, especially now that the crisis was so violently impacting on many people’s health. Implicitly, they were telling me that I could not really expect them to waste their time in chatting with me: my research was nice, but of no avail to anyone. At other times, my female informants playfully dismissed the men’s attitude of superiority towards me,
and towards them as well, with unexpected outbursts of resentment. One of my informants, Valia, once told me

‘We made them [the men] believe that they are essential to this place. They are not. If we stop working, the clinic stops working too. If they stop doing what they do, we can do our [work] and theirs too and this place keeps on working anyway.’

As for the male volunteers in general, I actually met very few in the context of the KIA, and they were not particularly friendly towards me. Even Yannis, with whom I worked closely side by side for fourteen months, barely talked to me: politics and football were not topics for a young woman, even though I was fond of them both. On my last day at the pharmacy, he realised with great surprise that I could actually speak Greek. In general, when he talked to me, it was in English and in an effort to explain things to me: me listening to his explanations, and eventually asking questions was the only strategy to engage in some form of conversations with Yannis. Dimitrios was the other male volunteer whose rather spectral presence haunted Friday mornings in the clinic: he silently entered the pharmacy, sometimes bringing in heavy boxes, sometimes mopping the floor. The women frequently teased him and made jokes behind his back about his unfriendly attitude. Since I first began to work at the pharmacy, he was my silent and gloomy smoking companion. After several attempts to share my cigarettes with him and despite my awkward efforts to engage him in chats, a couple of weeks after I started at the clinic, he said in a definitive tone: ‘some years ago I was married to an Italian. We have a child together but we’re no longer together. Sicily is beautiful, my ex-wife was from there, but in general I don’t like Italians.’ That was enough for me to give up any hope that we could at any point in the near future have a friendly talk. We continued to sit close to each other on the same bench for many months. No word was uttered though.

Similar dynamics occurred with the other men involved in the KIA in general. I was never directly asked who I was or why I was there; instead, male volunteers asked other volunteers who I was and what I was doing there. They
did this even if I was standing in front of them. They consistently ignored me throughout the period of my fieldwork. I often wondered whether there was a tacit and gendered code of behaviour that I was not aware of and that I had unintentionally infringed. I asked myself whether the ways I introduced myself and posed my questions had been insolent, arrogant or annoying. This situation was inevitably a source of anxiety about both the completeness of the ethnographic picture of the KIA I was building up, and about myself, as a person and as a researcher. However, I had to come to terms with the reality: whereas I could certainly work to become a better researcher, there was not much I could do in order be accepted by the men at the clinic. I started listening to how my female informants talked about men, be they their husbands, fathers, sons or work colleagues. Their comments were revelatory of the implicit code of behaviour that I had not initially grasped, while they also opened margins to better understand what kind of tensions and negotiations traversed the social clinic and informed its sociality.

Aware of how the ethnographer’s identity and positionality somewhat predetermine the context of the ethnographic encounter and exchange (Couroucli 2007), I read some of my informants’ reluctance to engage with me as an attempt to evade political conversations with me, as a young person, a foreigner and as a woman who, as many other foreigners who had landed in Athens, wanted to ‘study the crisis.’ Also, being Italian proved to be a double-edged sword, and my nationality often put me in quite an ambiguous position where I was somehow expected to understand Greece by virtue of a supposed cultural proximity: the common saying ‘Italia e Grecia: mia razza mia faccia’ (‘Italy and Greece: a race, a face’) epitomised the similarities between the two countries and their respective populations. References to common issues like corruption, laziness, bulky bureaucracy and the like, were followed by words praising how ‘we’ - Italians and Greeks as well as my interlocutor and I - shared values relative to the importance of family and kin ties, the capacity of living and enjoying a good life made up of meaningful relations, good food and optimal weather conditions.
At the same time though, as an Italian I was not really allowed to express any opinion or comment on Greece beyond, for instance, heartfelt yet superficial appreciation of the food, the beauty of the language, the hospitality of the people and, in the context of the social clinic, the surprising manifestation of solidarity of the people that participated in its activities. When talking politics or dissecting the facets of crisis, in a bitter tone my male interlocutors answered my questions with other questions: don’t you have the crisis in Italy? Why did you come to study the Greek crisis, your crisis isn’t bad enough? Your people elected Berlusconi for something like twenty consecutive years, he destroyed Italy, made a crisis - but only Greece received the visit of the Troika, can you guess why?

Although Italy and Greece had once had in common positive values and shared similar issues relative to statehood, the economic crisis that hit both countries seemingly had far more devastating effects in Greece than in Italy, if not according to economic measurements (see Laskos and Tsakolotos 2013), then certainly according to Greeks’ subjective experiences of it. Beyond any intellectual analysis, the crisis represented a sensitive issue and, more often than not, an overwhelming topic of conversation for almost any Greek I met during my fieldwork. The crisis in fact was source of national shame for many, as it retrospectively bespoke a political, technical and moral failure of Greece as a modern state. Rakopoulos (2015b) aptly observes that hegemonic narratives about the Greek crisis are very often underpinned by a subtle sense of guilt and repentance for having failed to keep up with Europe’s expectations.

So far, I have not been able to provide any coherent answer as to whether my fieldwork was actually conditioned by my nationality. Although I was aware of the historical relationship between Greece and Italy (see, for instance: Kornetis 2004; Clogg 2016), I somehow refused the hypothesis that my individuality could be subsumed by my nationality. In fact, it was mainly through my nationality that I became known in the social clinic and introduced to others by friends and acquaintances: ‘i mikri italida.’ Couroucli (2009) argues that tensions may arise when ethnography enters the realms of
conversations relative to politics, nationalism, and national identity; these topics, she contends, should prompt a thoughtful reconsideration of the relationship between the ethnographer as an outsider and the local community they do research in. At the same time, Couroucli highlights the limits of a merely synchronic analysis, and advocates for a more diachronic perspective that would allow one to take into account larger social dynamics and political configurations. In this regard, Couroucli reports the experience of the anthropologist Margaret Kenna who conducted her fieldwork in 1966-1967, on the small island of Anafi. The island served as an exile camp for political prisoners during the years of the dictatorship. In the 2001 edition of her book *Greek island life: fieldwork from Anafi*, Kenna offers illuminating insights on her past fieldwork experience, and explains:

’I became conscious that, for the islanders, trying to turn my attention away from the present and the recent past to the more distant past was a strategy to keep me away from the sensitive contemporary issues […] I was too naïve to understand why Anafiots would not freely answer my questions about those (more recent) times’ (2001: 148).

**Athens**

Heather Paxson’s monograph (2004) on modern motherhood in Greece opens with a suggestive description of Varnava Square, a small square in the heart of Pangrati. Paxson lived in Pangrati, a neighbourhood in the northeast of Athens, for almost two years in the mid-1990s: she evocatively described the sense of quiet and familiarity of the square and its frequenters. The wooden benches and the *periptero* (kiosk), the uphill streets leading to the Athens Centre seemed to have resisted, unchanged, the passing of time. Her description of Pangrati revived my memory of the neighbourhood upon my return to Manchester in January 2017: it was a block away from Varnava Square that I lived for eighteen months of fieldwork, and it was at the Athens Centre that I received my language training. From there I started discovering Pangrati, often following my Greek teacher Roza’s suggestions: a little tavern
in a secluded corner of Varnava Square, the family-owned bakery with huge windows, the Friday grocery market (*laiki*) on Archimidous Street, and a nice café at the end of street leading to Plastira Square.

Roza once made a list of all the anthropologists she had met over almost thirty years of teaching Greek as a foreign language at the Athens Centre: she often said ‘we need foreigners to explain to us what we are’, in a tone that I could not tell was of scorn or just bitter irony, ‘at least two generations of anthropologists have learnt Greek with us.’ Indeed, the Athens Centre, founded in 1978, is the most established school of the Greek language in Athens. Funnily enough, not only have many anthropologists studied Greek at the Athens Centre but, as a Greek fellow anthropologist once noted, the high concentration of foreign anthropologists residing in Pangrati had become ‘an anthropological cliché.’ My frowning expression at his words possibly compelled him to revise his sentence: ‘living in Pangrati’ he considered ‘was a part of my process of becoming an anthropologist.’ I smiled at his rephrased interpretation of my decision to live in Pangrati.

Besides any romantic considerations, Varnava Square was the place where my friends waited for me upon my arrival in Athens, late on the morning of 6th July 2015. There I also spent my first month in Athens: with four colleagues from Manchester, I shared a flat in a narrow lateral alley off Empedokleous Street. As I became quite familiar with the neighbourhood, I decided to remain in the area when my friends left: for some reasons, I felt safe. A friend had also explained that it would be easier to find flats to rent in Pangrati. Pangrati had been a neighbourhood where, in the 1980s, many professionals, lawyers and doctors mainly, used to have their practices: these were now converted into flats to rent. Although the neighbourhood had lost its middle-class allure over the past decade, it has recently become attractive for young adults and students: cheaper rent costs, fairly good public transport infrastructure, and a rather central position in the overall geography of the city. Funnily enough, many of informants from the social clinic considered Pangrati too working class, too popular, too packed: ‘if there’s an earthquake, you’re safe in Pangrati: the buildings would support each other, and no
building would fall, no one would get hurt’, Marina joked. As a foreigner, they seemed to expect me to live either in Petralona, a central, hipster neighbourhood where expats, well-off foreigners and wealthy Greeks resided, or in Exarcheia, the neighbourhood of solidarity, anarchism, alternative sociality and political upheavals which had, over the period the crisis, became the centre stage for riots and contestations.6

While I was not aware of the place that the neighbourhood of Petralona held in many Greeks’ perception of the city as divided along quite clear class lines,7 my decision not to reside in Exarcheia was actually motivated by what, in retrospect, I consider an ethnographic reason. Since the onset of the crisis, abundant literature, anthropological and other, has been produced on Exarcheia and its role in the crisis: as a crucial hub for riots and revolts, the headquarter of many antagonist political formations, and a lively laboratory for alternative practices of solidarity. Instead, I moved to the outskirts of the city, where acts of solidarity and practices of self-organisation were less vocal, definitely less appealing, but perhaps more effective in reaching out to people in need.

Also, my decision to pursue my fieldwork in the southern outskirts of Athens was motivated by the rich history of the neighbourhood where the social clinic was located. As previously mentioned, an average of twenty-eight social clinics of solidarity were spread across Athens and they were commonly referred to as KIA (Koinoniko Iatreio Alleleggui): this name was generally followed by the toponym of the neighbourhood in which they were located. In the thesis, I have omitted the exact location of the clinic, and have

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6 For more on the neighbourhood of Exarcheia, see, for instance, Vradis and Dalakoglou 2011; Brekke et al. 2014.
7 My Greek friend Maria, an architect specialising in urban planning, explained that generally, Athenians tended to assume one’s socio-economic background based on where one is from, or where one lives in the city: the western neighbourhoods, she told me, are considered the poorest, and people living there are generally seen as poorly educated, working class and generally characterised by a rather conservative and backward mentality. Meanwhile the Northern neighbourhoods of Kifissia and Chalandri were now seen as residential, hosting wealthier and middle class families: however it was the southern neighbourhoods that had once had this reputation: developed along the southern coastline, those neighbourhoods hosted several commercial activities during the 1990s, the years of ‘powerful Greece.’
only given a generic indication of it by situating it in the southern periphery of Athens. Although my informants there were aware of my work as a researcher, I have opted to anonymise any identifier of both people and the social clinic in order to preserve the anonymity of my informants and to protect the work of the clinic. This decision was also motivated by several events that occurred during the last few months of my fieldwork in Athens. In fact, rumours about the clinic started spreading across different voluntary organisations which were variously involved in the provision of healthcare. The clinic in southern Athens at which I had volunteered was alleged to be accepting donations of pharmaceuticals from some international pharmaceutical corporations. In a confidential communication, a fellow researcher working in another social clinic in Greater Athens reported to me that her informants frequently made reference to the social clinic in southern Athens in quite critical and harsh terms. This was seen as an example of the betrayal of the ideals of solidarity, and of an antagonistic stance towards the state. Some of my informants were somewhat aware of these rumours, and dilemmas about whether or not they should accept donations from pharmaceutical firms had become a hot topic of debate in the social clinic assembly (Chapter 5).

Most of my fieldwork was carried out in a social clinic of solidarity located in the southern outskirts of Athens. With poor infrastructural links to the city centre, the clinic served the population of the nearby neighbourhoods, which were equally badly served by public transportation. As reported in the statistics collected by the communication team of the social clinic, an average of 1,000 patients per year were accommodated and provided with primary healthcare, either free medical examinations or medications, or both. Crucially, the clinic did not provide any services to refugees, although it was located in proximity to one of the biggest refugee camps in the Attika region. A mobile unit of doctors and volunteers, which I occasionally joined, delivered medications, clothes and tinned food to the refugee camps. Although the experience of visiting the refugee camp as a volunteer offered me valuable insights into how my informants not only thought of solidarity, but also of care by means of pharmaceuticals, this thesis does not attend to
the complexities of the refugee crisis. Rather, it is concerned with the
quoting daily social life of the social clinic, and with the experience of those who
attended it as volunteers and care-seekers.

Alongside volunteering at the social clinic, a consistent part of my fieldwork
was carried out in a state-licensed pharmacy located in another densely
populated neighbourhood in southeast Athens. Within walking distance from
my flat in Pangrati, from March 2016 onwards I visited Viktoria’s pharmacy
on weekly basis, as Chapter 4 describes in detail. Viktoria’s passionate
discussions and her efforts to make me understand the complexities of
pharmaceutical compounds, reimbursement mechanisms, and Greeks’
complicated relationships with doctors constitutes a substantial part of
Chapters 4 and 5.

Outline of the thesis

Chapter 1 offers an ethnographic and historical overview of the work and
ideology of the Social Clinic of Solidarity where I conducted my fieldwork.
In particular, it focuses on how the social clinic appropriated, and generated
anew, discourses on the humanitarian and medical crisis that the state first
triggered in the aftermath of the 2009 economic crisis.

Chapter 2 looks at how the social clinic relates to and opposes the state and
its institutions, which were alleged to create exclusion and neglect among the
population. The chapter also describes how patients relate to the clinic as if it
were actually a state institution, to which they claim access through the idiom
of illness.

Chapter 3 traces how practices of care were relocated to the voluntary sector,
and ethnographically explores how a group of female volunteers engaged
with the process of sorting medications. I contend that this process, on the
one hand, resembled practices of care as they had traditionally been enacted
in the household and, on the other hand, it mirrored how state policies about
pharmaceuticals were absorbed into the household first, and then the social
clinic.

Chapter 4 addresses the consumption and circulation of pharmaceuticals in
Athens. It suggests that pharmaceuticals have always characterised the Greek
medical milieu, and that the distribution of pharmaceuticals proved to be the
most effective mode of care that the social clinic was able to provide to meet
the medical needs of an increasing number of patients.

Chapter 5 explores how pharmaceuticals as objects came to represent a mode
of reconstituting sociality and negotiating loss, and suggests that the
circulation of pharmaceuticals created a sort of emotive continuity in care
across different spheres of society, and across different time frames. The
circulation of pharmaceuticals between licensed pharmacies, households,
social pharmacies and households again seemed in fact to reconnect people
and to reconstitute a sense of belonging to the society in those individuals
who had experienced forms of medical neglect from the state.

Chapter 1
The suffering of others: grassroots responses to the economic
crisis, and the ambiguous horizon of humanitarianism
Figure 5: ‘Solidarity or Death! Medicines for All’ (Drawn by the author)
The local production of the humanitarian crisis

On a cold Tuesday afternoon at the end of November 2015, I travelled to the social clinic in the southern suburb of Athens to finally meet Doctor Vasilis. Thanasis, a very kind volunteer at the KIA, had managed to get me an appointment with him. ‘Since the crisis happened, the incidences of heart conditions have increased’ Thanasis said while knocking on the door of Doctor’s room, and he continued, explaining: ‘The Doctor is not only the founder [o idritis] but also a cardiologist at the clinic [o kardiologos]. He always has lots of appointments on Tuesdays. The patients [oi astheneis] come here because they cannot go to the hospitals. They can’t afford the hospitals any longer.’ Still standing outside the doctor’s room, Thanasis solemnly recounted how Doctor Vasilis, who everyone at the KIA referred to as Our Doctor (o giatros mas), had the idea of opening a solidarity clinic where free medical care could be delivered to those Greeks whose livelihoods and health conditions had dramatically deteriorated since the onset of the crisis.

As we entered the room, Doctor Vasilis was finishing writing a prescription for a patient he had just examined. He smiled at us, and politely invited me to take a seat, indicating the chair in front of his desk. The room was dark despite the huge neon lamp hanging from the low ceiling. The curtains on the windows were closed so as to ensure some privacy for the patients: the folding bed for examination was positioned beneath them. In the other corner of the room, a bulky EGC machine was temporarily placed against the ultrasound machine. Thanasis explained:

‘all the medical machines you see here are donations. A public hospital had to dispose of them, and donated them to us. They aren’t the newest models, but they work. They do their job well. The same with the ultrasound.’
Then, in quite a formal tone, he introduced me to the Doctor: ‘This is Ms. Letizia. She’s from Italy and she would like to interview you, Doctor. She is a PhD student in Manchester and she is very interested in knowing more about our clinic.’ The doctor looked at me distractedly, as though he were deciding what tone the conversation should take. With a sudden switch to English, Thanasis informed me that he would now leave so that I could talk to the doctor. As Thanasis left the room, Doctor Vasilis asked me in very formal and old-fashioned Italian if I was more comfortable with English, Greek or Italian. With some unease, I admitted that at this time my Greek was not yet good enough, but either Italian or English would be equally fine with me. Doodling on a prescription sheet on which the logo of the clinic was stamped in bold red characters, in Italian he asked what had brought me to Athens. As if indifferent to my answer, he abruptly started talking about the medical and humanitarian crisis that Greece had been going through since 2008. His words were so measured and his tone so composed that the statistics about infant mortality and the suicide rates that he listed sounded even more daunting. He explained:

‘Letizia, you have to understand that this is the worst humanitarian and medical crisis in the West. I am going to tell you something: we have the same infant mortality as an African country. But you see, we are part of Europe. People are dying because they cannot afford cancer medicine and vaccinations. We are at the point where people can’t afford to pay for their surgeries. We are now lacking basic medications too, and it’s not just about affording medicine. People are starving, they cannot afford basic food, milk and bread, and I’ll tell you something else: we are at the point where children faint at school, because they don’t eat for days. Families don’t have enough money to buy food. Can you understand how serious this crisis is? Teachers often bring food to the children, but even children have too much dignity to ask for help, so they don’t say anything, they don’t say that they are hungry and no one realises until they faint. Can you imagine the humiliation? What happens to children here doesn’t happen anywhere else in Europe. It’s unthinkable. Don’t you agree?’
I nodded, touched by his words, which resonated with many other similar stories I had heard since my arrival in Athens a few months before. ‘Greeks are suffering, and Europe is responsible for this.’

Drawing on my interview with Doctor Vasilis, casual conversations and interviews with volunteers and patients at KIA, this chapter will offer an ethnographic account of how discourses on the humanitarian crisis informed the work of the social clinic of solidarity during nearly a decade of austerity. In conjunction with the existing literature on humanitarianism and medical humanitarianism, I will situate the work and ideology of the KIA within ‘the on-going state of emergency, from a neglected chronic crisis into an acute humanitarian imperative’ (Good, Graynam and Del Vecchio Good 2015: 157) that the self-organised medical practice itself, several state institutions and many Greeks perceived as an imminent. As the economic crisis mainly resulted in many Greek people’s reduced economic capacity to afford basic goods such as food, clothes and medications, I will show ethnographically how ‘the language of deliverance’ (Redfield 2012) informed specific modes of care which were culturally and historically embedded in the milieu of past crises. In particular, my analysis will focus on how certain goods were delivered, how they came to stand for care, and what kind of narratives they generated. The materialities of care not only prompt a reconsideration of the most mundane aspects of care (Buse, Martin and Nettleton 2018) but allows us to analyse how diverse acts of care unfold through formal and informal settings, across diverse temporalities of needs and through diverse and multiple relations of dependency. In fact, the increasing dependency on material resources which intermittently flowed into the KIA as donations rendered its practices of care discontinuous and symptomatic. At the same time, another mode of dependence was established between the people attending the KIA and the goods they were provided with. In the final section, I will explore how the suffering body (Ticktin 2014) became an index of the deprivation that was brought about by the crisis, and an object of humanitarian care: in the context of KIA, I argue that pharmaceuticals, and lack of them, are a material manifestation of both the crisis and care. The suffering body is therefore not only the subject of ‘minimalist biopolitics’
but is also a product of and at the same time productive of a logic of direct assistance. The language of deliverance and the logic of direct assistance ultimately translated the temporary medical fixtures offered by the KIA into what Peter Redfield describes as ‘bioexpectations’ (2012b): objects that, for instance, ‘seek to foster basic life functions, offering health, nutrition, clean water and sanitation’ (2012b: 159).

**The birth of the social clinics of solidarity: the moral imperative to care for those who suffered the most**

*Statistical fetishism: quantifying the crisis*

At the time of my fieldwork, between July 2015 and January 2017, after three economic adjustment programmes (commonly known as memoranda, *menmonia*, in May 2010, March 2012, and July 2015), the reduction in public expenditure had severely impacted a wide range of institutions. The public healthcare sector underwent several budget cuts, which led to the merging and closing of many healthcare facilities, and cuts in pharmaceutical expenses, medical personnel and wages. The effects of austerity policies became particularly visible in people’s inability to obtain care. Between 2009 and 2014, the elderly in particular were more likely to report unmet medical needs: cuts to retirement pensions coupled with the introduction of a 25 euro fee for users of hospitals, along with difficulties in reaching services because of distance; furthermore economic scarcity and cost of transportation overlapped and further impaired their ability to access healthcare resources (Kentikelenis et al. 2014). The insurance coverage (IKA) which had guaranteed access to diverse healthcare resources was dramatically reduced, while co-payment requirements were introduced and increased. Since 2009, social insurance funds saw declining revenues as unemployment soared and

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8 From IKA website: ‘IKA is the largest Social Security Organisation in Greece. It covers 5,530,000 workers and employees, and provides 830,000 pensioners with retirement pension. IKA covers those in dependent employment in Greece or abroad for an employer who is based in Greece, as well as those who offer full-time or part-time personal labour on commissioned work agreements and are not insured with any other insurance agency. IKA also covers certain groups of people who offer their labour to various employers at various times and whose insurance is realised through their Union or Insurance Associations (e.g. porters, news-stand vendors, slaughterhouse workers, etc.) or through special provisions (e.g. exclusive nurses).
wages fell: social insurance coverage was linked to unemployment status, with recently unemployed people aged 20-55 years covered for a maximum of two years. By the end of 2014, almost three million Greeks had dropped out of the public healthcare system, which had meanwhile slowly been privatised, and increasingly linked to the private insurance system. At the same time, shortages in medicine and medical equipment occurred, while longer waiting lists jeopardised access to hospital admissions.

In 2014 almost half of Greek children were living below the poverty line; at the same time nearly a third of the poorest Greek households incurred onerous medical expenses. The situation was further exacerbated by the progressive increases in user fees and payments for medical services and drugs (Kentikelenis et al. 2014): in 2015, 26% of the population was unable to access the national health insurance (OECD 2015). 41% of Greeks were materially deprived, meaning that they could not satisfy basic needs such as healing, rent or mortgage payments, and food. In the same year, 22% of the population was reported as severely deprived (OECD 2015).

Although the deterioration in the quality of life became particularly evident in the field of health, the crisis had a no less dramatic impact on industrial production that, between 2008 and 2012, dropped by 23.3%: about 100,000 small enterprises were closed down (OECD 2015). Furthermore, a series of labour reforms eventually resulted in the deregulation of labour relations. A rapid increase in unemployment rates (from 12.7% in 2010 to 24.9 % in 2015, with a peak of 58.3% youth unemployment in 2013) and the reduction in the national minimum wage played a decisive role in the rise in poverty levels. In 2015, 41.5% of the population between the ages of 18 and 64 experienced deprivation in basic goods and services, as reported by the Hellenic Statistical Authority (ELSTAT 2015). By 2015, 12.3% of Greeks was reported to be unable to meet medical needs: this percentage was almost four times the EU average.

Although it is not possible to assess the causal role and incidence of austerity on epidemiological indicators, since the first implementation of austerity
measures adverse health trends and unmet healthcare needs have increasingly been reported (Kentikelenis et al. 2014). The HIV incidence in injecting drug users rose more than ten-fold between 2009-2012, while the incidence of tuberculosis more than doubled in 2013 (Global Burden of Disease 2016). State funding for mental health decreased by 55% between 2011 and 2012, while severe depression increased 2.5 fold between 2008 and 2011; suicides increased by 45% between 2007 and 2011; infant mortality jumped by 43% between 2008 and 2010, and the proportion of children at risk of poverty increased from 28% in 2007 to 30% in 2011 (Economou et al. 2014; Kentikelenis 2014). In the context of what has often been described as ‘the Greek public health tragedy’, several social clinics of solidarity were set up to respond to the unmet medical needs of an ever-increasing proportion of the Greek population (Kentikelenis et al. 2014: 748-749).

Since 2010, the public healthcare system has been progressively redefined: the government continued to implement reform programmes with the intent of capping the public health expenditure at 6% of GDP by 2012. In the same period, the nominal gross product decreased by 6.5% and health expenditure dropped by 12.1% (Economou et al. 2014). Crucially, while the public expenditure on health fell dramatically, private expenditure increased: for instance, informal payments to doctors soared to represent 30% of out-of-pocket payments (Economou et al. 2014) and posed a further threat to access to health care resources, which was increasingly regulated by individual economic capacity.

The KIA where I carried out my fieldwork has served as a free healthcare provider in the southern area of Athens since December 2010. The birth of this social clinic took place in a context of the proliferation of many different alternative, non-state providers of healthcare, such as that run by the Holy Archbishopric of Athens (Makris and Bekridakis 2013). Médecins du Monde was reported to have scaled up its operations in Greece since 2010 (Chauvin and Simonnot, 2013; Kentikelenis et al. 2014). Other non-governmental and non-profit organisations (Economou et al. 2014) together with more recent grassroots solidarity initiatives, began to occupy a decisive role in the
Athenian medical landscape (Cabot 2016a, 2016b; Vaiou and Kalandides 2015). Around 28 social clinics of solidarity have, since 2010, provided medical services to a large proportion of the Greek and non-Greek population.

Despite serving the common purpose of free healthcare provision, these non-state healthcare providers were rather diverse: some stemmed from spontaneous, informal, and localised mobilisation, while others were embedded within national and transnational institutional frameworks. Whereas the emergence of the social clinics of solidarity as generally been linked to the onset of the economic crisis (Cabot 2016a, 2016c), the presence of non-state healthcare providers was not peculiar to the years of the crisis. Already in the decade prior to 2009, the provision of healthcare had increasingly spilled over the boundaries of state health institutions, and was progressively outsourced to non-state providers. Interestingly, it was during the 1990s that the first neoliberal restructuring of the Greek state occurred (Laskos and Tsakalotos 2013), ranging from the liberalisation of the pharmaceutical market to the aggressive privatisation of many state assets.

For instance, as a consequence of an increasingly dysfunctional and fragmented public healthcare system, Ann Elizabeth Davis (2012) notes that, since the 1990s, responsibilities and care for mental patients was increasingly dispersed across multiple subjects and community-based care, where not only primarily patients and therapists were involved, but also care-workers, friends, family members and community members. A similar fragmentation of healthcare resources in Greece has been reported in a study conducted on breast cancer prevention in the years prior to the crisis (Gibbon, Kampriani and Zur Nieden 2010). In particular, Eirini Kampriani (2009) observes how Greek women were increasingly faced with the aggressive expansion of the private sector and challenges within the public health system. Furthermore, private and public healthcare facilities often did not conform to any national medical standards to provide breast cancer preventive screening. Many initiatives were in fact promoted by the Orthodox Christian Church ‘in the spirit of religious philanthropy’ (Gibbon, Kampriani and Zur Nieden 2010: 451), rather than being informed by public health concerns.
Multiple crises

Since 2010, the KIA has become the main care hub in the southern outskirts of Athens: as the volunteers explained to me, the birth of the social clinic was linked to the onset of the 2009 economic crisis and its debilitating effects on people’s ability and economic capacity to seek care. During the course of my fieldwork, many volunteers clarified that the clinic steadily expanded its capacity to accommodate more and more people as the demands to access its services grew as access to public healthcare resources was being restricted under the Troika’s demands for budget cuts. Between 2011 and 2013, the number of volunteers involved in the clinic’s activities more than doubled as the number of the patients grew dramatically. This constant inflow of patients contributed to fuelling the sense of an imminent humanitarian crisis amongst the volunteers of the KIA and amongst the people attending the healthcare facility. Interestingly, the adjectives ‘economic’ (ikonomiki) and ‘humanitarian’ (anthropistiki) were often used interchangeably by my informants to describe the current crisis, and it seemed to me that they were used for diverse purposes. First, when talking of the economic crisis, statistics and numbers were easily mobilised; they served to better convey the magnitude of the crisis, as if numbers could make visible and rationalise the subjective experience of the economic crisis. People’s subjective experiences of the crisis was at the same time absorbed and magnified into numbers and statistics. On a different level, the humanitarian crisis was still predicated on the same economic statistics, but was meant to generate a more emotional response.

My friend Alexis, who moved from Thessaloniki to Athens to finish his postgraduate studies, critically explained this:

‘the economic crisis is a discourse of the elite, of the educated people who can actually understand economics. When they say that the crisis is humanitarian, it is easy to understand for anyone because it created a cheap imaginary of people dying of poverty and diseases, just to say. Everyone knows about the long queues at the soup kitchens, and you look around you: lots of shops have been closed. It
means that people cannot afford to buy the stuff they may need, and it means that the owners of the shops now have nothing to make a living from. People don’t care about the reasons behind the shops closing, or why at some point they could not afford to go to the hospitals. They just see what is happening now: they see, let’s say, the humanitarian consequences of the economic crisis.’

At the KIA, references to the humanitarian crisis were activated to sustain and legitimate the work of the KIA itself. Greek anthropologist Dimitrios Theossodopoulos (2016) notes that a similar semantic overlapping between the economic and the humanitarian occurred amongst his informants in the Greek city of Patras. He suggests that ‘the humanitarian face’ (2016: 167) was somehow implicated in the very constitution of solidarity initiatives. Crucially, Theossodopoulos explains the double-edged aspect of many of these initiatives of solidarity: they indeed retained an empowering potential, but they also engendered the risk of depoliticising the crisis. Theossodopoulos’ critical understanding of the entanglement of solidarity discourses and humanitarian claims aligns with Didier Fassin’s (2011) crucial consideration on how humanitarian appeals tend to minimise the political responsibility towards a certain status quo: the humanitarian crisis itself becomes a generalised mode of governing which puts forward the right to live in the present, and relies on the physical evidence of suffering.

The risk of a humanitarian crisis as voiced by many Greeks was ultimately backed up when, in December 2015, the report from the UN delegate Juan Pablo Bohoslavky was released. The report was met with a sort of paradoxical relief by some Greek politicians and the clinic’s volunteers alike: if foreign and supposedly impartial UN delegates so clearly foresaw the symptoms of a humanitarian crisis, Europe must necessarily reconsider its own austerity policies towards Greece. After acknowledging and listing the deteriorating effects of austerity on people’s economic, social and cultural rights, Bohoslavky wrote that ‘it is therefore justified to speak about a humanitarian and human rights crisis in the field of economic and social rights in Greece.’ Particular attention was paid to the catastrophic condition of the Greek
healthcare system: the dramatic outlook was further corroborated by detailed statistics about the number of currently insured people who could no longer access any kind of medical resources.

Whereas the humanitarian crisis provided a strong narrative to the clinic to frame the KIA project of solidarity, the risk of a humanitarian crisis at the heart of Europe was put forward by many politicians in a desperate attempt to renegotiate the terms of the memorandum, and to obtain a reduction of the debt that Greece had accrued to foreign investors. Crucially, a further layer of contestation was implicated in the discursive unfolding of the humanitarian crisis: whereas the state institutions invoked the humanitarian crisis to contest Europe, the KIA referred to the humanitarian crisis to contest the state. Its responses to social suffering were therefore shaped through a ‘language of dismay, disappointment, bereavement and alarm that sounds not at all like the usual terminology of policy and programs’ but offered a more valid means for describing ‘what was at stake in human experiences of political catastrophe and social structural violence’ (Kleinman, Das, and Lock 1997: xi).

I want to suggest that the humanitarian crisis as it was discursively produced in Athens assumed the traits of a crisis of relationality between the state, its institutions and the citizens. In the process of reconfiguration of welfare institutions, new forms of exclusions and marginality occurred amongst Greek nationals who, despite being by default entitled to public healthcare, were increasingly being prevented from accessing it. At the same time, the reconfiguration of the welfare institutions generated a reconfiguration of the medical landscape and of care practices. In fact, prior to the onset of the crisis, the Greek health care system was universal and could be accessed either through national health insurance or private insurance. Between 2009 and 2011, Greece experienced a massive 28% drop in health expenditure per capita; the percentage of people who became unable to afford health insurance coverage increased dramatically. Following the implementation of austerity measures, unemployed citizens were only entitled to one year of national health insurance; long-term unemployed and self-employed citizens
who could not renew their health insurance plan were among the most heavily affected by these measures. According to the OECD report of 2015, 23% of the population reported unmet medical needs, while 26% were unable to access national health insurance (OECD 2015). I suggest that the presence of the social clinic emerged as a result of the reconfiguration of the public and the private, wherein the KIA attempted to redistribute healthcare resources and care at the bordering zone between an aggressively expanding private sector, a dramatically shrunk public one, and increasingly impoverished households. At the same time, the KIA became symptomatic of new modes of dependence on alternative forms of provision and redistribution of goods, namely food, clothes and medications.

Since 2010, the KIA has been collecting and distributing donations of food, clothes and medications to an increasing number of Greek citizens, and occasionally to migrants and refugees. At a moment where the state was held as the main bearer of responsibility for both the crisis and the dire conditions of economic deprivation that many Greeks were experiencing, the social clinic worked to fill the gaps left by the retreat and shrinking of the state care programmes. In this deeply polarised political context, the KIA was elevated to the position of a moral agent within the Greek medical and political arena: while the state withdrew from the provision of welfare services, the KIA started materially providing care. Peter Redfield (2013) observes how a similar self-validating dynamic occurs within Medicine Sans Frontiers, where the practical relevance that the NGO acquired on the ground feeds its moral legitimacy on the basis of the assistance it provides to the population in distress, and the objections it makes to the conditions that promote that suffering (Redfield 2006).

Deprivation, material lack, and the language of deliverance in ‘exceptional states of misfortune’

‘You know, Letizia, patients don’t take their medications [den pernoun farmaka] because they can’t find them in the pharmacy [sto farmakeio]. Actually, many cannot afford to buy the medications they need and the state is no longer able to provide
them. Almost three million Greeks can’t go to the hospital. If you are uninsured [anasfalitos] and go to the hospital for an emergency, they may take care of you, but then the hospital will pass your bill to the income revenue authority and they will chase after you. If you are not able to pay for the care you received, they’ll confiscate your house, your car, anything that can be seized. That's how many Greeks have become sick and also indebted. The crisis, you see, it’s no longer economic. It’s become a humanitarian crisis. The worst humanitarian crisis in the West. When you see your fellow citizens in such dire conditions, unable to provide for themselves and their loved ones, I personally feel compelled to help, to do something for those people that the state has left behind. And that’s how I had the idea of setting up this clinic. I am a doctor, and as such, I work to help people. When I graduated from medical school, I made an oath to always help people, and that’s what I’ve been doing, together with many colleagues, since December 2010. Have you ever heard that Miki Theodorakis’ speech? It says ‘no Greek should go hungry, no Greek should be left without a doctor.’ What’s happening now is the exact opposite: most of our fellow citizens are being left behind, and most of them have no access to healthcare. You see for yourself, I don’t need to tell you, we’re doing our best, but our social clinic alone cannot face the humanitarian crisis the country is going through.’

Doctor Vasilis clearly laid out what the clinic was meant for and to whom its work was directed. The fair provision and distribution of food (tropiema), clothes (rouxa) and pharmaceuticals (farmaka) was the main objective of the KIA: these were the goods people had become increasingly unable to afford. The system of provision the clinic had set up was based upon donations of goods from private Greek citizens and international donors, and worked thanks to the voluntary work of ordinary people, alongside medical doctors. Phaedra Douzina-Bakalaki (2017b) argues that these three different categories of goods (food, clothes and medications) relate to different economic realms: the household, the market and the state. She observes how the system of provision informing the Bank of Love, the Social Wardrobe and the Social Clinic in the small town of Xanthi were together meant to address
the ‘provisioning limitations of the household, the inaccessibility of the market and finally the retraction of the welfare state’ (2017b: 40).

While similar dynamics fully resonate with the system of provisioning of the social clinic, here I explore how the KIA provisioning system, in particular of pharmaceuticals, represented a specific mode of care that was historically produced and at the same contingent on the crisis. As premised in the opening vignette of this chapter, looking at the mundane aspects of care and at the materiality of the objects through which care is enacted and provided allows us to understand how practices of care unfold through and across different social spheres, and to go beyond the concept of care as a moral experience which can be labelled as a form of gift exchange that emotionally involves the care seeker and care giver (Kleinman 2013). Tatjana Thelen (2015) suggests thinking of care as a form of social organisation that has the potential to blur public and private domains, namely the state and the household.

In this sense, approaching care as an organising principle of society separates care from kinship while relocating it within the community which takes responsibility for certain needs of certain deserving receivers. Departing from Thelen’s understanding of care, I consider the KIA as a third care provider, which emerged at the intersection of the state’s retreat from welfare provision and the progressive impoverishment of households, in a moment of accelerated social and economic changes that the economic crisis had fuelled. Accordingly, I argue that the social clinic of southern Athens played a central role in the provision of care at a time when the Athenian medical landscape was dramatically fragmented into a myriad of solidarity initiatives, private medical facilities and increasingly inefficient public health care facilities. In so doing, I focus especially on the materiality of the care and its everyday transgression of the boundaries between private and public, the state and the household, the collective and the individual. By materiality of care I refer to those goods, food, clothes and medications that travelled back and forth between these realms, and traversed the diverse temporalities of the crisis across which the significance of these goods contextually changed according
to their fluctuating availability and shortage, the space where they were handled and the care they stood for.

The emphasis that the KIA’s volunteers put on the shortage of medications, clothes and food, and thus on the necessity to provide them to those in need, was revealing of what many of my informants considered to be the most terrifying signal of the crisis and the most humiliating circumstances people could find themselves in. Food, clothes and medications had leverage on deeply emotional responses to the fear of starving and falling sick, circumstances that the crisis made more likely for many. On more than one occasion, my informants recalled dramatic events from the past as terms of comparison to the present time. References to the German-Italian occupation of Athens in the 1940s, as well as to the Asia Minor catastrophe in the 1920s, were frequent and emotionally charged elements in my conversations with some of the female volunteers in the social clinic. For instance, Valia, a Greek-Egyptian woman in her 70s, recounted the time when, in the 1950s, she and her family were forced to flee Egypt and return to Greece as refugees. After having lost all their property, she told me that her family survived thanks to help from her neighbours and relatives who offered them food and clothes, and also some money to start a new life in Athens. When I asked whether this experience had motivated her to join the KIA as a volunteer, she nodded and with no hesitation, she explained:

‘Every Greek family has a story of refugees, and every Greek family has some relatives who died on the way back to Greece in the 1920s, or during the Occupation. We who survived have to keep this memory alive, it’s a sort of moral obligation. That’s why I think that we now have to help those who are in need. Once I was in need, as many Greeks are in need today. I remember that suffering, I can recognise it. I can’t forget it. When my father managed to start his commercial activity again, we became quite wealthy again. I remember when my mother forced me to invite our neighbour’s child for dinner. I did not actually like that girl, she wasn’t my friend, but my mother said that the child didn’t eat for days, and inviting her for dinner was an act of kindness. I now think that it was a very nice way to give her a meal
without humiliating her. It wasn’t charity, it was solidarity. And that’s what many Greeks do now, that’s how we learned to do solidarity.  

In this sense, the proliferation of many soup kitchens in Athens as well as the distribution of food as operated by many social clinics and other grassroots initiatives (e.g. the ‘anti-middle man movement’ described by Rakopoulous, 2015b) create a historical continuity between the past and present experience of the crisis. I suggest that in today’s Athens, the lack of food and the famine work not just as historical symbols of deprivation (Knight 2012b; Herzfeld 1988), but configured the terms within which concrete actions of neighbourhood cohesion rather than charity could be enacted. While the role of food has extensively been analysed in relation to the current crisis (Knight 2012a, 2012b, 2015; Sutton 2011, 2016), I focus on exploring how pharmaceuticals as objects of care, their provision and distribution, became a powerful symbol of solidarity and care. In fact, in the existing anthropological literature on Greece, these aspects have not sufficiently been analysed yet.

For instance, in her ethnographic exploration of the system of provision undergirding a soup kitchen, a social wardrobe and a solidarity medical practice in Xanthi, with particular reference to the latter, Douzina-Bakalaki (2017b) only briefly the free distribution of pharmaceuticals as one of the services that the social clinic provides. On quite a different note, Heath Cabot suggests that in the Athenian social clinics of solidarity that she studies, alternative health-care practices were pursued (Cabot 2016a, b): pharmaceuticals are mentioned as having a substantial role in ensuring some form of medical care to the increasing number of people who approached the

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9 Daniel Knight (2014a) argues that in Trikala, a small town in Central Thessaly, narratives of famine and related food hoarding are prominent when discussing the current crisis. The British scholar notes that his informants seem to rationalise their anxiety about the present crisis through narratives about past crises. In particular, he argues, specific events like famine, suicide, and colonisation inform people’s understanding of the present crisis through what Knight terms ‘cultural proximity’ (Knight 2012b). By this concept, Knight describes how significant events from the past shaped contemporary experiences of the crisis, and refers to different modalities through which past experiences of social and economic turmoil are embodied in the context of today’s crisis.
clinics. However, the role of pharmaceuticals in establishing new modes of care has not been problematised (see Chapter 4), nor has there been any exploration of how pharmaceuticals, and their scarcity and availability, have come to represent the measure of the care that could potentially be delivered by the KIA, and at the same time the signs of deprivation that the clinic was trying to cope with (Chapter 5).

Temporal continuities and critical ruptures: food and pharmaceuticals as ‘context shifting makers’

The vast quantities of blister packs and boxes of medications and the stockpiles of canned and dried food filled each and every corner of the clinic’s rooms: these paradoxically spoke of the scarcity of affordable goods in the market and the deprivation Greeks were suffering in their households. At the same time, they were a powerful visual reminder of the most pressing needs that the crisis had created and that the clinic tried to manage and accommodate. The material presence of these goods, which were there ready to be distributed, also made apparent the process whereby ‘basic needs are changed into commodity’ (Panourgià 2018: 139). During my time at the KIA, I met many women who patiently queued outside the clinic to receive their share of powdered milk or other kinds of baby food, as well as small bags of rice and lentils. Sometimes, some of these women approached me and asked for a cigarette. While we smoked, they often told me stories of how they suddenly found themselves unable to buy food for themselves and their relatives. Chrisoula, a young, unemployed single mother, explained while watching her two years old child closely:

‘Food is first for my child, he needs food, much more than I need it. He needs food to grow healthy and strong. If something is left, yes, I eat. Otherwise, eh, I go to sleep with a glass of milk and few drops of Lexotanil! My father still has a decent pension, and he helps me as he can. Sometimes he hands me fifty euros to buy stuff for the child; sometimes he brings me food. But some months are tougher than others for him too. He has bills to pay and medications to buy. Some months he cannot make ends meet either. And you know, children are expensive! Since I started
coming here a year ago, things are slightly better: I get nappies and some cans of good baby food for my child. The best thing is that I don’t have to pay! If he needs anything, like some medicines, those that children take, we can ask Maria [the pharmacist] and she helps us.’

When I asked her how she had heard about the social clinic, she laughed again and said:

‘Do you know how many people come here? How many acquaintances and friends of mine are in the same situation? The crisis put us all in the same boat. Anyway, a friend told me to come here and ask for help. She came here before because she needed to see a gynaecologist, but she could not afford to pay. She just came here, and saw the doctor. And she also got the medications she needed for free. This place is the only place I can go. It also gives me some hope, that there’s still solidarity among people’.

In his ethnographic inquiry into the experience of the economic crisis in Trikala, Daniel Knight (2012b) argues that food has become a ‘context shifting marker’ (2012b: 367); a contextual indicator of change whereby food no longer stands for commensality or festivities, but rather for fear and deprivation. Similarly, David Sutton (2016) points out that for the Greeks from Kalymons island, food is a matter of sociality and dignity (2001). Sharing food and feeding each other is also a practice of care and good neighbouring. Under the strains of the austerity measures (ta metra), Sutton’s informants often refer to food to describe their own experience of the crisis; being no longer able to afford food is therefore associated with a loss of dignity deriving from poverty or from not being able to care for family or friends. Following on Knight’s concept of ‘food as a context shifting marker’ (2012b) and Sutton’s suggestion that food can be a crucial element to sociality and dignity, I suggest looking at pharmaceuticals as a specific ‘context shifting marker.’

Attending to the materiality of the stockpiles of canned foods and the piles of medications first gave me a sense of the progressive descent into poverty that
many Greeks had, at different rates, experienced. This then provided an important ethnographic cue to understanding what the economic crisis meant on the ground, and how it impacted people’s everyday lives in terms of shrinking salaries as experienced in the private realm of the households, and of retrenchment of welfare services at the state level. The regimes of care supported by the clinic were not regulated only by culturally situated discourses and practices of care: they were also motivated by the moral imperative of relieving the suffering of ‘the less fortunate.’ As the utmost manifestation of deprivation, food and medications became symbols of care as it was delivered at the KIA. In this vein, the materiality of the goods provided by the KIA not only allows for the understanding of regimes of care as structured systems of provision, but also reveals the tangible expression of how care is thought of, sought and provided in times of crisis. This mode of care, however, does not only relate to the realm of medicine, but also to that of sociality. I suggest an understanding of pharmaceuticals as indicators of sociability and dignity, as well as of one’s wealth and good health.

In regard to their relation to the realm of sociability, during my fieldwork I saw how pharmaceuticals were talked about and shared among women in a caring effort to ease each other’s pain, as I will discuss extensively in Chapter 3. As described in Chapters 4 and 5 of this thesis, sharing medications is not only a form of recognition of each other’s pain, it also provides women with material references to voice their distress. In particular, as emerged from my fieldwork in the social clinic, the position that medicines retained in the imaginations of doctors and volunteers, as well as of the patients who attended the medical facility, related to the materiality of the medication as a tangible thing, as well as to the relief that a specific medication provided. As a volunteer myself in the social pharmacy, I was able to see how the provision of pharmaceuticals made different experiences of care and neglect visible. I argue that pharmaceuticals represented what Douzina-Bakalaki (2017b) describes as ‘familiar frames of reference’ within which people could more easily locate meanings of illness, experiences of the economic crisis and practices of care. In the years prior to the crisis, pharmaceuticals had already become a particularly apt and efficient tool to manage a population’s need for
medical care. Following on this note, it seems that Cabot’s (2016a) commentary on Athenian social clinics where, she argues, ‘alternative approaches to social and individual bodies in crisis are pursued’ (2016a: 256) falls short in its consideration of how the pharmaceuticalisation of care had long characterised the medical landscape of Greece. Rather, as I will extensively explore in Chapters 4 and 5, pharmaceutical-based care is upheld and pursued by the social clinic in continuity with both home-based and state-promoted practices of self-medication. In this sense, the pharmaceutical-based care provided by the KIA was a social and therapeutic response to the crisis, and it was produced and legitimated within a specific infrastructural and social setting.

The making of the suffering body: producing the political at the intersection of the medical and the social

With regard to the mourning performances that women enact in Mani, in the Peloponnese, Nadia Seremetakis (1990) observes how pain ‘integrates both physical and emotional conditions, individual and collective references, mourning and jural discourses’(1990: 483). Far from being an exclusively individual experience and in light of its antiphonic construction, the use of ponos is often directed ‘to manipulate institutions [and] points to the possibility of socio-political resistance’ (Seremetakis 1990: 483). Following from Serematikis’ understanding of ponos as both a dramatised ‘symptom of the dissonance between the self and society’ (1990: 483) and a form of truth-claiming (1990: 483), the next section of this chapter will analyse how ‘the suffering body’ as an object of humanitarian care was constructed through certain discourses and representations of the crisis. In particular, the section looks at the ‘antiphonic’ construction of suffering in which both patients and volunteers participated alike.

Collective suffering from the crisis, individual suffering for the crisis

‘Greeks suffer from the crisis [upoferoun apo tin krisi], that’s why they come here. We give them help [tous voithame dorean], we give them medications for free [ tous dinoume ta farmaka tous dorean]’. With these words Maria, the pharmacist in charge of the Friday shifts, explained the work of the KIA,
and of the social pharmacy in particular. As I will discuss further in Chapter 3, as soon as I started volunteering in the social pharmacy, I was taught about how medications needed to be sorted, checked, ordered and stored on the shelves. Contrary to my expectations, diseases rarely entered into our conversations: the medications we were handling were always referred to as something that would bring relief to people’s suffering, and not as a therapeutic solution to a specific disease. While instructing me about the location of the medications, Maria (like any other volunteer) never mentioned what those medications were for, and only vaguely referred to ‘cancer medications’ (oghologikà) or ‘psychiatric medications’ (psychiatrika, or afta me kokkino digramma)\(^\text{10}\) because they needed to be set apart and could be given only on specific prescriptions. As I realised over time, what mattered most for the volunteers was not the biomedical efficacy of the pharmaceuticals; rather it was the social meanings that the medications conveyed.

Similarly, those who entered the clinic as patients rarely named their disease. They always mentioned their suffering: a suffering that appeared to be deeply embedded in the unfolding of the crisis. While I was not allowed to attend the medical visits, where it is reasonable to assume that the experience of suffering was translated back into legitimate medical categories, halfway through my fieldwork I was confronted with a set of questions which ultimately led me to re-examine some of my assumptions relating to illness and suffering. While looking at the people sitting in the hall, I often asked myself ‘Are those people sick? What are they actually suffering from? Is their condition chronic? Will they find a definitive solution to their condition or will they just be given medications? Would I ever come to a place like this to search for care? What do these people expect from the clinic?’

Sometimes I just sat in the clinic waiting area, silently looking at the people waiting to be called in for either the medications or an appointment with the

\(^{10}\) ‘Afta me kokkino digramma’ means ‘those with two red bars’ in reference to the packaging of psychiatric drugs.
doctor. I occasionally overheard their conversations, and sometimes I exchanged a few words with them. The patients attending the social clinic (where priority was generally given to Greek nationals) were men and women, and of different ages, but with a slight prevalence of women in their 50s and over. Most of the time, women came in alone for their own medical appointments or to gather medications, but men rarely did: they were often accompanied by their female partners. In this sense, the waiting area offered a privileged ethnographic spot from which to observe the entanglement of diverse modes of care and multiple relations of interdependence which actually spoke of how medical care was, and at the same time was not, sought and found in austerity-laden Athens. In a brief ethnographic snapshot that appeared on the medical anthropology online blog Somatosphere, Miriam Ticktin (2013) describes how the waiting room in a medical facility can become a crucial ethnographic site to explore the relations between citizenship, bodies and illness. In sharing her own perspective on the waiting room as a potent site of political diagnosis, she argues that:

‘at the threshold of that biomedical reality, in the waiting room, the body is still recognised as a part of larger collective stories and smaller everyday practices. While one may be an impending patient, in the waiting room, one is recognizable to oneself and others in both social and medical terms. In this sense the waiting room is a place to diagnose not just bodies, but the politics of bodies and the politics of illness.’ (2013)

Following Ticktin, I consider that the waiting area of the KIA functioned as a temporary and transient space where people were at the same time socialised and medicalised. Suffering from the crisis as a collective narration which

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11Ticktin takes a critical stance towards the humanitarian policies that the French government has, since the mid-2000s, pursued towards undocumented migrants, and argues that the introduction of the ‘illness clause’, on the one hand facilitated the release of legal papers, the ‘illness permit’, to undocumented migrants whose lives were threatened by severe medical conditions and were therefore in need of medical treatment. On the other hand, she argues, the same clause led migrants to trade their biological integrity for political recognition (2006, 2011, 2013). She concludes that the social body of migrants and the process of medicalisation it undergoes perfectly mirror the humanitarian policies that both French humanitarian organisations and the government have established.
Available at: [http://somatosphere.net/2013/10/the-waiting-room.html](http://somatosphere.net/2013/10/the-waiting-room.html)
people could easily tap into was therefore upheld along with narratives of suffering for the crisis: each individual experience of the crisis in its medical manifestation became part of the collective narrative of the KIA, whose main purpose was relieving the suffering of ‘the most vulnerable and poor’ (ο πιο όδοι οι φτωχοι).

As described in the previous section of this chapter, care as delivered at the social clinic mainly consisted of material goods. Food and medications were aimed at bringing relief and aid to the patients whose suffering presumably originated from material deprivation. Interestingly, the perception of care as intrinsically linked to materiality was voiced by some of the patients with whom I occasionally engaged in conversation in the hall of the social clinic. Redfield developed the concept of ‘minimalist biopolitics’ (2012: 145) to emphasise how humanitarian actions are mainly concerned with the suffering body whose measurable suffering requires a response: the response, Redfield argues, often takes the form of, and is limited to, material care. In this regard, Redfield’s argument fully resonates with my ethnographic material. However, I suggest that in the Athenian context, suffering was measured and rendered commensurable through the rough quantification of needs: at the KIA, the amount of medications or canned food that a patient was given helped assess the patient’s needs, the extent of their deprivation, and by and large their suffering. At the same time, the more the KIA was able to meet the needs of an increasingly large proportion of the population, the more it gained moral legitimacy in the social and medical landscape of Athens. The language of deliverance that the volunteers used to describe the social clinic’s activities contributed to the crafting of new modes of dependency amongst the patients, while reinforcing narratives about the crisis.

For instance, Dimitris was a retired man in his late 60s, who had seen his pension being progressively reduced over the previous six years. His situation worsened further in the aftermath of the third memorandum, signed by the Greek government in July 2015, which required further budget cuts to state-funded pensions. Although formally entitled to access the public healthcare system, Dimitris’ monthly pension of barely 500 euro did not allow him to
afford all the medications his chronic heart condition required. The KIA provided him with the medications he needed in an effort to fulfil the biopolitical obligations that people expected to be accomplished by the state institutions. Besides medical resources, the KIA provided a narrative about social suffering with which Dimitris could identify and also contribute to. In this sense, Dimitris’ complaints about the state (to kratos) and the government (i kibernisi), its corruption and weakness, served as an emphatic premise over which he could describe the care he, like many other patients, received at the social clinic.

Anthropological literature has investigated how ‘suffering’ provides people with a language through which individual experiences of illness and suffering resonate with the experiences of the others. In the context of the social clinic, suffering was not exclusively related to individual experiences of illness, rather suffering fed and was fed by representations of the crisis as a series of events that rendered everyone poorer and more vulnerable. Suffering can therefore be seen an embodiment of the social, which was first expressed in individual terms and represented an appropriate response by individuals to the socioeconomic situation which the crisis had created.

With reference to the shared experience of the crisis as it unfolded in Central Thessaly, Knight (2012a) argues that through certain narratives, his informants contributed to the construction of the collective social suffering and solidarity on the basis of common adversities; in so doing, Knight suggests, they also presented a strong critique against the economic system.

The waning of the disease

Following on from these considerations, I read the waning of disease from the conversations I had at KIA as revealing of a precise representational strategy of suffering: on the one hand, volunteers referred to suffering as a

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Knight argues that the exchanges of narratives are based on shared experiences, therefore they intersect cultural, historical, and political imaginaries which potentially motivate “collective mobilisation, crisis negotiations, solidarity and collective suffering” (2012a:3) As he correctly points out, ‘suffering probably better describe[d] an experience that anyone else might share’ (2012b: 35).
widely shared, and therefore more intelligible, mode of experience of the crisis. Furthermore, representations of suffering could be conveyed more easily, and no medical knowledge was required to make it effective. On the other hand, suffering offered a source of legitimisation and belonging to the KIA as a community for those Greeks who experienced the crisis as a series of humiliating and destabilising events, which ultimately put their everyday lives in jeopardy. For instance, in his work on the aftermath of the collapse of Soviet Union, Serguei Alex. Oushakine (2012) argues that only loss and despair seemed to bind people together, by offering them a sense of belonging which had been lost with the dissolution of the Soviet state. In particular, Oushakine describes how individual and group narrations of trauma stories produced communities of loss; narratives about suffering, he argues, mediated relations among individuals, the nation and the state, and thus provide communities of loss with a socially meaningful subject position (2012). Following on Knight’s argument of how ‘narratives incorporate cognitive, affective and evaluative dimensions of the individual and collective experience’ (2012b), I consider suffering as a relational mode and a dynamic narrative process.

As a not-pathological condition, suffering could be validated through the recognition of the deprived body. Interestingly, Fassin (2012) observes how the language of suffering infiltrated the language of politics at a moment where the French government was striving to tackle urban poverty and marginalisation in the Parisian peripheries. He argues that ‘the vocabulary of suffering, compassion, assistance and responsibility to protect forms part of our political life served to quantify the issues involved and to reason about the choices made’ (2012: 2). Although Fassin makes clear references to policies and discourses produced at the level of the French state, it is interesting to see how the language of suffering helped crystallise representations of the crisis in the context of the social clinic. In this specific context, the suffering body to which the KIA was compelled to deliver care was constructed through references to past experiences of critical historical events as well as through dramatic considerations on the impossibility of
foreseeing any future. As Doctor Vasilis made clear to me on one occasion, the future was something that it was better not to think about. He concluded:

‘there’s no future here in Greece [den uparxei mellon stin Ellada]. We work to help people now; we make a difference in the present, in this crisis from which people are suffering now. We don’t have the capacity to make plans for the future. Actually, we don’t want to, we don’t want to replace the state.’

In Doctor Vasilis’ words, suffering served as a poignant representation of the present, in which the present vanishing of the state was indicated as generative of social suffering.

Arthur Kleinman, Veena Das and Margaret Lock (1997) argue that the representation of suffering cannot be separated from its experience, being both individual and collective. At the same time, they suggest that paying ethnographic attention to suffering and how it unfolds in people’s everyday lives may offer unexpected insights into what is at stake in people’s experiences of political uncertainty and social inequalities, of marginality and poverty. Ethnographic accounts of suffering are likely to transgress barriers which ‘separate individual from social level of analysis, health from social problems, representation form experience, suffering from intervention’ (Kleinman, Das and Lock 1997: x). At another level, suffering poses a separate question, which deals with the representation and intelligibility of one’s suffering to others. Kleinman, Das and Lock (1997) argue that the representation of suffering is a matter of meaning, language and representation, which are generally shaped by cultural factors. That is, ‘the cultural representation of suffering - images, prototypical tales, metaphors and models - can be (and frequently are) appropriate in the popular culture or by particular social institutions for political and moral purposes’. For this reason, they conclude that suffering has a social use. The cultural representation of suffering shapes it as an ethnographic attention to social suffering that can make apparent the ‘working of power in social life’ (1997: xi). Vinh-Kim Nguyen and Karine Peschard (2003) note that anthropological concerns with suffering rather with disease stem from an increasing
awareness that ‘biomedical nosology do not adequately cover the spectrum of afflictions present across the world.’ Anthropologists were prompted to seek ‘more inclusive definitions of affliction and, therefore, a fuller picture of how inequality translates into affliction’ (2003: 453). Along the same lines, Paul Farmer (1996) argues that the experience of suffering is hardly captured by statistics and graphs, rather it better emerges through a fine-grained ethnography, a far more apt approach to capture how diverse social forces, poverty and racism for instance, and historical contingencies come to be embodied as individual experience.

**Tackling the urgency of the present**

As has unfolded through the ethnographic material I have presented in this chapter, I explored how in the context of the KIA the economic crisis *(ikonomiki krisi)* was attributed with the traits of a humanitarian crisis *(anthropistiki krisi)*. Through a consistent delivery of goods, mainly food and medications, the KIA attempted to mitigate the effects of the crisis that had progressively pushed a large proportion of the Greek population into poverty. Whereas the technical solution that the KIA offered to local problems would have required structural and political answers, the state increasingly outsourced to the KIA and other social clinics the provision of healthcare, while repeatedly appealing to the humanitarian magnitude of the current crisis. Fassin (2012) understands humanitarianism as a generalised mode of governing that puts forward the right to live in the present, and mainly relied on the physical evidence of suffering.

In the Greek context where the progressive dismantlement of public health care facilities coupled with the dramatic curtailment of medical resources, the deployment of the humanitarian crisis enticed the social clinic to work symptomatically, in terms both of responsiveness to unforeseen and unmanageable events (Garcia 2010: 62), and of medical treatments provided. Following this, I have analysed how the KIA responded to the moral imperative to help by delivering care that was mainly aimed at the maintenance of physical existence and the defence of human dignity.
Redfield (2005: 330). Redfield (2005) framed this form of humanitarian action in terms of ‘minimalist biopolitics.’ Accordingly, I have introduced the idea of the materiality of care in order to better contextualise not only how the language of deliverance informed the work of the KIA, but also how it contributed to a very specific production and representation of ‘the suffering in body’ as the main object of humanitarian care. Through the ethnographic vignettes presented, I have highlighted how suffering was mainly associated with deprivation and poverty as a material lack, which could therefore be alleviated through the distribution of goods. In this way, the suffering body becomes not only ‘a morally legitimated body, which can be measured, recognised therefore understood and responded to by looking at the biological body’ (Ticktin 2006), but also the most revealing manifestation of the effect of the crisis.

Based on the premises laid out in this chapter, the next chapter will look at the controversial relations between the KIA and the state. It departs from Begona Aretxaga’s (2003) suggestion that ‘the state form has neither disappeared nor waned. Rather the desire for statehood continues to be intense in many parts of the world in spite, or perhaps because of the hollowed-out character of the state’ (2003, 94. See also Navaro Yashin 2002, Jansen 2015, Obeid 2015). Particular attention will be paid to how access to the KIA health resources was increasingly regulated through bureaucratic categories that the structure borrowed from state institutions, and will show how bureaucracy offered unexpected grounds for contentions and claim-making. In this context, I will hold bureaucracy as a ‘technology of visibility’ (Street 2014) through which people seek recognition, and therefore entitlement to care.
Chapter 2
At the intersection of kinship and the state: distributing care, managing neglect

Figure 6: A conversation with Foucault on technologies of power and bureaucracy. (Drawn by the author)
‘We are not the State’

‘Let’s go out, mikroula. Let’s go out and have a cigarette’ Antigone grabbed my forearm and almost dragged me through the already congested hall of the social clinic, where I had just arrived to start my shift in the social pharmacy. She walked me outside nervously, and we sat on the bench by the entrance of the small building that, in late 2010, the local municipality had donated to a group of volunteers and doctors to set up a self-organised medical practice.

‘We need to take a break, every now and then. Friday morning, you see? Friday is always hell and patients always have complaints and crazy requests’ Antigone ranted in anger. While nervously trying to light up the cigarette she firmly held between her lips, she uttered:

‘You see how they treat us? They make me mad! They don’t understand that we are not a hospital [edo den eimai nosokomeio], that we can’t help them all. And sometimes they yell at us as if we were responsible for everything that is happening in this damned country. They should thank us for what we do. And we do that for free! We don’t get paid for what we do and still, they treat us if we were state employees [dimosi oufalloi]. They come here without papers [xartouras] or with expired prescriptions [ligmena], and swear at us because they say they have the right to get medications [pharmaka] and medical examinations [iatrikes exetaseis] for free [dorean]. That man swore at me because I told him that we couldn’t give him the medication he wanted because his prescription was expired. To be fair, the prescription he had wasn’t even signed by any of our doctors. It was signed by a doctor from the Doctors of the World [iatroi tou kosmou], the medical practice in Omonoia. I know he needs the medication, I know he is poor, otherwise he wouldn’t have come here, he wouldn’t have a prescription from them. But we’ve got rules here, and we try to stick to them. This place would explode without rules. Anyway, I told the man that he needed to renew it, to see a doctor from here, and he went mad. We have rules, but they don’t understand the rules. They take it personally. We Greeks never care about rules and that’s why this country is ruined forever. One Friday or another I will go mad. You know, we are like a big family, that’s what we are meant to be, but you see, families often have problems.’
Antigone leaned against the wall behind the bench and took a deep breath. I remained silent, as I was surprised by such a frank outburst of anger. In fact, never before had I heard any volunteer openly complain about the KIA patients. The people involved in the KIA activities had always described it as a big family whose stability was never threatened by tensions, conflicts or frictions of any kind. Indeed, the volunteers frequently made references to the family, and generally conveyed a specific image of the clinic as a place where sociality was shaped on the example of fair kin relations, and where care was unconditional and motivated by love. This became particularly evident in March 2016, six months before the above episode, during a meeting in which myself and all the new volunteers were introduced to the guiding principles of the clinic, its organisation and its purpose. Anna, a psychologist at the KIA, bluntly declared that the KIA was, first of all, a family, where all were equal and where everyone was available, and had to be available, to help and everyone would be helped if in need.

Increasingly confronted with my informants’ claims on what kinship was thought to be, and what the state was supposed to do but rarely did, I realised that in everyday discourses the realms of the state and of kinship represented practical horizons within which my informants could position themselves towards the state institutions and towards each other. I was also frequently reminded that the importance of kinship ties emerged even more strongly during the crisis: thanks to the support of the family, many of my informants said they could not only navigate the economic crisis, but also organise, secure and rearrange their livelihoods. Stories about kinship were often reported to contrast, or even to maximise, the unfairness of the state: where the state failed to provide its citizens with welfare provision of any sort, kinship ties would supply their kindred members by either providing support to navigate hardships, or by mobilising nets of acquaintances in order to guarantee access to diverse forms of provision.

In their historical analysis of how the Greek welfare state developed in the aftermath of the 1974 dictatorship, Theodoros Papadopoulos and Antonios
Roumpakis argue that ‘the state locked into the family unit the responsibility for the provision of care and social protection, thus, minimising the employers’ and the state’s political and economic costs for societal reproduction’ (2013: 206). The two Greek scholars observe that

‘the persistence of a low-wage labour market was not historically accompanied by adequate welfare support, rendering thus the traditional role of the family essential not only as a welfare provider but also a key factor for the reproduction of flexible and informal employment patterns. Indeed, the family’s traditional role in protecting its members was maintained and consolidated in a welfare mix where the family was assigned the role of acting as the primary social shock absorber’ (2013: 207).

With particular reference to the historical constitution of a public healthcare system, Stelios Stylinadis (in Davis 2012: 38) considers that the country’s rare economic prosperity has never allowed the development of structures and systems of protection as complete as those in other industrialised countries. Greeks have had to rely more on personal initiatives and familiar supports than on direct financial participation in care on the part of the state.

Departing from this premise, this chapter will look at how the entanglement of state practices and kinship discourses reconfigured practices and relations of care at the KIA. Following on Thelen’s (2015) suggestion to look at care in order to overcome the dichotomy between private and public, or the household and the state, I will ethnographically attend to how evocative images of kinship provided a shared horizon for imagining care at the KIA. I suggest that these images of kinship were mobilised in opposition to images of the state; furthermore, kinship and the state were not just discourses (Pine 2017), but actually ‘sites of practices’ (Pine 2017: 87) which served as ‘moral templates for behaviours between people, and between people and the state’ (2017: 88). In this sense, I suggest that for the KIA volunteers, ‘kinship’ represented not only a common horizon of ideal care, but also a concrete referent to discursively organise and structure care, its relations and practices. At the same time, the evocations of kinship were functional to mitigating the
emergence of the state-like bureaucratic apparatus over which access to medical care at KIA was increasingly regulated. Crucially, bureaucratic papers over which contentions and tensions between the volunteers and the patients arose had been released by state institutions, but had lost their validity to access state welfare services while acquiring value to access the KIA; while these bureaucratic documents spoke of the diverse temporalities of the economic crisis, they were also telling of different patterns of care which involved kinship and the state.

This chapter engages with the anthropological scholarship that looks at kinship and the state as mutually constitutive entities (Thelen and Alber 2018): in so doing, it looks at how ‘specific languages of kinship and state move between scales’ (2018: 15) and how these movements contributed to shaping care outside the traditional dichotomy of state and household, the public and the private. The chapter will then analyse the bureaucratic documents which the KIA’s volunteers and patients handled: with these, patients tried to negotiate their entitlement to access the medical care provided at the KIA. In Chapter 1, I have described how care assumed the very material dimension of the provision of goods, namely clothes (rouxa), food (trofima) and medications (farmaka); I have considered them to be specific to a culturally situated dimension of care, and functional to establishing the social clinic as a trustworthy and reliable facility in the grassroots landscape of Athens. In this chapter, I will focus on how the access to care was regulated through documents which had previously been issued by different state institutions: those documents can be seen as a manifestation of the state’s process of ‘vertical encompassment’ (Gupta and Ferguson 2002); to put it otherwise, the evidence of the state’s re-appearance in places where it was least expected. At the same time, I will show how the bureaucratic documents offered unexpected spaces for both the people approaching the clinic and the volunteers to negotiate diverse degrees of access to the KIA services. In particular, I will focus on how kinship, illness narratives and normative ideas of poverty were strategically mobilised in order to entice or neglect care from the volunteers’ and patients’ sides respectively.
The distance from the state and the distance of the state: negotiable needs

‘We are not here to replace the state. We’re not funded by the state and we don’t have any relation to it. How could we? We’ve been abandoned by the state! We are here to put pressure on it, that’s our mission. To push for fairer and more inclusive reforms. That’s the only relation we have with the state.’

Costas, one of the few male volunteers that volunteered at the front desk of the KIA, was evidently annoyed with my relentless questioning about the social clinic, and about how it had managed to sustain itself for almost seven years. Who paid for the utilities? Who paid the rent for the building? Was it true that Syriza MPs gave the social clinic money? How did KIA manage to continue the provision of medications if it was actually illegal to distribute them outside state medical facilities? And what about the vaccinations and minor surgeries that were being performed in what was not really a medical environment? These questions were constantly ringing in my head and I relentlessly posed them to some of my informants at the KIA. More often than not, they offered clouded and confusing answers and explanations. Like some other volunteers, Costas vehemently clarified that the social clinic did not have any relation to any state institutions. However, I came to realise over time that the distance between the KIA and the state was a rather flexible and negotiable measure, which stretched and shrunk under the contingencies of need. On the one hand, the state needed the work of the social clinic to relieve the pressure on the collapsing public healthcare system by redirecting people to the free medical services that the KIA provided. On the other hand, the KIA needed, and counted on, a laissez-faire attitude from the state in order to keep the provision of medical services going.

As emerged from my conversations with some volunteers, it became clear that different state institutions overlooked the KIA’s ambiguous legal position, and allowed the clinic to distribute medications outside the official
channels of hospital dispensaries and licensed pharmacies. I was once told that, soon after its opening in December 2011, the KIA was visited by some delegates from the Association of Medical Doctors of Athens (ISA, *Iatrikos Sillogos Athinon*) who urged the clinic to shut down its activities because they did not comply with any state regulations relative to the provision of medical services. Valia, a long-term and dedicated volunteer, recounted that ‘three well-dressed men’ from the ISA unexpectedly arrived at the KIA on a Tuesday afternoon to investigate the work of the social clinic. They also wanted to inspect the facility. She described how they were particularly concerned with the quality of medical services provided; they argued that the doctors volunteering at the KIA could threaten the reputation of the medical doctors who were still employed in the private and public sectors: they might not be complaint with the medical deontology, and they might abuse their position of power as well. Valia clarified that Doctor Vasilis was not present when the ISA delegates arrived, but he was promptly informed of their presence. She explained that another volunteer, Eirini, immediately informed Doctor Vasilis who, as soon as he received the phone call, rushed to the KIA to talk to the ISA delegates. Valia explained:

‘Doctor Vasilis is a well-known and well-respected doctor. He arrived and patiently explained to those men what we do at the KIA. He reassured them that all the medical services we provide are perfectly compliant with the state regulations. We don’t improvise anything. We don’t give medications to anyone who asks for them. We provide primary healthcare, mainly. If we spot signs of more serious conditions, we send the patients to the hospitals, or refer them to specialists. Our doctors are committed and responsible doctors, and they are so committed that, in fact, they work here for free. It was a blessing that Doctor Vasilis promptly arrived and talked to them. He told them that we are a reliable structure where people can come and get some help. Doctor Vasilis made them realise that our KIA is important for so many people. It’s a matter of fact that many Greeks can’t go to the hospitals or can’t afford to see a doctor. It would have been irresponsible for the ISA to force us to shut down the social clinic: they would have been responsible for all our patients’ suffering. And we have more than 500 patients per year. Make your own calculation!’
Valia continued, explaining that soon after the visit of the ISA delegates, the KIA also received several phone calls from the PFS (Panhellenic Pharmaceutical Association, *Panhellenic Farmaceutikos Silligos*) and from the SFEE (Association of Pharmaceutical Companies of Greece, *Sindesmos Farmaceutikon Epixeiriseon Ellados*) that repeatedly asked for clarifications about the distribution of medications operated by the social pharmacy. The SFEE in particular was concerned with the modalities in which pharmaceuticals were collected from donors and distributed to patients. Once again, Doctor Vasilis’ intervention proved crucial and, as Valia reported in a great deal of detail, he explained to the SFEE that the distribution of pharmaceuticals was regulated on the same principles that informed their distribution in hospital dispensaries and state-licensed pharmacies. Furthermore, the pharmacists were in charge of checking patients’ prescriptions and distributing the medications. The only difference laid in the fact that the medications were given for free. Doctor Vasilis also assured the PFS and SFEE that the free distribution of pharmaceuticals was just a temporary measure to address the pharmaceutical crisis that many Greeks were experiencing, and would cease once the crisis ended. At this point, Valia’s words became bitter, as she mentioned the fact that the PFS and SFEE, as well as EIPYY (*Ethnikos Organismos Parochis Ipiresion Igeais*) continued to interfere with the activity of the KIA:

‘Every now and then we received visits and phone calls from these persons who are only interested in the bureaucracy of the KIA. They only want to see if we do things right, they don’t care about the fact that we are helping people. But they know that our work here is important, and they are afraid of this. If they force us to quit with solidarity, they know our people wouldn’t allow them to do so. They are afraid that we are really changing people’s attitude towards each other, and they are also worried that we are interfering with the pharmaceuticals market. We don’t care about the market, we do solidarity and we give people care [*frontida*], while they do bureaucracy and only worry about their profits. We also send medications to some hospitals across Attica that would otherwise collapse: they know this, but they want to control us, they want
to remind us that they have the power to shut this place down. They know that we help those people who they do not consider important: they care only about documents and papers. They lost their humanity, and they try to make us lose ours too.’

Valia’s words, together with Costas’ fierce defence of the KIA’s independence from state institutions, served as a departing point to reflect not just on the relation between the state and the KIA, rather on the ambiguous perception and ambivalent imagination of the state amongst my informants at the social clinic. In this sense, I suggest that these imaginations and perceptions of the state offered the KIA the space to position itself. As explored in Chapter 1, the volunteers at the KIA described its existence as a temporary fix for the state of emergency that the economic crisis had provoked. Accordingly, the aim of the social clinic was primarily directed to reliving exclusion and suffering through the provision of goods, mainly medications, as well as food and clothes. In these circumstances, the state was considered to be responsible for both the economic crisis and the dire conditions that many Greeks were living with, while it was also blamed for its inability to deal with the consequences of the crisis itself. In light of these considerations, I understand the common sentence ‘we don’t have a state’ (den exoume kratos) that many of my informants uttered as not being in contradiction with the perception of too much state that, through diverse institutions, was felt as interfering with the life of many people, and in the work of the KIA itself.

Akhil Gupta (2012) suggests that the idea of the state as something that should preserve and safeguard the health of all its citizens is so pervasive in everyday life that, when injuries or deaths occur, outrage at the state’s failure spread through the population. At the same time, Gupta argues, the state cannot be considered as unitary and purposive, rather it is characterised by ‘a complex array of institutions with multiple functional specializations, modes of operations, levels and agendas’ (2012: 46). I build on his argument, suggesting that, amongst my informants, the state was perceived as a unitary and coherent entity through what it did not do to resolve the economic crisis.
and to safeguard many Greeks’ health. At the same time, the state was perceived as an incoherent agent that manifested itself through diverse institutions. These institutions were undergirded by different rationalities that pulled in different directions (Gupta 2012: 47) and, as such, they represented ‘an excess of statehood practices: too many actors competing to perform as state’ (Aretxaga 2003: 396). In this light, while the institutions such as the ISA, PFS, SFEE and EOYYP posed a threat to the KIA, they also worked as a guarantee to its very existence: in an attempt to delegitimise the social clinic in the light of potential misconduct in the provision of primary healthcare (protovathmia iatrofarmekeutiki perithalpsi), they implicitly recognised its presence, and legitimised it as a temporary healthcare provider in the midst of the crisis. At the same time, these institutions capitalised on the presence of the social clinic, to which they temporarily outsourced the provision of services to those citizens that were deprived of social security (kinoniki asfalisi).

My understanding of the relation between the KIA and the diverse state institutions does not align with the emic understanding of the KIA that my informants held. While my informants described the existence of the KIA as an act of resistance towards the state, my work ethnographically responds to, and at the same time differs from Dimitrios Theossodopoulos’ (2014a) call for a more serious engagement, theoretical and ethnographic, with the concept of resistance. For the Greek anthropologist, ‘de-pathologising’ and ‘de-exocitising’ resistance configure an intellectual endeavour by which resistance should be located and understood within the theoretical framework of hegemony; that is, in relation to broader configurations of power and its entanglements with it. Theossodopoulos argues that we need to redirect ‘our critical attentions on the interplay of resistance with the working of power, and the distortions and compromises that arise out of this interplay’ (2014: 417). According to the Greek scholar, this would allow us to best capture local understandings of resistance and its meaningfulness, its potentials for questioning power and understanding social changes (Theossodopoulos 2014: 416), and in criticising neoliberalism (2014: 417). Following on his note, I have located the existence of the social clinic within a broader process
of the reconfiguration of state institutions and modes of provisions that had occurred with the intervention of the Troika. However, the retrenchment of the state from the provision of services did not mean the vanishing of the state, rather its waning and reappearance in the voluntary sector: the KIA did not represent a ‘zone of autonomy’ (Graeber 2007: 174) emerging from the inability of the state to impose its control. Rather I understand the emergence of the KIA through Andrea Muehlebach’s (2012, 2013) reading of the emergence of the Italian voluntary sector to which the neoliberal state has increasingly outsourced the provision of welfare services.

As I will explain below, I have relied on Stef Jansen’s (2014) concept of ‘gridding’ to describe the process by which the KIA began reproducing the state in an effort to regulating the access to its medical services and its resources. Jansen (2014: 243) explains:

‘gridding is not necessarily a state scheme and may consist in a variety of practices in different fields, on different scales and with different intensities […] Importantly, gridding process may unfold in interaction with each other and can be hierarchically nested: smaller-scale gridding may be dependent on and/ or precipitate larger-scale gridding. Particularly, the degree to which state-making is effective may be traced through the extent to which people experience institutionalised practices as gridded in ‘vertical encompassment’ (Gupta and Ferguson 2002).’

As emerged from the opening ethnographic vignette, as well as from Valia’s words, my informants at the KIA strongly defended the autonomy of the clinic from any state project, and repeatedly reaffirmed the project of resistance that the KIA was pursuing against the neoliberal resizing of the healthcare system. Nevertheless, they manifested some awareness of the risks that were implicit in the very foundation and presence of the clinic: that of complying with the neoliberal state project that they were opposing. One of the few male volunteers of the KIA, Costas, laid out this point clearly, and he clarified for me the KIA’s position towards the state. Annoyed with my questions, he answered them by posing other questions:
‘Don’t think we don’t see the backdrop of this situation? We see all the risks in fact. We might be seen as collaborators with the state, as if we are helping the state instead of contesting it. We’re not! We’re here and we’re taking care of those citizens that the state could not care less about. It looks like as long as we’re here, the state can sit comfortably and avoid thinking about those poor people who cannot go to see the doctors, or cannot buy medications. The state knows that we’re here to do what it should do. Do you think we don’t know this? We work hard to remind the state about its responsibility. But in the end, you can think whatever you like, but those people must be helped. What can we do? We too should abandon them?’

However, the autonomy of the KIA from state institutions was contextually renegotiated by the volunteers when collaboration with state institutions, hospitals in particular, resulted in successful medical stories. Stories of successful collaborations between the KIA and diverse public hospitals were generally reported by the only female medical doctor at the KIA.

Eleni, it was later explained to me, had, since the very first day, actively worked for the success of the clinic and was, in fact, playfully described as the ‘right arm’ of Doctor Vasilis. In one of my Tuesday visits to the KIA, the quiet atmosphere of the early afternoon was interrupted by her triumphant entrance to the KIA. ‘The boss is here! [the boss exetai]’ Costas exclaimed loudly, ‘any good news from the outside world?’ As Eleni entered, Maria and Stella, the two other volunteers who were busy cleaning the floor, gathered in front of the desk where Costas and I were sitting, and where Eleni had just taken a seat. She answered Costa’s question:

‘Yes, once in a while I bring good news. The good news for today is that we managed to find a bed in one of our hospitals for the husband of that woman who contacted us a couple of weeks ago because the husband needed urgent heart surgery. He was admitted to the hospital a few days ago. The surgeon who took care of him is one of Doctor Vasilis’ colleagues. The woman texted me today to thank us.'
She asked me to let the KIA know how grateful she and her husband are to us. She said we saved her family. Actually, we did nothing, it is just that solidarity always wins [i allileggi nikei panta].

Stella, Maria and Costas listened to Eleni in silence and nodded at her words. I nodded too, somehow sharing the joy of my fellow volunteers.

I do not intent to explore the contradictions and ambiguities implied in the concept of solidarity itself, but rather to investigate the relation between the clinic as non-state care provider of welfare services, and the state that meanwhile withdrew from the provision of welfare services. It seems to me that the KIA operated in a way that unintentionally contributed to reproducing forms of exclusion and marginality that had been produced at the state level. Often acting as a mediator between private citizens and the public healthcare sector, the KIA managed to reserve some positions in public hospitals for its own patients, those who were deemed more serious and in more need than others. Despite most of the volunteers always vehemently denying any relation or collaboration with the state institutions and convincingly praising the independence of the social clinic, both Doctor Valisis and Eleni explained that the KIA successfully managed to negotiate preferential access for its patients at some major public hospitals in Athens.

Sometimes the KIA also managed to arrange major surgeries in some of the city’s private facilities. With some smaller public hospitals in particular, the KIA developed more continuous collaborations: the KIA often supplied them with medications, and these facilities agreed to perform for free a certain number of medical tests, specialist examinations and occasionally chemotherapy, to the most urgent amongst the KIA patients. Besides the successful stories I was told about, I often witnessed for myself how triumphantly some of the volunteers communicated the outcomes of the fundraising they had set up, as in the case of a nine-year-old child who needed a kidney transplant, and whose mother had been referred to the clinic for economic and medical support.
As the next section will extensively explore, the KIA patients were uninsured and unemployed citizens who were no longer allowed to access public healthcare resources which had meanwhile been made conditional on having valid insurance. It follows that the KIA made public healthcare resources available to them that they would have been denied otherwise, but in so doing the KIA impacted on the already scarce public healthcare resources. This practice led to the further fragmentation of healthcare provision by creating a shadow healthcare system, which not only worked in the margins of the public one, but in close proximity with it. This in turn not only reinforced people’s perception of the KIA as a state institution on which they could make claims and advance requests, but also contributed to the creation of hierarchies of needs amongst the KIA patients themselves.

The bureaucracy of care: performing transparency, managing neglect

Over the fourteen months of the fieldwork I carried out at the KIA, besides Friday mornings when I attended the KIA as a volunteer in the social pharmacy, I also visited the social clinic on Tuesday afternoons when the social pharmacy was open to patients and the distribution of pharmaceuticals was scheduled at 3.30pm. Normally, I spent my Tuesday afternoons between the reception (grammateia) and the social pharmacy (pharmakeio). Based on the actual distribution of labour and the spatial organisation of the clinic, I considered the former as the public face of the KIA where, as I will show below, patients were confronted with what I call a proxy-state apparatus and its similar bureaucracy. I describe the latter as the domestic, private domain of women where a different labour of care was performed, as will be discussed extensively in Chapter 3.

During one of my first Tuesday visits, Costas was looking through the registers of patients and crosschecking the today’s appointments, bored. Meanwhile Maria, a talkative woman in her mid-50s who deliberately decided to speak only in English with me, had already taken her position at a desk from where she would collect the patients’ prescriptions. Caught between Maria and Costas, as the day went on I could see the hall of the clinic
getting crowded: mainly women entered, took a seat and quietly talked to each other. A few of them held plastic envelopes within which prescriptions and papers were carefully folded and stored. From that unusual yet privileged position, the complex bureaucratic arrangement behind the family-like management of the clinic suddenly became apparent to me. The materiality of care assumed a different dimension: not that of the goods that were being collected from donations and delivered to patients, but that of papers (xartoures or xartakia) through which care was administrated to the entitled care-seekers.

When Maria announced that the pharmacy was finally open (eimaste anoixti tora), a young woman walked to the desk and handed over the prescription she extracted from her plastic folder. Maria checked it quickly and whispered to me in English ‘She’s so young and already depressed… what can we do? The crisis. Do me a favour as you’re here, go inside and bring the prescription to Eugenia.’ She then turned to the woman and invited her to sit and wait for two minutes for her bag of medication (kathiste kai perimenete ena lepto tin sakoula sou). I took the prescription, passed by the desk and walked to the rooms which were forbidden to patients and to which everyone referred simply as ‘the pharmacy’ (farmakeio). Anna was the pharmacist in charge of the social pharmacy on Tuesdays. She was the owner of a pharmacy in a central neighbourhood of Athens and decided to join the KIA because she knew Doctor Vasilis personally and this reassured her that the KIA was a serious and socially important initiative. As the pharmacist in charge of the social pharmacy, Anna was entrusted to search for, select and prepare the medications according to the prescription she had received from outside. As a general procedure, after the parcel of medications was ready, the pharmacist had to write down on both the patients’ prescription and the register of medications how many blisters were given away (or how many pills), their expiration date and how long that amount of medications would approximately last. This was meant to prevent practices of over-consumptions on the patients’ side, and practices of over-prescription on the doctors’ side. These two habits were common in Greece, as many informants reported, and were frequently indicated by the volunteers of the KIA as the
main reasons for today’s abundance of donations. At a different level, the abundance of pharmaceuticals donated to the clinic was indicative of precise policies aimed at not just relieving the public healthcare system, but also at favouring the expansion of the pharmaceutical market (Chapter 4). In general, the practice of registering outbound medications allowed the volunteers to keep a record of the actual availability of medications in the pharmacy. While Eugenia was searching for the medications she needed on the shelves (sta rafia), I had a quick chat with Despina, Fotini and Valia, the volunteers that I spent many afternoons with, and with whom I became very familiar during my fieldwork at the KIA. Eugenia called me back and handed me a small bag with four blisters of pills and the prescription: ‘We have just enough spare blisters of this medication. They are still good, only they don’t have the fancy package. Tell her, and if she complains, tell her that she is free to go and buy it in a pharmacy.’ I nodded at Anna’s words, and left the pharmacy.

At the desk I handed the bag to Maria, who called back the woman for whom the bag was intended. Maria was checking the prescription of another patient when an old woman, with short disorderly hair and who was poorly dressed, walked to the front desk shouting and waving a medical prescription. The woman loudly declared that she was bored with waiting, that her request for insulin had already been rejected three times, that she was diabetic and resentfully claimed her right to get that medication for free:

‘You say you help everyone, but that’s not true! If you don’t help a poor woman like me [eimai ftoxi], who do you help? You’re not better than the other, you’ve become like the public hospitals [exete ginei san dimosia nosokomeia]! Take it, kid [Parte, paidi]! You see, I have the prescription signed by a doctor! Why don’t you want to help me? [ giati den thelete na mou boithisete?] What other paper do you need? My death certificate?’

Although the woman kept shouting at her, Maria did not show any interest in her, as if she was used to similar complaints. Possibly even more upset by Maria’s indifference, the woman violently slammed her prescription on the desk just in front of me and invited me to take it. I blanked, and anxiously
looked for Costas. Costas stood up, walked in front of the desk and patiently spoke to the woman. He explained to her why she could not be given the insulin she needed, and made it clear that he was aware of her needs, yet there were rules that must be respected for the sake of the KIA and the other patients. However, he tried to reassure her, and invited her to take a seat and to wait a minute (*kathiste kai perimenete ena lepto*): he would see if he could do anything to help her.

‘Waiting’, Ann Mari Sellerberg (2008) argues, is integral to state bureaucracies’ rationing of services and to their ability to calm down clients that have been denied resources. I consider that in the context of the KIA ‘waiting’ held the same meaning, while it also stands for how the state bureaucracy came to be reproduced in a place where it was not actually meant to be. Indeed, as I also happened to witness several times, when any of the patients made complaints, urged the workers to speed up the procedure, or tried to make a point about their rights to see a doctor or get medications, an abrupt ‘wait!’ (in its imperative form, *perimenete*) always arose from behind the front desk. Indeed, as Jane Cowan (1990) also noticed, the Greek grammatical imperative is starkly direct but also appropriate in all except the most formal situations (1990: 101). In the context of the KIA, the invitation to ‘wait’ was integral to the performance of bureaucracy together with the checking and displaying of documents. While the invitation to ‘sit and wait’ as uttered by the KIA volunteers offered a first glimpse of what Yael Navaro-Yashin (2002) identifies as the site of everyday life that becomes a ‘central domain for the production and reproduction of the state’ (2002: 135), I consider the bureaucratic papers that the patients were required to present at the KIA as a sign of the continuity between the KIA and the state at a time when the state proved increasingly unable to meet its responsibilities of health care provision.

In order to be registered and to access the free services of the KIA as patients (*astheneis*), people were asked to present some documentations which would prove their unemployment status (*anergos*), their (expired) health insurance as linked to their (un)employment status (*anasfalitos*), or whatever
documents could testify to one’s legal status within the Greek state. As these documentations were functional to what Herzfeld (1993) defined as ‘the bureaucratic management of personal, social and national identity’, those individuals who could not be read through the categories of these documents were likely to be excluded by both the state welfare provision and the welfare services of the KIA alike. Although the KIA always did its best to register as patients even those people who were not able to clearly prove their status, Costas explained that some people were denied the possibility of accessing the KIA services because they could not prove their condition of being unemployed or uninsured. They were denied access ‘although everything in their appearance and words suggested that they were far below the poverty line.’ He explained that many people had worked in the black market, and thus had never paid taxes or had health insurance; however, they somehow managed to access the public healthcare services through personal contacts and via informal channels, namely, by mobilising personal contacts, or handing bribes (fakelakia) and out of pocket payments to doctors.

Against any programmatic intent to accommodate all those people who could no longer access the public healthcare system, the KIA could not but rely on bureaucratic categories to fairly distribute care amongst the patients. Crucially, while the volunteers considered these bureaucratic documents to be essential to a fair distribution of care, those who approached the social clinic in search of care identified those bureaucratic documents with the ultimate form of neglect. In fact, the volunteers relied on these documents to finalise the registration of a person as a patient of the KIA: the rationale of the registration process worked through the ‘standardization, replicability, anonymity and portability’ (Gupta 2012: 144) of information. These, according to Gupta (2012), are the main attributes describing bureaucratic documents and procedures. Gupta suggests that:

‘by standardizing the information to be collected, the form allows the bureaucrats not only to obtain all the necessary data to make decisions, but also, in theory, to compare the needs of the applicants to arrive at a rational decision. The replicability of the form serves
the function of enabling the most efficient use of scare resources. It also enables the applicants to be anonymous because a person’s rank or status becomes irrelevant when all the forms are exactly alike. Finally, forms are portable both because they encode data that can be translated into statistics and because they can be moved up the bureaucratic hierarchy without a lot of contextual information’ (2012: 145).

The volunteers’ compliance with and adherence to this bureaucratic regime of care was meant to prevent clientelistic relations and to ensure fair access to medical care resources according to one’s entitlement. However, those who were denied access perceived the KIA bureaucratic regime as just a reproduction of the state bureaucracy: impassionate, and indifferent to people’s needs. As the bureaucratic rationale infiltrated the structure of care of the social clinic, the medical practice itself tended to create exclusionary mechanisms, which pushed further to the margins those vulnerable segments of the population who had been recognised by the state as no longer entitled to public healthcare provisions. Caught between formal exclusion from state care and a form of subordinate inclusion in the provision of care operated by the KIA, those who lacked bureaucratic papers tried to reaffirm their deservingness. By mobilising medical documents, namely medical diagnoses and prescriptions, people’s medical deservingness to access the KIA was produced at the intersection of the bureaucratic opacity of documents and the affective response that the volunteers occasionally offered to those people who were recognised as particularly deserving and in need of care.

As I mentioned earlier in this section, a person’s eligibility for the KIA’s services was ascertained on the presence of bureaucratic documents that could prove their current status as unemployed and uninsured. However, evaluations of another nature were sometimes put forward in the decision to register as a patient those who were not able to provide these papers: these encompassed evaluations of whether their appearance revealed signs of dire poverty, as well as speculations on their socio-economic and family background. Crucially, in the volunteers’ process of registering a new patient, the medical condition for which they were claiming help was considered
somehow secondary to the oft-assumed inability of their kin to provide them with care (*frontida*). In this sense, the volunteers assessed one’s deservingness to access the KIA services through a discrentional evaluation of one’s need for care, whereby the idea of family as the first care-provider remained the normative term of comparison by which care and neglect were assessed, and distributed accordingly. Elderly people were rarely rejected as patients as they were generally seen as particularly vulnerable, and even more so when they approached the clinic. Pensioners were not only the social category that the crisis hit particularly hard with dramatic cuts to their pensions, but their presence at the KIA was generally commented on in terms of the negligence of kin: the volunteers never refrained from commenting on the adult children’s responsibility to care for their parents.

Similarly, mothers with children were rarely denied access to the medical services of the KIA: most of the female volunteers showed a sort of gendered empathy towards mothers. Eirini, one of the volunteers working at the front desk, explained:

‘I know that I am contravening the rules of the clinic when I register someone with no papers. But sometimes these rules are just stupid, and after you’re registered, no one will check if you have papers or not. If a mother comes here in search of help, I just see a mother in despair and I couldn’t care less about whether she has documents or not. Whether she is Greek or not. She’s a mother and, as a mother myself, I can imagine the pain, the worries and the humiliation she feels in being unable to buy medications or milk for her child. I’ll tell you something, love is important but it won’t feed your child.’

Heath Cabot (2013) describes how the process by which refugees become eligible to receive pro bono legal aid at one NGO in Athens is fraught with determinants other than those posited by bureaucratic criteria. She argues that ‘the sociabilities and sensibilities of the NGO encounters’ (2013: 452) are grounded in the dialogical nature of the encounter between the NGO workers and the refugees. These encounters, Cabot claims, generate both ‘new ways
of knowing and perceiving when bureaucratic forms of knowledge production fail’ (2013: 454), and clarifies that, besides the NGO workers’ awareness of the necessity to comply with eligibility determinations, the bureaucratic frame within which they operate often enables workers to reject refugees’ requests for legal support unproblematically.

In the following section, I will follow Cabot’s line of inquiry to explore how those who approached the clinic tried to negotiate their entitlement to care above the medical deservingness that their diagnosis epitomised. In the case of refugees approaching the Athens Refugee Council in search of legal support, Cabot (2013) notices recurring narrative patterns emerging from refugees’ stories, and argues that they contain certain narrative and performative elements meant to ‘conform to yet also shape the expectations of audiences’ (2013: 456). These elements, Cabot crucially observes, occasionally leaked into ethnographic interviews (2013: 457).

During my fieldwork at the KIA, I was often presented with stories about loss of health and social security, about the crisis and the need for care. Whereas volunteers were often presented with the papers showing medical diagnosis or their medical records as official proof of their condition, I was often offered stories that centred on suffering and the crisis. It often happened that some of the people waiting in the hall to register or for an appointment approached me on my way out or during my solitary breaks where, sitting outside, I tried to quickly write down field-notes or chunks of conversations. Often, the youngest amongst the women who were sitting in the hall approached me for a cigarette or for a chat to kill time while waiting. As soon as they realised that I was not Greek, they questioned me about my presence at the social clinic and started telling me their stories of the crisis. It often felt as if they were trying to convince me that they really deserved medications, or even tried to justify their presence at the KIA. Sometimes it felt as if they were asking me to advocate for them at the moment of the registration. More than once, I was dragged into disputes between the volunteers and the patients where I was provocatively asked to express my judgement on the fairness of the treatment a person was receiving.
Contesting, enticing and deserving care

With her open smile and friendly manner, Antigone often invited me to sit with her at the desk in an effort to help me with my research: from behind the desk, she thought that I could better understand the procedures by which the KIA worked and patients were registered, and that I could improve my Greek while she could also practice her Italian that, she explained with some pride, she had learnt watching Italian films. I spent Friday mornings with Antigone when the workload in the pharmacy was not particularly heavy. Sometimes, she just stopped me on my way out for a break and, in her very cinematographic Italian, she would ask: ‘What are you doing with those boring, old women inside? Stay here with me, we can speak Italian and I will also reveal to you all the secrets of the clinic!’ (che cosa fai là dentro con quelle vecchie noiose? Rimani qui con me, possiamo parlare in Italiano e ti rivelo anche tutti i segreti della clinica!). Sometimes she just dragged a chair behind the desk and uttered a definitive ‘come’ (ela!). I was indeed pleased with having the chance to sit with her and look closely at how volunteers dealt with both the bureaucratic requirements of the clinic and the demands of the people who approached the KIA in search of help and medical care (frontida kai peritalpsi). I was especially curious about how the volunteers ultimately managed to reconcile the KIA’s vocation to provide care to anyone approaching the clinic with the apparent barriers that the bureaucratic papers posed to that project.

As I have already mentioned, the performance and display of bureaucratic paraphernalia figured as a means to convey a sense of transparency, impartiality and accountability for the KIA that, actually borne out of improvisation, became progressively stabilised through bureaucracy. As an ‘ideology of accountability’ (Herzfeld 1993) and a strategy by which ‘bureaucrats insulated themselves from social suffering’ (Gupta 2012: 23), bureaucratic practices provided the self-organised medical practice with a rationality to manage patients’ identity and entitlement. However, the process of registration of new patients was often fraught with tensions and
contradictions. Registration was based on filling out a form where one’s general information, such as address, date of birth, and unemployment status were recorded. Only a tiny section of the form was dedicated to the medical condition for which one was seeking care: ‘Do you have any condition?’ (*patheia exete?*) was the basic question that Antigone, like any other volunteer, would ask the person who was waiting to be registered as a patient.

This apparently simple question opened up detailed illness narratives that, more often than not, the volunteers did not consider relevant to the finalisation of the registration. In the middle of a person’s detailed account of her medical biography, I heard Antigone responding with firm but polite ‘I understand, but you need to talk to the doctor about this.’ At the moment of registration, people often handed the medical booklet with their medical records to the volunteer and asked her to check it: it was presented as irrefutable proof of one’s medical condition, therefore of their deservingness to access the medical services of the KIA. The medical booklet was also provided as evidence that a person had once been under state care: as the KIA was perceived as operating in continuation with the state, many of those who approached the KIA behaved as if it was auxiliary to the state, yet less than a state facility.

Alice Street (2012) offers a compelling account of the dual role of the health card over which admission to Madgad hospital in Papua New Guinea is regulated. She suggests that a health card, in which a person’s previous and future admissions are recorded, can be seen as ‘a technology of surveillance of, and intervention in the individual body’ (2012: 11). At the same time, Street argues, the health card also represents ‘a unique space of engagement with the doctor and appears to facilitate his/her recognition of the patient as a treatable subject’ (2012: 13). In the context of the KIA, the medical booklet was shown as a person’s attempt to prove themselves a deserving subject of care; interestingly though, at the KIA the medical booklet was used to elicit the volunteers’ positive response to one’s request to be registered at the clinic. The medical booklet figured as part of an attempt to mitigate the impartiality of bureaucracy, rather than to create margins of engagement between the
patients and the doctors. In fact, doctors were never present at the front desk: they apparently delegated the decision-making process relative to the new patients’ registration to the volunteers working at the front desk. For them, the rationale undergirding the registration process was not by any means biomedical, that is to say informed by medical knowledge. Rather, access to the KIA was ensured to those whose documents could prove their identity as unemployed, uninsured or a taxpayer. At the same time, discretionary evaluations, for instance relative to one’s extremely poor appearance, entered into volunteers’ processes of the decision-making: these evaluations spilled over both the bureaucratic and the medical, and contributed to create further frictions between the volunteers and those who were waiting to be registered as patients.

According to this, the registration process and the form that needed to be filled out not only ‘represent the prototype of bureaucratic writing’ (Gupta 2012: 144), but they actually offered unexpected moments of negotiations and tensions, contentions and mediations between the volunteers and the patient. In fact, the registration form and bureaucratic documents relating to a person’s unemployment or uninsured status accounted for just a partial view of far more complex life trajectories. At the same time, the complexities of the illness experiences, past medical encounters and paths of care could not be contained in a medical diagnosis, a prescription or therapeutic advice from doctors. These crucial aspects were often brought back into the conversations between the volunteers and those people whose documents were considered incomplete. In the context of the KIA, the function of bureaucratic documents was not confined to the governmental project by which the state renders its citizens visible and legible. Rather, documents became ‘transactional devices’ (Street 2012: 3) through which people tried to become visible to the state in a place where the state was formally absent, but its presence was constantly perceived and evoked as an object of desire. Over frequent references to medical documents, the reiteration of illness narratives, often voiced through lists of symptoms and medications needed, was used as a counter-argument to the volunteers’ insistence on the necessity for people to
provide any of the documents by which they could push through their registration as patients.

People’s use of illness narratives in order to elicit care offers a crucial entry point to rethink the terms of the debate on medicalisation that has, since the early 1970s, centred on the critique of medicine as a disciplinary power. In this vein, much anthropological scholarship has extensively investigated ‘the therapeutic role of the state in the management of broader social and economic aspects of its populations’ (Dewachi 2017: 20), and shown how the creation of medicalised subjectivities is always the product of a historically, socially and politically contingent way of seeing the individual and the social body as populations in need of management (Brotherton 2012). In this perspective, the medical encounters no longer configure the scene of treatment of a disease, rather ‘the scene of management’ of the care-seeker (Davis 2012:31). However, as more recent scholarly works have also shown (among others, Petryna 2013a, b), medicalisation can become the ground over which ‘hegemonic medical discourses and practices are variously taken up, negotiated or transformed by the lay population in their quest to maximise their health status’ (Lupton 1994: 95). The early debate on medicalisation has mainly focused on how the medical gaze, as a form of disciplinary power, was exerted by medical doctors as agents of the state, and was therefore functional to the creation of visible, passive and ‘docile bodies’ (Lupton 1994). Rather, I read the mobilisation of illness narratives as a strategy to return ‘the medical gaze’ that, in the early medicalisation critique literature (Illich 1976), has been described as mode of surveillance and medical domination that the individual withstands. I suggest that by mobilising illness narratives, the people who approached the KIA tried to become visible to the medical structure, and therefore to prove themselves subjects worthy of care.

For instance, in her compelling ethnography of the aftermath of Chernobyl nuclear disaster, Adriana Petryna (2013a) looks at how victims of the nuclear disaster crafted novel modes of making claims on the state at the intersection of legal and medical categories. She observes that illness experiences were
mobilised to renegotiate the terms of social and economic inclusion, and the
terms of the entitlement to welfare compensation. Petryna explains:

‘pain and suffering are experiences that are being
rationalised and to some extent made into social
instruments. This is not say that they are any less
authentic, but that new determinations and values are
being attached to them. Acts of suffering can carry
stakes beyond themselves, organise social behaviours
and inform policy actions regarding welfare, and
insurance, health care delivery and courses of
scientific investigation and funding. […] Citizens
have come to rely on the available technologies,
knowledge of symptoms, and legal procedures to gain
political recognition and access to some form of
welfare inclusion. Acutely aware of themselves as
having less prospects for work and health in the new
market economy, they inventoried those elements in
their lives (measures, numbers, symptoms that could
be connected to a broader state, scientific and
bureaucratic history of error, mismanagement and
risk’ (2013: 15-16)

Interestingly, the mobilisation of illness narratives was not exclusively the
patients’ strategy; often the volunteers themselves relied on patients’ illness
narratives to legitimate the position of the KIA as standing out as a reliable
healthcare provider in the midst of the ruined public healthcare system. The
following section analyses how certain normative ideas about care, poverty
and family shaped the provision of care as operated by the KIA, in often
contradictory ways.

‘We are the family they never had’: the urban poor, the imagined
community of the patients and the volatility of entitlement

‘We are here to help them. I cannot understand why they don’t come here
when they are in need’ Valia expressed her concerns while pulling a medical
booklet out of a crumpled plastic envelope, which attested to how her
neighbour had been diagnosed with psychiatric disorders and had received
state care for several years. The dates of her frequent hospitalisations at the
psychiatric hospital of Dafni were recorded, together with the diverse
diagnoses she had been given. In the past few months, Valia reported, the
woman had been suffering from frequent relapses and, according to her opinion, she had not received proper care either at home or at any hospital. Valia not only voiced her concerns about her neighbour’s health, but she also considered that the reasons for her dramatic relapse were linked to her family’s scarce economic resources and, mainly, inability to take proper care of her.

As with many public hospitals in Athens, the psychiatric hospital at Dafni [psychoiatreio] underwent a severe retrenchment programme by which medics and beds were drastically reduced in order to curb the state’s expenditure on the public healthcare system. As the major psychiatric hospital in Athens, Dafni served a large part of the Attika region, but its activity was now reduced to a telephone helpline and a day centre for psychiatric patients. Over the past five years, the number of beds had been cut to fifteen, and only patients with severe and acute conditions could be admitted and hospitalised for a maximum of two weeks. Located in a poorly connected western neighbourhood in the outskirts of Athens, the hospital was difficult to reach for many patients. As I will also show in Chapters 4 and 5, home-based practices of pharmaceutical care became more common at a moment when the public healthcare system was on the verge of collapse and increasingly unable to meet and accommodate people’s medical needs. As extensively pointed out in scholarly work (see, among others: Biehl 2004, 2012; Das 2015; Pinto 2014; Garcia 2010), in the face of the state’s withdrawal from many welfare programmes, the family is responsible for taking care of its ill relatives, thus taking charge of their health and learning to act as a proxy clinician (Biehl 2012).

While carefully leafing through the pages of the woman’s medical records, Valia continued explaining to Fotini and I the story of that ‘poor woman, whose husband was a seasonal worker with no education.’ From Valia’s perspective, it was predictable that no one could take care of her neighbour. ‘She does not have a family to care for her’ Valia repeated emphatically in an effort to make me understand how the KIA played a salvific role in the lives of many people by offering them help and care: the same care that neither the
state nor the family was able to supply any more. With a definitive tone, Valia expressed her concerns about her neighbour’s health:

‘We are here for them, to help them. I repeated this to the husband so many times, you wouldn’t believe it! But he was hard to convince. He kept on asking whether they had to pay some fees, because in that case he would have kept the wife at home and helped her as he could. At some point I had to force the husband to give me his wife’s medical records to make an appointment with our psychiatrist. I guess he did not understand how severe his wife’s condition was. But what can you do? He is a poor man. It’s not that he does not love her, it’s just he doesn’t know what to do. But I wonder who they think we are here for, if not for them.’

Valia closed the medical records, and moved towards the front desk where she would pass the documents to another volunteer who could book the appointment for the woman. Emphatically, she concluded that the woman would greatly benefit from meeting the KIA psychiatrist. Valia’s words led me to question what poverty meant in a moment when austerity made the lives of the majority of people precarious, and how poverty affected (or was imagined to affect) people’s care-seeking behaviour and their experience of illness.

As slowly became clear to me, the Athenian poor to whom the services of the KIA were mainly directed and the community of patients (actually constituted by the same poor) were thought and talked of in rather different terms. Those terms were constantly re-negotiated in order to reinforce the position of the clinic, and at the same time to moralise those non-compliant patients. In fact, as also emerged from Valia’s words, the clinic had been set up to help the poor who were apparently thought of as helpless, abandoned, and without the economic and emotional resources to cope with the crisis. In this sense, the category of poor was a composite one, which primarily described the recipients of assistance, charity or aid. Although stripped of agency, the ‘poor’ patients were expected to conduct themselves as insightful individuals, and be able to assess their health condition and to seek help accordingly.
Crucially, as also Das and Randeria also point out, ‘agency is given to some kind of poor people, while others are seen as merely a population to be managed through both policing and paternalistic interventions by the state’ (2015: 4) or, as in the case of the KIA, non-state providers.

However, ideas of poverty as they were mobilised at the KIA had no classificatory strength: poverty in fact was not exhausted in, but exceeded class. Also, as austerity eschewed class and economic categories to describe poverty (for instance, Panourgià 2018), the ‘poor’ mainly become an aesthetic category through which the KIA’s volunteers justified their own morality, while playing out the necessity of solidarity to reinforce social cohesion and give decent care to those neglected by the state, and often by the family as well. To reinforce their programmatic opposition to the state, the KIA could only take care of those that the volunteers considered abandoned by the state: the needier, the poorer, the more helpless. In this context, the idea of poverty relates to, but is not exhausted by, the terms of economic scarcity (Das and Randeria 2015). The image of poor upon which the KIA built its practices of care was in fact functional to the KIA’s stabilisation in the Athenian medical landscape, and did not actually mirror the diverse realities and complexities of what urban poverty in Athens was like.

In the volunteers’ understanding, poverty was also described through the inability of one’s family to provide a patient with appropriate care. Crucially, the impossibility of providing care was a defining feature of poverty, rather than a consequence of poverty itself. Beyond the idea of economic scarcity, poverty implicitly referred to the lack of emotional and social resources that the family could provide its members with. By and large, the poverty some of my informants mentioned implied the absence of a resourceful kin group that could help its members to navigate the state and its agencies. In this sense, family and kinship relations become the measure of the individual’s ability to successfully deal with the state as well as with non-state welfare providers. For instance, in her ethnographic analysis of how kinship dynamics often shape trajectories of illness, Das aptly points out (2015) that ‘it is often the complex layering of family relations with the institutions of the state that
comes to define the quotidian in the overall context of poverty and deprivation’ (Das 2015: 61).

Many of my Athenian friends and informants repeated that they had been able to get through the crisis only thanks to their families. Attending to their comments, I started paying more and more attention to how people referred to, and thought of, family and kinship: in the Greek context, the low level of resourcefulness of kin seemed to signal the threshold of poverty. As an emerging ethnographic thread which grew in importance during my fieldwork, I realised that the KIA volunteers also often talked of the clinic as something that, by and large, resembled a family. ‘For Greeks, the family is the most important thing’, ‘for Greeks, family has and will always come first’ friends often told me, while asking me if it was the same for Italians. I realised that around the issue of care, the family and the state were being differentiated, yet encountered each other again. In fact, by relying on the idiom of family and care, the KIA not only tried to stand against the state and its individualistic, merely biomedical approach to care, but also tried to ‘educate’ those who attended the clinic as patients and volunteers to a different kind of sociality and activism based on solidarity.

Whereas my informants always described family as the core of the Greek society, and opposed the stability and solidity of family to the weakness and unfairness of the state, I follow Das (2015) and Biehl (2012) who warn against any easy distinction between the family as the primary structure of care, and the state as an agent of neglect. In so doing, I could better contextualise how the unproblematic reference to the family as the agent of care translates into contradictory and controversial ideas about gendered labour and the state. Whereas the family may actually represent a structure of decision-making which may ultimately abandon and neglect its most vulnerable members (Biehl 2012; Das 2015), my informants drew neat distinctions between what a good family is and is not, and tried to transfer practices of good family care to the KIA. In this context, the kinship idiom proved good to act with (Alber and Thelen 2017) as kinship is likely to morph into social actions that may involve diverse individuals and institutions (Alber and Drotbohm 2015).
However, as I have shown, the clinic itself often neglected and denied care to those people who did not fall within its bureaucratic categories. Indeed, kinship itself selects and regulates the inclusion and exclusion of kindred members based on diverse categories, such as consanguinity and affinity. Following from how kinship offered the volunteers a referent to organise practices of care at the KIA, the next chapter will look closely at how the labour of care was mainly carried out by female volunteers, and was generative of meaningful relationships outside kin ties. In particular, it will focus on the organisation of the social pharmacy, and will explore how the volunteer women ultimately capitalised on the same gender expectations they often contested in order to engage with the consequences of the crisis.
Chapter 3
The unwaged labour of care: women, volunteerism, and new labour regimes of care under austerity

Figure 7: A collective medical examination at the KIA. (Drawn by author)
A sentimental education

Valia and I were sitting on the bench by the entrance of the KIA, and although our shift in the social pharmacy would end in less than an hour, we had decided to take another break and have a cigarette. It was getting dark and cold, and we were both wrapped in our winter jackets. When I bent over Valia who had offered me a lighter to light my cigarette, my attention was suddenly caught by the finely worked golden brooch pinned on her bluish silk scarf. I stared at it for a while, too long perhaps, and Valia possibly felt compelled to share its story with me. In a melancholic tone she recounted how her mother had once owned it, and passed to her when she was still a young girl. At the time she was given it, Valia confessed, she did not really appreciate its beauty because, like any young girl, she was attracted by flashier jewellery. The moment she started appreciating the elegance and simplicity of the brooch seemingly marked her transition to womanhood. Several cigarettes and chats later, I was able to weave together the different threads of her stories, and I could see how Valia’s transition to womanhood mainly meant her taking on the obligations to care for her more vulnerable family members, a duty that had previously been accomplished by her mother. Valia was nineteen when her mother passed away, and she had to take care of her father who had meanwhile fallen sick, and her father’s sister who had already moved in with them. Although Valia had a good and well-paid job in a bank in the commercial hub of Piraeus Port, she found it increasingly hard to reconcile her family duties and her job. The situation, she said, became even more complicated when, in the 1980s, she became the mother of two boys. They were now in their 30s but still living at home with their parents, because with the crisis, she explained, they both were only able to find short-term contract jobs with very low wages, and so they could not afford to live by themselves. As parents, Basileia concluded, her and her husband were obliged to take them back home and care for them.

Somehow, it seemed to me that the story of the precious brooch was intimately related to Valia’s family history and her role in keeping her family together. When she carefully made a list of a Greek wife’s duties, which
spanned from more domestic chores to sending good wishes (euxes) on kin’s, friends’ and acquaintances’ name days for instance, she often spoke in a complaining tone. However, having something to complain about also seemed to be a defining trait of her womanhood, and a source of prestige at the same time. In her attempt to explain what kinship meant to a woman, Valia slowly dragged me into a spiral of intimate chats about her marital life and endless complaints about her relatives. ‘Ah, little girl, if you have to find a husband, be sure that he is an orphan!’ She laughed, taking another deep puff from her cigarette, and continued:

‘At least, you won’t have to care for his parents and his relatives too. Yours are enough! And you know what? You pass from your father to your husband, if you are lucky. If you are not, you pass from your family’s control to your husband’s mother’s control - which is even worse. You accept bad things when they come from your family, because it is your family. But when they come from people who have just happened to become your family, that’s bad, so bad, you cannot even imagine how bad it can be, my little kid. Being an orphan, I am telling you, is the most important requirement a man should have.’ As I laughed with some unease at her words, she touched my knee with her hand and sweetly told me ‘ah, don’t worry kid! Things are different now, you can divorce much more easily, and you don’t need to get married to enjoy sex! Take one of my cigarettes, take it (parte)! Let’s have another one! In the end we are not paid for the job we do here, we can take all the breaks we want!’

I took a cigarette from the pack she handed to me, and again we started complaining about the number of boxes that were waiting to be checked and sorted in the pharmacy.

Developing through a self-reflexive consideration of my own positionality in the social pharmacy, this chapter will consider how the spatial organisation of the clinic mirrored a certain sexual division of labour, wherein the labour of care emerged as deeply gendered practices. In Chapter 2, I have provided an ethnographically informed description of the workings of the social clinic,
and suggested that statehood practices have infiltrated the social clinic by means of documents. Documents served to assess one’s entitlement to access the KIA’s services, and occasionally worked as exclusionary mechanisms by which often scarce medical resources were regulated. However, the bureaucratization of care was mitigated by recurring references to the family (oikogenia) and kinship, which the volunteers mentioned as behavioural models and moral templates for care.

Departing from Henrietta Moore’s suggestion that ‘familial relations shape women’s access to work and other resources, and also play a key role in producing and maintain gender ideologies’ (2013: 42), this chapter will look at the mutual overlapping of affective labour and gender ideologies, and how these were differently mobilised by women and men in the context of the KIA. In particular, in the next sections, this chapter will trace how the emerging voluntary sector offered a crisis-generated novel arena for women to engage with the social consequences of austerity. By engaging with practices of care outside the household, the women involved in the KIA actively contributed to the reconfiguration of practices of care, beyond the dichotomies of public and private, the state and the household.

This chapter suggests that the women involved in the activities of the KIA not only reproduced some gender ideologies they seemed to contest, but actually capitalised on them: the female volunteers with whom I worked closely for over fourteen months maintained that the provision of care was an exclusively female duty and priority, a form of affective labour which could therefore remain unwaged. In the Introduction to the volume *Revolution at point zero: housework, social reproduction and feminist struggle*, feminist scholar Silvia Federici suggests examining ‘the double character of reproductive work, as work that reproduces us and valorises us not only in view of our integration in the labour market but also against us’ (2012: 2). Following on Federici’s note, this chapter will analyse women’s labour of care and how it was shaped by the availability of pharmaceuticals. To conclude, I will argue that maintaining practices of care as an exclusively female duty allowed women to actively respond to the crisis within the terms
and demands posed by gender expectations. In this sense this chapter stands in continuity with Heather Paxson’s (2004) inquiry into how gender expectations have changed since the 1990s in Greece, and does so by looking at how gender expectations have changed further since the economic crisis.

The social pharmacy of women: social reproduction, gendered sociability and the ethnographic absence of men

Upon my arrival at KIA, Thanasis was standing at the main door, waiting for me. Thanasis and I had already met a few weeks before when he kindly arranged for me to meet with Doctor Vasilis, the founder of and the cardiologist at the social clinic (Chapter 1). Thanasis was a pale man in his early forties who had lost his job four years before, and since then he had been deeply committed to the cause of the KIA. As became clear after I had spent a few weeks at the KIA, Thanasis was one of the very few male volunteers who worked on shifts and was engaged with the KIA’s activities almost on a daily basis. As my fellow female volunteers also occasionally mentioned, most of the men involved in the KIA were working in logistics or were part of the communication team. For this reason, they only rarely showed up at the clinic.

In fact, the men volunteering at the KIA made few appearances at the clinic and only rarely physically engaged with any kind of work; even so, they were always praised for the valuable contributions they made to KIA. I was reminded that they frequently organised international fund-raising campaigns and projects raising awareness across Europe, especially in France and Italy. Some of them also went to report the KIA’s successful activities to the Minister of Health, and held workshops to educate people in practices of self-organisation. For instance, Douzina Bakalaki (2017b) notes that similar dynamics occur at the ‘Bank of Love’ soup kitchen in the northern Greek town of Xanthi where she conducted part of her fieldwork. She reports that

‘the volunteering men worked outside and above, in the streets of the town. Their visits to the Bank of Love were rare, short and of a supervisory nature. The women nurtured and dealt with produce and food,
while the men provisioned and dealt with money and commodity’ (2017b: 10).

Whereas the absence of men may be seen as an ethnographic shortcoming, their absence offered me an unexpected ethnographic cue, by which it became possible to reconsider how labour regimes of care were being reorganised within the KIA, and which gender ideologies actually informed them. Thelen (2015) examines how feminist scholars have emphasised the importance of the emotional aspects of care in the process of identity formation; this gender perspective adds a more processual view to the understanding of care as it was originally posed by social reproduction theory whereby care is seen as given to women and taken away from men. Following on this consideration, I also suggest that although these gender ideologies not only persisted, but also mirrored and were mirrored by the quite traditional dichotomy between the public as the realm of male sociality, and the private as the domestic domain of female relatedness (among others, see: Herzfeld 1986, 1988; Cowan 1991; Dubisch 1991; see also the Introduction and Chapter 2 in this thesis), the gendered organisation of the labour regimes within the KIA blurred the boundaries between these two, as will be shown in the following sections.

On my first day as a volunteer, Thanasis walked me through the reception hall of the clinic which was crowded with people waiting for the pharmacy to open, and offered me a quick explanation of how the distribution of pharmaceuticals worked according to a complex bureaucratic system of registration (Chapter 2). For the first time, I was admitted to the rooms which were generally referred to as ‘the pharmacy’ (to farmakeio) or simply ‘inside’ (mesa). In fact, only a few days before, I had been informed that I was finally granted the title of ‘volunteer in training’ (ethelontria stin praktiki), a position that also secured my access to the social clinic as a researcher. In my imagination, the pharmacy where I was going to work was an anonymous, medical, silent, clean and neat space, which may occasionally be overwhelmed with chats about the current political situation and alternative strategies for delivering care. Upon entering the pharmacy, the mess of
furniture, its random arrangement and the huge amount of medications stored in plastic bags and boxes of different sizes impressed me greatly, while a quite evident gender segregation surprised me even more. The three small rooms across which the pharmacy was organised were populated by women who filled the surrounding space, chatting loudly. The low ceiling, the absence of windows, and the walls covered with shelves running up to the ceiling made the place quite claustrophobic.

As we entered one of the rooms, Thanasis was playfully and loudly welcomed by the four volunteers who were sitting around a big table, intently sorting random blisters and packs of medications. Thanasis kindly introduced me to them, playfully invited them to take care of me and, with some pride and an abundance of detail, he explained that the social pharmacy would not be working as it was without these women’s patient work. He warmly praised their dedication to the cause of the KIA, where they invested their time and transferred their knowledge. However, it soon became apparent that the women’s knowledge Thanasis referred to had nothing to do with the medical knowledge that one might suppose would inform the activities of a pharmacy. Rather, he meant women’s practical knowledge (*pratiki gnosi*), a very feminine repertoire for organising the space efficiently, just as they would do at home. Thanasis playfully addressed them as the ‘housewives’ (*nikokyries*) who would welcome me, the foreigner guest\(^\text{13}\) (*xeni*), into their household (*nikokyrio*). Just before leaving, Thanasis emphasised that volunteering in the social pharmacy could be particularly boring, nevertheless ‘the girls (*ta koritsia*) know how to do it, and have worked out their way to have a good time together there.’ Thanasis’ remarking the women’s engagement with, and resilience to, the ‘particularly boring’ routine of the pharmacy seemingly served to reinforce and reproduce an image of virtuous, skilled and dedicated women, an image which the women themselves seemed to consciously tap into. At the same, his comment worked as a recognition of the crucial contribution the women were providing to the KIA as skilled housewives. In this sense, Thanasis’ passionate praise of their labour can be read as the male

\(^{13}\) In Greek, *xenos/ xeni* can be used to indicate both a guest and a foreigner.
acknowledgment of the necessary nature of women’s work; however, his praise assumed and enforced the idea of the labour of women as ‘essentially informal and circumstantial and limited to the private sphere’ (Salamone and Stanton 1986: 97).

When Thanasis left the pharmacy, a few seconds of awkward silence followed, as if we were all uncertain about how to speak to each other in the face of an evident age gap and, on my side, some linguistic hesitations too. Despina, Valia, Eva and Fotini introduced themselves again, warmly invited me to sit with them and, as an act of welcoming, they offered me some sweets (ta glyka) from a box that was open on the table, and some coffee (kafedaki) from a flask that one of them had brought in that afternoon. As I realised over the course of my fieldwork, sharing sweets and coffee, offering each other cigarettes, and engaging in intimate chats and gossip were part of the rituals through which the pharmacy was crafted into a domestic space, as different forms of care were enacted and relatedness amongst the volunteers was created. As soon as I started participating more actively in these rituals, my position changed from that of a foreigner and guest (xeni) to that of a family member daughter, (kori). With regards to the sharing of sweets and coffee as part of domestic rituals to welcome guests, Greek anthropologist Marina Iossifides (1991) suggests that ‘the sweets and coffee offered to guests afternoon visits are not considered proper food. They are treats and serve to bridge the divide between members of different households and loyalties’ (1991: 3). Similarly, Cowan (1990, 1991) observes that sharing coffee and sweets represented a gendered form of sociality amongst her informants in a northern Greek town. Cowan also notes that the act of visiting each other’s houses and sharing coffee and sweets signifies for women the end of their domestic chores (1991). Indeed, at the KIA, the act of drinking coffee and having some sweets represented a break from our labour, and was announced with ‘let’s take a break’ or ‘let’s go for a cigarette’ (na kanoume dialeimma; kanoume dialeimma gia tsigarro).

When Thanasis introduced me to the women that day, he briefly mentioned that I was Italian (mia Italida) and a researcher (erevnethria). This
information about my status as a foreigner provoked some curiosity amongst the women in the pharmacy, as well as my status as a researcher, which more often than not was equated to that of student, therefore perceived as inappropriate to my age. However, concern replaced their curiosity as soon as I declared that I was alone in Athens (meno moni mou stin Athena). Questions about my life, my family, and my work followed relentlessly: ‘Why did you come to Athens? Do you have a family of your own? Do you have a husband? Do you have children? Are you studying the crisis? Do you have a place to stay? Do you have friends in Athens? How come your mother let you go? When are you going back home? Is your mum old? Who’s going to take care of her?’ I had the impression that my answers to their questions raised some subtle disapproval amongst the women. When Despina abruptly asked me how old I was, my answer not only raised further concerns, but also led to comments that Valia described as stemming from some maternal concerns that any mother would have towards her adult, yet not married, daughter. In this sense, Despina’s comment ‘You’re 33, you’re not that young’ (eisai 33, den eisai toso mikri) sounded like a disconcerting recognition of my condition as a single and childless woman, and possibly an invitation to take on my responsibility as a reproductive body. This explanation actually came from my friend Christina when I told her about my first day in the clinic and reported how Despina had reacted when she discovered my age. Christina laughed and exclaimed that by the end of my fieldwork, my fellow volunteers would have definitely bent and crafted me into a proper Greek woman. Christina explained:

‘When they say ‘you’re not that young’ it means that you should already have children and a husband! It’s a bitter acknowledgement of your condition, and a suggestion. You know, Greeks are very traditionalist and women mainly have a place in society only when they get married, and even more when they have children. Things have changed a bit with the crisis, people no longer have the money to organise

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14 In her ethnography *Making modern mothers. Ethics and family planning in urban Greece*, Heather Paxson records similar stories as reported by foreign women who had moved to Athens (2004: 47-48). See also, Jane Cowan (1990).
weddings, but getting married is still important for women.’

As I have briefly mentioned in the introductory section, this chapter has developed through and within a set of methodological concerns about how to render questions pertaining to my private life as they were posited by my informants ethnographically relevant. Facing similar questions and methodological issues during her fieldwork in a Greek island village, Jill Dubisch comments:

I learned several things from the interactions, and I learned from them as much from the questions the women asked me as from what I asked them. For it was through the nature of the questions themselves - questions about family, my husband and children – that the women revealed to me what they considered the most important features of social life. And in addition I learned that these women, the important instigators and maintainers of social contacts, felt sorry for me. I was young, childless and far from home (1991: 36).

Drawing from Dubisch’s methodological suggestion, I argue that attending to my female informants’ questions and their reactions to my answers allowed certain ideas about womanhood to emerge ethnographically. These ideas were contextual in a historical and political moment where the crisis was experienced differently across gender lines (Vaiou 2014), and unevenly crisscrossed private and public domains. Aware of the age divide between myself and my informants, I describe their contrasting and often contradictory stance towards kinship, family relations and the labour of care they were entrusted with as indicative of their efforts and attempts to navigate and respond to a period of rapid social changes and changing gendered expectations of care under austerity.

While an increasing number of Greeks turned to solidarity initiatives to receive medical care, clothes, and other kind of material aid (Vaiou 2014), an increasing number of women became involved in these initiatives, as the rising rate of unemployment and the precarisation of labour regimes
paradoxically granted them more free time, and the opportunity to engage with the social consequences of the crisis in the terms and conditions set by their gender. In fact, the crisis not only contributed to exposing the fragility of the economic structure, it also compelled people to adapt their livelihood to new, changing conditions. In regard to the concept of crisis, Narotzky and Besnier argue that ‘crisis signals a breakdown in social reproduction, a mismatch between configurations of cooperation that used to “work” by producing particular expectations and obligations, and a different configuration of opportunities and resources’ (2014: 7).

The making of modern women: suffering and complaining, labouring and volunteering

Gossiping, judging, positioning: assessing the self while assessing the other

‘You see, my little girl (mikroula mou) they love to make couscous!’ Valia explained playfully, and continued ‘you know what it means? It means that they love gossiping! Greek women love gossip [einaí polí koutsompoles]. Gossip is a form of social update. How do you say it in English? Hobby? And well, you put everything in the couscous, as in the gossip!’ Valia then turned to Fotini and Despina, and invited them to stop chitchatting because, she thought, they would give me a bad impression of Greek women. She continued: ‘girls (koritsía), what impression are you giving to this girl [koritsí]? She is a foreigner [xeni] and she is here to study how we do solidarity in Greece [pos kanoume alleliggui stin Ellada]! We should teach her how we do solidarity, but all you give her to understand is how to make couscous [pos na kanoume kouskous]. She will write about how backward we are in Greece [alla tha grapsei toso piso eimaste stin Ellada]!’

Valia’s words were an invitation to her fellow volunteers to stop gossiping: they were talking intently about the wedding favours that Dimitra, another volunteer that I never met during my months at the KIA, had brought and left for them in the social pharmacy. As I could neither fully follow nor take part in their conversation, Valia explained that Dimitra’s daughter had just got married, and clarified that her fellow volunteers were not only commenting on the wedding favours, they were also speculating that Dimitra’s daughter
had accidentally become pregnant and that was the only reason for such a quick wedding. Despina laughed and concluded, ‘before, first you got married and then you got pregnant, now it’s the other way around… the girl gets pregnant, and then she possibly gets married. Nowadays, that’s the only way to get people married! Having a baby is a blessing for women anyway, and an endless source of worries as well.’

Dimitra’s daughter’s wedding offered my fellow volunteers a valuable chance to elucidate what the Greek mentality (*elliniki nootropia*) was like when it came relationships, marriages and married life, especially for women. In an effort to make me understand what being a woman was like, they did not refrain from sharing gossip with me about people I had never met, and their own personal stories as well. I read their will to make me part of their life stories (*istories zoes*) as a form of acknowledgment of my position of researcher, which was often voiced through comments like ‘do you want to write about us? Go then, write down my name!’ [Theleis na grapseis gia mas? \*Ela, kai grapse to onoma mou!\*]. At the same time, I consider their life stories as a part of a sentimental education that they tried to impart on me as a ‘young girl’ (*koritsi*). In light of the ethnographic material I collected over fourteen months of fieldwork in the social pharmacy, I suggest that my fellow volunteers and informants tried to ‘educate’ me at becoming a woman in a caring effort and out of affection for me. In doing so, they often opened up about their decision to volunteer at the KIA or about the strife they had to endure in order to craft spaces of autonomy according to what the sense of ‘being a modern woman’ (*mia ginaika tis simeras*).

At the same time, I follow Max Gluckman’s (1963) appreciation of gossip ‘as a culturally controlled game with important social functions’ (1963: 312) to describe how, in the context of the social pharmacy, gossip not only functioned as a crucial yet enjoyable activity through which the women created and maintained relatedness, it also provided them with terms to assess their own conduct as women in comparison with the conduct of other women. Crucially, Gluckman notes that gossip has positive virtues by which not only values, unity and morals are predicated, but also memberships to a certain
social group is sanctioned or denied. While Gluckman suggests that ‘gossip is a hallmark of membership’ (1963: 313), I consider my informants’ will to make me part of their gossip activities less as an attempt to grant me membership to the group of volunteers. Rather, including me in their gossip was a function of their personal effort to reason about, and make sense of, the changes triggered by the economic crisis and occurring at the social level. Accordingly, in the context of the social pharmacy, gossip functioned as social and moral commentaries through which the women volunteers tried to assess and reaffirm their positionality as women in a moment when traditional gender roles and expectations were reshuffled under the strains of austerity, and women’s substantial participation in solidarity initiatives contributed to reconfiguring relations of care within and outside the private domain of household.

From this perspective, I consider my informants’ stories about their and others’ private and social lives as not merely pedagogical, that is to say, a form of social reproduction of the gender dynamics that they seemed to contest. Rather, I hold them as offering novel insights into how women navigated gender expectations and negotiated modernity and autonomy within the limits that the same gender expectations imposed on them. By positing my own experience as a volunteer as ethnographically central to my informants’ unfolding of certain ideas of womanhood, I will show how the effort to craft the self into proper women is a collective and ‘polyphonic process’ (Seremetakis 1990). Greek scholar Nadia Seremetakis suggests that for Peloponnesian women, mortuary laments constitute ‘fragments of women’s self-reflexivity and [as] meta-commentaries on the relations between the self and the social and the cosmological orders’ (1990: 481). Through laments, Seremetakis claims, it is possible for women to voice their pain, which is ‘considered indispensable to the production and reception of truthful discourse in lament performances’ (1990: 483). Similarly, Anna Caraveli (1980) reports that ‘the main effects of lamentation of women of the patriarchal Greek village society are the establishment of a strong sense of bonding among them, and their reinforcement of social roles and modes of interaction which can best serve as strategies for survival’ (1980: 130). In her
analysis of the discursive styles of storytelling, Alexandra Georgakopoulou (1995) reports that the attitude of Greek women towards conversation is that of ‘providing good listnership, supportive elicitation, and reinforcement of other participants’ topics and contributions’ (1995: 462). In this vein, it was ethnographically productive to attend to the tensions that arose from the female participation in an initiative of solidarity like that of the KIA, whose emancipatory potentials were predicated on ideals such as gender equality, collectivisation of care practices and horizontality, and the reproduction of gendered roles. The latter was mirrored in both a sexual division of labour and in distinct spheres of socialisation within the KIA.

The refined art of complaints: voicing a successful suffering and the discursive production of womanhood

‘My husband, he’s a good man - don’t get me wrong! But he cannot understand why I come here [to the pharmacy] every Tuesday. He teases me because he thinks that it’s pointless what we do here. He says it should be for the state to take care of the poor and every Tuesday he tries to find some excuse not to let me come. Perhaps he’s right, but that’s not the point. What he doesn’t understand is that I can’t stand him any longer! I cannot bear to see him every day, all day. You know what? I come here, I switch off my phone and I can finally relax! For a couple of hours at least, I don’t have to worry about the dinner that I will have to cook, no thoughts about what the children want to eat. No family obligations, no phone calls. That’s why I’ve kept on coming here for the past five years. I’ve my girl friends here to chat and drink coffee with, and we smoke our cigarettes together, as many as we want! My husband quit smoking so now I cannot even smoke in the garden. Oh, we have such a nice garden, you should come to my house before you leave, Letizia! My husband planted roses all around the fence and they are gorgeous. I have good time for myself here, while I also feel I am doing something good for the less fortunate people.’

Here, Valia voiced what seemed to be the most common source of complaints amongst the women of the pharmacy: children, family life, domestic duties,
and marital relationships (see also Dubisch 1995: 215). Despina silently nodded as Valia spoke, and quickly added her own complaints:

‘I cannot even come here every week, you see? Now you tell me, how long have you not seen me for? Sometimes I have so much work to do at home that my days just pass by without even realising it. When we moved to Falirò, I told my husband that the house was too big, but he insisted that it was going to be fine, that there we would have enough rooms to host our children when they return from abroad, you know, my daughter studies in Cambridge and my son lives in Stockholm. Also, with so many rooms, one day, we would also be able to host our grandchildren. Of course, he wanted a big house. He doesn’t know what it takes to keep it clean and tidy. In fact, it’s just me to clean it up, and not him!’

Valia did not miss the chance to quickly pick up on Despina’s words, and replied:

‘Oh don’t tell me, Despina mou! I am so tired today [ax, simera eimai toso kourasmeni]. Yesterday I was so tired that I went to bed, and guess what? I couldn’t sleep! I ironed, tied, and piled up clothes and cloths [rouxa] all day yesterday: at night my legs were swollen, and my back broken. John [Basileia's husband] saw that I was so tired that he also suggested he hire someone to help me with the chores. With the crisis, so many women are looking for jobs now. We could afford to pay someone anyway. But I don’t like the idea of having someone around my house. Anyway, I came here today, and before coming, I cleaned up the house, went to the market [laiki], prepared the lunch, and I’ve also arranged the dinner for tonight. I am done for today with the house. I can finally relax.’

Valia turned to me, and concluded ‘I’m telling you something you might find odd, but I actually find it relaxing to sit here and count the pills: they make all my preoccupations and worries wane. Now you don’t understand what

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15 Palaio Faliro is a residential, upper-class neighbourhood on the southern outskirts of Athens.
we’re talking about, my little girl. But you will, when you have a house and
a family of your own to take care of.’

In spite of the frequent complaints about the burden of having a family and a
house to care for, it seemed that for my female informants, getting married,
making a family and building a household were nevertheless considered
essential to the realisation of their idea of womanhood. Although they often
recommended that I never marry a Greek man because they are extremely
demanding men who never grow up, at the same time they never failed to
praise their husbands for their ability to materially provide for them.

Much of the literature on Greece has extensively focused on the household
(nikokyrio) and the centrality of the family unit as both a social and an
economic sphere (see, among others: Campbell 1974; Cowan 1990; Friedl
1962; Papataxiarchis 2012; Paxson 2004). It has also been argued that the
ability of the household to successfully perform socially and economically
depends on men’s capacity to pursue the family’s interests in the public
sphere or by doing politics, and on women’s ability to artfully administrate
the economic and material resources of the household (Salamone and Stanton
1986). I want to move beyond both the understanding of gender
complementary as a structure of the household (Papataxiarchis 2012), and the
argument that a woman’s social prestige rests on the public recognition of her
husband’s and their household’s success (Salamone and Stanton 1986: 98).
Instead, I argue for a shift towards a perspective which could better highlight
the process whereby women become good women, at a moment when the
crisis not only affected the composition of the household, but also gender
relations (Vaiou 2014). The following section will therefore look at the
process of ‘being good at being a woman’ (Dubisch 1995: 207) and how this
was performed in the social pharmacy.

Much scholarly work on Greek women has explored the close relationship
between womanhood and motherhood (also Loizos and Papataxiarchis 1991;
Dubisch 1991; Paxson 2004): the accomplishment of womanhood has
generally been predicated on marriage as the fulfilment of a relational and
gendered self, as well as on motherhood as the realisation of an inherently female biological destiny (Paxson 2004). However, as Dubisch (1995, 2010; also, du Boulay 1974) suggests with regard to the women on Tinos island with whom she worked,

'maternity must not be seen only in relationship to children, but also in connection with the general duties regarding the maintenance of the house, which is not only the seat of family life but also a metaphor for family. Therefore, the demonstration of the fulfilment of maternal and housewifely duties, and the carrying out of activities that prefigure this fulfilment, can be seen as a part of being good at being a woman’ (1995: 209).

As much as the fulfilment of maternal and housewifely duties are experienced as necessary to the crafting of a good woman, these are also sources of complaints which are not only shared by and amongst women, but also contribute to forms of ‘competitive suffering which manifest themselves in constant complaints about the difficulties of everyday life, problems with work, illnesses and, particularly for women, personal relationships’ (Dubisch 1995: 214).

As mentioned in Chapters 1 and 2, the patients attending the social clinic mobilised autobiographic elements and narratives about their suffering from the crisis to entice forms of care and inclusions from the KIA. At the same time, the language of suffering from material, economic and medical deprivation provided the KIA with an entitlement to respond to the moral imperative to help the less fortunate. In the specific case of the women I worked with, complaints served to voice their suffering that instead seemed to be a source of pride and recognition. In this sense, they seemed to reverse the language of suffering in order to gain visibility rather than to entice compassion. Dubisch acknowledges that anthropological literature on the cultural role of suffering in Greece is limited because much of the
ethnographic attention has been paid to laments; she assumes that this ethnographic lack rests on the assumptions that expressions of suffering, and of emotions in general, ‘tend to be treated as statements of individual feelings, as natural phenomena, rather than cultural idioms’ (1995: 213). Rather, as Seremetakis (1991) also contends, emotions such as suffering are ‘embodied, conceptual, moral and ideational constructs that place the self in dynamic relations to social structure’ (1991: 4). Furthermore, as emerged from my ethnographic material and as is seemingly confirmed by others’ ethnographic work (Caraveli 1986; Seremetakis 1991; Dubisch 1995), suffering and struggle are not limited to occasions such as death and pilgrimage, but are also seen as on ongoing part of everyday life. On a similar note, Dubisch (1995) contends that ‘suffering is a pervasive cultural expression, in the everyday life and in the presentation of the self, especially female self’ (Dubisch 1995: 214). Greek scholar Seremetakis (1991) argues that autobiographic elements play a rather central role in the narrative development of each women’s lament (1991: 7). The biographic elements that Seremetakis individuates are constitutive of what Dubisch (1995) describes as the ‘poetics of womanhood’, which mainly revolve around ‘the importance of motherhood, proper keeping of the house, including handcrafts and food preparations’ (1995: 214). Following on from this literature, I see the growing intensity of complaints and the incremental emotional density of my informants’ discontent and complaints as a manifestation of the processual construction of a woman’s self and of her social prestige. In the case of my informants, this process seems to take place in the social pharmacy.

In the specific case of the social pharmacy that I describe as a domesticated public space, I follow Dubisch’s (1995) definition of the public that, she suggests,

‘must thus be broadened to include not only the world of men but also the world of women, even if they do not gather in what is conventionally designated as public space. That is, women may provide the public audience for other women’s performances, as well as the critical commentary that determines how such performances will be evaluated whether at religious
In the space of the social pharmacy, it is through complaints that modes of good womanhood can be heard, and therefore socially praised and acknowledged. In this perspective, complaints contribute to the iconic construction of a social, economic and existential status: Maria’s complaints about domestic chores stealing time from her voluntary work at the KIA sounded to me like an indirect celebration of her economic wealth, which was concretely materialised in a big house having several empty rooms. Implicitly she made also reference to her husband’s economic availability or, as Herzfeld would have it (1985), to her husband’s capacity to successfully perform in the public sphere according to the best interests of the household. Maria had in fact dedicated her entire life to the care of the family and the household, activities for which she had never received any remuneration. Indeed, housework and care are likely to fall in either ‘the order of gift exchange’ (Gonik 2012: 278), or to be seen as a natural resource or a personal service (Federici 2012).

Listening to the stories that, over time, Valia, Fotini, Despina and some of the other women in the pharmacy shared with me, I could sense how they were all charged with the ambiguous language of love and subtle resentment, that of kin obligations and efforts to negotiate a space of freedom and independence from family and their husband. Although most of the women complained about their life as a wife and mother, it seemed that they could not foresee any alternative for them outside marriage. Although dissatisfied with their lives, they could not help but invite me to find a man to marry. After a long and enraged rant about her husband and the boredom of marriage, Maria enthusiastically and proudly announced to us that her younger daughter was engaged and would get married soon. On another occasion, Valia confessed how ardently she wished that her son could find a good wife soon, so that she could stop preparing his food and ironing his clothes.
Indeed, I often got the impression that Valia struggled not to compromise her social image of being a strong, well educated, opinionated and independent woman, and in this sense, she framed her decision to leave her job after the birth of her second child in terms of rational considerations about what was better for their children, and for the household economy. In fact, after some reflection, Valia concluded that there was no point in keeping the job as her salary would have been used to hire a nanny, and her children would have suffered from their mother’s absence. Her husband, she said, did not interfere with her decision, and would have supported her in any case. However, it seemed to me that Valia somewhat unwillingly left her job due to pressure from her family, and became a devoted housewife: a role about which she never failed to complain about, although she seemingly took some pride in her position of housewife which I consider complementary and opposite to that of independent and opinionated woman. Both, I argue, are descriptive of women’s condition, and at the same time prescriptive of women’s relational conduct in both the private sphere of household and in the public sphere of social life. However, Valia’s narrative forced me to think more carefully about, and to question what kinship ties mean and imply to women at a time when gender equality within households and in the job market has supposedly been achieved. It also urged me to reflect on the extent to which kinship often speaks of subjection to a social, cultural and religious milieu which still links womanhood to motherhood (Paxson 2002, 2004), as well as of the fine line which divides the moral obligation to care and the exploitation of the female labour of both assistance and care (Federici 1975).

The conversations about love, husbands and family affairs proved to be interesting to me, although I could rarely take part in them as my status as unmarried woman meant I was neither a reliable nor interesting interlocutor: in my informants’ opinion, I did not have a clue about what family life implied and I could not even imagine what handling a husband could mean. Normally, when the conversation turned to ‘adult women’ issues, I could only sit and listen, and learn from them. Interestingly, and contrary to many feminist objections, my female informants somehow maintained care and housework as a gendered form of cultural capital, which not only defined
them as ‘being good at being women’ but, as I will show in the next section, granted them moral superiority which meant such works could remain unwaged, and at the same time could be mobilised to negotiate their presence in the political domain that the crisis had opened.

Labouring and volunteering: domesticating the space, disciplining the objects and carrying the burden of caring for others

‘Καθένας με τον πόνο του’
Each one with his own pain

On my first day in the pharmacy, and following on from Thanasis’ warm invitation to train me in the role of volunteer, Despina started passionately explaining to me how to look at the blister packs, and how to repair and rebrand the damaged packages and to check the expiration date. She carefully listed the different phases of the checking process, and taught me tricks and techniques to speed it up. ‘You’ll find your own way, don’t worry’, she told me in a tone that seemingly aimed to be reassuring: ‘after a couple of days here, you’ll do it naturally, without even thinking about what you’re doing.’ Besides the instructions on how to check and rebrand blister packs, Despina carefully made clear that psychiatric medications (psichiatrika), recognisable from two red bars on the package (kokkino digramma), had to be stored on a separate shelf as they could only be given on specific prescriptions. She taught me how to recognise the cancer medications (onchologika), which normally came in a light blue package and which needed to be stored in the fridge. She then reminded me that if I was unsure about anything, I should always either consult the list attached to the fridge or ask a more experienced volunteer. From that moment on, she warned me about the responsibilities I was going to share with them in ensuring the smooth functioning of the pharmacy. Being a volunteer, Despina clarified, was a demanding job which required commitment, dedication and attention; however, she continued, volunteering was also an extremely rewarding activity which had beneficial effects at the personal as well as social levels. She then continued, clarifying how the medications destined for public hospitals (nosokomekeia) had to be stored in the boxes kept under the table, while those sent from abroad had to be temporarily put aside in the ‘translation’ boxes (metafrasi) stored in a
corner of the room. On Friday, Christina a German-Greek woman with whom I also became quite close, would check and translate them into Greek. ‘Slowly you’ll learn how to read the medications. We will tell you more later’. At that point, Fotini handed me a small blue shopping bag full of medications and Despina gave me a pen: that was the ultimate sign that my training was finished, and I was finally ready to work as a volunteer.

Beyond the apparent disorder that I had initially perceived during my first days in the pharmacy, rational and precise procedures informed the volunteers’ work, and were meant to make good use of any minimal storage space the three rooms offered. Each and every corner was filled with cardboard boxes and shopping bags. A series of shelves running up to the ceiling were stuffed with plastic boxes in which blisters of medications had been carefully ordered. Each shelf and box was labelled with the latest date of expiration and the name of the medications it was meant to contain. As the youngest amongst the Tuesday’s and Friday’s volunteers, I was often asked to accomplish the tasks that my fellow volunteers found too physically demanding: climbing a trembling ladder to store boxes on the upper shelves was one of the main tasks I was routinely assigned, together with checking and ordering the smaller packages and blisters of medications in alphabetical order, according to the brand, the compound, and the expiration dates. However, as medications arrived randomly, I had often to undo the rows myself and my fellow volunteers had just ordered so as to put the new medications in the right place. Despite the efforts of the volunteers to keep the pharmacy tidy and ordered, the rooms were constantly on the verge of collapsing into a state of disorderliness: the perpetual cycle of receiving, rebranding, fixing, storing and handing out medications was strictly structured through rules and conventions so as to minimise the chaos.

Over fourteen months of fieldwork, I observed how many medications became familiar to me, and I was sometimes surprised by the ease and carelessness with which I handled some medications, or repaired torn blister packs and packages and rebranded some others. Medications became familiar objects as much as they were familiarised into a semi-medical environment.
as the pharmacy was supposed to be, but actually was not. The working table was disorderly: filled with blisters, small medical items of many sorts waiting to be checked and ordered, spare pills, vials, syrups, ointments and the like that were waiting to be checked and ordered. All these medical objects seemed to naturally integrate with the plastic containers of coffee, small boxes of baklava and sweets, and packs of cigarettes which were normally left on the table as tangible and mundane signs of the presence of the women. I consider these two apparently different orders of objects, which seemingly belonged to quite distinct spheres of sociality and materiality, as telling signs of what care was thought to be in its more mundane manifestations. I suggest that in the context of the social pharmacy, medications as well as coffee, sweets and cigarettes stood for the materiality and sociality of care in modes which resembled the domestic one.

In commenting on the reproduction of the domestic sphere in the context of a soup kitchen in Xanthi, northern Greece, Douzina Bakalaki (2017a) suggests that

‘the soup kitchen provided an extra domestic space for the performance of a certain kind of domesticity; crucially however this extra domestic domesticity did not confine these women to the household. Rather in becoming extracted into the public, domesticity provided a particular modality of engagement through which the cooks at the Bank of Love could escape the home and enter the domain of civic responsibility’ (2017a: 12).

In a similar vein, I suggest that the volunteers at the KIA engaged with the consequences of austerity through the modes and modalities available to them, and were thus contingent on their identities as housewives and mothers. In this sense, practices and socialities of care were extracted from the domestic and transferred into the semi-public. I argue that pharmaceuticals played a crucial role in the reconstitution of the domestic sphere into the semi-public arena of the social pharmacy.
In particular, my friend Ariadni’s statement alerted to the multiple positions and meanings that pharmaceuticals acquired, changed and retained, and how they travelled across different spheres of sociality while maintaining a certain continuity as a promise and a sign of care. In an effort to explain the important role that pharmaceuticals had amongst Greeks, especially Greek women, Ariadni said:

‘Each house has its ‘shrine’: the medicine chest in the bathroom. It’s very funny when women gather in someone’s house to have coffee together, because they immediately start talking about the pills they’re taking. My husband’s auntie used to take aspirin as a preventive medication. Coffee, cigarettes and aspirin: that was her elixir for a long healthy life. More than once she tried to convince me to take some. And couple of times, I also left her house with some aspirin.’

Ariadni’s description resonates with other stories I heard during my fieldwork and all centred on the quite common habits of sharing medical advice and medicines amongst women. As I will explain in detail in Chapter 5, the vast numbers of pharmaceuticals which arrived at the clinic on daily basis were mostly donated by private citizens, who had accumulated them over long span of time. As will be detailed in the next chapter, the uncontrolled prescription system and the practices of over-prescription contributed to the large accumulations of medications in each and every household. The presence of pharmaceuticals in different spheres of sociality can therefore be seen as an ethnographic cue for emergent forms of sociality as shown in this chapter, emerging modes of care (as detailed in Chapter 4) and as symptomatic of the novel relations between Greek people and state institutions (as in Chapter 5).

However, my informants’ familiarity with pharmaceuticals speaks also of the relationship between care, the state and the pharmaceutical market. Since the 1990s, controversial state policies relating to pharmaceutical pricing, distribution and prescription have been passed, all differently aimed at reducing people’s dependence on the public healthcare system by enticing practices of self- care. The wide-spread use of pharmaceuticals and over-the-
counter drugs coincided with the liberalisation of the pharmaceutical market in the late 1990s. In this same period, interestingly, lists of permissible over-the-counter drugs grew as a result of the state’s attempt to facilitate the expansion of the pharmaceutical industry. One of its main objectives was to fill the gap between urban and rural areas, including the remote islands. In fact, whereas the higher concentration of medical facilities and hospitals was peculiar to the former, infrastructural scarcity described the latter. Rural medical centres (agrotika) have long represented a never-fulfilled electoral promise, but in fact they never became operative. The widespread use of pharmaceuticals was therefore meant to enhance people’s practices of self-medication and reliance on pharmacists, rather than on proper healthcare facilities. Pharmacists in both rural areas and in urban neighbourhoods became the main health advisors and, as I was often told by my informants, they performed minor medical duties which should be carried out by doctors. In absence of a functional primary healthcare system and as a consequence of an uneven distribution of medical doctors across different areas, local pharmacists administrated medications to their customers, whom they had possibly known for a long time, and were able to follow the development of their health conditions.

Anthropological literature has already pointed out the existing relationship between sustained regimes of pharmaceutical self-medication and poor healthcare resources (among others.: Biehl 2004, 2005, 2010; Ecks 2005, 2013; Pinto 2014). Joao Biehl (2012) suggests that in the wake of Brazil’s fast paced neoliberalisation (2012: 246), pharmaceutical drugs are increasingly seen as substituting for care as relational practice: modern healthcare science has come to consider pharmaceuticals as synonymous with caregiving (2012: 251). Undoubtedly, Biehl’s argument of the increasing reliance and dependence on pharmaceuticals as contextual to the slow waning of medical infrastructures resonates with the Greek medical scenario. However, I contend that the pharmaceuticalization of care (Biehl 2007) was still experienced and perceived as a relational practice, at least amongst my Athenian informants. As such, practices and practicalities pertinent to pharmaceutical care were still performed by women who, as I have explained
in this chapter and will explore further in the next, take on the burden of care as newly shaped by the ‘materia medica available in a particular society or historical moment’ (Whyte, Van der Geest and Hardon 2002: 3). In this sense, women continued to perform the role of caregiver, as it was generally considered intrinsic to motherhood and womanhood. The labour that women were performing in the social pharmacy stood in continuity with the practices and relationalities of care as they were known and performed at the household level, across kin and amongst friends. Indeed, as Biehl (2012) also considers, in contexts of poor healthcare infrastructures family members are likely to learn to act as proxy clinicians.

**Care as unwaged work: shifting perspective on female labour of care and its reorganisation under austerity**

By ‘materialities of care’ Christina Buse, Daryl Martin and Sarah Nettleton (2018) point to the visible, mundane and often unnoticed aspects of material culture within the health and social care context. They argue that mundane materialities function as ‘a lens for (re)examining care practices in health and social care contexts. Attention to materialities can provide a way to make visible the ordinary, tacit and non-verbal aspects of care practices’ (2018: 245). Adding to the existing literature on care as form of labour and as social relatedness, the concept of ‘materialities of care’ provides a novel way to ground how practices of care unfold in their most mundane aspects, standing in for caring relationships and shaping, enabling or constraining practices of care. Approaching care through materialities enables an appreciation of care beyond what Arthur Kleinman (2013) describes as the moral experience of ‘doing good for others’ (2013: 1377). As emerged ethnographically, my female informants engaged with the most material and mundane aspects of care in a quasi-medical setting: the presence of the medications and how women handled them evoked a sense of care and relatedness that is often associated with the intangible qualities of the domestic space. As I have pointed out in previous sections, pharmaceuticals represented a ‘familiar frame of reference’ (Douzina Bakalaki 2017b) within which women could navigate and organise the social pharmacy. In the context of the social clinic, the labour of care unfolded, for instance, through repairing practices as my
fellow volunteers fixed torn blisters and packages, and through ordering activities which aimed to maintain the space temporarily neat and tidy. In this final section of this chapter, I look at the relationship between pharmaceuticals as familiar medical materialities, and practices of care as female labour.

Over fourteen months of fieldwork, I was constantly faced with seemingly contradictory attitudes, thoughts and behaviours from my female fellow volunteers. Complaints and laments about the burden of being a good housewife were uttered with what I understood to be something akin to pride. One woman’s stern comment about her demanding husband was met with general approval from the other women, who vehemently nodded their heads in understanding. Suggestions that I should never get married were followed by invitations to quickly change my status of single woman and find a husband soon. Taking care of relatives, children and the house were voiced as the most frustrating experiences a woman could ever have, however they were those same experiences that actually made them into proper women. The transition from a girl (koritsi) to a woman (ginaika) was seemingly marked by both the obligation to take on the burden of care for others and the capacity to cope with the boredom and repetitiveness of everyday domestic chores. Similarly, my informants complained about the repetitiveness of their volunteering activities, which were in fact interrupted by frequent breaks to grab a coffee and have a cigarette. Often, jokes about the unwaged work they were performing were whispered, and were actually signalling a certain intimacy between those who were sharing the jokes as well as a certain awareness of how their work was crucial to the provision of care, but actually often went unacknowledged.

Indeed, women’s everyday engagement with and dedication to the organisation of the pharmacy contributed to the expansion of the KIA’s net of donors, who considered the KIA to be the most accountable and reliable social clinic in Athens. Thanks to the women’s careful and constant work in organising the pharmacy, the KIA was able to store and provision vast amount of medications which were supplied to public hospitals in Athens as well as
across the Attika region. As laid out in Chapter 2, the relationship between the social clinic and public hospitals proved of some convenience for both the parties involved, beyond the KIA’s pragmatic declaration of no involvement with any state institutions. Nevertheless, the KIA supplied medications to public hospitals which became increasingly dependent on the KIA; the KIA was in turn supplied with medical services to which KIA patients had preferential access. Given the capacity of the social clinic to deliver its medical services and to ensure pharmaceutical coverage to an increasing number of people, it is reasonable to assume that the state should continue outsourcing the provision of primary healthcare to the KIA. A similar dynamic was observed by Andrea Muehlebach (2012, 2013) whose work in North Italy has offered a powerful cue to rethink the relationship between the voluntary sector and the state in a moment of neoliberal restructuring of its institutions. Muehlebach observes that the ever-expanding voluntary sector corresponded to the withdrawal of the Italian state from the provision of welfare services, which are in turn outsourced and taken on by different voluntary initiatives. What I want to highlight here is how crucial the labour of women is to the KIA’s expanding care capacity. However, their presence in the solidarity scene was often unrecognised, and their labour was rarely acknowledged as such. Rather, it was perceived in continuity with their roles of housewives as women, and ‘natural’ carers as mothers. Surprisingly though, they seemingly strove to live up to the expectations attached to their gender, rather than contesting them. Christina another fellow volunteer and close informant with whom I shared my Friday shifts, once described the pronounced gender imbalance in the clinic in rather bitter terms: ‘you see, most of the volunteers, we are all women. Still, the chief positions are all held by men who rarely show up at the clinic. When it comes to actual work, because we do actually work, it’s all on us.’ When I asked her what she thought was the reason for this situation, she answered that Greek women actually took pleasure in complaining, therefore their complaints should not be taken seriously. Christina was born in Germany, with a Greek father and a German mother, and she often put forwards her ‘German heritage’ to distance herself from situations or conversations she could not either understand or take part in.
Despite some initial perplexity about how to read the often contradictory explanations and behaviours of my female informants at the KIA, I later came to appreciate these statements through what Silvia Federici describes as reproductive work that, in the Italian scholar’s understanding, entails housework and domestic work, and actually contributes to a valorisation of women ‘not only in view of our integration in the labour market but also against it’ (2012: 2). In light of the process that I describe as an extraction of the domestic into a quasi-public sphere, the sexual division of labour as conjured up by the spatial organisation of the clinic actually provided women with the basis for a ‘intense female sociality and solidarity’ (Federici 2012: 25). In the context of the social clinic, women domesticated the pharmacy and disciplined the objects, pharmaceutical drugs and small medical items, by virtue of their skills as efficient housewives and their familiarity with different objects of care. I suggest that they capitalised on their virtues as good housewives to make visible and crucial their contribution to the successful functioning of the clinic. At the same time, their engagement with repairing and ordering the pharmaceuticals can be read as being in continuity with the practices of care as they were enacted within the household, amongst kin members, friends and neighbours. As briefly mentioned in the previous section, the greater availability of pharmaceuticals did not impact on the relations and practices of care, rather it contributed to reconfiguring them in light of the availability of newer medical technologies and ‘materia medica.’

Following on this note, the next chapter will look at how state healthcare policies concerning pharmaceuticals have progressively been absorbed into, and shaped, everyday practices of care. Drawing on the ethnographic material I mainly collected in a state-licensed pharmacy in popular neighbourhood of southern Athens, the chapter will unravel how my Athenian informants, mainly women, experienced and made sense of the economic and the medical crises. I suggest that they mobilised illness narratives and their needs for pharmaceuticals to make claims on the state: that is, to gain some degree of inclusion in the remainder of the public healthcare system. What I have described as the ‘will to be medicalised’ allows an interrogation of austerity
in its somatic aspects, while it also speaks of people’s strategic upending of illness narratives to negotiate access to pharmaceutical resources.
Chapter 4
The will to be medicalised: pharmaceutical compliance, chronicity and dependency.

Figure 8: Ethnographic encounters. (Drawn by the author)
The state of pharmacies

The phone rang for a long time before Viktoria picked up my call. Hesitantly, I introduced myself, then quickly explained to her that Despina, a mutual friend, had given me her number to arrange an appointment. Viktoria remained silent for a few seconds as if she needed some time to process all the information I had given her, then abruptly invited me to come to see her in two hours. Viktoria was the owner of a pharmacy in Neos Kosmos, with whom Despina had put me in touch as part of her efforts to help me with my fieldwork. ‘You can’t miss the chance to do some fieldwork in an actual pharmacy. You will see what effects the crisis had on retail’ Despina explained, and continued ‘The social pharmacies are a good initiative indeed, I appreciate it. But not everyone goes there. I assume that many people don’t even know they exist. And I also assume that many people feel ashamed of receiving leftover medicines from a social clinic. They call it solidarity, call it whatever you want, but at the end of the day it’s just charity.’ Although Despina’s comments sounded harsh, her argument was nevertheless reasonable.

Under the sharp sun of a March morning, I walked through the labyrinth-like neighbourhood of Neos Kosmos, dodging the cars parked on the footpath and squinting my eyes to read the names of the streets on the faded bluish plaques. When I turned into the street Viktoria had directed me to, I realised that there were five pharmacies open next to each other. As I later discovered, there was an average of 11,000 pharmacies in Greece, 3,739 of which were in the Attica region; including 134 hospital pharmacies and 44 social pharmacies (22 out of these 44 were in Athens). With an average of one pharmacy for every 1,200 people (Vandoros and Stargardt 2013), the amount of pharmacies I had stumbled across on my way through Neos Kosmos seemed reasonable. Neos Kosmos is in fact one of the most densely populated neighbourhoods in Athens.16

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16 According to ELSTAT, in 2015 there were 10,380 pharmacies operating in Greece, or 9.5 pharmacies per 10,000 inhabitants. See: http://www.kathimerini.gr/881012/article/epikairotita/ellada/95-farmakeia-ana-10000-katoikys-sfth-ellada-to-2015

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Once in front of Viktoria’s pharmacy, I stood by the main door and glanced inside. The shop was empty and I could not see anyone behind the counter. I timidly walked in, and looked around suspiciously. The shelves running along the walls were mainly empty and covered in dust. Only a few items were laid out on a few precarious stands by the counter. While I was reflecting on my next move, Viktoria appeared from the backroom and stood uncertainly while staring at me. ‘I’m Letizia. I called you early this morning’ I informed her. Viktoria bent her head to the side, as if to better make sense of my presence there: ‘Ah, it’s you. Give me a second and then we will talk, although I am not sure what we can talk about. Wait.’ She turned her back to me and walked into the backroom again. I waited a couple of minutes during which I walked between the shelves and looked at the products on display there: they were mainly homeopathic remedies, infusions, and cosmetic creams. All of a sudden, the description of empty pharmacies and the shortage of medications that had filled the chronicles of the Greek crisis appeared true to me too.

When Viktoria appeared again behind the counter, she apologised for making me wait and explained that she had to take care of four cats that were living in the storeroom of the pharmacy. While she was recounting to me the sad biography of each of her cats, an old man walked through the door and with a shaky stride approached at the counter. Viktoria welcomed him in a friendly way and asked him how he was today. He complained about his health and remarked that the medications the doctor had prescribed to him were not working at all: ‘It made me dizzy [zalizomai], and I have nausea [anagoula]’. Then he handed Viktoria a small plastic shopping bag (sakoula) filled with some blister packs (koutia), and a prescription (syntagi). Viktoria took the bag, thanked him and stored it underneath the counter, then she quickly read the prescription. ‘I have to order this. I don’t have it right now, at least not in

the dosage you need. Come back tomorrow, at around this time. And hopefully we’ll have what you need’ she said. The old man smiled and thanked Vicky. Before turning towards the door, as if he wanted to be sure that Viktoria would promptly forward his order, he mentioned again how bad he felt and how much those medications were needed. Viktoria patiently reassured him that she would not forget his order and she was in fact forwarding it to the pharmaceutical provider at that moment.

At that point I was already quite curious about the small bag that the man had just handed to Viktoria, because I had never seen someone returning medications to a pharmacy. She anticipated my questions and exclaimed:

‘Ah you see! You are quite lucky! As you arrived, you saw one of the most common scenes in Greece: people come to my pharmacy, complain about their doctors and decide to change their therapies, out of the blue! You saw the man that has just left? He gave me back five boxes of Tritace. He said that the dosage is not working for him. Could you understand what he said? He said that his doctor prescribed him the wrong dosage which he stayed on for a couple of weeks, then he decided to return to his previous regime with a bigger dosage and you know what? He probably went to another doctor to have it changed.’

I nodded at Viktoria’s words, but felt compelled to admit that I had not perfectly understood what the man had said. She explained:

‘They all say the same thing. They complain all the time. They are the patient and the doctor at the same time. They go to the doctor just to confirm their theories that doctors don’t know anything. Then they start complaining again, and they often yell at me, if I dare to say that perhaps the doctor is right, that what they are prescribed is actually right too, or that they don’t actually need that precise medication.’

Later that morning, when I told Viktoria about my fieldwork at the social clinic in southern Athens, she disappeared beneath the counter and remerged a few seconds later. ‘Take this bag! It is Tritace, the Tritace the man had just
returned, and you see, the blisters are almost new. You can bring them to the clinic and donate them to the social pharmacy. At least they won’t go to waste. I am sure lots of Greeks need it. It’s one of their favourite drugs!’ Viktoria added sarcastically. I took the bag and thanked Viktoria for the donation and the nice chat we had just had. From our first meeting in March 2016, I returned to her pharmacy almost every week until the end of my fieldwork in January 2017.

As I later discovered, one of the most common side-effects of Tritace is dizziness and, as also reported on the package, its posology (dosage regulation) needs to be gradually adjusted to the patient’s needs under the doctor’s supervision. However, many people with diverse medical conditions and on diverse therapeutic regimes, such as the man who walked into Viktoria’s pharmacy, tended to autonomously adjust their own therapies according to their bodily experience of certain symptoms. Viktoria’s comment about Tritace being a very common medication amongst Greeks also gave me a crucial ethnographic cue which helped me better make sense of the presence, circulation and consumption of different classes of medications at the KIA. Amongst them, Tritace and Lasix seemed to be the

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18 Tritace is an angiotensin converting enzyme inhibitor. By inhibiting an enzyme, ACE inhibitors relax the muscles around small arteries. The arterioles expand and allow blood to flow through more easily. Tritace contains ramipril and is used for the treatment of hypertension, cardiovascular prevention and renal diseases. It is also used in the treatment of symptomatic heart failure and for secondary prevention after acute myocardial infarction. Amongst the most common side-effects, metabolism and nutritional disorders as blood potassium increases are recorded; headache and dizziness are the most common amongst the side-effects relative to nervous system disorders. Vascular disorders such as hypotension, orthostatic blood pressure decrease and syncope occur. Non-productive tickling cough, bronchitis, sinusitis and dyspnoea are the most common side effects affecting the respiratory, thoracic and mediastinal apparatus. Gastrointestinal inflammation, digestive disturbances, abdominal discomfort, dyspepsia, diarrhoea, nausea and vomiting are listed amongst the gastrointestinal disorders that Tritace may provoke. See also: https://www.ema.europa.eu/en/medicines/human/referrals/tritace

19 Lasix (furosemide) is a loop diuretic (water pills) which reduces the amount of water in the body by increasing the flow of urine. It is a prescription drug used to eliminate extra water and salt in people who have problems with fluid retention. Swelling and fluid retention—also known as oedema—can be caused by congestive heart failure, liver or kidney disease, as well as other conditions. Lasix is also used on its own or together with other drugs to treat high blood pressure (hypertension). Elderly patients taking Lasix are more likely to have age-related liver, kidney or heart problems.
predominant medicines, as the massive quantities of these drugs donated to and stored in the self-organised healthcare facility clearly suggested.

After some online research including pharmaceutical blogs and different patients’ online fora, I learned that Tritace and Lasix are used to treat chronic conditions: the former to treat hypertension associated with symptomatic heart failure; and the latter, hypertension associated with kidney disease. Interestingly enough, hypertension and the consumption of these two medications assumed quite a clear gendered aspect, at least in Greece: as one of my informants in the social clinic explained, ‘mainly men take Lasix’ (Chapter 5). Indeed, when not associated with genetic factors, hypertension has a rather gendered incidence, with Greek men being more likely to develop it over the course of their lifetime because of harmful smoking habits and alcohol consumption. The scientific literature on minor chronic diseases has extensively detailed how secondary hypertension is in fact generally associated with behavioural factors which encourage obesity and with a sedentary lifestyle and stress (Janes, Stall and Gifford 1986).

As I also discovered from my online investigations, medications such as Tritace and Lasix work on the management of the health risks associated with heart or kidney failure as consequences of hypertension. In this sense, chronicity no longer refers to a medical condition, rather to the therapeutic regimes needed to manage health risks. The shifting attention from ‘being healthy’ to ‘being at risk’ has been signalled as indicative of an epistemological change occurring in the field of medicine; in particular, Joseph Dumit (2012) argues that today’s medicine is no longer concerned with enhancing individual health, but rather with managing and limiting health risks. There are quantifiable thresholds connecting, for instance, cholesterol levels to heart conditions, glucose levels to diabetes or blood pressure to hypertension. Patients with these conditions ‘are not cured nor [do] they die’ (Hardon and Sanabria 2017: 121): they just take ‘drugs for life’ (Dumit 2012). In fact, patients at risk can be treated indefinitely, therefore representing a particularly profitable market segment for pharmaceutical corporations. Crucially though, Dumit points out that health risks themselves
can be highly flexible: the numeric thresholds defining diabetes, hypertension and high cholesterol have been repeatedly pushed downwards over the past decade. New medications in new dosages have constantly been thrown into the market in order to tap into the new diagnostic categories that have been opened up by newly updated criteria for health and risk assessment.

While the vast amount of Tritace and Lasix that was stocked up in the social pharmacy definitely speaks to this trend about pharmaceutical therapeutic regimes, I suggest that it also hints at the entanglement of state health policies, structural flaws in the delivery of medical care, and market dynamics. Accordingly, I consider the opening vignette of this chapter as revealing of the double meaning of chronicity, which can here be referred to both as people’s medical condition per se, and the therapeutic treatment they comply with, in terms of self-diagnosis and self-medication. I suggest that paying ethnographic attention to practices of self-diagnosis and self-medication creates a space for rethinking how power relations between patients and doctors operate in a moment when many Greeks show a deeply medicalised understanding of their body, and doctors were increasingly seen as part of an even more inefficient and inadequate public healthcare system. The medical authority retained by doctors was contested and contrasted with the bodily experience of certain symptoms, which needed to be fixed through progressive adjustments of their pharmaceutical regimes. Furthermore, people’s needs and desires for pharmaceuticals and their inability to obtain them for free, as they used to before the crisis, seem to point to some structural changes which have occurred at the state level. As I will show in the following sections of this chapter, access to pharmaceuticals represents the battleground over which many Athenians tried to negotiate better degrees of inclusion in the meagre remains of the public healthcare system. I suggest that the scarcity of pharmaceuticals and the presence of escalating symptoms offered terms and means of contestations with which many Athenians could make claims on the state.

In his ethnographic exploration of health and medicine in Cuba in the late 1990s, P. Sean Botherton (2012) looks at the everyday pragmatic strategies
people engage with in order to negotiate the role of the state in providing health and social welfare. He suggests that in the context of escalating economic scarcity, the body became a diagnostic map of the crisis Cuba was experiencing in the aftermath of the collapse of the Soviet Union and the implementation of US sanctions. In Cuba, Brotherton clarifies, the shortages of pharmaceuticals and medical equipment compromised the ability of the Cuban state to guarantee universal healthcare. In the midst of dramatic socioeconomic changes, access to biomedicine was increasingly being made conditional upon individual economic capacity. Brotherton shows how many Cubans’ lives began to revolve increasingly around obtaining and trading pharmaceuticals and medical supplies, self-diagnosing and self-medicating in an everyday battle to meet their medical needs; at the same time, the transformation of the Cuban healthcare system was experienced by people as a loss and a betrayal by the state.

Following Brotherton, in this chapter I address pharmaceutical consumption and circulation in contemporary Athens. While the mapping of the circulation and consumption of pharmaceuticals allows a provisional assessment of the relationship between the state and the population, it also opens up spaces to investigate an emerging ‘values gap, whose symptoms include the growing division between populations that have access to drugs and the ability to pay for them, and populations that have neither and must rely on some other form of distribution’ (Petryna, Lakoff and Kleinmann 2006: 6). I draw on the long-term ethnographic fieldwork I conducted in a social pharmacy (Chapter 2 and Chapter 3) and in a state-licensed pharmacy in Athens, in order to develop further the debate that Adriana Petryna, Andrew Lakoff and Arthur Kleinman (2006) proposed on differential access to new medical technologies and the complex care delivery systems, the role of state and non-state actors in securing ‘health’ as a fundamental good and right of citizens.

By paying ethnographic attention to ‘the somatic mode of symptom formation as an idiom of interpersonal distress that reflects patients’ embeddedness in political and social processes foregrounding the body’ (Davis 2012: 133), I look at how my informants foregrounded their desire for state care through
escalating symptoms of distress and complaints about accessing pharmaceuticals. I argue that Athenians increasingly crafted their demand for state care through their demand for pharmaceuticals, which could in turn act upon their symptoms. In this context, pharmaceuticals offered them a ground upon which symptoms, rather than illness, become a mode of suffering from the crisis and a source of entitlement to claim state care.

**How illness interrogates austerity in its somatic aspects: dependence, chronicity and pharmaceutical scarcity**

‘I was impressed. Honestly, I was shocked by the amount of Lexotanil stored in the social pharmacy’ I tried to explain to Angeliki, one of my closest friends in Athens. Angeliki had herself volunteered at the KIA for some time, on her mother’s suggestion. Her mother, Eirini, was a medical doctor who had volunteered at the KIA between 2011 and 2014. As Angeliki did not seem at all surprised by my revelation, nor did she share my curiosity about the quantities of Lexotanil, I felt compelled to further explain my surprise. ‘It’s so weird. Didn’t you notice it? I have never seen anything like that. In Italy you need a medical prescription to get Lexotanil. Do you need any prescription here?’ Again my words had no effect on my friend who, quite indifferent to my concerns, continued to roll her cigarette. She looked at me perplexedly, while I continued my monologue on Lexotanil: ‘Angeliki, believe me, that’s disconcerting! Lexotanil is psychiatric stuff; it’s basically an antidepressant. You can’t guess how much Lexotanil I see flowing into the social pharmacy. As if more than half of Greece suffers from depression or anxiety. Or does it?’ I insisted, actually unable to make sense of the amount of Lexotanil blisters I had checked in to the social pharmacy that day. Furthermore, contrary to my expectations, Lexotanil was not stored on the same shelf where psychiatric medications were normally stored (as detailed in Chapter 3): this meant that it could be given without medical prescription. I wondered how Angeliki had not noticed this.

She finally responded to my questions with an impassive expression on her face: ‘Why are you so surprised? Also my mum, and she is a doctor, takes Lexotanil. I think she has been taking it for twenty years.’ Angeliki’s remarks
on her mother made me feel awkward, as if with my bad joke I may have inadvertently offended her or overlooked her mother’s condition. She continued:

‘Half a pill, every night before going to sleep. Nothing serious, really. Everyone does it here. Especially women. It’s not really about being sick, or depressed. It’s just that it helps you to sleep. It helps you with anxiety. I always tell my mum to quit coffee and her anxiety would probably reduce. But you see, all the Greek women are doctors and mothers, and would never accept suggestions from their kids. And I will you something else: you don’t need a prescription to get Lexotanil here. I mean, you would actually need it, but normally you go to the pharmacy in your neighbourhood [sto pharmakeio tis getonias sou], you know the pharmacist and the pharmacist knows you. You know what this means? It means that everyone tells the pharmacist that she will bring the prescription later. Then they never bring the prescription. No one cares, no one controls it. As long as you pay for the pills, no one gets upset. And I am going to tell you also something else, just to feed a little bit more your medical anthropology fantasies.’

In her deep and rough voice, Angeliki revealed that in Athens one could go to ‘her’ pharmacy and ask for just two or three pills, or for a partial refill of the drug she needed.

A few days after my conversation with Angeliki, I started investigating what my fellow volunteers in the social clinic thought of Lexotanil, and what kind of explanations they had for the vast amount of Lexotanil that was stocked up in the pharmacy. ‘What’s Lexotanil for?’ I kept on asking, but my question was always met with a mix of indifference and perplexity: ‘Why are you asking? Don’t people use Lexotanil in Italy?’ One of the KIA pharmacists, Eugenia, who was quite curious about my research and spent a fair amount of her time in answering my questions, cut it short: ‘Lexotanil is just Lexotanil,
and is good for your nerves [sta nevra sas]’. When I asked her what was the reason for the vast amount of Lexotanil that was being donated to the KIA, she admitted that she had never thought about it. She shrugged in an attempt to give me a reasonable answer: ‘It is very common in Greece, to have Lexotanil at home. Everyone has it at home. Perhaps because everyone at any time might need it.’

As Angeliki’s account suggested, the distribution of Lexotanil often took place without a prescription, and in fact it could easily be purchased from the pharmacy. A study conducted in Crete about people’s attitude towards medications suggest that pharmaceuticals easily purchasable from pharmacies were perceived as less harmful and safer: had they endangered people’s health, their distribution would have been regulated differently (Tsiligianni et al. 2012). However, people’s familiarity with Lexotanil and the ease with which it could be purchased should not imply that the medication was actually safe. Rather, the dependency Lexotanil creates reveals how new patterns of chronicity can develop out of local configurations and culturally situated understandings of care and health. As reported on its posology, Lexotanil is generally prescribed for short term relief to occasional states of anxiety. In fact, many of my informants reported how they themselves, or some of their relatives or acquaintances, had become heavily dependent on Lexotanil: the withdrawal symptoms were strong enough to create chronicity out of dependence, both psychological and physical. Furthermore, adjustments in the dosage were likely to occur in order to maintain the effectiveness of Lexotanil on symptoms. The literature on medical drugs belonging to the bromazepan class clarifies that the body easily adapts to new dosages; and so the dose needs to be progressively increased in order for the medication to continue to be effective. Crucially, since the onset

20 Bromazepam (sold under the names Lectopam, Lexotan, Lexilium, Lexaurin, Brazepam, Rekotnil, Bromaze, Somalium and Lexotanil) is a benzodiazepine derivative drug, patented by Roche in 1963 and developed clinically in the 1970s. It is mainly an anti-anxiety agent with similar effects to diazepam (valium). In addition to being used to treat anxiety and panic states, bromazepam may be used as a pre-medication prior to minor surgery. Bromazepam typically comes in doses of 3mg and 6mg tablets. [source https://wikipedia.org/wiki/Bromazepam]
of the 2009 crisis, mental distress associated with depressive and anxious conditions was said to have increased dramatically, as did the demand for and consumption of psychiatric medications (Simou and Koutsogeorgou 2014; Christodoulou 2017. See also Davis 2012 for an anthropologically informed approach to the mental health crisis and suicide epidemic in Greece).

At a moment when the public healthcare services were being curtailed and access to state care was made increasingly conditional on private insurance or individual wealth, pharmacies became places to which practices of care were relocated, and where quick and cheap therapeutic solutions could be more easily found. With regard to the specific role that pharmacies and pharmacists occupy in a context where pharmaceutical shortages are more likely and access to healthcare resources is uneven, Whyte, Van der Geest and Hardon (2002) suggest that pharmacies may function as part of the informal sector. They argue that in some pharmacies, medications are transacted in ways that do not necessarily adhere to standard protocol: pharmacists are part of the local community, therefore they are more likely to share local ideas about medications and to be more available to dispense them to meet people’s need for pharmaceuticals. Rather than following strict guidelines relative to medical prescriptions, pharmacists trust people’s self-diagnosis and comply with their requests for pharmaceuticals.

Whyte et al.’s analysis seems particularly apt for exploring paths and patterns of pharmaceuticals and pharmaceutical consumption in a moment where pharmacies became the most easily accessible place to which people can refer when in distress. In this vein, I suggest that, on the one hand, the predominance of certain medications, for instance Lexotanil, speaks of the relations between symptoms, pharmaceutical availability, and scarcity. On the other, it points to how the distribution and circulation of certain medications affected people’s understanding of their conditions by recognising and acting upon their symptoms. Following from this consideration, I am not interested in the medical and cultural history of nevra, but rather in exploring how Lexotanil offered nevra new, loose diagnostic categories, and gave way to novel medical discourses through which people
could interrogate, and eventually make sense of, the pharmaceutical scarcity that the crisis and then austerity then had brought about.

In his blog post ‘Athens, city of Xanax’, Greek psychologist Dimitris Petrounias\(^{21}\) (2016) reports that the consumption of Xanax and Lexotanil has skyrocketed since the onset of the 2009 crisis, and suggests that doctors hold the biggest share of responsibility for patients’ overconsumption of Xanax\(^ {22}\) and Lexotanil. These medications, Petrounias clarifies, are part of many households’ first aid kit. He also claims that for many people, their first contact with these medications occurred at home, with either a relative or a friend offering a pill as a quick fix for occasional states of depression or anxiety. Petrounias’ analysis resonates with some of my informants’ and friends’ stories about pharmaceuticals, particularly Lexotanil. In different circumstances, some of them described Lexotanil as ‘the housewife’s pill’ (\textit{xapi tis nikokyrias}). In particular, my friend Yorgos explained that women suffer from ‘nerves’ more than men, and they normally respond better to Lexotanil than men would do. He recounted how, in a moment of deep distress and anxiety after his father’s death, his mother gave him half a Lexotanil pill and he immediately fell into a lethargic state from which he only recovered after two days. He told me: ‘I think my mother is addicted to it, she just thinks that if it works for her nerves, it works for anybody else. I took it once and I felt like death for two days.’ When I asked him what he meant by ‘nerves’ and why he thought that women suffered from ‘nerves’ more than men, he laughed loudly. ‘I don’t know. Nerves are nerves, but Greek women also love to complain. And go mad easily.’ When I asked him

\(21\) \url{https://dimitrispetrounias.gr/Xanax/2016/} [in Greek]

\(22\) Xanax (Alprazolam) is used to treat anxiety associated with depression, repeated episodes of anxiety, and panic disorders. It belongs to a class of medications called benzodiazepines which act on the brain and nerves (central nervous system) to produce a calming effect. It works by enhancing the effects of a certain natural chemical in the body (GABA). Its dosage is based on the individual’s medical condition, age, and response to treatment. The dose may be gradually increased until the drug starts working well under the doctor’s supervision. Xanax may cause withdrawal effects, especially if it has been used regularly for a long time or in high doses. In such cases, withdrawal symptoms (such as seizures) may occur if one suddenly stops taking the medication. To prevent withdrawal reactions, the doctor may reduce the dose gradually. Xanax can cause addiction, and therefore it must be taken following a doctor’s prescription.
again whether nerves were just a women’s thing, he took some time to think about his answer, and replied ‘Not necessarily. Men suffer from nerves sometimes, and the pill, the Lexotanil thing, it is just a superficial fix, it’s just a denial of the reality.’

In her ethnography on the multiple ideologies of person, gender and community in a Northern Greek town, Cowan (1990) suggests that ‘to do something ‘from nerves’ (apo nevra) is to act out of bottled-up anger, anxiety, worry or upset’ (1990: 218). Cowan’s explanation resonates with Margareth Lock and Wakewich’s (1990) description of the experience of nerves amongst Greek immigrant women in Montreal. According to their ethnographic survey, nevra ‘is usually described as a feeling of bursting out, breaking out or boiling over; an experience, therefore, of crossing the natural boundaries between inside and out; between a controlled and an unruly body’ (1990: 238). While ethnographically tracing the changes in the political and biomedical landscape that underlay the delivery of mental health services in North Greece, Elisabeth Ann Davis (2012) contests the hypothesis that nerves (nevra) and depressive anxiety (stenoxoría) are culture bound syndromes, as has long been posited by much of the medical anthropology of Greece. This literature has generally related the idioms of nevra to traditional forms of emotional distress and restrictive socio-political conditions of life. According to this interpretation, nevra is seen as women’s coping mechanism and resistance to cultural and gendered expectations, which have long been interpreted in terms of honour (filotimo) and shame (dropi) and the pressures of modernisation (Lock and Wakewich 1990; see also Herzfeld 1980 for a thoughtful analysis of the above-mentioned concepts). Shifting her analysis beyond ‘the circum-Mediterranean region’ (Herzfeld 1980: 340), Davis suggests that depressive anxiety and nerves are cross-cultural syndromes (see also: Han 2012; Scheper-Hughes 1992), and represent a deeply gendered strategy for communicating distress (Davis 2012: 133). Women, Davis argues, tend to deny ‘the nature of their psychological problems and tend instead to express them through the unwitting complaints of their bodies’ (2012: 126).
Complaints expressed through the body are manifested as symptoms that, in turn, require a quick solution which is seemingly provided by readily available pharmaceuticals, either in the household or from the local pharmacy. Following on from this consideration I suggest that vernacular discourses about *nevra* progressively acquired medical legitimacy, once Lexotanil had become a common prescription drug on which doctors relied to treat those patients who experienced forms of distress. As Lexotanil infiltrated many people’s everyday lives and increasingly offered a pharmacological solution to their symptoms of *nevra*, medical discourses of Lexotanil became vernacular. This does not mean that Lexotanil as a medication lost its medical legitimacy, but rather that it increasingly gained it as it became more and more popular amongst people. When *nevra* is described as ‘the feeling of losing control, of having one’s nerves burst out or boil over. An attack is often accompanied by shouting or screaming or throwing things. Headaches, dizziness, pain and feelings of melancholy are associated with *nevra*’ (Lock and Wakewich 1990: 254), Lexotanil is readily prescribed, or easy to obtain in order to treat occasional depressive states, anxiety and panic states.

With specific ethnographic attention to symptoms, Veena Das and Ranendra K. Das (2006) argue that symptoms, their causes and their phenomenology, are deeply ingrained in people’s local worlds where meanings of suffering and diseases criss-cross local pharmaceutical providers, labour regimes and family arrangements. They suggest that pharmaceuticals must be accounted for in ‘the register of locals’ (2006: 172); or, more simply, through a thoughtful contextualisation of pharmaceuticals, and their circulation and consumption within a specific ‘local niche of care’ (2006: 27). By this term, Das and Das refer to specific experiences of care as it is rationed according to cash flow, to the proximity and accessibility of healthcare facilities, labour regimes and kinship relations. These factors, Das and Das explain, may have a dramatic impact on shaping practices of care, which are in fact increasingly oriented towards pharmaceuticals. In contexts where pharmaceutical resources are more readily available or represent the most effective strategy...
to control the illness, biomedical and anthropological definitions and meanings of self-medication exceed the concept non-compliance.

Compliance has generally been defined as ‘the extent to which a person’s behaviour (in terms of taking medications, following diets, or executing lifestyle changes) coincides with medical or health advice’ (Jay, Litt and Durant 1984). Das and Das (2006) suggest that self-medication as a mode of non-compliance with therapeutic regimes is often seen as only endangering one’s health. Actually, patterns of non-compliance with therapeutic regimes may be revealing of different modes of inhabiting and coping with the illness under certain socio-economic conditions. In the specific context of Athens, self-medication manifests as a novel mode of care which was made possible by the wider circulation of pharmaceuticals between households, among relatives and friends (see also Han 2012, 2013), and in the market (see, i.e. Ecks 2005). Given the historical and socio-economic specificity of austerity-laden Athens, where narratives and experiences of pharmaceutical scarcity intersected with illness narratives and complaints about state care, I suggest that self-medication actually becomes a mode of compliance. Examining this more closely, my informants’ complaints about pharmaceuticals highlights their desires and fears about their health (Das and Das 2006); at the same time, these stories are revelatory of their expectations and desires about state care (see for example Biehl 2004b). At a moment when pharmaceutical scarcity has been read as a failure of the state, I suggest that people’s desire for pharmaceuticals, and their will to be complaint with pharmaceutical regimes, represents an effective way to contest the state’s curtailment of funds for pharmaceutical expenses.

‘Through illness you can perceive the state’

Angeliki and Yorgos, like many other of my friends and informants in Athens, pointed out to me that medications were widely circulated between households, where they were mainly exchanged among women; apparently, women also gave each other suggestions about what therapy would better suit them according to their symptoms. This greater availability of and familiarity
with pharmaceuticals contrasted with many accounts of the pharmaceutical crisis that Greece has been experiencing for nearly decade. The economic crisis and the structural adjustment that followed since 2010 deeply impacted both the healthcare system (which has increasingly been tied to private insurance), and the provision of pharmaceuticals (which had previously been operated through a state refunding mechanism). In light of this, I suggest that the pharmaceutical crisis that Greece has experienced in the past nine years represents an unusual angle for an inquiry into the relation between the economic crisis, state health policies, and people’s experiences of both. 

In the five years prior to the economic crisis, total pharmaceutical expenditure in Greece almost doubled from 4.329 billion Euros in 2004 to 7.788 billion in 2008. In the same period, the pharmaceutical expenditure of the public system (namely the social insurance funds) increased from 2.4 billion in 2004 to 4.53 billion in 2008, and skyrocketed to 5.1 billion in 2009. The pharmaceutical expenditure per capita increased from less than 200 euros in 2000 to 700 euros in 2008 (Vandoros and Stargardt 2013). The reasons behind Greece’s high level of pharmaceutical expenditure are generally explained as the lack of measures promoting generics, electronic prescribing and prescription monitoring. Also, the relatively high price of generics is said to have negatively impacted the state budget, as did the high volume of prescriptions. At the same time, doctors tended to prescribe exclusively by brand name, therefore generics had never become a larger portion of the pharmaceutical market. Sotiris Vandoros and Tom Stargardt (2013) suggest that corruption also contributed to high pharmaceutical spending in Greece, where the unnecessary prescription of particular medications is said to have been incentivised through bribes paid to doctors by big pharma sale representatives. Furthermore, the abolition of the positive list in 2006 further contributed to the rising pharmaceutical expenditure; this meant that

23 The same study conducted by Vandors and Stargardt (2013) reports that there have been cases of suspiciously high prescription volumes and prescriptions for people who have already died. These cases have been listed and reported in the annual report of the General Inspector of Public Administration. However, it is difficult to quantify the effect on the total spending due to the unrecorded nature of such activities. Corruption, however, seems to be a widespread practice in healthcare in Greece, and it is not restricted only to pharmaceuticals. Informal payments by patients to doctors for hospital treatments are said to occur frequently.
any medication could be reimbursed. In 2007, for instance, Greece had the highest rate of antibiotic consumption per capita amongst the OECD countries. The substitution of older and cheaper drugs with newer and more expensive ones was also considered to be partially responsible for the rise of the pharmaceutical expenditure (Vandoros and Stargardt 2013). In order to comply with the demands of the Troika, in 2011 the Greek state started enacting several cost-containment measures aimed at the reduction of expenditure, and included price cuts and the reintroduction of a positive list of all the reimbursable pharmaceuticals. With the introduction of these measures, access to certain classes of medications depended on cash flows rather than on need, budget impact or effectiveness (Vandoros and Stargardt 2013).

Although an actual shortage of medications did occur, with big pharmaceutical firms stopping the provision of medications, it was rather people’s inability to pay for their own pharmaceutical regimes that caused a sudden drop in medical consumption. This in turn affected the volume of requests for medications every pharmacy used to receive from customers and which pharmacists often had to pay for in advance. In fact, before 2011, pharmacists obtained refunding from the state-funded insurance (IKA). As the public healthcare system became increasingly tied to the private insurance system, more and more people were no longer able to afford to pay, because of the lowering of wages or unemployment: payments and refunding were increasingly delayed, and pharmacies were under the constant threat of becoming insolvent and being seized by the banks to which pharmacists often turned in order to get loans and keep their shops open. Viktoria told me that she herself was on the brink of having her shop seized by the bank:

‘My name ended up on the bank’s black book. I was on the verge of losing everything: I became indebted to my family and to my partner, and spiralled downwards into even worse debt when I turned to the bank. I needed money to pay the pharmaceutical providers while waiting for the state’s refunding. Customers were unable to pay for the medications they needed; they were waiting for
the state insurance refunds as well. Payments were delayed for six, seven months and we were all waiting to get money back: I was waiting for money to keep my shop going, my customers were waiting for the money to afford the medications they needed. At that point, I did not realise that the crisis was going to be so tough. I am not sure things are going actually better now. Anyway, I am now taking daily orders - I mean people come here, make their request, they pay and I forward the order to the provider. It’s safer for me, financially speaking.24

According to Viktoria, she, like many other pharmacists in Athens, went into debt to their families first, and to banks later, in order to pay their debts to pharmaceuticals providers, while waiting for the state’s refunds. When a drastic drop in healthcare expenses per capita occurred, it was coupled with many people’s increasing reliance on non-state circuits of healthcare provision. I suggest that the retreat of the state from the provision of healthcare resources, pharmaceuticals and medical services in general, resulted in new modes of dependencies - economic, relational and pharmaceutical: resorting to pharmaceutical solutions was indeed the most efficient strategy to cope with the effects that the crisis had on people’s health and their increased needs for medical care in a moment when the state care services were axed in an effort to reduce the public debt.

However, the reliance on pharmaceutical solutions was not a completely new mode of care in the Greek landscape: in an attempt to close the rural-urban divide, in 1983 the PASOK-led government instituted the national healthcare system. Statute 1397 was meant to consolidate and extend the primary

24 Vandoros and Stargardt (2013) also explain that pharmacy mark-ups are currently 35% but are expected to be reduced. Also a rebate from pharmacist to social insurance funds has been implemented for products whose price exceeds 2000 Euros. The rebate varies progressively from 1.5% to 8%, depending on the price of the product. In addition, wholesaler margins have been decreased from 7.8% to 5.4% for prescription drugs. Despite the high concentration of pharmacies, the Ministry of Health has announced that 1,000 – 1,200 new pharmacy licenses will be issued to further increase competition in the pharmacy market. While such an initiative will increase access to care from the patient’s perspective, it will not reduce prices of pharmaceuticals as retail prices on the pharmacy level are a fixed function of manufacturer prices. Moreover, as pharmaceutical consumption in terms of volume is already very high, more pharmacies may lead to supplier-induced increases in demand (2013:3).
healthcare network that had been instituted in 1956: it was made compulsory by law that all the Greek medical school graduates would spend a year doing community medical service (a rural year, agrotiko). Young doctors were responsible for one or more remote villages, where they arrived equipped with insufficient medical equipment, a first aid kit and common analgesics and antibiotics (Davis 2012). As also emerged from the interview I conducted in November 2016 with Charalampos Oikonomou, Professor of Sociology of health at Panteion University of Athens, the reliance on pharmacological therapies was particularly strong and diffused in remote villages and islands: far from urban healthcare facilities, pharmacists often acted as a proxy doctor, dispensing symptomatic therapies and medications. The sale of and access to medications was initially facilitated by both the liberalisation of the pharmaceutical market in the 1990s and the wider distribution of over-the-counter medications. Easier access to over-the-counter (OTC) was primarily meant to reduce the burden for the primary healthcare sector (Tsiligianni et al. 2012).

According to a survey conducted in two separate areas in Crete, the accessibility of OTC medications frequently resulted, on the one hand, in polypharmacy, the inappropriate use of medications and increased risk of adverse effects and, on the other, in practices of stockpiling medications in the household for both current use and anticipated illness (Tsiligianni et al. 2011). Furthermore, the same study reports that the medications stored in large quantities were likely to be exchanged among relatives and between households, among friends and neighbours alike: antibiotics and analgesics in particular were exchanged for use in the event of future symptoms. Those classes of medications had been purchased from a pharmacist with no medical prescription. According to the same survey, medications with cardiovascular agents (56%), with endocrine agents (12%) and nervous systems agents (10%) were the most commonly stockpiled in the surveyed households. Although the above-mentioned survey refers to Crete, the regional data seems to align with a national trend. The Health Minister Andreas Loverdos reported
in 2012 that four in ten Greek households were sitting on quantities of unused drugs, with an estimated total value that exceeded one billion euro.25

In this context, it is reasonable to assume that the pharmaceuticals that had previously been bought and stored in households served people’s medical needs for some time after the onset of the 2009 crisis and the implementation of those austerity measures which impacted on the state-funded healthcare services. Given also the widespread tendency amongst Greeks towards polypharmacy and practices of self-medication, it is likely that the vast amount of medications that had been amassed in the households were later put into the circuit of social pharmacies. As also emerged ethnographically, the medications that arrived at the social pharmacy of the social clinic not only belonged to the drug classes that the survey indicated as the most commonly purchased and stockpiled, but their blisters were often only half-used, as if there had been a sudden change in the therapeutic regimen: the opening vignette of this chapter is again revelatory of this dynamic, where practices of self-medication intersected with state policies regarding the distribution of pharmaceuticals.

In this sense, having my fieldwork dislocated across the self-organised social pharmacy and Viktoria’s state-licensed pharmacy helped me to better locate the role of pharmaceuticals in shaping practices of care and narratives about the crisis. In fact, at the time of my fieldwork, the availability of pharmaceuticals was commonly perceived as, and associated with a well-functioning state: a good state was deemed able to provide ‘care’ for its citizens. The state provision of pharmaceuticals prior to the crisis worked through a complex system of public insurance and refunding mechanisms; however, the state never directly interfered with people’s therapeutic decision-making and the availability of pharmaceuticals, both prescription and over-the-counter, was held as a synonymous with a well-functioning state.

However, as also observed by Joao Biehl (2006) with regard to the Brazilian context, the consumption of pharmaceuticals is likely to skyrocket in the absence of optimal healthcare infrastructures. I argue that a similar entanglement of poor medical infrastructures and patterns of pharmaceutical over-consumption occurred in Greece both prior to and after the crisis. In both cases it was indicative of a dysfunctional healthcare system: before the crisis, the liberalisation of the pharmaceutical market and the spread of over-the-counter drugs functioned to relieve an unevenly structured public healthcare system. In the aftermath of the crisis, the reliance on pharmaceuticals still figured as the main solution to many medical conditions, although access to pharmaceuticals was restricted for all those citizens who had lost their insurance or the economic ability to afford therapies. The restricted access to pharmaceuticals that many Athenians experienced at the time of my fieldwork provided them with narratives of state neglect and abandonment. As far as the state was generally imagined as the main provider of pharmaceuticals, the common narrative came to be centred around the shortage of medications that ‘made people die’ coupled with the complaints about ‘having been abandoned by the state.’

While the public healthcare system was on the verge of infrastructural and financial collapse, the state collusion with pharmaceutical firms contributed to the even wider spread of pharmaceuticals, whose diffusion and consumption was somehow enforced also by doctors and pharmacists. According to what my informants described as the customary law of fakelaki (‘small envelope’ -a bribe), doctors and pharmacists usually received money and gifts from pharmaceutical companies in exchange for their efforts to promote certain kind of medications among patients. While I never witnessed any of these ‘exchanges under the table’ (misa), the majority of my informants were crystal clear in explaining to me the reasons behind the high demand, circulation and consumption of pharmaceuticals in Greece. ‘Pharmaceutical companies are like drug cartels. You know the story of the Mexican drug cartels? Well, it’s the same here with pharmaceutical companies. And the state collaborates with them, of course it does. The state
sold Greeks’ health to them’ I was once told by Marianna, one of my main informants at the KIA, with whom I had the chance to engage in many frank and intense conversations. ‘Those companies made great alliances and convenient deals with the state. And they still do, while people are dying from neglect and the scarcity of affordable and very basic medicine’ she concluded abruptly.

Although my informants’ accounts on state institutions’ corruption and collusio

n with pharmaceutical companies seem quite resonant with Akhil Gupta’s definition of ‘discursive construction of the state in public culture’ (2012: 77), their accounts may as well point to a different level of analysis where the state figures as both fantasies (Navaro Yashin 2002) and object of aspiration (Obeid 2015). In this sense, the dialectic of the state absence and presence in people’s life seems to produce contradictory effects of desire and disregard for it, as Michelle Obeid observes for the Lebanese context (Obeid 2015). In a similar vein, my Greek friends and informants resentfully commented on the malfunctioning of the State by highlighting its absence. Nevertheless, the rhetoric ‘We don’t have the state’ ( _den exoume kratos_) often coupled with the hope that a functioning State would be reengineered after the crisis ( _meta auti tin krisi_) (Chapter 1).

Pharmaceuticals and their narratives refracted different stakes and different stake-holders’ claims, desires and needs, but also provided a different perspective for looking at the complex relationship between the state, the population and the pharmaceutical market. Whereas the increasing reliance on and promotion of pharmaceuticals seemed to signal an important shift in how the process of medicalisation occurred outside the hospitals, the pharmaceuticalisation of care definitely reconfigured modes of relationality between ill citizens and the state. In today’s Athens the absence of, and the desire for the state (which I understand here as an aggregate of institutions) becomes apparent in the uneven provision, circulation and consumption of pharmaceuticals. It also manifests itself in people’s claims for pharmaceutical care. In this sense, pharmaceuticals prove to be not only ‘good to think with’, but also to ‘claim with’. Whereas by ‘thinking with pharmaceuticals’ I refer
to the potentialities of pharmaceuticals in opening up new ethnographic space to enquire about the relationship between the state and the population, by ‘claiming with pharmaceuticals’ I mainly point to the possibilities that people’s desire, needs and claims for pharmaceuticals may offer for rethinking the terms of medicalisation.

Ivan Illich (1976) introduces the term ‘medicalisation’ to refer to the growing tendency in Western societies both to frame everyday life issues in medical terms, and to refer to medical doctors to seek solutions. This ever-increasing reliance on medicalised solutions, as were pharmaceuticals for many Greeks, is productive of a certain set of consequences that Illich describes as ‘iatrogenic’, meaning induced by doctors and by the healthcare systems in general. Iatrogenesis appears everywhere that Western biomedicine has gained a predominant position in society. In order to resist various forms of iatrogenesis produced by such medical systems, Illich argues for the deprofessionalisation of the health-care establishment, and urges a return to individual and collective autonomy in defining and treating illness. In the Athenian context, the two movements generated by iatrogenesis, as Illich intended it, became observable: in first instance, pharmaceuticals as biomedical technologies were being re-socialised outside the strictly biomedical environment, thus creating a process of collectivisation of practices of care. At the same time, people’s subjective perception of symptoms became the ground over which pharmaceuticals were claimed and medical authority contested. Indeed, as Deborah Lupton (1994) also observes, ‘hegemonic medical discourses and practices are variously taken up, negotiated and transformed by the lay population in their quest to maximise their health’ (1994: 95).

I consider this latter point to be particularly important for rethinking ‘the therapeutic role of the state in the management of broader social and economic aspects of its population’ (Dewachi 2017: 20): as I have showed throughout this chapter, the availability of pharmaceuticals in the market and easier access to them were functional to a therapeutic, though not necessarily coherent, state project aimed at relieving the public healthcare system by
enhancing people’s autonomy and responsibility. However, in the aftermath of the implementations of austerity measures, the state’s inability to continue providing medications clashed with people’s expectations for the state provision of pharmaceuticals. In this context, what I call ‘the will to be medicalised’ is the ultimate product of this ongoing reconfiguration of therapeutic projects: people mobilise and upend their experiences of pharmaceutical deprivation to contest the uneven provision of care as operated by what is left of the welfare state.

Through pharmaceuticals you can be seen by the state
Since the 2009 economic crisis, the public healthcare system has been on the verge of collapse: the privatisation of its assets, a steady reduction in the numbers of medical personnel, the merging of hospital facilities and a reduced availability of pharmaceuticals rendered access to medical care and therapies uncertain for many Greeks. As hospitals and pharmacies in Athens, as elsewhere in Greece, were poorly supplied, many Greek citizens had to increasingly face and cope with this scarcity of pharmaceuticals. Many began to rely on the pharmaceutical provision operated by many social clinics of solidarity as they were in turn very well supplied with a vast amount of second-hand pharmaceuticals that private citizens and donors donated to these self-organised healthcare facilities.

Anthropological literature on the flourishing of Greek grassroots initiatives in times of crisis has highlighted their innovative characters, and especially highlighted their potential in promoting alternative socio-economic models. Instead, I suggest that this mode of provisioning - namely the exchange and provision of pharmaceuticals - resembled on a larger scale the exchange of pharmaceuticals as it usually occurred within and between households, amongst relatives, friends and neighbours. As I have also discussed in the previous sections, Greeks had in fact stockpiled significant amounts of medications in their households, and these medications were likely to be exchanged in case of need and illness as act of kindness and care amongst relatives, friends and acquaintances. As reported in a survey carried out in
Crete (Tsiligianni et al. 2011), people showed a tendency to exchange medications, especially analgesics and antibiotics, as purchased from the pharmacist. Indeed, the amount of Panadol, a generic painkiller, that arrived on a weekly basis at the social clinic was implicitly telling of this trend. The same study also reports that the decisions in matters of pharmaceutical regimens and the exchange of medications are normally taken by women. As I have also suggested in Chapter 3, female volunteers organised the social pharmacy, where they basically reproduced the domestic space: handling medications as objects of care was a female duty.

In the aftermath of the first memorandum in May 2010, Nea Demokratia government started implementing policies aimed at limiting public sector expenditure; the healthcare system was particularly affected by the budget cuts, and underwent a severe restructuring as the public expenditure on pharmaceuticals was dramatically reduced. In order to manage pharmaceutical waste and control pharmaceutical expenditure, stricter controlling mechanisms were put in place. In particular, the introduction of an electronic prescription system, the enforcement of electronic records for patients and the obligation for doctors to prescribe the compound, not the branded drug, were all measures intended to break down expensive and unhealthy habits such as overprescription, overconsumption, and polypharmacy. The wider circulation of generics especially was meant to reduce the monopoly of a few pharmaceutical firms over the Greek pharmaceutical market. The absence of controlling mechanisms for prescription practices, polypharmacy, the excessive availability of over-the-counter medications and corruptive practices involving pharmaceutical sale representatives, doctors (and occasionally pharmacists); these were commonly indicated as the main reasons for the progressive deterioration of the public healthcare system and its accrued deficit.

Although these measures were presented as necessary to improve and ensure fair, equal and good quality care for all, many people’s perceptions of these same measures were radically different: instead of promoting the image of an efficient, modern and transparent public healthcare, they were just seen as the
utmost manifestation of the state’s unreliability. Electronic prescriptions and patients’ records, as well as the priority given to generics, were in fact seen as the state’s interference in the citizens’ therapeutic options: the extent of a citizen’s medical condition could not be reduced to a medical diagnosis, for which the now-available therapeutic offer was mainly generics. In this context, the perception of the state, its absence and its presence, was contextual to the services it provided, or failed to provide. The complaint that people frequently uttered - ‘we have never had a state’ - acquired a different meaning: the state’s presence was now perceivable through the controlling power it was exerting on citizens’ therapeutic options. At the same time, the state was absent in what it was not able to do, or to provide: fully inclusive, quality medical care that should ideally have been tailored on people’s actual needs, and not on the contingencies of the crisis.

In 2015, a state-funded campaign to promote generics was launched and took over both the public debate and people’s everyday conversations. At the time of my fieldwork, generics were being widely promoted and advertised: huge banners in the streets and posters on public transport were released by the Ministry of Health, which called for citizens to behave more responsibly towards pharmaceuticals. By clarifying that generics were not second-class drugs, the state medical institutions invested generics with new political meanings, mainly those of social and financial responsibility in the current phase of economic austerity. As Corin Hayden (2007) observes in the case of post-crisis Mexico, generics represented ‘a powerful site for the reassertion of the national public interest or the public good’ (Hayden 2007: 475). The state-sponsored program to promote generic drugs can indeed be read as an attempt by the Greek state to prioritise citizens’ health in the aftermath of the economic crisis.

Generics were in fact cheaper, and therefore more widely affordable: their availability and accessibility came to implicitly signify the state’s will to render pharmaceutical care a political priority. However, the state-sponsored campaign to favour the implementation of generics was generally met with reluctance from people, if not outright refusal to take generics. Alongside the
widespread perception that the lower price of generics was indicative of its lower therapeutic efficacy (Tsiligianni et al. 2012), doctors persisted in prescribing the branded medications. During one of my weekly visits to Viktoria’s pharmacy, she explained to me why the campaign for generics was actually a failure. She showed me a prescription filled in accordance with the new regulation, whereby doctors were required to prescribe just the compound. However, in many cases, doctors added a hand-written note suggesting the name of the branded medications they considered more appropriate to treat a certain condition. When I asked Viktoria why she thought the doctors continued to prescribe branded medications, she simply said that doctors were still taking bribes from pharmaceutical firms, and this habit was hardly eradicable.

However, in reviewing prescribing practices, Van der Geest, Whyte and Hardon (1996) suggest that ‘prescribing is a social act […], is the main thing expected from a physician. […] Doctors attempt to increase their good reputation by prescribing profusely.’ Following their argument, it is reasonable to think that many Greek doctors’ tendency to prescribe branded medications is motivated by their will to comply with patients’ requests in a manner that is culturally and socially acceptable: ‘not prescribing, which might be good on biomedical grounds, would then be irrational by cultural criteria’ (Van der Geest et al 1996:160). As Van der Geest et al. (1996) also individuate a correspondence between the concreteness of the prescription and the concreteness of the medicine, I suggest that a prescription of generics is perceived by patients as a gesture of misrecognition of one’s medical condition and related pharmaceutical needs, as the lack of bioequivalence between the patented and generic drugs often contributes to disqualifying generics (Hardon and Sanabria 2017), ‘the identity and efficacy of a medication can be hardly reduced its active chemical ingredients’ (Hayden 2012: 76). The efficacy of a medication, Hardon and Sanabria argue, ‘is not reducible to the chemical properties, but it is articulated, elicited and informed within a meshwork of experimental, regulatory, and care settings’ (2017: 126).
The will to be medicalised

While I was not able to further explore doctors’ negative attitude towards generics, many of my informants considered generics as second-class medications, a cheap and inefficacious substitute for proper medications. In this context, what emerged as an interesting contradiction was the relation between doctors, patients and pharmaceutical options, and how they entered into relations through the prescription of medications. Crucially, although the majority of my Athenian informants showed distrust - if not scorn - towards doctors, they seemed to agree with them for once: both converged on the refusal of generics. While Viktoria provided me with an emic perspective on why doctors refused to prescribe generic drugs, one of the organisers of the KIA, Alikì, offered an interesting explanation as to why people did not want to be prescribed generic drugs.

A few days after my visit to Viktoria’s pharmacy, as on any Friday, I made my way to social clinic early in the morning. Holding my plastic glass of iced sugary coffee in one hand and the small plastic bag of Tritace that Viktoria had given me two days before, I walked into the pharmacy ready to use Viktoria’s donation as leverage for investigating my fellow volunteers’ opinions on pharmaceutical circulation and consumption in today’s Athens. Maria, the pharmacist in charge on Friday mornings, Anna and Christina were sipping their coffees and considering whether or not to have a cigarette before starting their shift. Yannis had already collected a huge black bag of medications from the corner where the bags were piled up and was ready to move into another room to start organising the medications in alphabetical order. As I was still standing at the door with Viktoria’s bag in my hand, Maria invited me to leave my backpack under the table, and to join them outside to enjoy the morning sun and a cigarette. ‘What’s that bag? Did you bring sweets?’ she asked playfully. ‘No, no sweets today!’ I replied, ‘no sweets, but Tritace for all! A friend - she owns a pharmacy - gave me some blisters of Tritace to donate here.’ With a gesture of her hand that seemed to point at some complex reality ordinary people could hardly imagine, Maria exploded in an emphatic complaint about Tritace. ‘More Tritace? More
Tritace? We have stored so much Tritace that we could save Africa, if in Africa they only suffer from hypertension! Next time you see your friend, tell her that we don’t want Tritace. The KIA thanks her, but doesn’t accept Tritace any longer. Tell her, and don’t take more Tritace from her, or you’ll take the responsibility to check all the Tritace from now until the end of your life. And you will also have to write your thesis on Tritace. This is Maria’s prophecy for you!’

As we made our move to leave the pharmacy, Aliki appeared and with a loud ‘good morning!’ she ironically asked whether we had any intention to start working that day. As she was also the person who had organised the pharmacy since the very first day of the KIA, I considered her unexpected presence in the pharmacy as a chance not to be missed to finally talk to her. While the rest of my fellow volunteers went outside, I chased after Aliki and asked her whether we could talk as I had some questions to ask her about the clinic. ‘Come inside, I have some work to do but I’ll listen to you. Let’s see if I can give you the answers you need. Come’. As we went back into the pharmacy, Aliki pulled a folder of papers out of her bag, and took the huge book of International Pharmaceuticals from a drawer. ‘What’s this book for? What are you doing?’ I asked her. She took the papers and waved them in the air, explaining to me that it was a list of names of foreign donors, and foreign pharmaceutical companies. The medications that had recently been donated to the KIA were scribbled down on other papers.

‘I am checking if those medications have Greek equivalents. I mean, I need to see if the medications sent from abroad are approved by the Panhellenic Association of Pharmacists. Sometimes we receive medications that can’t be circulated here, that don’t exist in Greece. In that case, either we throw them away, or we send them to a Papas [an orthodox priest] who has a mission in Tanzania. I mean, there I guess the rules should be far looser, looser even than here.’ Aliki continued:

‘At this point I guess we should stop accepting all kinds of medications. The pharmacy is
exploding, we’ve filled each and every corner, and we also moved lots of boxes into the doctors’ room. The point is that most of the medications we receive are not really important. I think you’ve noticed it already, we have lots of hypertension pills, we’ve lost of generics, people keep on bring them in, but we rarely get important medications, like anti-cancer ones. It happens, but you see, what is brought in here is just medications that do not really save lives. We have already sent some boxes to some hospital pharmacies around Greece, and we are still full of medications that people don’t want because they say they are of lower quality. They say that they want the same medications they used to get. I’ll tell you something, they don’t understand that there’s no actual difference between a generic and a branded drug. I am telling you something, these Greeks think that generic drugs are not good, if they get generics, their disease is not serious: if you are really sick, you cannot take generics, that’s how Greeks reason. I sometimes think that people see generics as offensive, as a lack of care or as neglect by doctors. We have tons of medications and we don’t know what to do with them. People try to take generics, try to trust them, but then… they cannot make it, they carry on with it for a while and then, they bring their leftovers here. It’s a waste, and one of the main purposes of this pharmacy was to avoid waste. And to teach people how to be more responsible and careful with medications. Greeks, and I guess you’ve already noticed this, are strange. They complain all the time, they argue with doctors and they tell the doctors what medication they want, what is better for them. Doctors just surrender out of exasperation. But then, they get upset with the doctors because they say they got the wrong diagnosis, the wrong medication. So, that’s a reason why we have these piles of medications, not completely useless but almost useless medications.’

As was also reported in the survey on habits relating to pharmaceuticals in Crete, there was a widespread consensus amongst the population that generics
had lower efficacy as they were cheaper than the branded medications (Tsiligianni et al. 2012).

Van der Geest et al. argue that ‘as a powerful technical device and cultural symbol, medicines acquire a status and force in society’ (1996: 160). In this sense, I suggest that Athenians’ manipulations of claims, needs and desires for pharmaceuticals represent a powerful critique of state care services, and the reforms that were being implemented in relation to pharmaceutical provision. In this vein, the idiom of illness and the demands for pharmaceuticals signalled people’s dissatisfaction with what was left of state care. Beyond people’s skilful negotiation of pharmaceutical prophylaxis and therapeutic options, contesting dosages and claiming for branded medications, people’s medicalised understanding of health was often rephrased in terms of self-care and responsibility. Following Whyte et al.’s (2002) argument that pharmaceuticals are always lived in relation to local context and problems, I suggest that in today’s Athens pharmaceuticals not only offer a way to cope with social vulnerability and economic uncertainty, but they also provide people with terms through which they can advance and make claims on the state, and how it was being restructured under the pressure of the Troika.

The changes that took place in the provision of pharmaceuticals, from the shortage of medications in the aftermath of the economic crisis to the introduction of stricter controlling mechanisms in times of austerity, all signalled different modes of dependency and relationality between the state and the citizens. In this sense, people’s will to be therapeutically compliant, or what I call the will to be medicalised, can be seen as both an act of resistance towards the neoliberal reforms that the state was implementing, and as a strategy whereby people wanted to actually be seen, and therefore recognised, by the state as citizens and subjects worthy of care and with a right to pharmaceutical goods.

However, the terms of people’s desires for the state were built upon the two conflating ideas of what the state is and what the state should do: the state
should provide easily accessible and affordable healthcare resources, but it should not interfere in people’s decision-making when it comes to their therapeutic regimes. In this context, I suggest that many Athenians’ need for pharmaceuticals definitely voiced a desire for the state, while implicitly pointing to their struggle to be recognised as entitled to welfare benefits. Indeed, people’s demand for medication was always in relation to stories of death and abandonment: the state was always held to be responsible for those deaths, the primary cause of which was the lack of access to medications. Interestingly, Athenians’ complaints about forms of state neglect showed a crucial moral twist: whereas in contexts other than the Greek one, state healthcare institutions called for a responsible use of medications as the moral duty of any responsible citizen, but in Greece citizens criticised the state as ‘immoral’ for letting people die from the lack of, or restricted access to pharmaceuticals that should be provided, and made available to citizens by the state.

During my fieldwork, many of the KIA’s patients, as well as many of Viktoria’s customers, recounted to me how some people they knew (sinadelfoi) were left to die because they could not afford medications. Yannis, an old man from the Peloponnese who I met at the KIA, told me about how one of his friends began to die from heart disease after his social insurance had expired. Unable to renew it as a consequence of his prolonged unemployed status, Yannis’ friend could not by any means afford the medications he needed. ‘What State is this?’ Yannis asked me bluntly while handing his documents (xartia) to Antigoni, the volunteer who was taking care of his medical records. ‘Do you know of any other place where people are left to die like this? I am sick, and I want my pills, I need those pills [eimai arrostos, thelo ta pharmaka mou. Anagkazo auta ta pharmaka]. But if you are poor, there is nothing left for you here in Greece’ he concluded sadly. People complained about their health and claimed their right to receive pharmaceuticals

Following on from the above discussion, the next chapter will be devoted to analysing how pharmaceuticals acquired different meaning and values
Whyte et al. 2002) according to both the different social spheres in which they were handled, and to the diverse modes of care as they were enacted in different contexts. By mapping the different spheres of exchanges (Appadurai 1986) across which medications were circulated and consumed, I will ethnographically explore people’s attitudes towards pharmaceuticals as objects of desire, the social meaning they are invested with, and the political potential they may possibly acquire and retain in a moment of rapid socio-economic changes.
Chapter 5
Beyond the biomedical value: pharmaceuticals at the intersection of the social and the economic

Figure 9: Sorting pills in the social pharmacy. (Drawn by the author)
Late one warm Friday morning in mid-October 2016, there was no electricity at the KIA: lights were off all over the building, and the volunteers started to become anxious about the medications stored in the fridges (\textit{sta psicheia}). About seven containers of cancer medications (\textit{onchologikà}) and some packs of insulin were in fact stored there: with no electricity, in a couple of hours the fridges would start defrosting and the medications would deteriorate badly. The fridges were old, common kitchen fridges that people from the neighbourhood had donated to the clinic some years before. Eirini, one of the volunteers working at the reception, nervously walked back and forth between the clinic entrance and the small room where I was sitting with Yannis, Anna and Christina. Maria, the pharmacist in charge on Fridays, had left as soon as she found out that there was no electricity, as it would be impossible to work in the pharmacy: it did not have any windows and also, with no air condition working, the room would heat up quite quickly,

As the small room was the only one with a window, we decided to sit there to have our morning coffee and to chat. Actually, we could barely fit in there as the room was stuffed with medical supplies and boxes of medications waiting to be stored. The small table was disorderly, covered with shopping bags of medications that needed to go through the first phase of selection: grouping them in alphabetical order, and parting those sent from abroad from the Greek ones. Eirini walked back into the small room, stood at the door, looked disconcertedly at the table and then stared at me for a few seconds. In English, she started to talk:

‘A catastrophe! A terrible loss for the KIA and the people who might potentially receive those medications: you can imagine how many people need cancer medications and cannot afford them. They can cost more than 700 euros. Who has that much money? With the crisis, who can afford them? The crisis has already killed many people. Here at the KIA, you see, we can save lives with our medications, but we cannot fix the electric board. And if we cannot fix the electric board, we won’t possibly save any life because the
medications would go bad. Isn’t this grotesque?
Welcome to Athens, little Italian.’

Yannis praised Eirini’s theatrical talent and her perfect Greek pronunciation of English words, and immediately picked up on her anxious comment: cancer medications were rarely donated because they were extremely expensive, although they were amongst the most needed and requested medications.

Besides Yannis’ consideration on the actual costs of anticancer medications, what rendered them particularly valuable was the severity of the medical condition they were meant to treat. Cancer was in fact generally considered as the ultimate disease. Also, it seemed to me that cancer medications were affectively and emotionally charged: the volunteers empathised with the suffering of the person who had previously owned the medication, and with what their kin had possibly experienced while taking care of the sick. However, the volunteers seemed to be comforted by the idea that the medication donated to the clinic could possibly help someone else; relieving someone else’s suffering or, at least, giving them hope. In the case of anticancer medications, their value was assessed on how rarely they were donated, their actual market cost and the severity of the medical condition they were meant to treat. As they were expensive, donations of cancer medications were also seen as a particularly strong act of care from the donor towards strangers.

Insulin was instead a far more common medication and was not particularly expensive; however, the chronicity of a medical condition like diabetes associated with the situation of chronic economic scarcity deriving from the crisis granted insulin a special position within the social clinic. Donations of insulin were generally met with enthusiasm by the volunteers: first, it was not a common occurrence to receive parcels and donations of insulin, and secondly it meant that the clinic could reach out to those people whose need for insulin had previously not been met because of its unavailability. In this sense, its value was more social than merely biomedical: after all, as Doctor
Vasiliki once explained to me, ‘diabetes is not a particularly severe condition, people learn to handle it, and live with it.’

By ethnographically attending to the emergence of pharmaceuticals as objects of care, I follow Yael Navaro Yashin (2009) and suggest that the pharmaceuticals as objects represented a mode to reconstitute sociality and to negotiate loss. By ‘loss’ I describe the loss of entitlement to access public healthcare resources and the loss of health. My Greek informants experienced the former as a consequence of the crisis, and the latter as either a chronic condition or a sudden deterioration of their health. Drawing on the fieldwork I conducted in both a social pharmacy and in a state licensed pharmacy in Athens, I argue that loss is also the precondition for pharmaceutical efficacy; whereas the loss of health is the ground over which pharmaceuticals become medically effective, it is people’s loss of social inclusion that pharmaceuticals attempt to repair and compensate for. As explained in detail in Chapter 3, the pharmaceuticals that were stored in the social clinic had previously belonged to other sick individuals, and they were later donated to and appropriated by those who needed them now. This circulation created a sort of emotive continuity in care across different spheres of society and across different time frames. The circulation of pharmaceuticals across licensed pharmacies, social pharmacies and households seemed in fact to reconnect people, while also reconstituting a sense of belonging to the society for those who had experienced forms of medical marginalisation and social abandonment.

As I will show ethnographically, pharmaceuticals generated affective responses in the people transacting and consuming them, the volunteers and patients. I suggest that this affective response was upheld by the actual materiality of pharmaceuticals as objects, which were in turn attributed with, and defined by, different values. These values not only changed according to the different spheres of sociality in which the pharmaceuticals were handled, but the same values also generated clashes and contradictions by virtue of the different rationalities underpinning them. The common ground upon which these values were measured was in fact that of loss: the intensity of loss and the affective response it conjures up served to the KIA as a measure for
distributing entitlement to care, and to confirm its legitimacy in the newly reconfigured Athenian medical landscape. In particular, the following sections set out to explore how these diverse values were underpinned by diverse modes of care; these were increasingly regulated on pharmaceutical availability, accessibility and scarcity. With reference to the Athenian context, I suggest that the availability, accessibility and scarcity of pharmaceuticals are revelatory of how state policies concerning the provision, circulation and consumption of pharmaceuticals infiltrated and were shaped into domestic relations, at first within and between households, and later through the social clinic.

**Symptoms without disease: pharmaceuticals as an idiom of illness**

‘Take those! I don’t want to see them again in my life!’ Anna joked and handed me a blue shopping bag full of spare green blisters of Lasix. As on any Friday morning, I was with my fellow volunteers at the social pharmacy at the KIA, sitting around a huge wooden table to check and sort the medications donated to the clinic. At the time of my fieldwork, Anna had already been volunteering in the clinic for five years: every Friday morning she made her way to social clinic and joined the group of female volunteers who had, over time, organised and made the pharmacy work more and more efficiently. When Anna handed me the bag she did not want to take care of, I asked her what was wrong with Lasix, and whether she knew what Lasix was for. She playfully explained that she did not like the colour of the blisters and found it difficult to read the expiration date stamped on them. She was not able to give me any explanation about that medication: ‘It should help people to pee, I think. Mainly men take it, I guess. But I don’t really know. I am not a pharmacist, and I stopped taking medications long ago. I turned to homeopathy ten years ago, I started practising yoga and quit with any chemical stuff. Anyway, it doesn’t matter what I do, or what I think. I just don’t know what we are going to do with all this Lasix.’

26 Lasix (furosemide) belongs to the class of medications called diuretics. It is used to treat oedema (fluid retention) that occurs with congestive heart failure and disorders of the liver, kidneys and lungs. It is also used to control mild to moderate high blood pressure. It may be used in combination with other medications to treat more severe high blood pressure.
When I questioned Anna about her decision to turn to homeopathy and yoga, she framed her choice in terms of self-awareness and resistance to what she considered a mainstream understanding of health and illness as promoted by pharmaceutical companies. As with many other informants involved in the KIA’s different activities, Anna held diverse and often contradictory positions towards pharmaceuticals. Whereas she reckoned that distributing medicines to people in need was a responsible act of care towards the sick and the poor, she said that she personally avoided taking pharmaceuticals to treat herself because ‘they just poison our body and our brain.’ Also, as with the vast majority of the volunteers, Anna did not have any clear idea about what the medications she sorted in the pharmacy were precisely for. For most of them, pharmaceuticals simply represented the most immediate and effective response to other people’s medical needs: the materiality of pharmaceuticals seemed to condense and render visible a healing power that would otherwise be invisible. Alongside the healing power that pharmaceuticals retained, they also represented a specific mode of care, as it was concretely enacted in the social clinic.

As I described in Chapter 3, the prominent role of women in organising the social pharmacy shaped it in such a way that it resembled a domestic space, whereby practices of sharing of pharmaceuticals at home were relocated from the household to the clinic, thus in the neighbourhood. As I have also suggested in Chapter 4, the circulation of pharmaceuticals as operated by the KIA did not really represent an alternative system of provision, but rather the reproduction of a domestic mode of care, which was in fact based on pharmaceuticals. Crucially, this mode of care was made possible by the greater availability of pharmaceuticals in the years prior to the 2009 crisis. In the aftermath of the crisis, the progressive retreat of the state from the welfare provision, together with budget cuts to pharmaceutical expenses, redrew the boundaries along which pharmaceuticals were sought and provided. Viktoria’s state-licensed pharmacy, the KIA and the households of my informants represented three different realms across which the needs and demands for pharmaceuticals were crafted, met or unmet accordingly. I suggest that the presence of, and reliance on pharmaceuticals, their sharing
across and within households, and later in the social clinic, offers a privileged
entry point to understand how state care policies concerning pharmaceuticals
have been absorbed and translated into domestic relationships. Similarly, Han
(2012a,b, 2013) describes how, in an economically deprived area of Santiago,
the practice of sharing pharmaceuticals amongst friends and neighbours
actually represented an act of care that was implicitly informed by some state-
promoted mental health programmes, which are in fact mainly centred on the
distribution of psycho-pharmaceuticals.

In the light of their familiarity with pharmaceuticals, my female informants
showed some form of lay knowledge about some of the medications that were
stored in the social pharmacy. As far as I understood, it was quite an empirical
knowledge and mainly stemmed from their personal experiences with
common drugs, such as those for chronic conditions such as cholesterol or
high blood pressure, or painkillers of different kinds (see also Chapter 4). It
was very common for them to comment on the medications they were
checking in terms of how some of their own relatives, friends or
acquaintances were taking or used to take them. Statements such as ‘my
husband has taken this for years because his heart stopped beating as it
should’ were very common answers to my occasional questions about some
of the pharmaceuticals that we were sorting. Through the empirical
knowledge they gained from their experiences, the women of the social
pharmacy developed a peculiar capacity to translate biomedical information
into lay terms: they managed to attune and adapt the biomedical register of
pharmaceuticals to the everyday reality of care. In fact, frequent references to
diverse realms of everyday life and to mundane experiences of diverse
symptoms provided them with a common ground over which pharmaceuticals
were described and their posology adjusted. Crucially, their effects and
efficacy were assessed in environments and terms other than the merely
clinical one: medicines met urgent needs (Van der Geest and Whyte 1989),
and most of these needs were met through what Dimitra, my friend Yorgos’
mother, described as a network which shaped, and at the same time was
shaped by, the circulation of medications.
During dinner, Yorgos playfully asked his mother to tell me about her complicated relationship with medications. In a plain and calm voice Dimitra explained to me:

‘They [medications] make you feel safe. You know yourself what you need. Before you take it, you’re already better because you know it will make you feel better in a couple of hours, or even less. It could be a Panadol, or a Tavor, any medication. It’s a psychological trick, I think. To tell you the truth, Tavor is my favourite: it clears up all my bad thoughts, all the pressure I feel. I go to bed, and I don’t think about anything. I just nicely fall asleep. We women are more exposed to stressful situations; we are under more pressure than men. Society puts much more pressure on us than on men. Perhaps that’s why we take more medications. You also create a network, and the pills are part of it: you talk with your friends and they share the same feelings, the same experiences. They take the same medications you take because they feel the same as you. You don’t have a Tavor at home, but one of your friends surely has and you get it from her. It’s ok.’

In the specific case of medications like Lexotanil, Xanax and Tavor27, these medications were often playfully described by the women volunteering in the social pharmacy as ‘my best friend.’ Their comments very often aligned with Dimitra’s comments about Tavor. The sorting process was frequently accompanied by comments which were descriptive of these medications’ posology: Tavor was considered the best solution for a good and deep sleep and to wake up well rested and with a clear mind the next day. Xanax was generally described as too strong and very addictive, like a drug (narkotiko), but good for strong insomnia. Lexotanil was described as not always effective for insomnia, but always reliable for anxiety [anchos]: ‘you have to know how to make it work better for yourself.’

27 Tavor (Lorazepam) together with Lexotanil and Xanax, belongs to the drug class of benzodiazepine. It is used to treat anxiety disorders and, intravenously, for status epilepticus. It may also be used for alcohol detoxification, insomnia and agitation.
As I discussed in the previous chapter, in a climate of general scepticism and distrust towards medical doctors, as it frequently voiced by my informants, the lay knowledge about pharmaceuticals that was produced on the basis of personal experiences was perceived as more reliable and relatable (see also Van der Geest and Whyte 1989: 353). As pharmaceutical knowledge was produced through social relations, it was far more attentive to those factors (affective, social and cultural) which biomedicine tends to discard as it is generally concerned with the biophysical aspects of the therapy (Etkin 1992). Interestingly enough, the possibly adverse effects of sharing medications were either overlooked or simply ignored: medications were often just assumed to be good, and their efficacy was predicated on the assumption that if it was good to treat one’s personal condition, it would be good to treat anybody with the same condition. It seems to me that medications were often completely disassociated from any medical diagnosis, and were only meant to offer a symptomatic solution to certain symptoms, whether anxiety or period pain. Han offers a compelling description of how medications were exchanged amongst the women living in a poor neighbourhood in Santiago, and concludes that ‘in the wake of the most commonly experienced of symptoms, women and men have developed a practical knowledge base - a local formulary of go-to medications - for their alleviation’ (Han 2013: 292). Similarly, my Greek informants exchanged medications on the basis of similar experiences with similar symptoms.

In their anthropological analysis of the meanings and uses of pharmaceuticals in diverse social and cultural contexts, Van der Geest and Whyte (1989) point out that pharmaceuticals can easily be unbound from the professional fields of doctors and pharmacists; they actually ‘break the hegemony of professional and enable people to help themselves […] particularly in those societies where it is difficult to control their circulation and use’ (1989: 348). However, the use of and reliance on pharmaceuticals presupposes people’s biomedical understanding of their body: on this note, Anita Hardon and Eileen Moyer (2014:107) call for an ethnographically sensitive approach to the ‘micro-dynamics of power, the specificities of local market in which medical technologies generate value, the social and intergenerational
relations in which they are embedded.’ In this sense, it is crucial to address how pharmaceuticals ‘mediate new ways of relating to doctors, fellow patients, families and communities, and evoke new ways of feeling and being in the world’ (Hardon and Moyer 2014: 108).

**Illness, loss, dependence: socialising experiences of pharmaceutical care to make sense of institutional neglect**

‘You know how much it costs to hire a private nurse to give you an injection? Twenty-five euros, and most of the time they are not even nurses, they are just women who had given injections to all their relatives, to their neighbours, and they know how to do it. Still, they wanted to be paid as if they were trained nurses. Who can afford to pay so much for an injection? And then one has to pay for the medication, the syringes and the like.’ Viktoria was preparing the syringe and in a confident gesture, shook the small ampoule she was holding. The liquid and the powder mingled, and when the compound was ready, Viktoria pushed the needle into the ampoule. Switching to English, Viktoria continued to explain the case of the woman who was waiting to be given her injection:

‘This lady needs this injection once a week. And this medication is terribly expensive, she can barely afford it and she doesn’t receive any help from the state any longer. With the crisis, more and more people lost the state benefits and, with the meagre pensions they receive, they have to cover their medical expenses and try to make a living too. She has a chronic autoimmune disease, a form of very strong rheumatism, which has been deforming her bones over the past ten years, and the therapy she has been on is incredibly expensive. Each week a hundred euros go on it. On the top of that, she should have to pay for a nurse to give her the injection. She asked me to give her the injection and I couldn’t tell her no. Actually, I should not do that, I am a pharmacist, and only nurses and doctors are legally allowed to give injections. The first time I handled a syringe I was scared, I was terribly scared and my hands were trembling. But then I realised how scared this woman was of her illness and how in need of help she was. I couldn’t step back, and I just did it. It was a long time
ago, and now it has become just part of my weekly routine.’

The old woman nodded at Viktoria’s words with quite a dramatic expression on her face. She moaned, looked at me and then all of a sudden she took off her shoe and showed me her swollen and almost deformed foot. ‘You see, kid, how bad I am!’ she spoke slowly to allow me to understand, ‘And this injection, this injection is painful. As if sharp knives tear my flesh apart. But the pain from the disease, you can’t even imagine it. Some mornings I cannot even move, I cannot walk. But who’s going to cook? Who’s going to take care of the house? Viktoria is such a nice girl. The best pharmacist we could have here! I come here, every week, and I know I am going to have some relief for a few days. Until the next week.’ With uncertain steps, the woman walked behind the counter, folded the sleeve of her flowered shirt and gave her arm to Viktoria. She turned her head away as if she was trying to ignore the pain she had just described to me. She continued to moan deeply, while Viktoria tried to comfort her. In a soft voice, she reassured the woman that the pain would be over in a few seconds. When the injection had been given, Viktoria kissed the woman on her forehead and in an intimate tone she invited her to sit. Then she turned to me again:

‘She’s such a sweet person. I feel so sorry for her. She’s a kind of grandmother. Sometimes she comes here just to complain about her life. You see, this pharmacy is more like a living room than an actual pharmacy. People come here because they just need to talk. Sometimes they don’t even buy medications, or don’t even need them at all. Sometimes they need them but cannot afford them. The crisis messed up people’s lives. You arrived here at a moment where things are getting slightly better. But not for everyone, and for many there is no hope that their situation will get any better.’

Viktoria’s description of her pharmacy as a place where people often gathered in front of the counter just to chat and to share their everyday concerns resonated immediately with what I had perceived about the place, but that I had not yet been able to verbalise.
During my weekly visits to her pharmacy, I could see how the local people stopped by and walked in just to have a chat with Vicky, or to update her on the latest gossip or their conditions. Sometimes I had the sense that they asked for medications just to make other people aware of their condition, as if some sort of recognition could derive from their need for medications. I suggest that the need for medications that Vicky’s customers voiced was actually an index of one’s suffering, both socially and medically. Similarly, Veena Das (2015: 28) suggests that one must consider ‘illness as indexing of the disorder of the social and the political.’ From this perspective, she argues, it becomes possible to capture the specificity of the conditions in which people’s experience of illness and care unfolds. In this sense, as also emerged from both Vicky’s words and her customer’s explanation, the experience of illness served as a filter to make sense of the experience of the economic crisis. For her, the crisis ultimately resulted in the loss of the state benefits that she used to receive, and in growing economic hardship in meeting her medical needs.

As the literature on medical anthropology has highlighted, in a context of weak or flawed healthcare infrastructures, pharmacies are likely to become the place where medical care can be more easily sought. The role of the pharmacist as a retailer has morphed into that of a proxy-doctor who is consulted for medical advice. During my fieldwork at Viktoria’s pharmacy, I was able to observe how her customers asked her for suggestions and advice on the best medications; at the same time, the general atmosphere of the pharmacy suggested that people gathered there for reasons other, not exclusively medical. For instance, as a daily ritual, at around 12.30pm a group of women used to walk into the pharmacy and chat with Viktoria while waiting to pick their children up from the nearby primary school. Their chats were filled with complaints about their domestic chores and suggestions on how to treat period pain: at that time, Maca tablets seemed to have gained a good reputation amongst the group of women, although Viktoria kept telling them that it was not any different from Panadol. Complaints about their economic situation also never failed to come up in their conversations.
The more time I spent at Viktoria’s pharmacy, the more I realised that the pharmacy’s customers were mainly women, and they more or less all shared the social status of housewives and similar conditions of economic dependency on their husbands, or in some cases, their kin (as described in Chapter 2 and Chapter 4). To their husbands and their kin, they were bound mainly through the obligation to care, which seemed to have intensified during the years of the crisis. In that period, state benefits and pensions had been drastically reduced, and the role of kin as the first provider of social security in terms of care provision had expanded accordingly. Eva was one of the most talkative women who came into Viktoria’s pharmacy late every morning. Holding firmly to her plastic glass of Freddo Espresso, she normally stood at the threshold of the pharmacy in order to smoke her cigarette and at the same time not to miss any of the conversations happening inside. As I often joined her for a cigarette, we developed some degree of familiarity.

When she asked me why I was in the pharmacy so often, I explained that I was writing a thesis about how people used pharmaceuticals in Athens, at a moment when the public healthcare system was collapsing and medications seemed to be a more easily available medical resource. She looked at me with her eyes wide open in surprise, then with a sudden and circular gesture of her hand which seemed to point to the impossibility of any easy explanation, she warmly suggested that I should change my research because, even in twenty-five years, I would not be able to understand the complicated relation the Greeks have with medications:

‘I tell you something, girl. Before the crisis, you could go to any pharmacy and get anything, even antibiotics for a broken nail. Since the crisis, they decided that people have to pay for all the medications. They should get a refund from the insurance, but it takes so long that in the end people are left with no money. Now you tell me? How can we pay for the medications if the state has left us with a miserly salary and pension? I know that people often exaggerated with taking medications, I am not telling you the contrary. But my mother almost died from pneumonia last year. And you know why? Because it was cold, it has never been so cold in the past forty years. Anyway, she didn’t heat up her house so as to
save some money from her pension, which is nothing, to be honest. You know, don’t you? How the government keeps on cutting the pensions and salaries of people, they want to make us die, I think. When she fell sick, first we went to the hospital but you cannot imagine how many people were waiting there to see a doctor. Because you know what happened with the crisis, don’t you? They fired so many doctors from public hospitals that you’ve to wait days before you’re able to talk to one. So we decided to go a private doctor, to speed up the situation, but after he examined her, he refused to prescribe her antibiotics because he said she was fine overall and she had just caught a bad flu. The pain in her chest and in her back was because of her age, he said. And he was so annoyed with her: he even asked her if she had studied at the medical school because my mother suggested that perhaps she needed antibiotics. He told her that she was that kind of woman who loves complaining about their health, just to get attention. And he also said that the time of antibiotics for a flu was over. I took her back home, told her to stay warm because I would help her with the bill. Not that we’re so wealthy, but my husband still has a good job and we have only one child. To cut it short, you know what I did? I came here and asked Vicky to give me the antibiotics for my mother. At first, she refused because I didn’t have a prescription, but I managed to persuade her. She knows me, she knows that I am not the kind of person who takes antibiotics for a flu. She also knows my mother, and she also knows that you cannot trust doctors too much. I explained to her how my mother felt, I told Vicky about her symptoms and she agreed that it was probably pneumonia. That’s how we sort out things in Greece where, the proverb says, everything is forbidden and everything’s possible.’

Even in the story Eva recounted to me, the crisis figured as the overarching frame to people’s ‘illness narratives’ (Kleinman 1988), as if the reasons for their medical conditions could be dislodged from the biological and relocated in the social. At the same time, the access to the pharmaceuticals that Eva and her mother obtained seemed to ensure some sort of control not just of the mother’s symptoms, but of her situation in general. In this regard, Van Der Geest, Whyte and Hardon (1996) have extensively described how in different contexts, people perceived their access to medicine as a chance to better
manage their life and to make projects for the near future. The request for antibiotics that my informant’s mother advanced to the doctor can therefore be read as an attempt to manage her personal experience of the medical and social crisis. Beyond the ethnographic specificity of the vignette, I could see some recurrent features in women’s speeches and attitude towards pharmaceuticals, as if their complaints became not just an attribute of womanhood as also teased out in Chapter 3, but through complaints they could voice their distress, be it either social or medical, or encompassing both.

At Viktoria’s pharmacy, in front of the counter, the three chairs seemed to be an invitation for people to sit and chat. Sometimes I too sat there with some of her customers who often shared some of their stories with me, and showed me prescriptions and the receipts for the medications they got. While prescriptions are seen to function as a legitimisation of sickness, as a proof to the environment of one’s sickness and entitlement to the role of sick (Whyte; Van der Geest and Hardon 2002), they also seemed generative of discourses where the medical crisis could not be separated from the social crisis which many Athenians seemed to experience, and which resulted in ‘bodily modes of suffering’ (Kleinman 1995: 11). Michael J. Oldani (2004) formulated the concept of ‘thick prescription’ to make sense of all the activities relative to pharmaceutical production, circulation and consumption. These activities, he argues, are generated through the relationship between pharmaceutical company sales reps and doctors, and between doctors and patients. Oldani is mainly interested in tracing the ‘pharmaceutical gift cycle: a three-way exchange network between doctors, salespersons, and patients’ (2004:325).

Following Oldani, I suggest that the idea of ‘thick prescription’ could be rendered inclusive and sensitive of those interactions and transactions which involve sick people and pharmacists alike: these are not only generative of narratives and activities where pharmaceuticals acquired values other than the biomedical. In fact, prescriptions can also be powerful means of contestation and claims through which people try to make their right to state care heard. As I described in Chapter 2, prescriptions played a crucial part in regulating the access to the pharmaceutical resources made available in the KIA.
Contentions and negotiations arose between the KIA’s patients and volunteers over prescriptions, and their legibility and illegibility. In Chapter 4, I described how the introduction of the electronic prescription was meant to enhance the diffusion of generic drugs, whereas in fact doctors continued hand writing prescriptions for the branded drugs. The materiality of the prescription also bears not only the signs of people’s illness, but also the traces of the changes occurring at the state level in terms of state care policies.

In light of my fieldwork in a licensed pharmacy of Athens, sharing the experience of illness mainly through the prescription of certain medications, the description of symptoms, and the pain they brought about represented a way to share a sense of loss and abandonment that many of my interlocutors felt as a consequence of the crisis. Accordingly, the access to medications seemed to provide both social and medical relief to the loss of both health and of entitlement to welfare benefits. As Van der Geest and Reynolds pointed out (1989), pharmaceuticals not only enhance the perception of illness as something tangible: they also facilitate the communication about those experiences that would be otherwise difficult to express. In the Athenian context, the meaning of pharmaceuticals was therefore disjointed from the strictly biomedical one, and entered the realm of sociality insofar as pharmaceuticals represented a concrete referent around which people could verbalise and share their social distress.

Following Sarah Pinto’s argument about the capacity of pharmaceuticals to create new kinds of bonds and intimacy when they enter different social worlds (Pinto 2014: 20), and contrary to Van der Geest and Reynolds’ point about how pharmaceuticals more often than not imply an individualisation of the experience of illness (1989), I suggest that in Athens pharmaceuticals contributed to recreating forms of social relations and intimate bonds among individuals who shared not just experiences of symptoms and illness, but also similar conditions of social abandonment and marginality. As emerged from my fieldwork, the idea of a maximised individual autonomy and self-responsibility that the wider market availability and affordability of pharmaceuticals seems to entail and promote (Ecks 2005) was disproved in
the light of the multiple relations of dependency that developed around pharmaceuticals. Whether dependency was declined in terms of economic support to access medications or in the search for help to have them administered, people gathered around pharmaceuticals, and through pharmaceuticals they could concretely share and take care of each other beyond the doctor-patient relation. Whereas the role of kin in relations of care has extensively been explored by some medical anthropology scholarship (see, among others, Biehl 2012, Das 2014, Pinto 2014), here I am interested in how relations of care spill over into the realm of hospitals and households, enter the neighbourhoods and are relocated in the pharmacies.

**Values and social lives of pharmaceuticals**

Since the very first days of my fieldwork in Athens, discourses on the medical crisis the country had been going through for the previous five years reinforced and overlapped with discourses on the shortage of pharmaceuticals, the most prominent sign of which was the empty pharmacies all over the city. Whereas the shortage of pharmaceuticals proved to be a strong argument in supporting humanitarian narratives on the crisis (Chapter 1), the actual affordability of pharmaceuticals was rarely mentioned. This point was discussed by Costas, one of the volunteers at the social clinic, who bluntly explained to me that the issue at stake was not the availability of pharmaceuticals *per se*, but rather the fact that people could no longer afford them. Not only had people’s salaries dramatically dropped, but also the state had stopped providing people with benefits and reimbursement for medical expenses. As reported in national and international newspapers, the rate of unemployment in Greece peaked between 2010 and 2015. However, medical insurance was still linked to the employment status; as a consequence, almost 3 million Greek citizens were at the same time unemployed and excluded from accessing healthcare resources. In this context, alongside primary healthcare services, the social clinics of solidarity that spread across Athens worked hard provisioning and providing pharmaceuticals as an essential means through which care could be enacted and delivered. In this sense, pharmaceuticals opened up a space where the social could aggregate around
the medical and the medical could actually boost the political by moving a critique to the current status quo: many citizens were increasingly prevented from, or denied access to medical care.

The reason why pharmaceuticals, and their provision and distribution, came to represent a crucial issue in contemporary Athens may be traced to a variety of modes of governmentality, which had over time been enforced in the pursuit of different political and economic ends at the state level. In Chapter 4 I provided a brief retrospective of how state care has changed since the onset of the crisis and with the implementation of austerity measures. Some anthropological scholarship has extensively explored neoliberalism as an economic project meant to diminish the role of the state in the provisioning of welfare services while allowing private initiatives to flourish (see for example Wacquant 2010; Muehlebach 2012). In addition, neoliberalism as a political project aimed at shaping new forms of responsible subjectivity has entered the anthropological debate, with a focus on new modes of self-government and self-care (Rose 2000, Berlant 2011, Gershon 2011).

In recent years, many European countries have witnessed the progressive dismantling of the welfare state, whereby the provision and access to healthcare resources have increasingly been linked to the introduction of a system of private insurance. In the aftermath of the 2009 economic crisis, Greece aligned itself with this trend, whereby the process of privatisation of social security funds was accelerated. Under the supervision of the institutions known as the Troika (ECB, EU, and IMF), the structural adjustments the Greek state passed dramatically challenged the idea of health as a right of the population. Entangled in the neoliberal transformation of health as a privately purchasable commodity, Greece experienced the resurgence of the role of the private sector in the public provision of health.

Since the 1990s, in Greece, pharmaceuticals have represented the cheapest and quickest means through which care could be delivered; in the same period, the Nea Demokratia government launched the first programme of neoliberalisation of state assets in an effort to modernise the state and make it
competitive in the international market. This historical moment, known as ‘the powerful Greece’, also witnessed the increased availability of OTC drugs, facilitated by the newly deregulated market and the introduction of new pharmaceutical products. OTC medications were sold without medical prescription and were meant to treat a wide range of symptoms. Furthermore, the ease with which medications were reimbursed by different state institutions reinforced practices of over-prescription (on the part of doctors) and favoured modes of self-medicalisation on the part of people. The greater availability of OTC medications enhanced practices of self-diagnosis and self-medication among the population.

While people seemed to increasingly attain the neoliberal imperative to self-care, it was the slow deterioration of the public healthcare sector that pushed the pharmaceuticalisation of the health care. A re-conceptualisation of the varying responsibilities of the individual, the corporation and the state was tied in with the process of neoliberalisation of the healthcare system. In this context, the wide availability of and the easy access to pharmaceuticals were used to cover up the progressive dismantlement of the public healthcare system. Furthermore, distrust towards doctors and frustration about medical infrastructures in general, which most of my informants complained about, seemed to have boosted a greater reliance on pharmaceuticals rather than on medical personnel. When I asked my informants whether this situation was a consequence of the crisis or not, they quickly clarified that the Greek healthcare system had never been particularly functional or completely inclusive. The crisis, of course, contributed to its worsening, yet the crisis could not be held as the main reason for its collapse.

In the years of the crisis, facing escalating healthcare expenditure as well as rising numbers of insured people, the Greek public healthcare system became increasingly inefficient in terms of both the quality of care provided and its capacity to accommodate people’s medical needs. Already, in the years immediately before the crisis, pharmaceuticals proved to be a particularly apt tool to manage the population either in rural and urban areas where public hospitals often represented the only place where people could refer to in case
of sickness. Roger Mark Selya (1988) observes that the feasibility of using pharmacies as supplements to the primary healthcare system was being explored by the authorities in the city of Cincinnati (USA) in order to improve medical care for those medically underserved people. Furthermore, he argues that practices of self-medication are no longer typical of third world countries where people either request OTC remedies from a pharmacy, or prescription drugs that the customer feels are appropriate to treat the ailment at hand, or to request advice from pharmacy personnel as to what would be appropriate to take (1988: 409). Selya suggests that in developed countries with diverse forms of government, pharmaceuticals are used as direct sources of medical help. In particular, he points out how the pharmaceutical industries favour more intensive use of pharmacies and pharmacists as sources of direct health care (1988). As has been widely explored by Biehl (2012), pharmaceuticals are likely to become the only available medical care resource in contexts of widening inequality and poor healthcare structure. In Brazil, Biehl points out, the greater availability of pharmaceuticals in the market does not necessarily mean fairer or easier access to health care: the access to pharmaceutical resources is in fact conditional on the actual economic capacity of the individuals and their kin. In this sense, Biehl’s consideration seems to directly apply to the Greek context where pharmaceuticals had progressively become the main means of delivering healthcare, although the financial crisis had threatened access to pharmaceutical resources for an increasing number of people.

In this context, the social clinic of solidarity, represented a crucial hub for the provision and distribution of pharmaceuticals outside market dynamics and the control of state institutions. As briefly sketched at the beginning of this chapter, the way in which pharmaceuticals were thought of and handled in the social pharmacy differed from, and at the same time was aligned with, what I describe as ‘the pharmaceutical pop culture’ informing practices of (self)care in today’s Athens. In this vein, both the organisers and the volunteers at the self-organised medical practice contested the excessive reliance on pharmaceuticals which, in many of my informants’ view, was promoted by doctors themselves and was structurally facilitated by the very
organisation of the healthcare system. However, as I will describe below, pharmaceuticals proved to be the only medical resource that the social clinic could offer to its patients with some continuity. What emerged from many conversations with the pharmacists at the social pharmacy, as well as from my own experience as a volunteer, was that there was indeed a rather contradictory stance towards people’s needs and desires for pharmaceuticals. On the one hand, the social pharmacy tried to favour, promote and enhance a more responsible use and consumption of medications. The purpose of this was reinforced through the system of pharmaceutical provision the volunteers had set up: the citizens were not only invited to donate their medications, but were actively enticed to recycle them. Avoiding jumping from one therapeutic regime to another, being compliant and making responsible use of medications were amongst the basic suggestions that the clinic made to people who showed some desire to participate in its activities. As I was reminded on several occasions, the ultimate aim of the social clinic was to raise people’s awareness about the medical and economic costs of wasting pharmaceuticals: the invitation to more responsible behaviours, which had over time been taken up by many citizens, aligned with and built up the urgency to help those fellow Greeks who were prevented from buying medications.

Although harsh criticism was levelled at the progressive and irreversible pharmaceuticalisation of care, pharmaceuticals remained the only form of medical aid that the clinic was able to provide. Furthermore, through pharmaceuticals, the clinic has been able to manage the ever-increasing inflow of patients that it would not have been able to accommodate otherwise. Having over time became the central hub for the free distribution of pharmaceuticals, the social pharmacy started to be perceived as both a threat and an opportunity for investments by pharmaceutical companies. During the final months of my fieldwork, between October and December 2016, I observed how some European pharmaceutical firms had already started sending parcels of medications as donations to the social pharmacy; very often the notes accompanying the parcels mentioned a moral urgency to help people in a country which had been on the verge of economic collapse, and
which was being further strained by the massive inflow of refugees since August 2016. Oldani (2004) describes the distribution of free sample of new medications with which big pharma sale- persons and doctors alike engage with as a ‘pharmaceutical gift cycle’. By ‘pharmaceutical gift cycle’ he is pointing in particular to how the pharmaceuticals market continues to expand its profits by testing new medications, and in so doing it also redirects the patterns of pharmaceutical consumption. Although on a larger scale, a similar process seemed to occur in Greece at the time of my fieldwork. Some of the volunteers at the KIA were well aware of the risks hidden in accepting those donations. In fact, some volunteers took a rather critical stance towards the possibility of accepting new branded medications from pharmaceutical companies. During one of the Monday assemblies, the same volunteers strongly opposed the possibility of accepting them. Had they been accepted, the moral and political integrity of the social clinic would have been compromised by its collusion with pharmaceuticals companies.

Moved by a different rationality, that of humanitarianism (Chapter 1), other volunteers considered that accepting those donations would not compromise the reputation and the political commitment of the social clinic, insofar that no money was directly involved in the transaction. Furthermore, the greater availability and variety of medications would have allowed the KIA to accommodate an even larger number of people, and to expand its service to the refugees that were occupying the disused airport of Elliniko. A long-term activist and organiser of the social pharmacy, Aliki, strongly affirmed that accepting help from those companies was a matter of rational behaviour that, she clarified, was actually lacking in many of her fellow volunteers. As the companies involved in the donations would not have any economic return from the distribution of the medications they had sent, it was completely fair to accept them. Furthermore, most of the medications sent from abroad were desperately needed and they undoubtedly represented an invaluable resource to help an increasing number of needy people. Arguing against the possibility of accepting donations from pharmaceutical firms were those volunteers who interpreted it as a form of collaboration with those pharmaceutical companies that had, in previous years, contributed to the worsening of the healthcare
system and triggered corruptive practices amongst doctors and pharmacists, bureaucrats and MPs alike. It was in fact common opinion among the volunteers that all those involved in health affairs had received substantial bribes from pharmaceutical representatives. In order to have their products boosted in the market, they paid money or gave gifts to healthcare professionals, who in turn were alleged to have pushed people towards an excessive consumption and reliance on pharmaceuticals. Although never explicitly addressed, the same volunteers suspected that allowing those pharmaceuticals firms to collaborate with the clinic could mean providing them with a favourable ground upon which they could start testing and circulating their pharmaceutical products. In spite of the reluctance of many volunteers, the collaborative perspective prevailed and more and more parcels of medications began to flow into the clinic almost every week, to the relief of many volunteers who did not have to check the blisters individually. Being new and untouched, they did not have to go through the same careful checking and labelling process that the blisters donated by private citizens had to. Unfortunately, as Eirini told me with some disappointment, some of these medications were of no use: either were they sent in ridiculously small amounts, or were ‘too new’ to the Greek market and they had no opportunity to be distributed. In fact, many of the patients of the clinic often refused to accept those pharmaceuticals that they had never taken before. ‘They want the medications they know. They think we have everything, as if we were a state-licensed pharmacy. They complain all the time, they don’t want generics, they don’t want those medications whose blisters are torn apart. They don’t understand that we can provide only second-hand medications. Greeks are conservative and pedantic even when it comes to medications.’

In the light of the above analysis regarding the entanglement of pharmaceuticals in the everyday social life of many Athenians, I want to highlight the diversity in the understanding and use of pharmaceuticals in and outside the social clinic. There, I suggest, pharmaceuticals were considered and valued beyond their biomedical significance, at least amongst the volunteers. The people I worked with in the self-organised medical practice, volunteers and patients, attributed utmost importance to pharmaceuticals in
virtue of their potential in reconstituting some form of social cohesion. In
their view, pharmaceuticals would not only allow people to be reintegrated
into society by virtue of the health recovery they could enhance: they also
acquired a special moral value. As a sort of luxury good whose price had
dramatically increased at the market level, the social clinic distributed
pharmaceuticals for free. In this sense, the social clinic transacted
pharmaceuticals both outside the logics of markets and against state
regulations. Despite everything, the volunteers made clear that no money had
ever circulated in the social clinic as either a private donation or as financial
aid from institutions, although in many conversations money figured as the
main referent to quantify the value of the pharmaceuticals that had over time
been donated to the clinic. Once Valia, one of my main informants, informed
me with some pride that a parcel of medications worth of 8,000 euros had
been sent from Switzerland, where a school had managed to collect a fair
amount of medications to be sent to the clinic. While she was not able to
provide me with any further information about the school and the promoter
of this initiative, she was quick to monetise the donations. On another
occasion Vasiliki, a longterm volunteer in charge of managing international
relations with foreign donors, loudly announced that the medications sent by
Medicine Sans Frontiers equated to almost 20,000 euros. I suggest that
quantifying donations in terms of money functioned to measure the impact of
the social pharmacy on society, and the reference to money was also used to
increase the moral worth of the social pharmacy that managed to distribute
pharmaceuticals for free and with no economic returns.

Pharmaceuticals as objects of affection: money, materiality and the
affective responses to the crisis

Aimee Placas (2016) considers how money became an everyday topic of
conversation in crisis-plagued Athens. In so doing she traces how ‘money
talks’ have changed first with the introduction of the euro in 2002, and later
during the implementation of austerity measures. She suggests that the change
in attitude towards money was mainly due to the crisis, as the availability of
money became an everyday concern for many citizens. In this context she
argues that the ‘intimate financial details of households have become
moments of shared cultural intimacy at the level of the nation.’ I assume that a similar dynamic was at play in the social pharmacy where ‘money talks’ were ambiguously mobilised not just to quantify the biomedical value of the donations, but also to elevate the position of the social clinic towards the state which was in fact indebted to the pharmaceuticals industry to €1.05 Bn and was no longer able to supply medications to an increasing number of citizens. Crucially, money and pharmaceuticals were not just entangled in the volunteers’ conversation, but they were also mobilised to criticise the state. As reported by the head of the Attica Pharmacists’ Association, Yannis Dagres, in 2015 Greece faced a shortage of 140 medicines which used to be supplied by three pharmaceutical companies. In fact, the shortages mainly arose from liquidity problems and from manufacturers deliberately reducing supplies. In an interview released to The Pharmaceutical Journal on the 2nd of July 2015, the spokesperson of the PanHellenic Pharmaceutical Association, Dimitris Karegeorgiou, bluntly declared that ‘nobody can afford to pay for their medicines. There’s no more credit. No one can afford to buy medicines from wholesalers or pharmaceutical manufacturers.’

Sometimes excel sheets were circulated among the volunteers to give them a sense of the work that had been done: the amount of a given medication was reported together with corresponding monetary value. Vasiliki, a very talkative pharmacist who was the spokesperson of the clinic and in charge of international relations, explained that it would be silly to lose the opportunity that money donations would provide. What she normally did was to take the donor to the pharmacy, or to send him a list of the medications needed which would equate to the money donation. In so doing, no money would concretely enter the pharmacy, but the pharmacy would still benefit from it. Although money was a frequent reference to assess the value of the medications donated, money was generally associated with practices of corruption

characteristic of the state, as Yannis pointed out. He explained that ‘wherever money enters, something bad happens. Because of money, families can split up. Can you just imagine what would happen if the clinic starts handling money? Everyone is a good person here, but money has the power to corrupt everything and everyone. Even those you wouldn’t expect.’ Like Yannis, many other volunteers mentioned how the clinic had categorically rejected financial aid, even in those cases where the money could have helped to improve the services the facility offered. Furthermore, it was common sense among the volunteers that accepting money would have meant becoming subjected to the will of the donors, and likely the clinic would have lost its independence. Being indebted to the donors would in fact have meant having to change the ethics informing the work of the clinic and, as Valia commented, the clinic would have become just another charity supported by a generous philanthropist. Similarly, financial aid from different state institutions had repeatedly been rejected: accepting it would have resulted in working closely with the state institutions that the clinic criticised and opposed, at least ideologically. In my informants’ opinion, getting money from the state would have equated the clinic with NGOs, which in Greece were widely considered as employment centres for the relatives of state workers and the bureaucrats of political parties. Despite how money was generally talked about in rather negative terms, volunteers constantly made reference to money in order to further emphasise the value of the medications donated or stored in the pharmacy.

The relations between money and pharmaceuticals proved to be quite ambiguous in the context of the social clinic, as well as the attitudes of the volunteers to both. Whereas the entanglement of pharmaceuticals and capitalism has extensively been explored in terms of pharmaceuticals’ capacity to generate the inflow of capital in the Global North by exporting new medications, patents and global health trends to the Global South (Sunder Rajan 2017), in the context of Greece this relation must be situated and problematised in light of the local ecology of care (Das and Das 2006). However, it seemed to me that converting monetary donations into pharmaceuticals had the power to morally ‘clean up’ money as it was invested
for a social purpose. In this sense, money was no longer a sign of individual wealth, and by becoming objects of care it contributed to improving society by directly and positively impacting on the health of many citizens. Given this premise, I argue that pharmaceuticals were able to generate emotions and affective responses in both the volunteers in the pharmacy and the people who received them for free. I also suggest that at the intersection of the economic and the social lies the affective response that pharmaceuticals generated in the individuals.

In fact, as also emerged from the very first conversation I had with Maria, the pharmacist in charge on Fridays, the price of a medication established not only its medical worth, but through its price it was possible to measure its social value. In the case of anticancer medications, Maria clarified that they needed to be checked with extra care because they had a value of hundreds of euros. While it is undeniable that anticancer medications were given a special status because of the severity of the medical condition they were meant to treat, in the routine of the pharmacy they were always referred to in terms of their economic rather than biomedical value. Maria often called me closer and with some pride showed me the price impressed on the package of some medications. ‘You see, this costs five hundred euros’ she pointed out to me while checking an anticancer medication ‘and the person who had owned it donated it to the pharmacy, and we can now give it for free to someone who would never be able to afford it. And you see, it’s pretty new, and it hadn’t been used much. That person would have died soon. Poor man, but at least his relatives didn’t throw it away. They might easily have. This won’t go to waste. Rather it is helping someone’s else life.’ Maria, and the other volunteers alike, read people’s willingness to donate their medications as a clear sign of a change in their attitude. She also made the point that people increasingly donated their medications to the clinic because they experienced it as a reliable and trustworthy place where something concrete was being done to help their needy fellow citizens.

‘For sure, people have gained awareness of many Greeks’ conditions of hardship. They
know that many people cannot afford medications, they have read many stories of people who died because they couldn’t go to the hospital or because they had to drop their therapies. You know, they couldn’t buy the medications they needed. Now they know all this, and they want to help. You see, the pharmaceuticals they bring? In another moment they would have thrown them away, or could have let them expire in the bathroom cupboard. The most important fact is that people trust us, they see that we do all this work for free and no one gets money for what he does. Over time we’ve gained more and more visibility, which means that we’ve received more and more donations and that allows us to reach out to more people. People proved to be incredibly generous and want to help with what is in their means, although they rarely become volunteers here. They bring their bags and say they hope their donation will help someone else. Many of our donors don’t even walk into the clinic, they just leave the bags at the door. Perhaps they don’t even imagine how much their donation means to us and to those who will receive it. Sometimes we open the bags and all we find is just one or two blisters in a damaged package. Sometimes they bring simple Panadol [very cheap painkillers]. But I’ll tell you, it’s not important what they bring, it’s the act of giving that matters the most. People want to help with what they have, that’s the point. It’s their way to say: we know many are suffering from the crisis, but they are not alone.

Pharmaceuticals lived several social lives insofar as they were recycled in different moments and travelled across pharmacies, households, and social pharmacies; the different phases of their uses became evident in the several handwritten updates of the number of pills left in the blisters. In addition, many packages bore the signs of their owners’ medical stories and of their therapeutic routines; the days of the week on which a given pill had to be taken, or the times of administration were often written down on the package. I will come back to this point later to describe the affective response the medications seemed to generate among the volunteers at the social pharmacy. In this context, the afterlife of medications was allowed by their re-
introduction into the solidarity circuit after having carefully been checked, fixed and re-labelled by the volunteers. I suggest that the work the volunteers carried out could be defined in terms of repair practices that in fact entailed multiple forms of care, responsibility and expectations. As techniques through which medications could be repaired and distributed afterwards, these practices reproduced and at the same time altered the conditions of medical inclusion. Equally, forms of tacit and lay knowledge about pharmaceuticals seemed to emerge in a way that resembled what Van der Geest and Whyte Reynolds define as the indigenisation of pharmaceuticals.

As emerged ethnographically from my fieldwork in the social pharmacy, pharmaceuticals were able to create bonds and affective responses among people in light of the persistent imagination that their circulation across households and among people contributed to the creation of a sense of belonging to the same community. Drawing on Yael Navaro Yashin’s idea of melancholic objects as objects bearing the memory of sociality (2009), I see pharmaceuticals as healing objects that help to reconstitute a sense of belonging by virtue of the circulation across different social spheres where they were successively re-appropriated by several individuals. People apparently managed to relate to the community through those medications that had belonged to others: this created not just temporal continuity over which the phases of the crisis became evident, but also a sense of affective bonds among individuals who shared the same conditions of vulnerability. Navaro Yashin sees the objects characterising the landscape of Cyprus as having the capacity to create ‘an economy significantly out of objects and belongings to Greek Cypriots, and a political system that would not gloss over but also explicitly organise, administer and support such misappropriation and (re) possession’ (2009: 3). Whereas Navaro Yashin considers that the role of objects is situated in a precise historical and political situation,31 which does not bear any resemblance with that of today’s Athens, I found her ethnographic analysis of objects as discharging affects through the circulation

31 Her fieldwork was conducted in Cyprus in the aftermath of the partition between Turks and Greeks.
and re-possession to apply very well, at least in terms of process, to the circulation and repossess of pharmaceuticals in the ethnographic context I analyse. I am interested in how ‘affect is generated in a community that has recreated its life and livelihood significantly on the basis of objects and properties belonging to another community’ (Navaro- Yashin 2009).

Pharmaceuticals as objects, in my ethnographic example, contributed to recreate a sense of social and medical belonging: as objects that would probably have been destroyed, pharmaceuticals were ‘recycled, domesticated and incorporated, quite creatively in fact, into the social orders’ (Navaro-Yashin 2009: 5) and in the medical routine. Through what I have considered to be repair practices, affective responses were generated, while a process of personifying the medication donated was also put in place. Often my fellow volunteers described the medication they were checking by commenting on (or imagining) what the donor had suffered from, who had taken care of him and who had brought the medication to the clinic. In this sense the recounting of the donor’s suffering became possible through the materiality of the medication, which in fact bore the signs and the symptoms of the disease; at the same time the awareness of one’s suffering boosted the affective responses to the medical donations. Navaro-Yashin suggests that ‘the relations people forge with objects must be studied in their historical contingency and political specificity’ (2009: 9), and argues that those relations may arise, for instance, in situation of a long-term state of emergency or crisis, which have been created by way of keeping certain people and things out, by excluding them by means of borders, as in the case of Cyprus, or governmental politics in the case of Greece.
Conclusion
The pharmaceuticalisation of care

Crisis serves as a transcendent placeholder, because it is a means for signifying contingency; it is a term that allegedly allows one to think the otherwise
Janet Roitman (2013: 9).

While the implementation of austerity measures has, since 2010, pushed people into a downward spiral of unemployment and poverty, in July 2016 the Syriza government passed a law by which people who had previously lost their entitlement to access public healthcare resources have been formally re-admitted to public hospitals. However, many people’s right to access public healthcare facilities was only legislated, but never implemented. The material conditions for their access have in fact remained unfavourable: the few public hospitals which were not shut down during the crisis have not received sufficient financial support from the state, and there were not enough paid medical personnel to manage an increasing number of patients flowing back into public healthcare facilities. The availability of pharmaceuticals has remained inadequate, as has the supply of medical equipment to public healthcare facilities. In this situation, the KIA has continued to supply medications to public hospitals in Athens and, occasionally, across the Attika region. While the public healthcare system was on the verge of a structural collapse, a thriving private healthcare sector has flourished and, across the wealthier neighbourhoods of Athens, luxury medical hubs have mushroomed. The progressive decline of the public healthcare sector and the blossoming of the private one mirror not just an increasingly starker societal polarisation between the poor [fotoxoi] and the rich [plousioi] who were differentially able to access healthcare resources on economic lines; it has also made clear the ‘expanding therapeutic itinerary in which individuals seek out diverse avenues, both state sponsored and informal, in biomedical, spiritual and alternative medicine to achieve personal fulfilment of their notions of health and wellbeing’ (Brotherton 2012: 7).
In this sense, the end of the economic crisis as officially announced by Alexis Tsipras in August 2018 has not corresponded to any actual improvement in terms of distribution and accessibility to healthcare resources. Consequently, the existence of the social clinic, which the volunteers was long considered to be contingent on the crisis, no longer represents ‘the other face of the crisis’ (Cabot 2016a), but rather the utmost visible manifestation of the process of reconfiguration of the medical landscape. Consequently, the KIA, together with the wider constellation of solidarity medical initiatives, now figures as a novel permanent healthcare provider which has played an increasingly significant role in the provision of care, alongside private and public healthcare providers. I claim that the presence of the social clinic where I conducted my fieldwork and other social clinics of solidarity in Athens and elsewhere in Greece can therefore be understood as a diagnostic of how the state has progressively withdrawn from the provision of welfare services and reconfigured the medical landscape accordingly. At the same time, I hold the presence of the KIA to be revelatory of the state’s changing bio-political projects, which have progressively led to the individualisation of health and the privatisation of healthcare, amongst many other processes in the neoliberal restructuring of its assets. I have suggested that the expanding presence of a voluntary medical sector is one of the most visible signs of this process of state reconfiguration.

In the gaps left open by the state’s withdrawal from service provisions, diverse projects of social welfare flourished as temporary forms of contestation to the state, which was not only deemed responsible for the crisis, but also alleged to marginalise an increasing portion of the Greek population. However, over nearly a decade of austerity, these same grassroots initiatives have become more and more institutionalised, and the state has increasingly outsourced healthcare provision to them. Andrea Muehlebach (2012) notices that similar dynamics have taken place in Italy where, she explains, the rise of voluntarism actually corresponded to the state’s withdrawal of social service programmes. Muehlebach concludes that the Italian neoliberal state cultivated citizens’ selflessness in order to advance some of its most controversial reforms, which were all aimed at the redefinition of the welfare
programmes.

As laid out in the introduction and throughout the chapters constituting this thesis, I have suggested that the KIA has become increasingly aligned with state institutions. Accordingly, I have considered the bureaucratisation of care (Chapter 2) and the pharmaceuticalisation of care (Chapters 4 and 5) as evidence of the KIA’s tendency to perform like a state institution. Indeed, the KIA has taken on the biopolitical responsibilities that the volunteers, the citizens and the patients considered to be duties of the state. In taking these on, the practices of care as pursued at the KIA point to people’s imagination of the state when it comes to the fair provision and equal distribution of healthcare resources. As emerged ethnographically, the state my informants longed for was a form of fully inclusive welfare state which could provide citizens and non-citizens with entitlements and rights to free education, healthcare, social protection and pensions. As has been made explicit in the thesis, I have considered the state to be composed of different institutions designated to dispensing services and documents to citizens and, occasionally, to non-citizens. Indeed, what emerged as ethnographically relevant was the role of bureaucracy, as a form of ‘practices and representations of the state’ (Gupta 1995). Therefore, the presence of a bureaucratic structure within the KIA acted as a powerful ethnographic cue to trace the waxing and waning presence of the state in people’s lives, and in places where the presence of the state was least expected. In the face of volunteers’ requests for documents, those registered as KIA patients seemingly related to this medical facility as if it were a state facility. As I argued in Chapter 2, the traveling of bureaucratic documents across and from diverse state institutions and the KIA compelled people to consider the KIA as a delocalised manifestation of the state. I have therefore suggested that at the KIA, the bureaucratisation of care as a performance of transparency was meant to convey a sense of fairness and stability to a solidarity structure whose provision of medical services was initially born out of improvisation. However, the progressive bureaucratisation of care also signalled the progressive stabilisation of the KIA as an accountable healthcare provider which has, over time, gained recognition and legitimacy within the Greek
Another aspect related to the continuity of practices between the KIA and the medical institutions of the state emerged in what I have identified as the pharmaceuticalisation of care. In spite of a critical stance towards the state, KIA never actively contested or attempted to subvert the modes through which medical care was administrated in the medical institutions of the state. While lamenting the lack of a functional primary healthcare system and the disconcerting ease with which doctors and pharmacists prescribed or suggested pharmaceuticals to patients, the KIA volunteers could not but rely upon pharmaceuticals to deliver medical care. In fact, pharmaceuticals provided a ‘familiar frame of reference’ (Douzina Bakalaki 2017a) within which volunteers and doctors alike could organise practices and practicalities of care. The progressive pharmaceuticalisation of care as an effective and economic mode of care came first under state-sponsored programs, whose aim was to reduce the inflow of people into public healthcare facilities and to lessen the population’s dependence on public healthcare resources. Crucially, as I have also highlighted in Chapter 4 and Chapter 5, the widespread use of pharmaceuticals, which have been made increasingly available on the market since the 1990s, encouraged practices of self-medication that, in turn, promoted new modes of (supposedly) responsible self-care. In a similar vein, Van der Geest, Whyte and Hardon suggest that ‘self-medication is encouraged in reaction to the overdependence on medical services. For consumers, it is a movement to assume greater responsibility over their health. For the state, it is a welcome opportunity to economize on healthcare. It also benefits the pharmaceutical industry’ (1996: 165).

Drawing on anthropological scholarship that has investigated the relationship between poor healthcare infrastructure and the widespread use of pharmaceuticals (see, i.e. Garcia 2010; Biehl 2012; Pinto 2014), the entanglement of impoverished healthcare infrastructures, pharmaceuticals and practices of self-medication have represented the departure point of this work. Whereas much anthropological literature has analysed how pharmaceuticals became a valid yet cheap substitute for poor infrastructure
of care, in the Greek context the outbreak of the economic crisis radically changed the terms of the relationship between pharmaceuticals and healthcare infrastructures. I suggest that in austerity-ridden Athens, pharmaceuticals themselves became an infrastructure of care in the absence of functional medical infrastructures. In defining medical infrastructure, I have drawn on Street’s (2014b) understanding of infrastructure as that ‘which is neither an abstract nor a physical stuff, it is the relationships between people, stuff, and space that enables health systems to work.’ While the absence of adequate pharmaceutical supply and provision became a defining feature of the public healthcare system, the informal provision of pharmaceuticals as operated by the KIA figured as a timely response to that pharmaceutical scarcity. This response came in the form of continuity of practices of care that state institutions had initiated.

As premised in the introduction of my thesis, I have focused on how practices of care as enacted with and through pharmaceuticals came to represent a community-based mode of care. I have suggested that the KIA absorbed and appropriated modes of pharmaceutical care that were peculiar to home-based care practices; I have argued that these practices had been shaped and enticed by certain state policies concerning pharmaceuticals whose greater diffusion and affordability on the market was favoured in order to relieve the public healthcare system back in the 1990s. As I have also laid out in Chapter 3, in the context of the social clinic the process of sorting pharmaceuticals as a practice of care generated relationships and relatedness amongst the female volunteers that took part in the KIA’s activities. I have argued that, around pharmaceuticals, new regimes of affective labour emerged and further blurred the boundaries between the private and the public. Accordingly, I have analysed the role of pharmaceuticals in reconfiguring practices of care by looking at scholarly works that have discussed how pharmaceutical drugs, and the lack thereof, allow people to have different experiences of illness, care and disregard (Biehl 2004b, 2012; Ecks 2005; Petryna 2013;). In Chapter 4, I described how the impossibility for people to access pharmaceuticals provided them with the terms to contest and make claims on the state’s medical institutions. As an ethnographic probing of the concept of
governmentality, what I have described as ‘the will to be medicalised’ can be read as a ‘technology of visibility’ (Street 2012), a paradigm that substantially inverts the terms of what Scott (2009) considered the state’s attempt to make society legible coherently with a project of statecraft. Drawing on Street (2014), I have suggested that ‘the will to be medicalised’ falls into the realms of people’s strategic upending of their experiences of suffering and loss in order to become visible to the state, and thus to be included in the remains of a meagre welfare provision. In this sense, people’s quest for pharmaceuticals spoke to two different forms of suffering; suffering that was said to derive from both a medical and social conditions that the crisis had possibly exacerbated. In turn, it resulted in forms of social exclusion or, as Biehl (2005) would have it, zones of social abandonment. Indeed, as I also showed in the five chapters constituting my thesis, there were significant ethnographic slippages in my informants’ stories relative to the crisis and experiences of illness on the one hand, and their need for pharmaceuticals and the scarcity of healthcare resources on the other hand. In this context, the condition of illness offered unexpected margins to the emergence of new relationships between ‘the sickened citizenry and the state’ (Petryna 2013a: xxv). Illness came to represent more a political and social, rather than the biological, condition over which claims on, and complaints against the state could be advanced (Petryna 2013a). As I also teased out in Chapter 1, the idiom of illness and that of the crisis overlapped in ways such that illness came to be dislodged from the individual body and relocated in the social body: the KIA expanded its services and reputation at the interplay of the political and the medical in a context of diffused poverty and institutional neglect.

A final point that needs to be made as a conclusion is in relation to the role and meanings that pharmaceuticals acquire when they leave the clinic, enter the households and work to shape kin and neighbourhood relationships (see i.e. Pinto 2014; Han 2013; Biehl 2004a). In arguing that pharmaceuticals have contributed to cementing a sense of relatedness and care amongst people, I have followed the anthropological scholarship which has extensively focused on how in some contexts biomedical technologies, and pharmaceuticals in particular, become the substratum over which lay medical knowledges are
produced. Pharmaceuticals can in fact be adapted to, and interpreted according to, local cultures (Hardon 1987; Van Der Geest, Whyte and Hardon 1996:158). Similarly, pharmaceuticals can undergo a process of indigenisation (Whyte 1992; Ektin, Ross and Muazzumu 1990) while opening up and retaining novel imaginaries about health, diseases and wellbeing (see for example Delvecchio Good 2001; Dumit 2012). Entering into dialogue with these different bodies of literature, I have shown how the pharmaceuticalisation of care in Greece has followed patterns which aligned and at the same time diverged from those devised by some anthropologists. Their ethnographic inquiries have specifically pointed out how pharmaceuticals contribute to the making of compliant and atomised subjects. Anthropologists have made sporadic incursions into the realm of the sociality of pharmaceuticals (see Paxson 2004:109; Han 2013; Pinto 2014; Ecks 2017), but have usually focused on how the pharmaceuticalisation of care is a response to and a consequence of forms of state neglect and abandonment (Garcia 2010; Biehl 2004, 2012). Scholars have argued that pharmaceuticals legitimate forms of disregard and violence against the most vulnerable members of families and households (Han 2011; Biehl 2012; Pinto 2014), and I am aware that this mode of care could apply in the Greek context. However, what emerged from my fieldwork in Athens is that the circulation, sharing and exchanging of pharmaceuticals reinforces social bonds amongst kin, friends and, often, acquaintances. The materiality of pharmaceuticals represents a tangible and concrete manifestation of care which, at the same time, retains the promise of recognition, inclusion, belonging and therefore care.
Afterword

In January 2018 the Social Clinic of Solidarity of South Athens received a notification from the Pan-Hellenic Association of Pharmacists (PHF). The notification urged the social clinic to cease its activity of pharmaceutical provisioning. Informants and friends from the KIA explained that the Pan-Hellenic Association of Pharmacists considered the crisis to be over, and therefore people’s financial capacity to afford healthcare resources was restored to normality. Christos, the manager of the KIA Facebook account, boldly declared that the only reason why the Pan-Hellenic Association of Pharmacists wanted to shut down the social clinic was for more economic reasons: the KIA’s presence in the medical landscape was threatening the Greek pharmaceutical market, thus negatively affecting the profits of many pharmaceutical firms. Christos’ explanation also voiced many people’s appreciation of the collusion between the PHF and the pharmaceutical firms, amongst which Novartis stood out. Indeed, Christos’ interpretation of the recent notification was passionately embraced by other volunteers who, in ardent online posts, claimed that ‘solidarity will win again’ [allileggi tha nikesei] and the KIA would continue to work in spite of any threats. The work of the KIA has in fact been crucial to the survival of many citizens whose health was put at risk by the crisis, and the lack of adequate state provision of medical care. After several days of heated online debates, the situation had apparently returned to normality. Whereas I cannot say what negotiations occurred between the actors involved in the controversy, the KIA has continued with its activity of provisioning and distributing pharmaceuticals to people. For the KIA volunteers, the crisis was not over at all: an ever-increasing flow of patients crowded the waiting hall of the clinic, and an even larger number of people were still queuing to receive medications for free. Contrary to the projections of the macro-economic indicators which signalled the economic recovery of the country, many Greek citizens’ entitlement to public healthcare resources had not actually been restored, nor had their economic affordability actually improved: people were still relying on the
KIA for free medical services, as well as on other similar medical grassroots initiatives.

Some months later, in May 2018, I received an email from Eirini, one of the most active members and organisers of the KIA. The subject field of the email was incisive: ‘the KIA has been sentenced to death.’ Always uncertain about how to navigate the highly metaphorical nature of the Greek language, I opened the email with mixed feelings of scepticism, expectation and some morbid curiosity. Eirini informed that the KIA had just received a notice of eviction, and had been given three months to dismantle its activities and to clean up the building it had restored and occupied for the past six years. Friends and informants from the neighbourhood voiced their anger towards the state institutions and the market, while remaining confident that ‘solidarity will win’ [allileggu iha nikesei] because ‘solidarity is our weapon’ [allileggu einai ta opla mas]. After a couple of days of heated online posts about mobilisation in the neighbourhood where the KIA is located, the local assembly and international mobilisation as well, Eirini emailed me again. Bluntly she informed me that the KIA had managed to negotiate with the local municipality, which finally agreed the concession of the small building. The closing line of the email was emphatic: ‘solidarity won’ [ allileggu nikesei].

Crucially, while the KIA was being exhorted to end the pharmaceutical provision and notified of its imminent eviction, the headlines of Greek newspapers and public debates were occupied by the Novartis scandal. As reported by AMNA, a Greek press agency, as well as other international agencies, the Swiss pharmaceutical corporation Novartis was alleged to have actively corrupted and bribed Greek public authorities, politicians, academics, and doctors, to expand its profits during the apparently unprofitable period of the crisis. Corruption by monetary and other favours allowed Novartis to promote the circulation of their products into the Greek market, while giving them a competitive advantage and boosting sales. Doctors were enticed to over-prescribe Novartis pharmaceutical products with the lure of economic favours; politicians were requested to put the Novartis products at the top of the positive list of pharmaceuticals in
exchange for money, gifts and other forms of remuneration. The Pan-Hellenic Association of Pharmaceuticals and the Pan-Hellenic Associations of Pharmacists were alleged to have favoured Novartis’ monopoly over the Greek pharmaceutical market. As resulted from investigations, between 2006 and 2015 the same politicians who imposed austerity and dramatic cuts to health budgets, closing down hospitals and laying off doctors and staff, actually allowed Novartis to expand its profits. Interestingly, the market manipulation was initiated in a moment when the rhetoric of the cost-containment was put forward to justify the progressive dismantlement of the public health system. Meanwhile, the management of the social insurance which had previously regulated access to public healthcare resources was transferred to the Novartis: the passage to a private insurance system was ultimately accomplished under the auspices of the state institutions. In January 2015 the electoral victory of the leftist party Syriza was hailed with hopes that austerity measures would be reversed, a functional welfare system would be re-engineered, and a fully inclusive public healthcare system would soon be reconfigured. However, in July 2015 the Syriza-led government agreed on the third memorandum, which ultimately resulted in more austerity measures aimed at further reducing the public expenditure. However, three years after the so-called capitulation of Greece to the Troika, in January 2018 the macro-economic indicators triumphantly declared the economic recovery of the country. The same optimism was voiced by the people close to the Syriza government: in August 2018 Greece would in fact exit the programme it had subscribed to with the Troika in July 2015. However, Syriza MPs and supporters strategically omitted the fact that Greece would remain indebted at least until 2052, the ultimate deadline by which Greece must pay back its debt to the so-called Institutions (International Monetary Fund, European Commission and European Central Bank).
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