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Intersecting vulnerabilities and compounded risks of women asylum seekers working in care during COVID-19 in Ireland

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Abstract: This article explores findings from a qualitative participatory study with asylum seekers in Ireland employed in the healthcare sector during the COVID-19 pandemic. By extending an intersectional analysis framework, we demonstrate how the vulnerability of care workers living within the international protection accommodation system 'under the care' of the state intersects with power exercised by the neoliberal care market and is compounded by global health controls instituted during the pandemic. Participants reveal a lack of autonomy and forms of precarity that were not faced by other care workers, particularly increased risk of exposure to COVID-19 and multiple forms of stigma.

Keywords: care worker, asylum seeker, COVID-19, intersectionality

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Introduction

The COVID-19 pandemic initially seemed to generate greater political salience to paid care work in health and social care sectors and unpaid informal care in private settings (Fine and Tronto, 2020). Care was regarded as an important lens to both understand what occurred in our societies during the pandemic and to support the study of care to reconsider social inequality and the future of care work (Daly, 2021). Yet, a few years on from the onset of the pandemic there are questions about whether there has been a consistent focus on care in public discourse or if the long-term consequences of the pandemic will 'transform, and draw needed attention to, the place of care?' (Tronto and Fine, 2022: 4). This revival raises opportunities to refocus on: the power dynamics in arranging care which influence the economics of paid and

unpaid care (Keller and Kittay, 2017); how inequality is exacerbated by the commodification and globalisation of care; the gendered, raced and classed nature of care work (Hankivsky, 2014); and to underscore how poorly remunerated paid care work is (Rummery and Fine, 2012). Perspectives informed by the feminist ethics of care have been concerned that the burden of informal and institutionalized care largely falls on working class and minority women (Held, 1995). Feminist care ethicists have also critiqued the importation of care labour from low- and middle-income countries to fill 'care deficits' in developed market economies (Tronto, 2015). Contributors to care discourse have been urged to continue to expose relationships of power and domination within the demographics of the care workforce which have been profoundly shaped by legacies of colonialism, slavery and racism (Narayan, 1995) and to think about how feminist ethics of care theory intersects with race and other identities (Raghuram, 2019).

Centring relationality within feminist ethics of care perspectives allows for an examination of the situation of 'all those persons who are marginalized and excluded in contemporary global relations' (Robinson, 1997: 119). While Global Care Chain scholarship has helped expose inequalities constructed through the globalization of care work, it may have inadvertently privileged aspects of transnationalisation (Yeates, 2012). The informal and paid care work provided by refugees and asylum-seekers has been less visible in this field. Recent scholarship has challenged the construction of people seeking international protection as receivers but not givers of care. Caring relations of refugee women providing unpaid care labour in their homes, volunteering for community organisations and caring transnationally for families who have yet to be reunited have been identified (Larios, 2019). Informal care provided by asylum-seekers

responding to a high level of care needs exposed by the barriers they and their families face in accessing the state welfare system and formal care services has also been considered (Herz et al, 2022). Yet existing work has not sufficiently explored the routes that asylum-seekers take into paid care work and their experiences in care markets.

This article contributes to the visibility of paid care work provided by asylum-seekers by exploring the experiences of a group of women working in the health and social care sector in Ireland during the COVID-19 pandemic. We underscore the intersections of race, gender, devaluation of care work, the precarity of seeking international protection as factors that can compound exclusion and thwart autonomy. Given that asylum-seekers are not economic migrants nor is their entry into the care workforce facilitated through transnational recruitment, we know less about their experiences of working in the care sector. To explore this, we first provide some context including variance in the rules of migration regimes. The post-colonial position of the Republic of Ireland constrained solidarity with other decolonised and decolonising nations (McVeigh and Rolston, 2022). There have been limits to integration of migrants including nationals of *other* former British colonies, who often experience racialized power dynamics within Irish society. There are also unique legacies, particularly the dominance of Catholic institutions, which have shaped Ireland's two-tiered public/private health and social care sector. The Health Service Executive (HSE) oversees the provision of the publicly funded healthcare system.

Ireland's management of its obligations to provide international protection also has specific features. Applicants are accommodated in Ireland's system of Direct Provision and Dispersal (DP) while they await a decision from the Department of Justice. This system was introduced in

2000 as an ‘emergency’ response to accommodate increased numbers of applicants. The International Protection Accommodation Services (IPAS) oversees and allocates places in DP centres located across the country, mostly managed within privately owned hotels and tourist lodges. These congregated settings provide shared catering facilities, bathroom and laundry facilities. Space in a shared bedroom is allocated to single asylum-seekers and families with children are also often accommodated within one room. While the system was designed for a stay of around 6 months, typically asylum-seekers reside in DP for several years while they await a decision as there is a significant backlog in processing applications. Since 2018 people seeking international protection in Ireland have been granted employment rights but only after a supreme court case was fought by an asylum-seeker (European Database of Asylum Law, 2022). Currently, asylum-seekers must still wait 6 months after they make an international protection application before they can seek employment (European Union Agency for Asylum, 2022).

Ireland has been severely and continually criticised for human rights concerns arising from the operation of the DP system (Breen, 2008; Working Group on the Protection Process, 2015; Government of Ireland, 2020). When the COVID-19 pandemic emerged in Ireland there was a heightened awareness about the inhumane living conditions and the health risks in the congregated facilities of DP (Gusciute, 2020; Irish Refugee Council, 2020a; Murphy, 2021; Isaloo, 2021). A parliamentary Special Committee on Ireland’s response to COVID-19 framed the State’s duty of care for asylum-seekers as ‘vulnerable adults and children’ (Houses of the Oireachtas, 2020: 36). Importantly, the Special Committee acknowledged that the pandemic care work force included ‘residents of direct provision centres and others were migrant workers

who, because of the low pay in the (nursing home) industry, were forced to cohabitate with fellow workers in over-crowded living conditions and thus also could not self-isolate' (Houses of the Oireachtas, 2020: 15). This revelation of the multiple caring relations of asylum-seekers showed 'glimmers of an awareness which recognises the intersecting and overlapping identities of care giver and care receiver' (Daly and Edwards, 2022: 8). Moreover, a submission to the Special Committee identified specific difficulties facing this cadre of care workers (Irish Refugee Council, 2020b). Our article echoes and expands on this evidence.

Furthermore, a review of the international protection system commissioned by the Government pre-pandemic but undertaken during the initial waves also recognised that 'some applicants are making an invaluable social contribution as frontline health workers during the current COVID-19 crisis' (Government of Ireland, 2020: 76). In a subsequent Government paper setting out reforms to the international protection system the Tánaiste, Ireland's deputy head of Government, stated that he was 'very aware that large numbers of asylum-seekers and former asylum-seekers have been essential workers in this pandemic working in areas like healthcare' (DCEDIY, 2021: 9). Our research seeks to build on the awareness of the dual positionalities of asylum-seekers in Ireland as care receivers and care givers. We do so by exploring the intersectional vulnerabilities a group of women asylum-seekers experienced during the initial waves of COVID-19 through examining the conditions of their work in the health and care sector as well as their informal care relations within and beyond life in DP.

Methods

Our qualitative empirical approach utilized semi-structured interviews to explore lived experiences of a group of vulnerable care workers. Our sample comprised women care workers

residing in DP centres located around Ireland and working in the health and social care sector during the initial waves of the COVID-19 pandemic in 2020. In October and November 2021, we held three preparatory discussions online with two potential research participants each[1]. These discussions foregrounded a participatory approach, allowing asylum-seekers to suggest a range of themes that we might explore in our research. They emphasized that they supported social justice-oriented research which could 'make some noise' to influence changes in the conditions of asylum-seekers in Ireland.

After receiving ethical approval[2], we conducted six 1-1 interviews online via Microsoft Teams between June and September 2022 including four women who participated in the preparatory discussions. While our project had facilities for translation, all interviews were conducted in English[3].

Our original recruitment goal was six-eight respondents and attrition partly relates to time lapsed while waiting for the outcome of our ethics review. We maintained utmost flexibility in scheduling to facilitate participation of women with multiple, competing demands on their time. While generalizability is limited, the findings are highly relevant to a small cadre of less visible care workers[4].

All participants are Black women originating from sub-Saharan Africa who are applicants for international protection. All had experience of working in hospitals and nursing homes during the initial waves of COVID-19 in a broad range of care roles[5]. An ethics-informed decision was taken to not collect demographic information nor ask about factors leading to forced migration. We are White researchers, one an Irish national with extensive experience in migrant support,

and one a dual American-British national. Both researchers have worked extensively in sub–Saharan Africa as researchers and international development practitioners.

To reveal the unprecedented challenges to care work and congregated living that the pandemic presented, our interviews explored: the care impacts of the COVID-19 pandemic; arrangements for care giving; perspectives on care receiving; informal care networks within DP; peer support among care workers; whether participants feel 'cared for' as asylum-seekers; and how they think asylum-seekers could be better supported to give and receive care.

We edited transcripts generated by Microsoft Teams and shared a draft with participants to check accuracy and ensure their consent to utilize contents. Thereafter the co-authors developed a coding frame and the first author used NVivo 20 qualitative software to assign codes to transcript content. The co-authors reviewed the coding results, including concept maps demonstrating relationships between codes and their relation to micro and meso factors. These were reviewed with our research team and research advisory group. We also shared a summary of our findings with participants and sought another round of input from them which elicited some additional points along with suggestions of issues to raise when engaging with policy actors. Presenting the findings herein, we have used pseudonyms to maintain confidentiality and differentiate participants.

Our analysis is informed by Fiona Williams' (2018) framework which drew from Patricia Hill Collins' (1997) illumination of the experiences of Black domestic workers and Kimberlé Crenshaw's (1989) analysis of how sex and race intersect to disadvantage Black women. Williams sought to capture multidirectional dynamics at micro, meso and macro levels shaping

the experience of paid care work in neoliberal care markets. We extended this framework to identify how asylum-seeker status and care work within COVID-19 intensifies these factors. Our analytical framework is presented in Table 1.

Table 1: Intersecting precarity of asylum seekers working in care during COVID-19	
MICRO	Intersecting inequalities of race, gender and migration status of care workers Challenges of living in DP exacerbated by COVID-19 Reliance on partially suspended public transport Lack of autonomy and uncertainty of international protection applicants
MESO	Migration – care- work nexus Routes into care work for non-economic migrants Barriers to joining care workforce from congregated setting Precarity of 'agency staff' filling gaps in health workforce due to toll of COVID-Power dynamics displayed by provider management of health workforce
MACRO	Transnational political economy of neoliberal care markets and privatized services Global Health Governance impacting public health decisions taken at national level Anomalies in COVID prevention in care work Risks in international protection accommodation

In the findings sections that follow we explore the multiple intersecting impacts of the particular context of delivering care in the COVID-19 pandemic and specific structural factors bearing on asylum-seekers living in State constructed DP system in Ireland.

Findings

At the outset we stress that all factors intersect in influential ways shaping day-to-day experiences of research participants. COVID-19 introduced a vast series of macro level impositions mandated through global health governance which translated into decisions taken by national governments. These impacted: functionality of health systems, migration regimes, the economy and escalated care commitments and care labour to unprecedented levels. We present three analytical levels - from macro to meso micro -to trace the compounded burden of pandemic restrictions on institutional structures resulting in severe limitations on the autonomy of asylum-seekers working in care in Ireland. Rather than centring a care ethics critique of how autonomy encourages privileged irresponsibility for care (Held, 2006; Tronto, 2013) we are concerned about a lack of autonomy asylum-seekers have over basic and intimate details of their everyday lives, particularly within their living arrangements and spaces (O'Reilly, 2018).

Macro:

The emergence of a novel coronavirus in late 2019 placed intense demands on national health and care systems and set in train unparalleled public health responses restricting movement and interrupting the global economy. When the pandemic began to emerge in Ireland the Government established the National Public Health Emergency Team (NPHET) for COVID-19 to develop and implement strategies to contain the outbreak. After the World Health Organisation (WHO) characterized COVID-19 as a global pandemic, the Government issued measures to curtail the spread of the virus during the initial waves of the pandemic from March 2020. These instituted a societal lockdown which imposed stricter restrictions on movement and lasted longer than similar measures in other European countries. Key rationales for the

measures were to avert deaths, particularly among the elderly who were considered most vulnerable, and to protect Ireland's already strained two-tiered health care system. The burden on public and private health and social care providers revealed significant weaknesses intrinsic to Ireland's political economy of care which has been driven by neoliberal profit motives.

Our participants identified how macro dynamics restricting movement and the ability to socially mix compounded at meso and micro levels. Within health and social care workplaces, SARS-CoV-2 prevention protocols recommended by WHO determined practices for health workers. Participants highlighted that they were dismayed by what they perceived as anomalies in prevention measures. Sarah, a care worker deployed to an Irish hospital during the initial wave of COVID-19 shared the following:

> "The doctors were tested, but the rest of us were not. We were just asked to go home and self-isolate and if we have any symptoms that somebody would call us, and if there was any symptoms that we should let them know...I kind of found it unfair. Even though we are doing our best, giving it our all, it was only doctors that were being tested the rest of us had to go home." (Sarah)

Some carers also expressed that they were sometimes put in positions where they were not required to wear personal protective equipment (PPE) mandated for the clinical prevention of SARS-CoV-2. Harriet felt that she was being asked to take risks in the nursing home she worked in saying:

> "I was told that you are a close contact. I never knew that resident has some symptoms of COVID. When attending to the residents we use gloves, we use mask and apron. But that is the normal PPE, but we need, the ***proper*** PPE for COVID prevention. I was still new by

that moment on that difficult pandemic period. They were supposed to tell us *despite someone has symptoms or not you have to protect yourself by using this kind of PPE*. You never know because some symptoms they may not come out...and you might find someone is positive, but there's no symptoms. So how are you going to protect yourself and protect other residents?" (Harriet)

Sarah revealed the emotions that she coped with as an international protection applicant and a care worker who faced very high-risk working conditions during COVID-19. She said:

"I was really scared because, I fled to my country, coming here for protection. And now I was put in a war front…I know the line of job...you were still scared. I'm not even Irish, I'm just a refugee and I have to go through that and this was like seeing my life on the line." (Sarah)

Macro level controls restricting travel to prevent the global spread of COVID-19 interrupted migration trends, including limiting the movement of forced migrants. Meanwhile, the public health threats inherent to informal settlements and overcrowded congregated accommodation left refugees and asylum-seekers exposed to SARS-CoV-2 (Raju and Ayeb-Karlsson, 2020; Hintermeier et al, 2021). In Ireland, COVID-19 outbreaks within DP accommodation contributed to the assessment that the system was *not fit for purpose* (Government of Ireland, 2020). Every participant in our study experienced ineffective COVID-19 prevention within DP centres. They identified a lack of consistent implementation of the measures issued by Department of Justice and Equality and the HSE (2020) to protect DP residents during COVID-19. We explore this alarming reality further as we consider how the translation of macro level

public health guidance complicated meso and micro factors of precarity for asylum-seekers working in the care sector.

Meso:

At the meso level our participants were constrained by institutional, political, economic and cultural processes which were often changed and strained during the pandemic. Pre-existing structural dynamics within the migration-care-work nexus, along with emergency public health protocols, wrought new forms of control over our participants' lives. Stressing that our participants are not economic migrants, several recalled how they found an initial employment option in Ireland through vacancies common within low-paid, devalued care work. We did not collect information about their work experience prior to arrival in Ireland, and several recounted that they endeavoured to obtain an educational qualification which would be recognised by Irish health and social care sector employers. Some participants detailed how they took online care skills training during the COVID-19 lockdown within their small, shared bedrooms in DP. These constrained settings presented many challenges to complete course work: tensions were raised between roommates trying to follow their own online class versus those wanting to rest; compromises were made such as sitting in stairwells during lectures, and class times conflicted with a fixed catering schedule resulting in missing meals. Such sacrifices made by asylum-seekers to get their foot in the door through training, demonstrates a certain level of dedication to work as carers.

Once ready to look for a job, asylum-seekers faced specific barriers to joining the care workforce during the initial waves of the pandemic. Initially, some faced stigma due to living in a congregated setting, though as more care workers eventually succumbed to COVID-19 they were deployed to fill care workforce shortages. Ruth recalled:

> "When you call any nursing home - they just ask you *where you coming from*? If you just say you're coming from (DP) accommodation they say *unfortunately, we cannot take you because you are living in a shared accommodation*. So, at first, they couldn't take us...they came to take us when [there] was shortage and nobody like to work for them." (Ruth)

The terms offered by care sector employment agencies were precarious as they predominantly issued very short-term contracts. Importantly, international protection applicants would not be offered permanent employment by the HSE, or private firms operating hospitals and nursing homes given that their work permits are issued for only 12 months[6]. Harriet reflected on her employment process:

> "[There was] a shortage of staff...it's an HSE nursing home. So they are trying to look for the agency staff, which are not permanent staff, just temporary job. So I had to register with [an] agency and I was lucky to get that job, though it's not...a guaranteed shift because our duty is to cover the HSE staff." (Harriet)

She was dismayed that she was unable to parlay this into an opportunity to be offered a HSE contract saying "I'm qualified to get employed with HSE. But since I applied, I've not got that opportunity. Yet, they are short staffed. We are just asking ourselves *what are they looking for*?" (Harriet)

Ruth brought attention to another factor of precarity at the intersection of employment, international protection regulations and public benefits. In Ireland, asylum-seekers are granted a medical card to access free health care and prescription services, but they are not entitled to this benefit once they are employed. This becomes problematic when a worker isn't contracted full time. Ruth shared how this conundrum impacted her during shift work:

> "When you are working now they take off your medical card…like COVID you will need medicine and sometimes you are not working the whole week you cannot even afford to pay for your medication...a health worker could be considered for the situation like medical cards, you know? Because it is sad sometimes that you become sick, and you cannot help yourself...you should be insured...because being a health worker it's a challenge. It's not like any other job." (Ruth)

The HSE and private health care providers introduced a solution to address some of the risks that workers living in DP posed in the workplace by arranging temporary housing for this cadre of care workers during their short-term contracts. Our participants found that there were anomalies in COVID prevention measures in these settings as well. Chioma recalled that she was dismayed by the guidance. She said:

> "I'm not allowed to (visit other carers in their room). But when I'm going to work, I go to work in the same car with [other carers]. So, for us it didn't make sense. You're not allowed to go outside. You're not allowed to do anything. You are just closed in the room. But the reality was we were COVID negative, all of us, but we're being treated like people who were positive." (Chioma)

Temporary accommodation also raised another risk for asylum-seekers: the potential loss of their room in DP. Ruth detailed how these arrangements served the needs of employers but fell short of the duty of care for employees. She said:

> "That time when they need us when there was shortage, they could get you a hotel somewhere. When they have staff, it's stress for you to come back. You tell the nurse manager who took you they say *no you are finished [working] you are supposed to go home*. Even they don't provide for you taxi to take you back. You will just feel I'm really being used because when they need me, they will provide [transport]. But now when they don't need staff, they don't care how you are going back [to DP]'. And the management [of DP] don't care how you will come...Some of my friends [management] gave out the room [in DP] ... they tell you no longer have a space...Luckily for me, they didn't give out my room." (Ruth)

Furthermore, IPAS, the institution responsible for asylum-seekers' housing, did not facilitate the removal of these care workers from pandemic front lines. Ruth continued:

> "[IPAS] could make it easy. We have to send email, they won't reply. Without reply, management cannot receive you. They say *we are waiting the report from IPAS*. IPAS is really uncaring. It's so bad. You were on the line of duty, it's not like if you are the one who just decided to miss the accommodation. But you were really working, and they know. The people who are helping us are people from NGOs and others. I know my friend who had to sleep outside. He had to go to [a migrant rights NGO] and say, 'look, I was doing health work and my hotel told me to go out and they said IPAS are not answering. So,

I'm now living on the street. I don't have anywhere to stay'. [A migrant rights NGO] had to accommodate." (Ruth)

Our participants reveal complex intersections at the meso level of care, migration and employment regimes which reinforced their precarity at the height of the COVID-19 pandemic. These, in turn, impact on them day to day as they try to balance their lives and care relations.

Micro:

At the micro level asylum-seekers providing care within Ireland's response to the COVID-19 pandemic faced unique challenges within their everyday experiences. Employment provides one way to integrate in society yet when entering the care sector to fill gaps exposed by the impact of COVID on care workers, our participants, who are all Black women from sub-Saharan Africa, experienced forms of exclusion. Ruth spoke to us about how racialised stigma and discrimination shaped her engagement with residents confined to nursing homes during lockdown saying:

"The people you are always caring for you for years and years are no longer with you. So, these...are new people, mostly we were agency staff...Like the situation already is bad. Their relatives cannot visit them. As we are new, they don't know us...They're Irish, and different Indians, Africans [are caring for them] ...mostly they withdraw, like they didn't like us...but I understand how they were feeling. *New people are treating me, and I am missing my family*. You have to be understanding where you put yourself into their shoes." (Ruth)

Harriet spoke about coping with nursing home residents' negative reactions to different workers joining the care sector. She said:

> “There’s one resident...because of dementia and everything she hated all Black staff...she didn't want any African person to go close to her. And two ladies, they were trying to provide care to her, and she started screaming *no, no, no. You are hurting me. You're hurting me*...they came to understand that lady that she's not OK. But...now she's very OK to everyone. She can even come to you and try to hug you and everything.” (Harriet)

While racialised discrimination and unequal social relations may be common to micro level experiences of migrant care workers, our participants detailed that they faced unique challenges. Intersections at the axis of the living in the congregated setting of DP during a pandemic while working in the health and care sector on the frontlines of the COVID-19 response intensified daily. Increased exposure to the risk of SARS-CoV-2 spreading within the congregated setting of DP accommodation was a key factor shaping the experiences of our participants. Nala conveyed that she perceived differences in the application of COVID-19 prevention measures for DP residents to actions taken by individuals working in DP centre management. She recalled:

> “We were many using the same door, we were sharing bathrooms, we were sharing tea rooms because you can’t have a kettle in your room. You are not allowed to cook in your room. We’re sharing the taps where you get water. We’re just sharing everything. At some point during lockdown, we even asked if we can open the doors, so that we don’t touch many doors ... [DP centre staff] said for fire safety we can’t open them...but with them, in the reception, they’ve got the corridor door open.” (Nala)

Harriet indicated how the inability for care workers to isolate provoked fears among the other DP residents. She said "It was very difficult because even other residents, they were scared of us. Because we have to share the laundry, we have to share the kitchen, we are using the same corridor to pass." (Harriet) Moreover, Sarah recalled another form of stigma she experienced as a care worker. She said that within DP:

> "people just kind of avoided me, *don't come into my room, you work in the hospital*...I felt kind of stigmatized, because you're just trying to help, but it didn't feel good because people actually think that you actually pose a danger to them." (Sarah)

These sentiments were echoed by Ruth who returned to DP after being temporarily accommodated elsewhere during one of her short-term work assignments. She said:

> "You don't want to say where you are working because everybody was scared. Like you are working in nursing home and yeah, there's a lot of COVID cases. You are roommate is arguing with you *why you are working there? You want to bring again this COVID again!* Me, I just want to continue with the work... It was like it's something bad we are doing. It was like you are not doing the normal work." (Ruth)

After Sarah had been exposed to COVID-19 in the hospital she worked in she had to find a way to avoid common areas in DP, particularly the dining hall as communal eating had not been discontinued in her DP centre. She continued:

> "I told my friend *I have been in close contact with someone who is COVID [positive] and I am meant to self-isolate*. So, my friend would bring me food and put it through the

window of my room...I had not yet been positive. I was just a close contact. I didn't want to create a scare." (Sarah)

Negotiating these unique challenges of the front lines of a once in a lifetime pandemic created specific forms of stress among our participants. Ruth reflected:

"If I was in my own house at least I feel it could be less stressful...somebody living outside [DP] you could say it's normal, everybody was scared with health workers that something could happen. But I feel like it didn't affect [other care workers] directly like the way I was affected." (Ruth)

A common example of a micro impact of macro level restrictions was regarding the operation of public transport. In many countries there were suspensions to transport systems during COVID-19 lockdown and in Ireland these changes practically eliminated an already very limited public transport system. This limited affordable options asylum-seekers relied on to travel to and from hospitals and nursing homes for their shifts. The precarity of low paid care work extends to ability to afford transport and most asylum-seekers are reliant on limited public facilities to get to work on a day-to-day basis. Sarah shared that:

"For me it was much more difficult during the COVID period because, transportation practically stopped working...the bus services were quite bad. You would just have one or two buses going on that route. The bus would not run until 10:00/10:30 and working in the care field, you have to be there by 8:00. It wasn't consistent, there was days you would just stand there, and the bus wouldn't come and you still just have to find your way. So, I'd have to get a taxi to take me to work. And coming back, I had a colleague who was driving,

and the colleague would just drop me off at the [DP] centre, on her way to her own home." (Sarah)

Mandisa provided a detailed example of how restricted public transport affected her ability to properly rest between night shifts at a nursing home. She said:

> "After finishing my shift at 9:00, I'll take a taxi from my workplace to the bus station to take a 9:50 bus. I'll be here [in DP centre] around 11:00. I'll go and see if there's something that I can take from the lunch menu…Afterwards I'll only be able to rest from 16:00 to 18:00. That is my period of sleep. 18:45 I'm going out because my bus is 19:05. Even though my shift is 21:00 I have to leave early because of this bus and then take a taxi. How much time do I have to rest? I'm on my feet the whole night. The only time I can rest is if I cut down shifts. But if I can't do more shifts, at the end of the day I'm just working [to pay] for transport." (Mandisa)

When comparing the context of our participants with other care workers we note that pandemic restrictions created extreme challenges to providing care on the frontlines. Other care works may have been able to maintain prevention protocols in their own homes and rely on their own transportation to and from work. Our participants also revealed that throughout this period they were also living with the daily stress and uncertainty of awaiting a decision on an application for international protection. Chioma spoke about the impact of a lack of autonomy in her everyday life. She lamented:

> "I think as an asylum-seeker, you get to that point whereby you just accept anything. You don't challenge anything because you know, you are not even given an option. It's *THIS* or

THAT...I've zero stability at all. What people don't understand is Direct Provision cripples people. Not only mentally, but emotionally...It's not that asylum-seekers are not grateful. We are grateful, but the system breaks us. I personally want to feel like I'm a part of a place. But right now, there's no place that I can feel like I'm part of. I just feel like I'm stuck, that's all." (Chioma)

Nala also revealed the inherent care deficits that asylum-seekers face saying:

"It's not easy to leave your own place of growth. You're leaving everything. You leave your family. You leave your children... you leave the other support, like the friends you have when you grow up with, your own community. And you don't know where you are going. You don't know what are you going to do" (Nala)

Nala also reflected on the kind of care that would make a difference within Ireland's provision of international protection suggesting "maybe if there's consistency... If they can give support to everybody." (Nala) A source of support that participants did identify was found among the peer group of other care workers who are asylum-seekers. Chioma said "some of us formed close bonds" (Chioma) and Sarah told us "We supported each other. We all did. We saw people die. We saw people get through it. We saw people go from bad to worse." (Sarah) Yet Chioma also identified that the dilemmas she and her peers encountered because of the realities of their living arrangements combined with the stress of care work during COVID imposed limits on mutual support. She reflected that "we are not helping each other with anything. We are just venting at each other." (Chioma)

The compounding of micro, meso and macro factors expose the very real and challenging everyday contexts and dilemmas our research participants faced. The unique and intersecting

precarities of living in the congregated setting of DP, working in the health care sector during the initial phase of COVID 19 when tensions and anxiety were high and simultaneously trying to maintain their own, other residents and their families' health provides insights into a range of care deficits this cadre of vulnerable care workers experienced.

Discussion

In this article we explore how structural controls and COVID-19 pandemic restrictions uniquely impinge on day-to-day experiences of care workers whose immigration status limits their autonomy Within unprecedented challenges of care work in the COVID-19 pandemic, intersecting factors at the micro, meso and macro levels impacted women seeking international protection in intense and compounded ways that revealed a range of care deficits at work and in their accommodation. While the DP system has been continually critiqued since its inception, our participants reveal specific challenges of living within this system while contributing to the health care workforce. As international protection applicants their lack of autonomy was exhibited by decisions made about them by IPAS, DP management, the HSE and private care market agencies. The opportunity to take on precarious employment gave rise to vulnerability to potential homelessness.

We underscore that inconsistent application of COVID restrictions within DP centres heightened all residents' vulnerability. For this cadre of care workers the simultaneous lack of agency to effectively implement COVID-19 prevention guidance as residents of DP centres or the ability to consistently protect themselves adequately in care workplaces rendered them more acutely

vulnerable. Our participants shared that they noticed differentiated application of COVID prevention measures that were able to be implemented by DP management. Furthermore, their positioning on lower rungs of the healthcare workforce meant that they could not access all available prevention protocols which could increase their exposure to SARS-CoV-2. Moreover, they faced dual forms of stigma, both from potential employers and from other residents within DP centres regarding the perceived risk they embodied when working in a hospital, nursing home or other care setting.

We find that while these women formed part of the cohort of essential workers who were deemed invaluable and lauded for their valiant efforts within the COVID crisis their multiple intersecting vulnerabilities presented greater day-to-day challenges than front-line care workers who could rely on their own transport and maintain prevention protocols within private accommodation. When considering how our participants' experiences compare to other groups of migrant care workers navigating the precarities of gender, race and migration status, our attention is drawn to dilemmas faced by international protection applicants in accessing and engaging in employment, a right afforded to them in Ireland only since 2018. COVID restrictions seemed to construct a further set of precarities and barriers to asylum-seekers' ability to make a sustainable contribution to the health and care workforce. We find that our participants faced everyday experiences of discrimination and racialized reactions on the basis of gender, race and ethnicity which are among the dominant factors shaping the global care labour force. Yet, the sensitivity shown by our participants to those receiving their care demonstrated a generosity and deep understanding of possible reasons for discriminatory or hostile attitudes expressed towards a different cadre of workers brought in to fill care

market gaps in the COVID crisis. We underscore that this cadre of workers may not have initially intended to have a career in care and yet they demonstrate care values (Sevenhuijsen, 2004), such as compassion and nuanced sensitivities to the complexities of care dynamics in the workplace.

The power held by employers over this cadre of care workers was exemplified by shifting attitudes and rapid changes which disadvantaged them and further increased their precarity. The conditions of short-term employment contracts and temporary accommodation changes leaned heavily towards the needs of the employer while threatening the security of asylum-seekers' state provided accommodation and access to free health care. At first, employers 'wouldn't touch' people living in DP, then once they were needed to fill care workforce gaps employers decided where and when workers would be moved out of DP, telling DP management, not workers and leaving them no time to prepare. Employers seemed to treat care workers as an economic unit rather than as someone who has personal caring relationships. Our participants also provide evidence of the inability for IPAS to respond in a timely manner to ensure asylum-seekers could be re-accommodated in DP after returning from providing care on the front lines of the pandemic. Such treatment gave rise to extreme outcomes, such as vulnerability to homelessness while still living 'under the care' of the State. Ironically the 'risk factor' for becoming homeless was making an invaluable contribution to the COVID crisis. The complexity of our participants' experiences reveals a lopsided approach where care workers are not cared for and where the dilemmas, they were put in accentuated the negative mental health impacts of the precarity of life as an asylum-seeker. As we continue to assess the emerging evidence of the long-term damage of the COVID crisis on mental health we

must examine the impact on care workers, particularly vulnerable asylum-seekers working in care.

Conclusion

In this article we provide detailed evidence of how care workers who are asylum-seekers responded to the unprecedented care needs revealed during the COVID pandemic. Our analysis supplements the identification of asylum-seekers' paid work in the Irish health and social care sector and adds to the growing evidence of the lack of care within the congregated settings of DP accommodation. Moreover, our findings reveal that the DP system was incapable of effectively responding to the risks presented by a communicable disease pandemic and unable to facilitate the role some international protection applicants played as health and social care workers within the pandemic response.

Our adoption of Williams' (2018) micro, meso and macro framework synthesizing intersectionality, the transnational political economy of care and the ethics of care, enabled us to contextualise this analytical tool for use in pandemic times and to consider the unique experiences of people seeking international protection working in care. Our extended framework facilitated coding our data to identify the specific and intersecting factors at work at multiple levels. By considering the compounding of macro, meso and micro level impacts wrought by COVID-19 restrictions we demonstrate increased health and wellbeing risks among a cadre of vulnerable care workers. We appreciate the depth of the original framework in

revealing how the interplay of gender, race and migration imprint on daily experiences of these care workers through to the wider structural controls enacted within the care sector.

The ways in which we have extended Williams' framework allow us to demonstrate how COVID-19 generated new and complex barriers for this cadre of care workers whose pathways into the health and social care sector differ from other groups of migrants typically discussed in the literature on transnational movements of care labour We analyse how the interplay of care, employment and migration regimes exposes vulnerabilities of this cadre of care workers. We also demonstrate how being regulated by an international protection system struggling to adequately safeguard the health of applicants starkly revealed existing care deficits of DP. Learning from our participants' experiences could support the State to enact the practical application of care, recognise and address these vulnerabilities.

Taking macro level global health dictates as a starting point we reveal the uneven application of pandemic mitigation and how this added complexity to the operation of privatized care sectors and placed burdens on care labour. We find all the various complexities are compacted at the micro level where the lack of attentiveness to care needs of asylum-seekers overall and of this particular cadre of care workers is apparent. It is our sincere wish that this article effectively raises the voices of a vulnerable cadre of care workers and 'makes some noise' to influence changes in their living and working conditions. The findings suggest the marginalisation and exclusion of asylum-seekers in the labour market and we hope this work informs an ethic of care toward these workers in Ireland's health and social care workforce. The dilemmas they

encounter demonstrate care deficits which must be addressed within the expected dismantling of the current Direct Provision and Dispersal system and Ireland's wider obligations to provide international protection, uphold human rights and safeguard public health.

Notes

1 These discussions were facilitated by Dr Naomi Masheti, a member of our research advisory group, representing Cork Migrant Centre, a migrant rights organisation.

2 Ethical approval was granted by the University College Cork Social Research Ethics Committee (Log 2022-026).

3 This was not by design; language was not an exclusion criterion.

4 While there are no official data on asylum-seekers in the health workforce, it should be considered that if all women seeking international protection were working in health and social care, they would make up only 1.11 per cent of this workforce (calculations based on data from Government of Ireland [2020] and www.statista.com).

5 We did not collect information on job titles.

6 See: www.irishimmigration.ie/my-situation-has-changed-since-i-arrived-in-ireland/ labour-market-access-permission/

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Conflict of interest

The authors declare that there is no conflict of interest.

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