RETHINKING CARE LABOR ON THE EDGE OF PRECARITY: IMMIGRANT WOMEN'S EXPERIENCES OF THE COVID-19 PANDEMIC PERIOD

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ABSTRACT

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Keywords: immigrant women, caregiving labor, COVID-19 pandemic, companionship, precarity

This thesis aims to investigate how immigrant women in Turkey have experienced the COVID-19 pandemic in terms of women's caregiving labor. The research focuses on the immigrant women's experiences of companionship for COVID-19 patients. How immigrant women accept the work of companionship for COVID-19 patients is discussed both from the personal perspectives of women and the roles played by different actors. The state, employers, health institutions and employees have caused immigrant women to be exposed to the risk of disease with different roles in this process. In this context, the role of state is analyzed by the continuity of immigrant women's employment in precarious, temporary, and low-waged jobs during the pandemic period. The changes experienced in the context of neo liberalization in Turkey's health system since the 1980s resulted in an increase in the workload of doctors and nurses during the pandemic period. In order to cover the increasing needs, the labor of immigrant women has been demanded by both employers and healthcare workers. On the other hand, employers have manipulated immigrant women's acceptance of companionship work by exploiting their relationship of trust and acquittance with immigrant women as a means of pressure. Even though immigrant women who work as companions for COVID-19 patients are exposed to the risk of disease and know that they are in a disadvantageous position compared to other healthcare workers, they have tried to facilitate the companionship process for both themselves and their care recipients with various strategies.

ÖZET

GÜVENCESİZLİĞİN UÇLARINDA BAKIM EMEĞİNİ YENİDEN DÜŞÜNMEK: GÖÇMEN KADINLARIN COVİD-19 PANDEMİ DÖNEMİ DENEYİMLERİ

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Anahtar Kelimeler: göçmen kadınlar, bakım emeği, Covid-19 pandemisi, refakatçilik, güvencesizlik

Bu tez Tükiye'deki göçmen kadınların COVID-19 pandemi dönemini nasıl deneyimlediklerini kadınların bakım emeği işi üzerinden araştırmayı amaçlamaktadır. Araştırmada Türkiye'ye farklı ülkelerden, farklı zaman dilimlerinde gelen kadınların pandemi döneminde koronavirüsü hastalarına refakatçilik etme deneyimlerine odaklanılmaktadır. Göçmen kadınların koronavirüsü hastalarına refakatçilik etme işini nasıl kabul ettikleri hem kadınların kişisel açılarından hem de farklı aktörlerin oynadıkları roller açısından ele alınmaktadır. Devlet, işverenler, sağlık kurumları ve çalışanları bu süreçte farklı rollerle göçmen kadınların hasta olma riskine maruz kalmalarına sebep olmuşlardır. Bu bağlamda devletin rolü göçmen kadınların güvencesiz, geçici ve düşük ücretli işlerde çalışmalarının pandemi döneminde de devamlılığı üzerinden okunmaktadır. 1980'lerden itibaren Türkiye'nin sağlık sisteminde neoliberalleşme bağlamında yaşanan değişimler pandemi döneminde doktor ve hemşirelerin iş yüklerinin daha da artmasıyla sonuçlanmıştır. Artan ihtiyaçların karşılanabilmesi için göçmen kadınların emeği hem işverenler hem de sağlık çalışanları tarafından talep edilmiştir. İşverenler ise göçmen kadınlarla aralarındaki güven ve tanışıklık ilişkilerini baskı aracı olarak kullanarak kadınların refakatçilik işini kabul etmelerini etkilemişlerdir. COVID-19 hastalarına refakatçilik eden göçmen kadınlar hastalık riskine maruz kalmalarına ve diğer sağlık çalışanlarına göre dezavantajlı olduklarını bilmelerine rağmen çeşitli stratejilerle refakatçilik sürecini hem kendileri hem de bakım verdikleri kişiler açısından kolaylaştırmaya çalışmışlardır.

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1. INTRODUCTION

All over the world, the COVID-19 pandemic has intensified the inequalities across different social and economic classes and increased the visibility of already persistent inequalities between these different classes. Immigrant caregiver women, just like other disadvantaged people, have experienced hardships of the pandemic in exacerbated forms. In this COVID- 19 pandemic period, working as companions at hospitals to assist COVID-19 patients has emerged as a new employment area for immigrant women in Turkey. I first heard this from my father who was the companion for my grandfather in the hospital room. He mentioned that in one of the rooms there was an Uzbek or Turkmen woman who was taking care of the patient, even more meticulously than my father cared for his father. Although my father explained the role of immigrant women with a reference to her gendered abilities, his observations have led me to question the precarious positions of immigrant women.

I evaluate immigrant women's position as precarity due to their immigrant identity and their limited access to certain services in the countries they have migrated. Even if they immigrate legally, most of them are not able to maintain this status hence they experience difficulties due to their lack of citizenship status. To utilize gender category as an analytical tool allows us to consider how immigrant women accept certain jobs which have been historically associated with women (Mahler and Pessar, 2006; Lutz, 2010). Caregiving work is just one of these employment areas and caregiving for COVID-19 patients is just a new facet of it.

Until this time, in the Turkish context, the live-in caregivers' situation during the COVID-19 pandemic, specifically companion work, has not been studied. By focusing on the changes in the lives of immigrant women during the COVID-19 pandemic and discussing how and under which conditions they accept to work as companions, this thesis discusses the state's role in enabling immigrant women to work in insecure conditions. I state that employment of caregivers in precarious and risky environments for COVID-19 patients is one of the results of the changes in Turkey's healthcare system since the 1980s and immigration policies. In addition, by pointing out to the employers' role I discuss how trust and familiarity relations affect women's decision-making processes. Through these fac-

tors, although immigrant women are constructed as bio-politically vulnerable, from their standpoints each of them evaluate the risk of contracting the virus differently and make different choices. By highlighting the interplay of different factors' roles in women's decision-making processes I believe this thesis contributes to both migration studies and medical anthropology literatures.

1.1. The Context of the Research and Methodology

In this thesis, I will point out the changing daily lives and risk perceptions of immigrant women who had been working as live-in caregivers for the elderly before the COVID-19 pandemic and accepted the companion work at the patient's home or the hospital contexts later on. Work patterns of immigrant women during the pandemic may vary, hence I will be focusing on (i) What kind of concerns they had in the decision-making process (ii) What kind of conditions led them to accept working as companions, if the immigrant women accepted to work as companions without any experience of caregiving.

My preliminary questions are as such: In which ways has the COVID-19 pandemic rendered the precarious conditions of the immigrant caregiver women more severe? Under which circumstances do the immigrant women accept taking care of COVID-19 patients in the patient's home or in the hospital? How do they construct their subjectivities concerning the perception of the risk of illness in relation to their work as companions? How do they evaluate their physical and psychological health condition since the beginning of the pandemic?

Based on semi-structured in-depth interviews with 10 women who came from post-Soviet countries, I explore how the COVID-19 pandemic conditions have affected immigrant women's lives and how women coped with their exacerbated precarity in different ways. At the beginning of this research project, I was planning to conduct interviews with immigrant women from Central Asian countries since I observed on the online accounts of employment agencies and in daily life that most of the immigrant women who are looking for caregiving work are from this region. However, during the research process, I also got in contact with immigrant women from Georgia and Armenia who are also part of the Turkish care labor market in a relatively non-visible way compared to Turkmen and Uzbek immigrant women. Immigrant women from Georgia and Armenia have less visibility on the employment agencies' social media platforms. Since Armenian

and Georgian women have been living in Turkey longer than Uzbek and Turkmen they have a higher chance of finding a job through social network and acquaintances. However, immigrant women from Uzbekistan and Turkmenistan are more likely apply to consultancy firms to find a job and they use social media platforms like Facebook to navigate job offers.

The fact that consultancy firms make Uzbek and Turkmen women more visible may also be because employers prefer Uzbek and Turkmen women because of their religion and Turkic origin. Although immigrants who have Turkish origin have a much advantageous position, this status is not static and the status of immigrants who are of Turkish origin changes over time by the policies of Turkish state (Danış and Parla 2009). During my interviews, I could only talk to Karina, who is one of my Armenian interlocutors, about this issue. She told about her experiences with Turkish and Armenian employers that she was more satisfied with Turkish employers in general and she explained that she had many problems with an Armenian employer in the past years. Although her experiences do not reflect the whole picture, considering Turkey's political relations, we can think that Armenian and Georgian women are not preferred as much as Uzbek and Turkmen women. In addition, considering language and cultural affinities are important components of caregiving work, employers prefer Uzbek and Turkmen women (Akkan et al. 2019, 26).

In accord with that, the number of immigrant women coming from Georgia and Armenia and working in elderly care is lower than that of Turkmen and Uzbek women. There are two major reasons behind this differentiation: first, during the COVID-19 pandemic, each country has implemented different border policies, hence immigrant women in Turkey have experienced mobility restrictions at different degrees. For instance, Turkmenistan has kept its borders closed and that is why caregiver women I know could not see their families since the beginning of the pandemic. As we learn from Nurdinova's study, the government of Uzbekistan called Uzbek citizens back from Turkey and arranged flights. However, some immigrant women continued to work in Turkey, while the sick, elderly and pregnant people were prioritized in that call (Nurdinova 2021, 22).

As a result, the immigrant women from Turkmenistan, Uzbekistan, and Georgia became more visible in the Turkish care labor market. However, many immigrant women from Armenia had a chance to visit their country of origin because the church provided them free bus trips at the beginning of the COVID-19 period. I could not learn which church provided this opportunity. Considering that the Turkey-Armenia border has been closed I assume that they went through Georgia. My Armenian interlocutor Karina mentioned that and explained after she became unemployed, she unwillingly decided to visit her

country and live with her family to limit her living expenses.

Second, some of the immigrant women from Armenia, due to their long-term experiences in elderly caregiving work, demand higher wages than Uzbek or Turkmen women. Although they could earn more in the caregiving work, some women prefer lesser paying jobs like dishwashing because they are more comfortable. For women to make such a choice they should not have an urgent need for money. What is an urgent need and what is not is also shaped by women's points of view. As immigrant women from Uzbekistan and Turkmenistan are less experienced in caregiving, and they live in Turkey for a shorter time compared to Armenian and Georgian women, they have fewer work options when they have an urgent need.

1.2. The Theoretical Framework and Literature

Caregiving work of immigrant women is a subject that has been studied extensively in the academic scholarship and particularly in the case of Turkey. Women's immigration from less affluent countries to countries which demand low wage paid workers has been studied by feminist scholars, scholars who specialized in migration issues or welfare state policies. Such studies from a macro perspective demonstrate that women's immigration trends coincide with the globalization trends including the changes in the logic of welfare states (Hochschild and Ehrenreich 2012; Sassen 2003). With the incorporation of immigrant women's labor, care sectors became dependent on the labor of immigrant women but still caregiving work considered as worthless (Parreñas, 2015) . As caregiving is considered to only belong to the private sphere, it has been named as reproductive labor hence its value is not recognized under the capitalist system. However, many feminist scholars argued that reproductive labor is not independent from the productive labor; unlike the condition of productive labor is to have reproductive labor (Federici 2019; Bhattacharya 2013). To explain with an example, one of the basic conditions for women and men to work in many countries today is to have someone who can take care of their children, elderly and help with housework.

Although the devaluation of caregiving work stems from the fact that it is constructed in the private sphere and under the responsibility of women, the relocation of caregiving work to public spaces did not change that either (Tronto, Joan C. 2013). Accordingly, immigrant women have continued to conduct caregiving work in insecure and low-waged

conditions. These conditions stem from work permit systems which reflect the demands of countries they migrate. Working conditions at domestic or private spheres are very similar but they are shaped by the conditions of the migrated country.

To examine work permits which determine the working conditions of immigrant women is important to understand why women accept to work as companions for COVID-19 patients. Like in many other countries such as Singapore, Canada, Great Britain, the work permit system in Turkey is causing employees' dependence on their employers. In this sense, the work permit system in Turkey is not unique.

Parreñas et al. (2020) in the context of Singapore, discuss that these work permit systems allow employers to hold the power that "allows to use 'soft violence' as a tool to implement arbitrary control over the employees' acts". Here, soft violence refers to immigrant women's choiceless position that leads them to accept every order of their employers to protect their legal status and continue to earn money. One of the examples regarding the implementation of soft violence is the confiscation of immigrant women's passports by their employers. This well- known practice is implemented to one of my interlocutors Armin and she agreed to hand over her passport to the employer because she received an advance for her father's surgery. As in Armin's story, immigrant women must fulfill the demands of their employers due to different obligations and there is no mechanism to control the demands of employers.

In the Turkish context, Ayşe Akalın (2018) states to benefit from immigrant women's "availability" and "gendered capacities" the work permit system has been used as a form of governmentality in the Foucauldian sense. Rather than "availability", Dilan Eren (2018) uses the concept of "biopolitical vulnerability" in reference to biopolitics (Foucault, 2003) and exploitation (Balibar, 2013). Eren (2018) discusses that Balibar's formulation of exploitation such as taking advantage of others' vulnerabilities is inherently biopolitical so she emphasizes "biopolitical vulnerability" rather than "biopolitical availability". In the context of companion work, I believe immigrant women's situation is beyond being available. Due to immigrant women's availability their exposure to risk increases during the companionship work. Hence, I also use "biopolitical vulnerability" in explaining this issue. While close circle of COVID-19 patients might be available at the same degree with immigrant women, immigrant women are enabled by the state and potential employers to work as companions. The state bends its rules to take advantage of immigrant women's presence in Turkey and employers choose to rent immigrant women's labor to take care of their loved ones without taking any risk. Hence, I prefer to use "biopolitical vulnerability" as it directly points to the state's and employers' role.

In this context, precarious conditions are created by immigrant women's biopolitical vulnerability. In Judith Butler's words immigrant women's lives are seen as "grievable" (2012, 148). Due to their immigrant identity, they are already seen as the "other" hence to lead them to companion work is both result and part of the process regarding immigrants' perception by the state (Wimmer and Schiller 2002, 309). As immigrants have different citizenship, and their return to their home countries is expected, immigrants' loyalty to the state is always in question. That is why I argue that the idea of citizenship which assumes organic ties between the citizens and their country restrains citizens' abilities to recognize the vulnerabilities of immigrants.

Those who are most vulnerable and live in precarious conditions have been already pushed into the margins of society, and existing inequalities have shaped who will continue to live and in which conditions (Rose 2021, 215). Immigrant women's companion work is a certain way of governmentality that situates women as part of the group who will be made life and has exposed them to death risk. Although companion work does not directly include medical support, immigrant women through providing emotional support, and sharing the fears, concerns of patients contribute to the process of life making. However, companion work can be also considered an example of "indirect murder" as Foucault discusses because exposing women directly to the disease and increases the risk of death for immigrant women (2003, 256).

I discuss that working as companions represents immigrant women's ability to adapt themselves to the changing conditions (Jokinen, 2016), and I interpret working as companions as part of this dynamic process to cope with the hardships of the COVID-19 pandemic period. In this sense, I do not see immigrant women's precarity that results from their legal status as a static condition. Rather, as McCormack and Salmenniemi do, I evaluate precarity as a dynamic process that includes "temporality, uncertainty, and unpredictability" (2016, 4). Similarly, Ettlinger (2020) discusses the "multiple subjectivities of actors which lead them to act differently in the particular conditions". These theories do not see actors as static, dependent on the form of governmentality. They recognize that with the individual experiences and positionality of each actor, they will respond differently to the same conditions their responses may change to same conditions over time.

Within this legal framework, immigrant women's already precarious conditions have not been eliminated but rather immigrant women have become more vulnerable toward their employers and Turkish state policies. Here, I use precarity to refer to immigrant women's insecure work and living conditions in Turkey. Although these conditions of the informal economy are shared by many different economic classes, immigrants

due to their legal status experience precarity in a much strict way than citizens. As I present, within the immigrant groups, the experience of precarity differs due to policies of countries of origin and women's specific conditions. In addition, immigrant women's experiences of precarity are shaped at the intersection of their specific situations such as age, the experience of caregiving, and their responsibilities toward their family members. Concerning their different positions, immigrant women make different moves in times of crisis like the COVID-19 pandemic to earn their livelihoods.

Companionship work represents a continuity in the state's dependency on immigrant women's labor to provide care services for elderly. Conversely, companionship work reflects changes in Turkey's healthcare system policies. During the COVID-19 pandemic already persistent problems of health care workers intensified and their role have not been sufficient to cover the needs of patients and their close circle. One of the crucial changes is the introduction of 'Performance Based Payment' for health care workers in 2004. By the organization of a point scoring system, performance of health care workers has been evaluated by the number of patients they checked and the point of illness the patient has (Elbek, 2018, 2014; Pala 2007). The introduction of this system has resulted in the derogation of relationships between doctors and their patients. Due to the point score system, each disease is equivalent to a different score and doctors have pushed to attend to the complaints of patients whose potential diseases will bring them more points. In addition, this system requires doctors to see more patients. The other reason of derogation is that the state separates state hospitals and private hospital then invests more in private hospitals. While 80 percent of the people in Turkey goes to the public hospitals, the patient care time of the state hospital doctors and nurses who see more than 100 patients a day has decreased to less than 5 minutes. Hence, the quality of doctors' examinations has decreased (Elbek, 2014) During the COVID-19 pandemic period, although people were reluctant to go to hospitals for their routine controls, due to the increase in the number of people who went to the hospitals with COVID-19 complaints, the quality of healthcare professionals' care labor has decreased.

1.3. Outline of This Thesis

This study begins by providing historical background of immigrant women's arrival from the former Soviet Union countries to Turkey. Conditions of immigrant women's arrival and stay in Turkey are important factors to understand the current dynamics in their lives.

By situating the legal framework of immigrant women's living and working conditions into the related theoretical context I discuss their limited options to navigate COVID-19 conditions. Accordingly, I provide an overview of Turkey's healthcare system, together with the policy changes I underline how the deficiencies have been created in the system. In this context, the companionship work has become necessary to take care of especially elderly patients. The state and potential employers by different strategies choose to use immigrant women's labor for companionship work.

Then, I elaborate on how the immigrant women's perception of care recipients and employers affect their decision-making processes together with their economic conditions. Related to women's perceptions I discuss how they evaluate the risk of contracting the virus and how they interpret their caregiving practices. Immigrant women's evaluation of the risk of contracting the disease results in different representations of themselves. Through analyzing their representations, I present immigrant women's different strategies to cope with the risk of disease in the dangerous environment they work in.

2. IMMIGRANT CAREGIVERS' WORK IN THE CONTEXT OF TURKEY

2.1. Arrival of Immigrant Women in Turkey

In the Turkish context, previous studies reveal that hiring a domestic worker is not a new practice for the upper class (Bora, 2005). Since the 1990s, the increase in the number of immigrant women has allowed not just the upper class but also the middle class to employ domestic workers (Kaşka 2009, 9). The increase in the number of immigrant women corresponds to the period of the dissolution of the Soviet Union. From the 1990s onward, immigrant women mostly arrived from the countries formerly part of the Soviet Union, and Turkey's position has started to change from the "country of emigration" to the "country of immigration" (İçduygu & Yükseker 2010, 442). In addition, due to Turkey's position as a gateway to the EU countries, immigrants have begun to arrive from Iraq, Afghanistan, Iran, and African countries. The arrival of irregular immigrants has contributed to Turkey's position as a "transit country" (İçduygu & Yükseker 2010, 443). The major difference between these two groups of irregular immigrants stems from their purpose of staying in Turkey. Immigrant women from the post- Soviet countries, after their arrival, work in the informal domains of different sectors such as textile, domestic labor, and tourism mostly to support their families. Whereas immigrant women from the post-Soviet countries plan to return to their country of origin, irregular immigrants from the neighboring countries aim to immigrate to the EU countries. In addition to that, Turkey's need for cheap labor of immigrant women to cover the lack of welfare state services such as child and elder care are significant conditions that have affected the implementation of less strict border rules for immigrant women (Toksöz and Ulutaş 2012, 88). Due to these factors, immigrant women's entrance to Turkey has been supported by border policies, and their entrance to the country is allowed as far as the state needs immigrant women's labor that is extracted in insecure conditions and unpaid (Erder 2007; quoted in Lloyd 2018, 82).

Immigrant women's entrance to Turkey is the first step of the creation of their illegality by both countries of origin and host countries. Even if immigrant women enter Turkey legally, after a short period, many of them become illegal. Immigrant women who arrive in Turkey with tourist visas or without any document, when their visa periods expire return to their country of origin, and hence, each time to pursue new visas, they make several trips between their countries of origin and Turkey. This type of irregular migration is also named shuttle migration and it mostly refers to the mobility type of immigrant women from the post-Soviet countries. Due to the geographical proximity, and compared to the EU countries, Turkey's less strict border regimes have allowed immigrant women to pursue legal status through the pattern of shuttle migration (Lloyd, 2018; Akalın, 2018; Toksöz & Ulutaş, 2012).

In this way, immigrant women have pursued legal status in terms of their entrance to Turkey, however, they had continued to work informally because there was no legal arrangement that allows immigrant women's work legally. Moreover, shuttle migration had required additional expenses such as trip fees, and fees for the expired visa periods. Immigrant women who cannot afford these expenses or cannot remain unemployed to make trips, eventually, had continued to stay in Turkey illegally (Toksöz & Ulutaş, 2012). In this sense, shuttle migration has created a type of border economy that provides economic benefits for both country of origin and host countries due to immigrant women's trip expenses. In other words, to benefit from women's labor in the informal economy, the Turkish state has determined the illegal stay and informal working conditions of women. From the side of countries of origin, immigrant women's migration has been supported due to countries' need for remittances. In this sense, the Turkish state together with countries of origin had determined and produced immigrant women's illegality that renders women directly vulnerable legally, and socially (De Genova, 2002). As long as immigrant women's labor power is required, their illegality is not problematized.

2.2. Legal Conditions of Immigrant Domestic Workers in Turkey

To understand immigrant women's dependency to their employers, it is necessary to understand the legal framework of working and living conditions. Until 2012, there was no rule that obliged immigrant women to obtain a residence permit to stay in Turkey for more than one month. In 2012, a new regulation was introduced that directly defined the terms for domestic workers in Turkey. However, through the new regulation,

immigrant women without tourist visas were allowed to stay in Turkey for up to 90 days and in that period, they are expected to obtain a residence permit. Without residence permit, immigrant women's stay longer than 180 days was made illegal (Akalın 2018, Demirdizen 2013).

While this new regulation has aimed to avert informal working conditions and shuttle migration, it also binds domestic workers to their employers. The first reason for domestic workers' dependence on their employers is that immigrant women cannot apply for the residence permit themselves, the employers should start the application process. In the first place, the condition of getting the residence permit depends on domestic workers' prior residence with the citizens, or people who have a residence permit (Demirdizen 2013, 335- 336). If immigrant women have a prior residence permit that is valid for at least six months, their potential employers can apply for work and residence permits. Through the work permit, immigrant women register their workplaces as their residence addresses. Hence, as Ayşe Akalın discusses, this work permit system is a kind of "sponsorship that immigrant workers had become more tied to their employers as long as they want to stay regularized" (2018, 425). In this context, immigrant women must accept any order from their employers to protect their legal status. Besides, I have observed the obligation of employers' application for the work permit shapes the context of employer-employee relationships. For instance, Nina, while talking about her old employer said that:

> "They were very nice people, they were the first ones who got me residence permit."

and she remembered her former employers with a smile. Hence, Nina interpreted her former employer's application as if it was solely the result of their personal choice. This interpretation leads me to state that Turkey's work permit system ties immigrant women to their employers emotionally and eventually, immigrant women might want to compensate for the 'niceness' of their employers. In this case, Nina believed that application to work permit system was left to the discretion of employers.

On the other hand, although those regulations offer some advantages like domestic workers' inclusion in the public security system, whether immigrant women will be entitled to pension or not in their country of origin is uncertain (Demirdizen 2013, 337). My interlocutors confirmed this problem and even explained that still, many immigrant caregiver women do not work under the public security system. From the side of employers, the main reason for not providing health insurance is to keep their payments lower. Employers

agree to pay caregiver a little more without paying for the healthcare system. Caregiver women accept to work under this system as they need to earn more money. However, my interlocutors do not raise criticism toward their employers, or they do not criticize the state structure.

2.3. Paid Caregiving for the Elderly in the Turkish Context

Since the foundation of the Turkish Republic, families in Turkey are seen as the main ones responsible to provide care for the elderly. The state provides all care necessities only when there is nobody to take care of the elderly (Akkan et al. 2019, Atasü Topçuoğlu 2021). Despite the changes in the traditional family structure of Turkey such as the increase in the number of "nuclear families, low fertility rates, and aging of population" (Buğra and Keyder 2006, 221) women in families are still considered as the main care provider. This gendered expectation from women while reflecting patriarchal ideals also constructs the background of AKP rule's policies regarding caregiving and family. In this vein, one of the most crucial steps is the introduction of the 'cash for care scheme' in 2007 that includes different policies to transfer allowances to family members who take care of the elderly (Akkan 2018, 82). There are two criteria to benefit from this system: first to have a disability of at least 50 percent and second, the dividend income of adult household members must be under 2/3 of the minimum wage (Akkan et al. 2019). Hence, the cash-for-care system is exclusive by implementing different criteria for potential beneficiaries and has deficiencies to cover the needs of care providers. Although this scheme points out the state's role in supporting families, cash allowances are not enough to cover the needs of care providers.

In accord with the privatization trends in the world, since the 2006 law which allows private entities to run nursing homes, there is an increase in the number of institutions that provide care services for elderly and/or disabled people in Turkey (Akkan 2018,83). However, there are different eligibility criteria, to provide institutional care services. For instance, the needs of elderly are covered only in the absence of families otherwise residents' contribution is necessary. Due to this criterion, both private and public institutions are not inclusive to cover different needs of the elderly population in Turkey hence they fail to cover the needs of the elderly (Akkan et al. 2019, 8-12).

Although Akkan et al. (2019) point to the escalating role of immigrant caregivers in

Turkish families as an indicator of changing family roles, many feminist scholars have agreed that changes in the traditional familial roles do not create a direct rupture. Rather, the Turkish state seems to be supporting the changes in traditional familial roles by supporting families with different policies such as the cash for care scheme. By stressing these two facets of recent policies, Aybars et al. state that Turkey's care policies while organized around 'implicit familialism' move to a form of 'supported familialism' (2018, 116).

These demographic trends and the changes in the welfare system are not specific to Turkey. Just like the Turkish system, "Italian welfare regime is described as 'familistic' in which families have a fundamental role in providing the basic welfare services (Näre 2013, 187). Lena Näre calls the "transnational market familism", as a relatively new model which is perceived as an ethical solution. Because, without sending elderly people to nursing homes, the inclusion of immigrant caregivers, allows family members to be at the center of caregiving work (2013). In this way, "elderly people are not carrying the stigma of being abandoned by one's family members" (Näre 2013, 188). However, the COVID-19 pandemic period has resurrected the fear of carrying this stigma. As I discuss in the next chapter, these labels regarding staying or even dying alone, make companion work necessary for the employers.

The COVID-19 pandemic has created new needs to employ caregiver women from the perspective of employers. Due to the risk of contracting the virus, relatives or friends of COVID-19 patients cannot take care of their loved ones directly. As my interlocutors confirmed, in some cases children or grandchildren of patients might have coronavirus too, or they might be in the risky category hence they may need someone else's assistance for their patients. My interlocutors' patients also include the elderly who are brought from nursing homes hence probably there is nobody to take care of them. From the side of employers, in a crisis like COVID-19 due to the lack of a welfare state, citizens are also made dependent on immigrant women's labor.

3. THE ROLE OF THE STATE IN IMMIGRANT WOMEN'S COMPANIONSHIP WORK

While the Turkish state has supported familistic ideas by stressing "care out of love is better than care for money" I argue that this has changed drastically during the pandemic (Topçuoğlu, 2021). Hiring a caregiver for COVID-19 patients has become the proof of families' love toward their loved ones. When employers cannot take care of their patients themselves or do not want to take the risk of contracting the virus, they employ immigrant women as companions. In this way, the close circle of patients show their love toward their patients by saving them from being alone in a hospital room or at home.

Whether at homes or hospitals the state has not structured a program that might could cover the needs of patients and their close circle. Hence, this structure is facilitated by the state's health system policies. The lack of such a structure stems from long-standing changes in Turkey's healthcare system. While the neo-liberalization of healthcare system has brought deficiencies to the quality of doctors' services and to their relations with patients, in the COVID-19 period the state has allowed different actors to take part in the caregiving network by enlarging the implementation of such COVID-19 measures. Although immigrant women worked as caregivers before the pandemic, during the COVID-19 pandemic the number of immigrant women who work as caregivers and their visibility have increased. In the following chapter, I discuss the role of different actors such as employment agencies, security staff and the role of state in binding the implementation of such measures like the HES codes. In addition to that by presenting the problems in access to healthcare services and vaccines I state the dilemma which caregiver women face during the pandemic.

3.1. The Role of Employment Agencies

I was following the websites of agencies who employ caregiver women, while at the first time there was no word about the working conditions of immigrant women during the COVID-19 pandemic period, after 2021 summer one of them stated in their website:

> "Because of the risk of contracting the disease before, private companions are not allowed except for pediatric patients. However, since the increase in the number of cases and serious patients increases the burden of hospitals, health personnel and intensive care services the Ministry of Health has given permission for employment of companions especially for patients over a certain age and in need of care." (Damla Human Resources, 2021).

Through this statement, the consultancy firm affirms the need to employ companions for COVID-19 patients. Although not all COVID-19 patients need assistance during their treatment period, the elderly and especially people with severe symptoms need assistance for their personal needs like going to bathroom. In that vein, employment agencies share content regarding how important it is to find caregiver women for COVID-19 patients and what criteria should be considered.

Caregiver women assist Corona patients in hospital rooms but if the patient is taken to the intensive care unit these women's jobs come to an end. Then the hospitals' intensive care unit nurses continue to take care of patients' personal needs. Employment agencies state that caregiver women who take care of COVID-19 patients are quarantined for 14 days and they have a coronavirus test before and after the companion work. Besides, the agencies claim that the women who work as companions for COVID-19 patients are not directed to other patients and those who take care of regular patients are not sent to companionship work. In this situation, employees of the companies decide which immigrant women will be directed to which patients. These agencies do not mention that they pay attention to another criterion other than the references of immigrant women.

Contrary to these statements, all interlocutors said that there is no legal or medical control mechanism to follow women's quarantine period. When they leave the patients' room at the hospital or home, they are free to go. In this procedure, I do not problematize the immigrant women's freedom of movement but rather I problematize how their health and the health of their potential care recipients are jeopardized by the state and employment agencies. In other words, due to the lack of a medical or legal control mechanism, a public health crisis has been created for all.

Similarly, when caregiver women leave the hospitals, they cannot benefit from free COVID- 19 tests. For example, Reyhan said when she was discharged, she used to go

and get tested by herself with her own money. Referring to the role of state authorities Nina stressed "they did not even do the Corona test." Only Karina mentioned that her employers paid for the COVID-19 test because doctors advised to her employers to hire a caregiver woman after the test. When the patient whom Karina cared for at the hospital was transferred to her home, her doctor suggested the patient's daughter to hire the caregiver after a Coronavirus test. In this situation, again the health of Karina is considered only due to the concern to protect the health of the patient. Otherwise, her health is not that valuable from the side of employers.

In this framework, I argue that the companion work of immigrant women is a response of the Turkish state to the COVID-19 pandemic. Hence, the state consciously chose to cause health risks for the immigrant women and people around them. Once again, the labor of immigrant caregivers becomes essential to cover the deficiencies of the Turkish healthcare system. By allowing immigrant women to work as companions at hospitals, the state benefits from immigrant women's precarious legal condition and contributes to the informal economy. Through these processes, the Turkish state prioritizes its citizens' health over the immigrant's health. As my interlocutors confirmed, although they did not have a work permit, their entrance to the hospitals was not problematized by the security and medical staff. As Nina narrates:

> "The hospital authorities did not ask anything extra. They asked for my work permit and insurance which are asked everywhere, even when you start working at a restaurant. So, these are common questions. The doctors did not ask anything else either. It may have been because I did not stay in the hospital too long. The hospital staff and doctors are too busy to keep track of people and they do not care about the foreigners at all. I did not see anyone else in the hospital working like me. I believe because I stayed at the hospital for a short period of time, no one asked me anything."

Although Nina is in an illegal position due to her work and living permits, after the questions of hospital staff she could be able to work as a companion. She stayed in the hospital for two days and that is why she thinks that nobody asked her anything. Nina thinks she did not receive any questions about her work/living permit due to her duration of stay in the hospital, but she did not know she would be asked these questions regardless of how many days she was going to stay in the hospital.

Although Nina has experience in caregiving, as working in restaurants is much comfortable for her, she does not prefer caregiving work in recent years. However, she cannot reject the request of her acquaintance so accepts companionship work and after that she

continues to work in the restaurant. In her comparison between working in restaurants and hospitals, she does not make any differentiation in terms of the illness risk. Rather, she is comparing both places by the workload.

However, whether immigrant women have work permits or not is more crucial in the context of companion work to be able to analyze the state's role in the reproduction of their so-called illegal position. In accord with Dilan Eren's (2018) arguments, I observed that during the COVID-19 pandemic period, the immigrant women's legal and economic vulnerability is used by the employers and healthcare staff to cover the deficiencies of Turkey's health system. In the following section, I discuss how different rules have measures have stretched to benefit from immigrant women's labor and which actors contributed to this process.

3.2. LFH Code

Life Fits Home (Hayat Eve Sığar-HES) is the slogan of quarantine days in Turkey which is used firstly by the Minister of Health. While the state promoted people to stay at home through this slogan, later on, an application and code system with the same slogan were launched. With the introduction of LFH codes it has become mandatory to use it at the entrance to many social areas such as shopping malls, hospitals, and public transportation. This issue has brought the discussion of limitation of individual freedoms. The system of LFH code tracks down individuals to detect the individuals who are diagnosed with COVID- 19 or contacted individuals. Although the application was introduced for protecting the individuals' health by revealing the risk status of places in which they are at, it has also brought up discussions about the violation of privacy.

To get the LFH code, citizens use their ID numbers and non-citizens use their passport numbers. When I had asked my interlocutors whether they could get LFH codes or not, they all said that they could easily get their LFH codes even with their expired passports and they do not face problems while taking a bus or visiting shopping malls. Similarly, during the lockdowns, immigrant women had continued to lead their daily lives without encountering any obstacles. Nina explains how she tackles down her immigrant position:

"On weekend lockdowns I say that I am a tourist; the police understand that

> from the way I talk, and they let me go. They do not know that I am washing the dishes.".

As they are aware of the necessity of their labor Nina advocated that:

> "Whether they want to give the LFH code or not, they will have to. Immigrants work everywhere in Turkey. If we do not do these jobs, who else they will be able to find to work in these jobs.".

Nina reveals that the immigrant women know the value of their labor in the context of the informal economy and to know that their labor power is essential for the Turkish state and society empowers them at least at the discursive level. Nina knows that the state is not interested in her work permit or how she got the LFH code to work, hence she benefits from the control mechanisms expanded by the state for immigrant women's continuation to work.

3.3. Security Staff

Two of my interlocutors Reyhan and Gül told me that the security staff of hospitals provides communication between potential employers and caregivers. As Reyhan did, caregiver women give their telephone numbers to security personnel and potential employers ask them to contact the caregiver women. This information led me to include interviews with security staff from different hospitals. My interlocutors did not share the names of these hospitals, but I had some based on the information they gave in the interviews. I visited 3 different public hospitals in Istanbul and tried to conduct interviews with security staff. However, the security staff gave answers that I knew were lies. When I asked them whether they know the companions they all said that it is forbidden to let anyone into the Coronavirus patients' room, and the patients are not allowed to stay with companions. However, based on the interviews I conducted, I suspect that they have a major role in the communication network between patients' close circle and their potential care recipients. They may even be making money out of this job, but I could not reach any information to confirm this assumption.

3.4. Doctors and Nurses

In addition to the role of security personnel, Fatma mentioned that she found caregiving work through her nurse friend who works in one of the well-known hospitals. As she explains:

> "The request came, the nurses know me, they called me there. They said, please, we need a companion, can you help us, and I accepted."

I do not have any information on nurses' role in this communication network. However, I have a sense that if nurses know women they met before, they can call and ask for companionship work. It is also interesting that the nurse asked Fatma whether she could help them. Both sides are aware that companionship work is done for money. Yet, nurses and immigrant women do not have the same status. The nurse's question leads me to think that she evaluates caregiver women's labor as undervalued compared to nurses. The use of the word help implies that immigrant women will complete the jobs which are not preferred by the nurses such as assisting patients for their bathroom needs.

Related with these points, when I was explaining my research topic to an inspector who affiliated with the social security institution said that they cannot control the work of immigrant women. I know that when inspectors visit small businesses with immigrant workers, they impose fines according to different criteria like the number of prior warnings they had. However, when they inspect hospitals, the inspector said they cannot impose fines or close hospitals. He is knowledgeable in the field of fines due to allowing immigrants without a valid living/work permit to work, and he said that fining a hospital for letting an illegal immigrant work in their premises would mean fining a state for not abiding by law. He then asked whether it would be possible to fine the state or not and answered it himself:

> "No."

The other reason as he explains in the pandemic period, they cannot shut down hospitals. Even if they try to impose heavy fines, they will face barriers to implement those fines. Hence, they also contribute to the unauthorized employment of immigrant women by staying silent.

3.5. Vaccination

In Turkey, vaccination process has begun in January 2021, then different segments of society began to be vaccinated gradually. While discussions continue about who should be prioritized in vaccination, in our interview Karina asked my opinion about the vaccination issue and then stated:

> "They do not vaccinate foreigners, of course. Although if they did, it would help us, and we would be helpful for the state. It would be nice if they did."

Karina lives in Turkey for a long time, but still, she considers herself as 'stranger'. By situating herself as a 'stranger', she does not demand anything from the Turkish state. However, she is also aware of her contribution to the state through her caregiving work. Although Karina does not directly make requests, she expects some rewards for her contributions. As I infer from our conversation, she is afraid of not being able to work as she gets older and of being in a difficult situation when she gets old because she cannot save. Hence, she expects to have material benefits like retirement pension to cover her needs when she unable to work.

Indeed, when the state has reached widespread vaccination stage, the same criteria as citizens were applied to immigrants and refugees who entered Turkey legally. After immigrants came to Turkey, even if they had lost their legal status that did not create any difference. On April 13, 2020 the testing and treatment services for COVID-19 provided for anyone without considering the legal status of people (Özvarış et. al. 2020, 4). However, in practice, those without legal status already hesitate to go to the hospital for fear of being caught and deported by the police. Besides, even if they go to the hospitals there are practical reasons that block their access to the COVID-19 treatment and vaccination (Yasin 2020, 46). Since unregistered people cannot make an appointment for vaccination, the personnel in hospitals are having trouble to register those for vaccination. Besides, the language barrier blocks immigrants to access the necessary information and explain their situation (Özvarış et. al. 2020; Yasin 2020).

This is the dilemma that the state creates for immigrants and causes them to encounter obscurity in their everyday lives. While immigrants who do not hold legal status can get the LFH Codes, can work as companions, whether they will have access to a COVID-19 vaccine has been an ambiguous issue throughout the COVID-19 pandemic.

4. DECISION-MAKING PROCESSES OF IMMIGRANT WOMEN

Certainly, not all immigrant women accept to work as a companion. For instance, Karina by saying "If there is Corona patient, I will not go dear, I am afraid of dying, I am still young." refuses potential work offers. In the context of companion work while Karina says that, for other patients she stressed "she would gladly go and take care of patients".

In the comparison of both statements, she likens working as a companion to death. In the time of this conversation, she had been unemployed for 15 days. It is possible to think that her opinion may change under conditions such as unemployment lasting longer and staying away from a place to stay. At least Karina might reconsider working as a companion.

However, immigrant women who accept to work as companion evaluate the risk of death and contracting the virus together with their specific conditions and consciously accept it. In women's decision-making processes, economic needs, their relations with former employers, recognition of care recipients' precarity and evaluation of them by religious references are significant factors to push women's concerns regarding their health into the background. By discussing how each of these factors resonate with immigrant women's conditions and result differently I present the varieties among immigrant women's decision-making processes.

I state that economic needs are not the only reason to accept companionship. The most visible case that leads me to think is the story of Fatma. In terms of economic needs Fatma is in a more advantageous position than my other interlocutors because she is married with a Turkish citizen, she owns her home in Georgia. Despite all, she accepts to work as companion and represents herself as a brave woman. In another case, Gül works secretly from her husband because her husband is already sick, so she does not want to make him uncomfortable. When I asked her much detailed questions, she stated they need money because they had a house built in their hometown. At first, I understand why she accepts to work as companion, as owning a home may even be one of the reasons for migration. However, what I need to underline is that this is not a crucial reason to continue their lives during the pandemic. That is why I find it important to present various factors that

affect women's acceptance to work as companions. By showing these varieties I present the role of different layers in women's decision-making processes. I discuss how women interpret their economic needs together with the exploitative relationships and concepts like the perception of care recipients, and relationships with former employers which they are incorporated.

4.1. Economic Needs

In Turkey's legal context, although immigrant women's insecure work and living conditions are used by employers and state institutions to benefit from women's labor in such risky work, immigrant women have specific reasons to prefer working as companions over other employment areas. For instance, one of my interlocutors who migrated from Turkmenistan, Reyhan explained that she could not take her payment for two months from the previous home she used to take care of a child. As she explains:

> "I took care of a child for two months and they did not give me a penny. Two years ago, they were unfair to me. That is why I do not want to go to housework. You can't complain when you could not get your money, you do not have a residence, work permit. I tried so hard, and I could not do anything.".

In such cases, immigrant women cannot make any complaints to legal institutions as they do not work legally. Due to this experience, Reyhan prefers companion work, as she said:

> "I heal the patients, I take care of them very well, hence employers are not unfair to us.".

In this narrative, Reyhan correlates getting paid with the success of her caregiving practice. I infer that, due to its time limit companionship work might result in women's concrete descriptions regarding themselves and caregiving work.

On the other side, as employers have made payments in time, she said: "So, I like to work at hospitals". This point suggests as to take payment in time is vital for Reyhan, she

prefers to work as a companion besides all the risks. Moreover, in the context of working as companions, employers accept to pay higher than regular caregiving fees. Caregiver women determine the payment but in general, they earn higher than usual caregiving work. Women set the fee according to their experience in caregiving and economic situation of employers. However, my interlocutors are aware that the wage paid to them is not very compelling for the employers. For example, Fatma mentioned that children of her care recipient divide the payment between them, and each pay a smaller amount.

The economic return of working as companions becomes one of the main reasons to accept the work. Reyhan's explanation demonstrates the same point:

> "After the virus, there is no fearless life. I had the same fears at two companion works. You feel scared anyway. I have two children. You cannot work if you are afraid. Of course, you are scared. You are putting your life on the line. I got paid daily, even though it was not enough, we had to work.".

With these factors, Reyhan and many other women by suppressing their health concerns, accept companionship work as it seems more advantageous than other forms of caregiving due to its higher payment. Therefore, by setting the price for their companionship care and sharing it on different platforms like Facebook, immigrant women try to reach out to their potential employers. (See Appendix B.)

4.2. How Care Recipients are Perceived by Immigrant Women

The identity and position of care recipients affect immigrant women's decision-making processes. For instance, one of my interlocutors conveyed that her friend accepted companion work because "The patient is entrusted to her by the family members.".

As the patient is alone, that there is nobody to take care of, outside of the caregiver woman, the caregiver woman recognizes her care recipient's needs and acts on them. Likewise, Reyhan accepts one companion work offer as she says:

> "They said there is no one, would you take care of him, he came from the nursing home.".

As the patient is completely alone, Reyhan recognizes the needs of her potential care recipient and accepts to take care of her/him.

In another case, Nina accepts working as a companion because she feels like she is responsible to her former employers as she explains:

> "I could not say no because they are familiar. Otherwise, I would not have accepted it, I was afraid. He begged, he said "Oh, I could not find anyone to take care of."

In Nina's case, her former relationship with the employers affects her decision-making process. Even though she is not willing to take care of the patient and does not have any urgent economic need to accept companion work, the demand of her previous employer creates a type of pressure on her. Since she accepted the work because of pressure, she could not continue to work for a long time and left the hospital two days later. Later, she hears the news that the patient has died. Hence, she felt lucky that she did not witness this.

Nina could not refuse the offer of her former employer because of the trust relationship between them. In this case, Nina's former employer uses the trust in their relationship in an exploitative way. From the employer's perspective, he requests companionship from Nina through their familiarity. As the employer knows Nina, his familiarity creates trust towards Nina (Frederiksen, 2014). However, trust by the way its constructed is already exploitative in the sense that trust relations push individuals to reciprocate for someone else's words, behaviors and so on (Skinner et al., 2013).

In addition to that, caregiver women might interpret the identity of their care recipients in reference to religious, cultural meanings of caregiving. For instance, if the care recipient is a mother, caregiver women might think of 'the sacred position of motherhood' and might evaluate their work in the context of tendance. As Sümbül said, "Heaven is under the feet of our mothers" and referred to her religious expectations by providing care for the elderly lady. Although her explanation is clichéd still means a lot to her to be able to deal with the risks of companionship work. While this interpretation is a kind of strategy to reduce her health concerns it is also exploitative as it detracts her from the real problems. The instrumentalization of motherhood concept is used in Turkey as a long-term practice. Since the foundation of the Turkish Republic, the concept of motherhood has been used by politicians for different aims and while some mothers are seen as divine some others are not (Göker, 2016; White, 2003). Hence, the motherhood concept is acquired by different actors and used in exploitative ways and Sümbül by

internalizing this idea contributes her subordination to unequal working conditions.

The explanation of Sümbül is based on her religious beliefs and in the light of religious expectations she evaluates the outcomes of providing care for the elderly (Lovelock & Martin 2016, 387). In my interviews, caregiver women highlighted the unearthly value of their caregiving work which is much valuable than their salaries or other material benefits. As Reyhan puts it: "I take my prayer, that old people's prayer is enough for me.".

In caregiver women's narratives, the position of elderly who are vulnerable and in need of their care recipients intersect with the value of providing care to them. Hence, I argue that cultural and religious references through crystalizing needs and vulnerabilities of the elderly affect immigrant women's decision-making processes. By the interpretation of these concepts my interlocutors contribute their subordination to unequal working conditions.

Immigrant women during the COVID-19 pandemic period consciously undertake companion work and they are aware of the risks, so they consciously accept to assist patients. Immigrant women are aware that compared to hospital staff their lives are undervalued. In addition, many women are not at young ages and some of them have chronic health conditions such as diabetes, and blood pressure which place them under the risky category. In the next chapter, I discuss how immigrant women conceptualize the risk of contracting the virus and what are the methods they implement to eliminate the illness risk.

5. CONSTRUCTION OF SELF AS CAREGIVER

In the narratives of my interlocutors, I come across different stories regarding their defining themselves with perception of illness risk and caregiving work. My interlocutors conceptualize these issues around their characteristics and religious, ethical beliefs. By pointing out their religious and ethical motivations to accept working as companions my interlocutors construct themselves as an ideal individual from the perspective of neoliberal system. Since they cover their unequal position compared to hospital staff by fulfilling their responsibilities. In this chapter, I first demonstrate how my interlocutors make sense of illness risk and how their interpretations block them to criticize the healthcare policies of Turkish state. In addition, I explore that religious and cultural references are coping mechanisms for my interlocutors which allow them without facing with the dangerous side of companionship work continue to work.

5.1. Being Conscientious or/and To Have a Religious Faith

At the beginning of this research, I was expecting to hear more critics about the unequal position of immigrant women compare to roles of doctors, nurses, and other hospital staff and I was assuming that immigrant women procure such requirements as medical equipment on their own. Contrary to my expectations, except Nina, my other interlocutors said that both public and private hospitals provide medical equipment such as masks, gloves for free. In addition to using medical items properly to protect themselves each of my interlocutors mentioned different practices they implement to decrease the risk of contracting the virus. I was also expecting to hear how each of these women felt terrified, how they were afraid of contracting the virus during working as companions for the COVID-19 patients. Some of them talked about their fears much clearly but I realized that each of them evaluates the risk of contracting the virus in accord with their own risk conceptions. It became possible for me to realize this connection more deeply with an answer of Fatma who cared for three different coronavirus patients. When I asked her,

have you ever been afraid of contracting the virus, she replied with a self-confident tune.

> “Normally, I am a kind of woman who likes to take risks. Do I look like a coward? I am not afraid of anything, not even of a bomb.”.

We were having this conversation on Whatsapp Video Call and after I looked at my interlocutor’s face, besides my confusion after her answer, I saw a woman who knows and is aware of what she said. I infer from our conversation; the immigration process and the uncertainties are getting her used to taking risks in her life. Although this association between her character features and decisions may seem surprising, while she was explaining how she protected herself during the work, I understand the layers in her self-identification. As Fatma explains:

> “After wearing 2 masks, I was tying my hair, wearing a hat to cover my hair. I was covered everywhere. No, I never took off the mask. Although I was eating outside, I was not taking off the mask when I was with her/him, even at the balcony. If I had taken off the mask, perhaps, I would have been a Corona patient too. I always worked with gloves because I was taking them to the bathroom, changing their underwear, making them seated. I had to. I was touching the wheelchair. There could have been germs everywhere. I was taking the gloves outside and leaving them in trash.”

By underlining these protective measures, she stated: “I always protected myself” and she expressed that it is her success to do not contract the virus despite the risky environment she worked in. She also sent me photos which were taken in the hospital while she takes care of two Corona patients in the same room. (See Appendix B.) Based on my interpretation she shared those photographs to prove that besides the risky conditions she worked in, she successfully protected herself and she stayed positive during the companionship work.

My other interlocutors also mentioned their eating habits that including onion, garlic similarly Reyhan talked about the importance of a proper diet. As she puts it:

> "It is up to you, to eat, if you say no, I will start diet, I will lose weight, I will not eat this, so if you say that I will not eat it, you will contract the illness.”

In both Reyhan's and Fatma's narratives, implementation of such measures allows them to represent themselves as responsible individuals who know how to protect themselves. Although my interlocutors do not define themselves directly as "conscientious", from their explanations I infer there is such distinction in their minds, and they categorize some daily habits under this definition. In their perceptions, my interlocutors are aware of the potential risks of contracting the virus. With a reference to Ayşecan Terzioğlu's (2011) discussion of conscientious/unconscientious (bilinçli/bilinçsiz hasta) categorization of patients, I demonstrate similar comparison that in the minds of my interlocutors. Although in her research, Terzioğlu makes this inference by the narratives of cancer patients, my interlocutors use similar logic while describing themselves. By learning and implementing such protective measures they internalize the idea that they are as individuals responsible to protect themselves and the internalization of this idea restrains them to criticize or blame the responsible ones for their precarious position.

While representing themselves as individuals who are aware of potential risks and successfully protect themselves, my interlocutors did not raise critics about the structural problems that situate them in the front line to contract the virus. Besides, except Fatma, my other interlocutors clearly stated that they are afraid of contracting the virus.

I was wondering how women perceive their health conditions to accept such risky work despite their awareness of the unequal status. My interlocutors are not that young and some of them have chronic health conditions such as diabetes, and blood pressure which place them under the risky category. In addition, working as companions demands constant heavy physical attendance of caregiver women. My interlocutor Reyhan works as a companion even though she has a femur fracture and waits for the opening of borders to be able to get surgery. By using painkillers regularly, Reyhan tries to feel better. Reyhan's sister Gül who is my other interlocutor also uses pain killer for her headache regularly.

Outside of these physical health problems, my interlocutors have other stress factors in their lives. Due to the closure of borders, except one of my interlocutors they could not visit their hometowns, so they miss their children and loved ones. As they have to continue to send remittances my interlocutors prioritize their economic needs. Gül, for example, works secretly from her husband, and this creates another layer of pressure in her life. Reyhan said that she could not visit her hometown due to the border closures she misses her son but there is nothing she can do.

In these narratives, two different versions of my interlocutors are represented together. On the one hand, they highlighted the importance of protecting themselves in different

ways. On the other hand, they stated that they calmed their fears with religious beliefs. For example, Gül says "God forbid" every time she touches her patients. Similarly, states:

> “Of course, you are afraid, you entrust yourself to God, you take refuge in God that is how you go.”.

As the above-mentioned narratives suggest, caregiver women’s perceptions regarding the risk of death or contracting the virus is shaped by their religious, cultural, and ethical beliefs which are not independent of their ethnicity, and economic, gendered positions (Brown 2020). That is why while one of the caregiver women represents herself as resistant to illness due to her practices like taking vitamins and the medical knowledge that allows her to protect herself; the other woman without any medical knowledge, only believing in the power of religious ideas might accept the possibility of death or illness affirmatively. In this sense, while the economic, gendered positions of women might reveal some shared beliefs, there are still significant factors like age that lead women to interpret the risk of illness differently. Therefore, individuals interpret the given risk possibilities by their subjective understandings of fatalism or trust to scientific and medical explanations (Ibid.).

5.2. Value of Caregiving

Until this point, I did not discuss the meaning of care and what caregiving can encompass. In most general level, Fisher and Tronto define care as “... a species of activity that includes everything that we do to maintain, continue, and repair our ‘world’ so that we can live in it as well as possible.” (1990,40). As there is no single definition of care, caregiver women, their recipients and employers might define care in different ways and the value of caregiving work is defined by the interpretations of the actors (Zelizer, 2005). Care is always subjective, relational, and embodied. In the context of companion work, care includes both physical assistance and emotional support to patients.

Contrary to my expectations, my interlocutors do not recognize the value of their labor; they unvalued their work compared to the role of doctors and nurses. Related to the context of caregiving, I find it important to think about the area of power that caregiver women have in response to their responsibilities in the companion work. Although

caregiver women have a great responsibility in terms of close monitoring of patients, they do not have medical expertise or knowledge which might be helpful to intervene in a case of emergency. This lack of expertise while causing uncertainty in the role of caregiver women results in depreciation of companion work in their eyes. Based on my interpretation, caregiver women devalue their work because they do not have an education like other hospital staff, but they have experience or at the beginning, they have familiarity with caregiving practices. Even if caregiver women do not have experience, they bring their familiarity and caregiving practices to the forefront. Some of my interlocutors who have prior experience of caregiving shared memories that refer to their life-saving practices.

When I asked them how their routine day in a hospital room was, they listed almost the same tasks. These include giving the patients' medicines, assisting patients during the meal and toilet times, controlling the patients' serum. Although these tasks are certainly important as they require the close monitoring of patients, my interlocutors underestimate their role in performing these tasks. In this sense, they did not recognize the essential aspect of their work. By doing that, they contribute to the devaluation of caregiving work at the discursive level (Stevano, 2021). However, they perform multiple tasks during the companion work. Pandey et al. (2021) question how caregiver women while performing such an essential role and called 'essential workers' their labor is undervalued. Pandey et al. (2021) after discussing whom we call essential is directly related to the period and society we live in explains that societies' biases result in under-valuation of caregiving work. However, in the Turkish context, only doctors and nurses are considered essential workers, and to my knowledge, caregivers are not considered as such. Accordingly, caregiving work, which was previously devalued, has not gained value despite being carried out in more risky conditions during the COVID-19 pandemic period.

Besides providing physical assistance, caregiver women undertake the role of informing their employers about the situation of their patients. All my interlocutors mentioned that after the routine control of doctors and nurses they inform their employers, they make video calls to show the patients' situation to their employers. From the side of employers who worry about their loved ones, this might be the crucial role of caregiver women. Otherwise, relatives of patients as could not see their patients, they could not get information frequently.

However, from the side of immigrant women, video calls represent the supervision of employers. Employers call whenever they want to check the patient's situation and whether the immigrant women taking care of their patient well. By this mechanism, the surveillance of immigrant women does not change in the hospital context.

Along with these tasks, working as companions demands to provide emotional assistance to patients. This part of companionship work creates much pressure on my interlocutors, and they find the emotional work part of their job much valuable than their physical assistance to patients. As a part of their emotional work, my interlocutors continue to address their care recipients as mother or father. By doing so, caregiving women make it easier for themselves to keep the companion work on. Additionally, addressing their care recipients as mother or father is part of the strategy to reduce the concerns of patients. For instance, my interlocutor Gül feels the pressure of taking care of COVID-19 patients as she says:

> "I was saying as everybody trusts me like I am their sister entrusts their parents, I should heal them. That is why as they (employers) trusted us, we wanted to take care of patients as if they are our mothers and fathers."

In Gül's narrative, again the trust relation with her employers creates pressure on her. She feels obliged to heal her patient to reciprocate the trust her employers have in her. Thus, caregiver women are also emotionally exploited by their employers. My other interlocutors had mentioned similar conditions and interestingly they correlated the recovery of their patients with their emotional support. Although caregiver women undervalue the physical part of companion work, they bring emotional work to the forefront. Patients' recovery becomes the caregiver women's success and if their patients are taken into intensive care units, they feel both sadness and stress at the same time. Gül and my other interlocutors have mentioned about how they feel sadness after their patients taken to intensive care units.

To ensure patients' recovery, caregiver women call their care recipients as mother and father, they talk about the future and most importantly they lead their patients to dream about the process after their recovery. Through enabling their patients to dream about the future and reminding them that their children and grandchildren are waiting for their recovery, caregiver women provide emotional support to their care recipients. For instance, Reyhan says to her patient:

> "I will take away you to my hometown, I will live with you, I do not have a mother or father, you are my mother, you will be a mother for me. Let's get well soon, I will take you away. I was talking like that, and they were coming around."

Similarly, Reyhan says:

> "You see them like your mother and father. You stay with them and take care of them as how you would take care of your own mother and father. As a human, we see them as our own mothers and fathers. We call them mother and father. We ask them how many grandchildren they have, how their situation is. We do not separate them from our own parents. They are already paying us. About eating, they do not want to eat. We say that if you put something in the sack, it will sit upright but if you do not put anything in it, will it sit upright? She/he says "no". Then we say that if you eat something, you will come around; if you do not eat, you will fall ill. Of course, we reassure them. We say you will get better if you eat and drink water."

Through these tactics, my interlocutors while providing emotional support to their patients they also represent their belief in the important role of emotional labor for the recovery process of patients. Remarkably, as these anecdotes suggest companion work requires different skills from constant caregiving work. With the words of Le Breton:

> "...companion work dissuades patients from their wish of death by saving them from loneliness and leads to their reappreciation of life"[1] (2019, 32).

By the accompany of caregiver women, patients do not lose their connection with the outside world, and they continue to remember their pre-disease state.

From the other side, as Reyhan explained to me the disease process is not easy for both patients and their companions. In the words of Reyhan:

> "When they cannot stand their own pain, they can curse us and get angry, but they can communicate well too. It is hard to take care of patients when they are unwell. We have to accept them. Their situation causes despair when they cannot handle their pain, swear, and get angry. You try to feed them, but they do not accept. You give them moral support. You cannot abandon them just because they bring you down. You have to keep your promise, you laugh and say "Okay, whatever you say I will not leave you, you are my darling, you are my everything." We are talking to them like that. We feed them, give them their medicine, boost their morale. There is no such a thing like getting angry.

[1] Translation is mine.

> We give them moral support although they bring you down and we raise our own morale. We are talking like that."

Although I find these sentences very exaggerated, I see this as a kind of negotiation between patients and their caregivers. Both sides are aware that after the recovery, they will not see each other again and it was the first time for some of my interlocutors have met with their care recipients. In this context, caregiver women through building this intimacy at the discursive level, through addressing their care recipients as mother or father create an environment in which both sides might feel much comfortable. By doing so, caregiver women might decrease the level of pressure on themselves, or they can much easily adapt themselves to the hospital conditions.

In the context of my research, I indicate the reason of calling care recipients as mother and father is related to reducing the stress of contracting the virus. The other reason for calling care recipients as mother and father is related to the organization of caregiving work. Especially, in the context of companion work, I agree with the idea that "the vast majority of intimate caregiving work is best accomplished with personal responsibility and emotional attachment" (Bakım Kolektifi 2020, 89). To provide caregiving work in the best possible way, caregiver women might use this form of attachment as a tactic to represent themselves as better caregivers. I reach this conclusion from the comments of my interlocutors. During some of the interviews, they talk about how good they are at caregiving work, so I felt like they see me as a potential employer.

Moreover, calling care recipients as mother and father does not include a promise that their relationship will continue after the recovery process. My interlocutors were aware of this dynamic and after the recovery process, the rupture in their relations with both employers and care recipients might cause sadness on the side of caregiver women. For instance, Reyhan complained about how employers became indifference toward caregiver women after the patients' recovery process. Thereby, she refers to their changing position in the eyes of employers and in a way, points out how their needs became unimportant due to the rupture in their relationship. Here, the rupture is not only about material needs, rather includes emotional distance between the caregivers and their recipients. In this sense, the intimacy between caregiver women and their recipients constructed temporarily. During the companionship period even if immigrant women are witness to most special moments of their patients and having a very close relationship with them the relationship between them with the beautiful saying of Bilir, represents a kind of "impossible closeness" (imkansız yakınlık).

6. CONCLUSION

In our neoliberal world, the COVID-19 pandemic has brought new necessities and Turkey's unprepared healthcare system could not be sufficient to cover the needs of patients and their relatives. This research depicts the general picture of immigrant women's companionship work for COVID-19 patients during the pandemic period. Although the companionship work for Corona patients has become necessary due to the deficiencies in the healthcare system, the fact that this work is done by immigrant women is related to economic, social, and political reasons.

Immigrant women have their explanations to accept such risky work. In women's decision- making processes economic reasons, their relations with employers and their perception of care recipients function together. These decision-making processes reveal the role of exploitative side of relationships between immigrant women and their acquittances. Despite the risk of contracting the virus, some women accept the companionship work to satisfy the expectations of their acquittances. The inability to be critical about these relationships also restrains women to question their unequal position compared to employers and hospital staff. Nevertheless, immigrant women by developing different strategies make easier to conduct caregiving work and detract from the disease risk.

Further work is required to understand how immigrant women are affected by working as companions. In future research, conducting interviews with employers and expanding the sample of research is necessary to be able to demonstrate e a more extensive knowledge.

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APPENDIX A: INTERLOCUTORS' PROFILES

Name	Country	Age	Experience in Caregiving	Living Conditions	Companionship for COVID-19 patients
Sümbül	Turkmenistan	41	Yes	Lives with her friends	No
Gül	Turkmenistan	41	Yes	-	Yes, at hospital
Reyhan	Turkmenistan	40	Yes	Lives with her friends.	Yes
Fatma	Georgia	-	Yes	Married	Yes, at hospital
Nina	Georgia	39	Yes	Married	Yes, at hospital
Karina	Armenia	42	Yes	Lives with her sister.	No
Armin	Armenia	42	Yes	Lives with her sister and friends.	No
Nergis	Georgia	-	Yes	-	No
Lane	Uzbekistan	52	Yes	-	No
Altıngül	Uzbekistan	33	Yes	Lives with her friends	No

APPENDIX B: PHOTO OF HOSPITAL ROOM

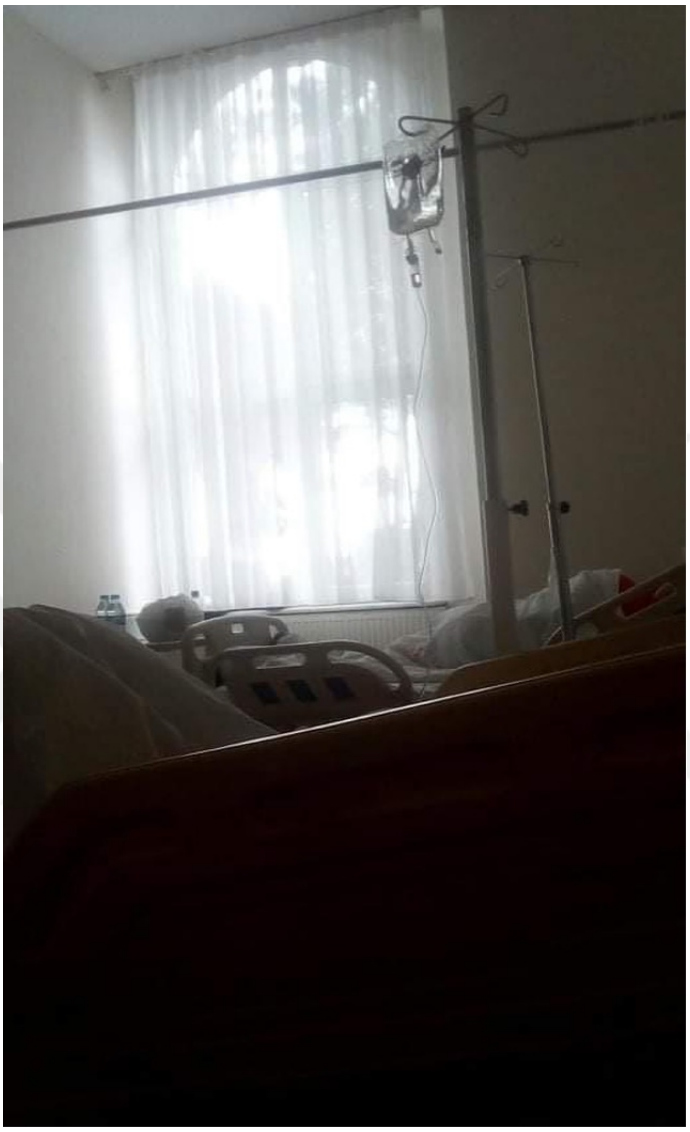

Figure 1 The hospital room in which Fatma takes care of two COVID-19 patients.