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To cite this article: Katherine Ravenswood, Fiona Hurd, Amber Nicholson, Andrea Fromm, Kirsty McCully, Melissa Woolley, Tanya Ewertowska & The Participant Researchers (2023) Community support workers' experiences of working during the COVID-19 pandemic, *Labour and Industry*, 33:2, 263-280, DOI: [10.1080/10301763.2023.2209922](https://doi.org/10.1080/10301763.2023.2209922)

To link to this article: <https://doi.org/10.1080/10301763.2023.2209922>



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Published online: 10 May 2023.



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Community support workers' experiences of working during the COVID-19 pandemic

Katherine Ravenswood^a, Fiona Hurd^a, Amber Nicholson^a, Andrea Fromm^b, Kirsty McCully^c, Melissa Woolley^b, Tanya Ewertowska^a and The Participant Researchers

^aFaculty of Business, Economics & Law, Auckland University of Technology, Auckland, New Zealand;

^bDepartment of Policy and Strategy Public Service Association Te Pūkenga Here Tikanga Mahi, Wellington, New Zealand; ^cEarly Childhood Education, NZEI Te Riu Roa, Wellington, New Zealand

ABSTRACT

This paper investigates the way in which COVID-19 has exacerbated the poor work conditions within community support work in Aotearoa-New Zealand. It examines the invisibility of care work in New Zealand during the COVID-19 pandemic, in terms of Government policy and communication, societal recognition of care work, and the spatially hidden nature of the work. It does so within the of gender norms in the socio-cultural, socio-spatial and socio-legal spheres that render this work and workers invisible. This paper documents the experiences of community support workers and contributes to our theoretical understanding of frontline health workers' experiences of work during a global public health crisis.

ARTICLE HISTORY

Received 25 May 2022
Accepted 28 April 2023

KEYWORDS

COVID-19; community support; work conditions; precarious work

Introduction

This study explores community support workers' lived experiences during the COVID-19 pandemic in Aotearoa-New Zealand. Community support workers help people live in their own homes, providing a wide range of support activities largely focused on personal care and support (such as assistance with showers and medical care), but sometimes including elements of household management. Although clients of community support are generally older people (HCHA 2020), they can vary in age from babies through the life course, and require rehabilitation, disability support, or palliative care for example. This is a significant part of Aotearoa's health sector, with community support services provided to well over 100,000 New Zealanders (New Zealand Productivity Commission 2015). The New Zealand community support workforce comprises approximately 16,000 workers, and is highly feminised (Douglas and Ravenswood 2019; EY 2019; HCHA 2020). While the national and international responses to COVID-19 continue to unfold, it has become clear that the inequalities that existed prior to the pandemic were only exacerbated by it: women have shouldered a greater burden of unpaid care (Clark et al. 2021; Seck et al.

CONTACT Katherine Ravenswood  kravensw@aut.ac.nz

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2021); and those in low paid essential healthcare jobs have experienced greater stress and exposure to infection, with less recognition than healthcare professionals and without the financial resources of higher paid jobs (Almeida et al. 2020; Heintz et al. 2021; Staab et al. 2020). Existing labour market inequalities and gender-wage gaps in the health care sector contributed to these worsening conditions (Camiletti and Nesbitt-Ahmed 2022; World Health Organization and the International Labour Organization 2022).

Even at the beginning of the COVID-19 pandemic, it was clear that women were shouldering the burden of care provision to elderly, young and disabled globally, with community health workers, personal aides and domestic workers facing considerable difficulties including lack of access to personal protective equipment (PPE), subsidising their work from their own income, insufficient state support for job or income loss, and difficulties moving around during lockdown (Staab et al. 2020). Although the healthcare sector globally has not experienced job losses like other industries and sectors, work conditions overall have worsened. This has been more so for frontline low wage health-care workers, the majority of whom are typically women. Existing labour market inequalities and gender-wage gaps in the health care sector contributed to these worsening conditions.

In the face of these conditions, the healthcare workforce in general was idolised as 'heroes' in the early stages of the pandemic, epitomised in the 'Clap for Carers' campaign that spread globally (Gallanti 2022; Hales and Tyler 2022). However, the idealisation of this work hid the lack of protection of these workers; and was largely focused on doctors and nurses, failing to recognise the work of other healthcare workers. Instead, the reification of 'the healthcare worker' perpetuated the ideal, self-sacrificing stereotype that undervalued feminised carework prior to the pandemic (Gallanti 2022; Hales and Tyler 2022). The ideal heroic healthcare worker rhetoric overshadowed any potential for discussion of employers and state duty of care for healthcare workers (Hales and Tyler 2022).

The deifying rhetoric of healthcare workers that renders the reality of 'self-sacrificing heroes' invisible, and generally overlooks non-professional healthcare workers, is the same that plays out in research during COVID-19. In health and medical journals, the focus is on healthcare professionals, usually in hospital settings. Where 'community' or 'home based' healthcare is mentioned, any personal aides or healthcare workers are often subsumed into a broader sample that includes doctors, nurses and other professionals (see for example, Ayton et al. 2022; Karni-Efrati et al. 2022). Much of the research in the social sciences on care work has focused on unpaid care work (Abendroth et al. 2022) or, importantly, informal and domestic workers (Ogando et al. 2022).

Research does indicate that those working in home and community care experienced worse conditions than prior to COVID-19 (Kelleher et al. 2022; Rivera-Nuñez et al. 2022). Globally, care workers involved in home-based care experience poor work conditions such as night shifts, split shifts or short hours, poor pay, lack of access to predictable working hours and increased workplace health and safety risks. During the COVID-19 pandemic, these risks have included higher risk of infection, and of fatality, from COVID-19 than the general population (International Labour Organization 2022). In Australia, disability support workers reported that they lacked appropriate PPE, experienced a drop in hours of work,

and commensurate financial insecurity and even in the very early days of the pandemic were concerned that the disability workforce would be overlooked in broader health and employment policy as the pandemic progressed (Cortis and van Toorn 2020). This paper, therefore, aims to record the experiences of community support workers in New Zealand. It asks 'what was the impact of policy decisions on community support workers in Aotearoa during the COVID-19 pandemic?'

The following sections illustrate the continued invisibility of this workforce to policy makers, including prior to the pandemic and provides contextual information about the workforce. In doing so, we place these issues within the context of international research on care work. Subsequently, we outline the research design for this participatory research, and the findings, illustrating the effect of COVID-19 policy decisions on these workers. The paper then discusses the implications of these decisions for the ongoing provision of community support, and the current actions being taken by unions to address the systemic discrimination inherent in the regulatory environment that affects community support workers in Aotearoa.

Invisibility of community support work

Invisible work is work, such as care work, that is carried out but is not seen by society (Laugier, 2021). Early feminist research on women and invisibility at work illustrated how invisible privilege – held by men – kept women out of senior roles in organisations. It's focus on privilege and seniority meant that the way in which discourses expecting women to be loyal and devoted to their work and leaders, was used to keep women in their place at work. Invisibility at work, from that perspective is a combination of factors that operate at an organisational level to perpetuate the privilege of some, and to silence others, such as women (Lewis and Simpson 2012). However, because this earlier work focused on the organisational context, often white collar or professional organisations, and on inter-personal interactions used to do gender (Deutsch 2007; West and Zimmerman 2009), it largely failed to consider the way in which social norms and institutions operate to make some groups of workers and some kinds of work invisible in society (Lewis and Simpson 2012).

Community support work, the focus of this article, is work that sits at intersections of invisibility, including organisational practices, systemic discrimination and broader national employment practices (Lokot and Bhatia 2020; Nasol and Francisco-Menchavez 2021). Hatton (2017) situates her theory of invisibility within the broader context of care work and dirty work – work that may be both paid and unpaid, but is generally overlooked in work and employment research, and is undervalued or invisible to the economy. However, Hatton (2017) argues that while understandings of invisible work, such as those related to care work, have highlighted the way in which social institutions have made women's care work invisible, they have not addressed the other mechanisms at play in invisible work. Hatton (2017), therefore, defines invisible work as work that is made invisible through three categories: legal, cultural and spatial. These three mechanisms do interact, and are dependent on national and cultural contexts. Community support work is made invisible through an

interplay of all three mechanisms. The following section presents the context of community support work in Aotearoa, applying Hatton's (2017) model of invisibility to this context.

Invisible community support work in Aotearoa New Zealand

Sociocultural mechanisms

Sociocultural mechanisms are those in society which, for example, view women's work as lower skilled and lower value. As has been well explained in care theory, care work, especially aged care and disability support work, is made invisible through sociocultural mechanisms. Primarily, this is through the ongoing assumption that all care work is of low value, due to it being an innate skill that women hold (England and Alcorn 2018; Hartmann and Hayes 2017), in line with Hatton's (2017) 'naturalisation of skill'. However, gendered mechanisms operate in conjunction with a hegemony of class, whereby society assumes women who do these low skilled jobs are of a lower class, less educated, and with fewer opportunities (Ravenswood and Harris 2016).

Emotional and identity work are part of sociocultural mechanisms that maintain invisibility. In the context of community support work, there are a number of ways in which this occurs. Community support work, through the provision of care and support, entails significant emotional labour involved with being a kind, listening ear as one example. Patiently encouraging clients to engage in support, such as when clients may be reluctant to be showered, dressed or take medication is emotional labour that is required, yet invisible. Furthermore, a face of positivity, care and motivation is required even when community support workers are working in difficult and dirty conditions (Ashforth and Kreiner 2014; Clarke and Ravenswood 2019). Community support workers are required to embody a cheerful, patient, caring professional yet this is not recognised in how their work is visible to either clients, society or employers.

Sociospatial mechanisms

Sociospatial mechanisms refers to those that make work invisible because the work occurs outside of the traditional workspaces. There are two key means through which sociospatial mechanisms are at play in community support work. Firstly, the work takes place in the community, inside individual clients' homes. Thus, it takes place within the domestic sphere. A further sociospatial mechanism that renders community support work invisible is the spatial organisation of the work. In addition to working in people's private homes, community support workers are spatially invisible from their own employers because they work out and about in the community. This has been further exacerbated as larger national and multinational community support providers dominate this sector, and tend to have minimal presence as an employer locally. Instead, they often operate a nationally based call centre that is the main point of contact for allocating clients and work to their employees; and the point of contact if support workers need assistance with any part of their work. The national 'call centre' nature is increasingly managed digitally through apps which provides an interesting juxtaposition to Hatton's (2017) example of how digital work is invisible sociospatially. Community support work is physical work, not

digital, but is often managed and organised digitally. These sociospatial mechanisms mean that community support workers may seldom see other colleagues or supervisors (Ayalon 2012; Macdonald 2021).

Sociolegal mechanisms

Hatton's (2017) definition of sociolegal mechanisms relates only to the divide between consideration of being in 'employment' or not. With the latter, the qualifying point for sociolegal mechanisms that make work and workers invisible is that legal structures are designed to exclude the work as employment. For example, informal work or illicit work or work undertaken without pay (e.g. household work, volunteer work). However, we propose that sociolegal mechanisms be expanded to include those legal mechanisms, even within employment, that make work invisible. This expansion is compatible with the model's underlying assumption that the cultural and national context is paramount in its application. In Aotearoa, the legal funding mechanisms for community support work create a complicated indirect employment relationship. For example, while this work is predominantly publicly funded, it is outsourced through several government agencies to private sector employers. One single community support worker could provide services to clients who each are funded by a different government agency – all in their employment for the one private sector employer (Moore et al. 2018). This fragmented employment relationship legally separates these workers from the protections and visibility associated with being employed in the public sector (Ravenswood 2023b). The way in which the outsourcing model is implemented through different government agencies makes it difficult for the workers to call attention to any mistreatment or poor conditions because of the lack of clarity in who the funder, or indirect employer is (Ravenswood and Kaine 2015). Thus, while they are considered to be employees, the sociolegal mechanisms make them invisible employees. Furthermore, community support workers often carry out work for their clients that is essentially deemed 'non-economic' as it is not included in funding models or remuneration, such as the social connections, noting of change in clients' moods, stopping to chat that are essential, yet invisible, to the wellbeing of those receiving community support services.

Community support work is rendered invisible through all three of Hatton's mechanisms of invisibility. The consequences of this invisibility for workers are evidenced through the poor conditions experienced by community support workers. Although hourly wages are now higher as a result from union action beginning in 2012, community support workers still experience uncertain and antisocial hours. As research conducted just prior to the COVID-19 pandemic found (Ravenswood et al. 2021):

- Split shifts are common: 38.3% worked 'shifts' of 1 hour or less, 33.2% worked shifts of two to four hours.
- A majority (84.7%) of community support workers have 'guaranteed' weekly hours, indicating on the inverse that nearly 15% do not experience this legal entitlement.
- Only 41% have a permanent full-time job.
- Underemployment is an issue: 61.5% of community support workers would like more hours per week.

Furthermore, the lack of resourcing in this sector, and isolated nature of the work has negative health and safety implications for workers, including workplace violence (Craven et al. 2012; Ravenswood et al. 2017), and concerns over earning a gender equal wage from their work (HDSR 2020).

However, those on the margins can challenge the hegemony (Lewis and Simpson 2012; Hatton 2017) and while these conditions persist, it is despite considerable effort from community support workers and their unions. Their actions have significantly increased hourly wages and reduced the lack of guaranteed hours. There are two core actions taken by community support workers (and other care and support workers) that had a significant impact on work conditions (HCHA 2020; Ministry of Health 2020): 1) legal action resulting in the Care and Support Workers (Pay Equity Settlement) Act 2017; and 2) legal action that resulted in the Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016 and the Guaranteed Hours Funding Framework introduced by the Ministry of Health in 2017. While huge, and hard earned, wins for community support workers, research has shown that the resulting legal frameworks did not achieve the intended goals, with managers working around requirements, sometimes taking potentially illegal actions, to minimise their costs (Douglas and Ravenswood 2019; Ravenswood and Douglas 2022). This is, in part, due to these frameworks overlaying a basically inadequate funding model (Ravenswood 2023b), and the same mechanisms outlined above that Hatton (2017) argues work together to make certain work invisible. Given this ongoing invisibility despite workers' action prior to COVID-19, this article focuses on community workers' experiences, recording the impact of COVID-19 on them.

Methodology

This project explored the wellbeing of community support workers in New Zealand through the COVID-19 pandemic. The research question guiding this was *What challenges have community support workers experienced, and how has this impacted their wellbeing during COVID-19?* The research followed a Community Based Participatory Research (CBPR) approach (Nicolaidis and Raymaker 2015), with academic researchers working alongside two community partners: E tū and Public Service Association Te Pūkenga Here Tikanga Mahi (PSA) unions, and their community support worker members. CBPR emphasises community involvement, equal partnerships between community and academic partners, and research for action (Nicolaidis and Raymaker 2015).

The university researchers, E tū, and PSA worked collaboratively to identify the community need and project design as well as recruiting community support workers to take part in the research. The union partners recruited participants by approaching delegates and sharing research advertisements in member networks. Snowball sampling was also used, with some participants sharing the research with other support workers. To take part in the research, participants needed to self-identify as community support workers, and have experience working during the COVID-19 pandemic and consequent lockdowns.

A total of 87 participants were interviewed throughout 2021 for this project. Aligning with the CBPR approach, in the first phase, a group of 18 community support workers were initially recruited, interviewed using an in-depth semi-structured approach, and trained as participant researchers by the university research team. In the second phase,

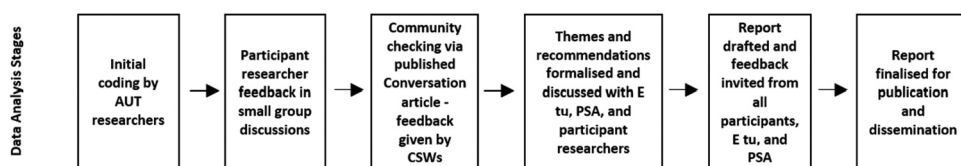


Figure 1. Staged analytic process.

the university researchers and participant researchers then interviewed a further 69 participants. Of these 87 participants, two were not union members, and for a further 13 union membership information is not known.

Participants reflected the composition of the workforce in community support, although demographic information about this workforce is limited. For example, women (93%) and those of Pākehā (82%) descent make up the majority of the home care support workforce, and 55% of the workforce are over 55 years of age with very few under 30 (HCHA 2020). Private providers oversee approximately 70% of the work in home and community support (HCHA 2020). Most participants (51), were employed by for-profit organisations, while 34 worked for not-for-profit care providers. The participants included 84 support workers, and three participants worked in adjacent roles including coordinator, service manager, and community worker. While the research primarily focused on support workers in home and community care (58), there were also 18 participants in disability support services, and eight in organisations classified as other (generally offering both home and disability support).

Participant researchers were able to carry out as few or as many interviews as they preferred, and with some choosing to recruit their own participants for interviews. In-person interviews were carried out where possible, however with the changing pandemic situation and rural locations of some participants, most interviews were carried out via zoom and phone calls. The interviews were semi-structured around two core issues: 1. what wellbeing meant to participants, and how wellbeing was linked to their work, and 2. how their experiences as community support workers through the COVID-19 pandemic impacted or enhanced their wellbeing. The interviews were sufficiently structured to allow the participant researchers to feel a sense of confidence in interviewing, while ensuring all questions were open, and not leading participants. Some participant researchers chose to follow this interview schedule, while others had a more open conversation, guided only by the two issues above: understandings of wellbeing and experiences of wellbeing during COVID-19.

A staged thematic analytical strategy was used (Hennink et al. 2017), with discussions between the university researchers, PSA and E tū, and the participant researchers occurring throughout. The stages of analysis are outlined below in Figure 1.

Initial open coding within the university research team yielded a total of 87 codes, each with between two and 250 references. These codes were then analysed within, and across codes to produce themes. The themes were presented to the wider Participant Researcher groups and Union partners for feedback and refinement. Final themes, conclusions and recommendations arising from the project overall were discussed again with the same groups and refined to reflect the collective understanding of the research team – Union partners, participant researchers and the academic members. This analytical process

yielded a large number of themes across the data set. The themes covered a wide range of areas relating to understandings of wellbeing and experiences during the COVID-19 pandemic. This paper focuses on a section of this data related to the meta-theme of invisibility of the community support worker, and how this invisibility was exacerbated through the COVID-19 pandemic.

Findings

As illustrated above, sociocultural, sociospatial and sociolegal mechanisms have rendered this workforce invisible. This means that the skills, knowledge and experience required to successfully provide support, is often not recognised by employers or society at large, reflecting their invisibility in government policy. In this section we present the findings along three key themes of: 'lack of understanding of the role', 'societal recognition of support workers as essential' and 'the impact of government policy'. In particular, we present the way in which distant decision making led to threats to support workers' health and safety, financial insecurity, and a negative impact on community support workers' children.

Lack of understanding of the role

This theme describes the way in which participants felt that the complexity of the job was not well understood by the general public or policy makers, who have little to do with this type of work unless someone close to them needs community support. As mentioned above, the general perception of community support is that it is mostly housework for older clients, with only some personal care involved: 'I mean, they think we're cleaners. We do a lot more than clean, you know' (P17). Or that the work involves largely social tasks: 'some people would just think of it as having cups of tea with people' (P3).

However, participants described the complexity of their work which covers a vast range including disability support, rehabilitation support, palliative care, dementia care, and support for all age ranges:

That's one client. I have another client where I take her - she has cancer. She's very young and she has cancer. We take her from her bed to the bathroom just to shower her, dry her up, change her clothes and then put her back to bed. (P19)

Some tasks performed by community support workers would once have been carried out by registered nurses, such as wound dressing, PEG feeds, stoma and catheter care:

I've worked with a six-month-old because her parents needed help because she had to be nostril fed and they had to get a peg feed into her. I already had a child who was being peg fed, so I was able to help them. (P4)

The nature of the job is that support workers work in close proximity with their clients, are exposed to bodily fluids and provide intimate care:

Personal care. It can be anything from a bed bath to a full two-person hoist shower, colostomy bag, whatever. Colostomy bags are the worst. Especially when they come out and blow. (P31)

Participants described the variety of skills required, with each client having different needs and different home settings. Beyond the task-based skills required, care often required significant so-called 'soft skills' of empathy, behaviour management and problem solving:

one of the things that's not really regarded with us ... You're playing personality games all the time. You've got to change yourself every half hour or hour to fit in with the personality and the character of the person that you're with at the time. It does your mind in sometimes. You go in there bright and breezy, and they want somebody that whispers or vice versa. (P61)

Support work also involves observing the health (mental and physical) of the client, and determining when there are changes that warrant reporting for further assessment and care:

We need to find a way to address it and if that means bringing in a family, if that means collating the data, you know, and saying to those caregivers that go into that client ... in a month's time and then work out a plan with the support of the relatives, actually going and say look, now is the time and you address it with another assessment. (P17)

As well as not understanding the complexity of the role, the broader context of providing care in people's homes, often alone, is not well understood by those who do not do the job itself.

Societal recognition of support workers as essential workers

Participants linked this lack of understanding of the nature of the job with a societal devaluing of community support work. Support workers were described as being 'underground' in their invisibility, with one participant describing:

... it's like a little underworld where, all over your city, women, mostly in uniforms in little cars, are getting in and out of the cars and going into houses and doing things that nobody has any idea about, you know. (PR12)

This invisibility was directly linked to the gendered nature of the work:

And people will forget again or go back to our normal lifestyle and we will forget about those largely invisible people. Yeah, I think that's the danger out there of that. We will slip back to being those women who do women's work and are paid peanuts, because it's an extension of what of what women do. If they're not caring for the family, then they're caring for someone else's family. (P36)

However, the discourse of the essential worker during the COVID-19 pandemic did challenge the invisibility of community support workers to some extent. For some, it proved to be a source of pride and a welcome contrast to the historic lack of societal recognition, leading to some support workers feeling that they were more valued and appreciated for their work:

As essential worker - what I felt is I felt so proud because my job is not just a caregiver – it is a frontline job. So people finally gave us some recognition that we are essential workers because normally, what we used to think is IT professionals are the most needed people. But now, nurses, doctors and support workers, like me, are frontline workers and we are so proud to be called essential workers. (P5)

However, even official essential worker status was not enough for some people to re-think their perception of community support work, and some participants were actively challenged on their essential worker status:

Even now, you hear some people saying you just go into people's homes, and you're not really that important. (P18)

As essential workers, community support workers were legally allowed to travel during strict lockdowns which limited the movement of people to a small area, such as 5 km or 10 km radii. Additionally, many retail or services such as supermarkets (themselves essential workers) provided priority queues to essential workers during lockdown, so that these workers would not have to wait in long, time intensive queues. The invisibility of support workers as essential workers meant that, some participants reported being challenged when joining priority queues at supermarkets. Some were even stopped by police and questioned on their being out and about during a lockdown to check that they were adhering to regulations:

Sometimes you get stopped by a police officer ... if they see you, because you can't go driving around, like place to place ... It's out of bounds ... But being an essential worker – being a support worker with your tag on you - you do get to go to [another suburb]. (P49)

These challenges to their essential worker status not only affected their morale but added more time and emotional labour costs to their daily work. While, as illustrated above, some workers were appreciated and felt pride in being essential workers, others saw this lift in recognition as just temporary and not creating permanent change to the gendered invisibility of their skills, contribution and work, even during the pandemic itself:

So, in that respect, the pandemic did elevate us up to essential, and people were maybe a bit more aware ... [but] And people will forget again or go back to our normal lifestyle and we will forget about those largely invisible people. Yeah, I think that's the danger out there of that. We will slip back to being those women who do women's work and are paid peanuts. (P36)

The impact of government policy

This wider societal invisibility was also reflected in government policy and communications, particularly during the COVID-19 pandemic. Participants felt '... invisible almost especially to government' (P68). The lack of government recognition meant that there was a perceived and real gap in what policy makers understood and what happened on the job. The lack of government recognition and gap in understanding meant that community support workers experienced threats to their safety through firstly, a persistent lack of quality PPE throughout the first two years of the pandemic, and a lack of specific and realistic guidance for community support work. A lack of specific guidance meant increased uncertainty for community support workers, and greater

financial insecurity for some – due to policy decisions not always applying well to community support.

The disconnect between policy makers and those doing the work led to lack of resourcing for community support, and inconsistent messaging for the sector. This issue was perhaps most pronounced over the provision of PPE for community support workers.

But also, I felt a bit of a disconnect and at times, I had some rude words to say to them on when they were making like - there was enough PPE and things like that, you know. I just felt that at the front line, that some of the information wasn't quite correct. (P36)

At times, these policy gaps highlighted lack of understanding at government and policy level of the job of community support, and the tasks carried out daily, leading to unsafe conditions:

Yeah, and then you get told, you're wonderful [as an essential worker] . . . but get to the back of the queue and you don't deserve gloves and masks because you're not getting up close and personal with people. How do you wash someone's bottom? Do you stand at the other end of the hallway and do it? How close do you have to be to wash somebody's bottom? Where you change a baby's nappy – at the other side of the room from them? No. Well, it's the same with an adult. Oh, right, okay. So maybe you do need a mask. Well, you can have one mask for that client for that week. But it's a surgical single use mask. What's the point? (PR16)

A lack of attention to this core essential service by policy meant that there was not sufficient detail in guidance to employers or support workers on how they would be protected in potentially COVID-19 positive client households, and how clients would be supported and protected from COVID-19:

Well. That's the scary thing now. It's that uncertainty. My understanding is that we don't go if someone's got Covid and if there's even a hint of a suspicion, we report it in and so. We would get stood down if we go into the home with someone with Covid, we get stood down. We have to self-isolate. So you just have to protect yourself. (P77)

Additionally, government and organisational communications provided little clarity to support workers about their work entitlements during the pandemic:

But right now, I don't know what that means if, for example, I couldn't work or had a vulnerable person at home. I don't know whether - I think I'd get paid regularly but I don't know. You know, like it's just the messaging – it's about the messaging that communication is not very clear. And I don't know who to ask or how to access information. (P16)

Some of the lack of clarity included whether household management would be provided during lockdowns, which meant that some community workers did not know when or how much work they would have, potentially affecting their income. In general, support workers felt that the factors which led to financial security were eroded during the COVID-19 pandemic, and therefore experienced greater financial insecurity than prior to the pandemic:

I took a financial hit during lockdown by being on the subsidy, but I'm ever so grateful that the subsidy was available. And that just seemed very what's the word - It certainly felt like the government was looking after us even if our employer wasn't. (P37)

Although the government instigated wage subsidies and additional sick leave pay for those affected by COVID-19, these policies did not apply well to this sector. For example, the government provided wage subsidies for those who could not work during lockdown, either because they were vulnerable to COVID-19 or because their workplace could not operate under lockdown regulations. Some participants reported that if they worked during lockdown, they had lower take home pay than those who were not working and instead receiving government subsidies, in some cases due to a decrease in hours. Furthermore, the government's sick leave policy and other subsidies did not work for many support workers because they worked for more than one employer in order to cobble together full time employment – and the policies were aimed at more standard employment with single employers.

Many felt a sense of insecurity around hours, and for some whether they would be able to continue working at all:

I was in one of the vulnerable groups, and we don't know whether to continue work or to stay home or whether I will be financially supported or not. (PR5)

This uncertainty over hours exacerbated concerns they had over whether they would be eligible for the New Zealand's government COVID-19 wage subsidies:

And with the wage subsidy, it had to be applied for every four weeks by the employer so that was a stress as well, that I knew it was going to run out in four weeks' time, and I had to let my employer know I do want it again for the next four weeks and I wanted again for the next four weeks. I just felt that it was not easy to communicate with them, and that I was somehow making life difficult for them - making more work for them. (P37)

In particular, participants felt that this lack of financial acknowledgement was symbolic of the societal view of community support work.

Government policy on childcare for essential workers was another key policy gap that highlighted the way in which community support work's invisibility and the distance of decision makers from the job impacted support workers. While policy meant that support workers should have had access to childcare during lockdowns and other COVID-19 restrictions this was not always accessible in rural communities or because of the irregular hours that community workers work, such as evenings and weekends. This had a significant impact on support workers and their families. In several cases, support workers had to take their children to work with them:

I remember there being a bit of pressure put on the other colleague that I worked with, who had a child as well and they she was taking her child to work and he had to sit in the car. That was the key moment where I was like, I have to do something about it because it was cold and you know, when you're desperate, you've got to do desperate things. (P1)

For other support worker parents, they were concerned about their children, themselves and their clients through a perceived higher risk of children of essential workers spreading COVID-19 at daycare:

But still they're kids - they touch each other, they play with each other. So they're not in a bubble. So I didn't let my baby to go to a daycare during the pandemic because I just got so scared. So it was my family, - we got support from each other to support the mother of a child, what will we have. So recognising those things would be really great. (PR5)

Although this support worker could draw on family to help provide childcare, others did not have that support. In the following example, the support worker possibly got infected at work, and in addition to being concerned about spreading COVID-19 to their child, had no childcare support:

And then I brought it home to my son and then I got really sick, there was no backup, because his father doesn't live here. I didn't have any support in the community to help with childcare. I thought, you know, because it happened that quickly, I thought I'd be able to work something out but as time goes on, it doesn't really work like that. (P1)

This last example shows that the way in which all of the policy gaps, invisibility and lack of understanding of the work involved in community support work by decision makers had multiple and significant negative impact on workers, and on workers' families. In this example (prior to the Omicron variant which was widespread in the community), the worker was not sufficiently protected at work, and then while sick with COVID-19 had little or no support to care for either herself or her child.

Where to from here?

Although community support workers were designated essential workers during COVID-19 in Aotearoa-New Zealand, our participants felt their work remained invisible and undervalued. In some instances being essential workers even created issues during their work day, for example all essential workers were entitled to drive during lockdowns, and were offered priority entry at supermarkets, however a lack of public and police knowledge that support workers fell into this category led to them being questioned while undertaking these activities as part of their daily work. At a policy level, infection control advice and policy did not include provisions or advice for these workers, and their clients, in the community. Furthermore, policies aimed at supporting essential workers during this period, such as wage subsidies, COVID-19 sick leave entitlements and childcare provisions, did not account for the nature of community support work. Needing to work during this period, yet not receiving these policy supports, had significant negative impacts on these workers and their families. So, while some community support workers were classified as essential workers, the lived experience mirrored the rhetoric of support workers in service, with little felt reciprocal duty of care from the state or their employer (Gallanti 2022; Hales and Tyler 2022).

Research has often focused on gender and how that has undervalued community support work and kept work conditions poor, concentrating on sector wide or policy processes. In this paper, we augment this theoretical body with the lived experiences of community support workers during COVID-19. The participants experiences suggest that the gendered stereotypes of this work as low-skilled, and unimportant (Charlesworth and Malone 2017; England and Alcorn 2018; Hartmann and Hayes 2017) have remained throughout recent changes in the COVID-19 pandemic, rather than this crisis being used as a catalyst for paradigmatic changes (Heintz et al. 2021). The sociocultural, sociospatial and sociolegal mechanisms (Hatton 2017) that maintain the invisibility of community support workers appear to have endured through COVID-19 (Almeida et al. 2020). Crucially, mismatch between policy measures and the context of the community support sector meant that there were significant negative impacts on community support workers in the

Aotearoa-New Zealand's government COVID-19 response. Enabling a better understanding of worker needs requires a deep understanding of policy outcomes for these workers. This research contributes to that understanding, both in Aotearoa and internationally.

The need to highlight the experiences of these workers has been strongly emphasised from within the sector previously. It was support workers and their unions who instigated the legal action leading to regulatory change that increased hourly wages and training opportunities in this sector; and led to payments for the travel between clients on the job. Their activism also led to paid breaks for these workers being accounted for in the government's 2021 budget – what might feel a small win, but significant for those who may work 12 hour days, and often on a 12 days on, 2 days off cycle. Their activism in television, print and radio media kept the issue of provision of PPE in the media spotlight for nearly two years (McCully and Ravenswood 2020; Ravenswood 2023a).

Our research highlights that a very different approach is needed in order to ensure that community support workers' skills, experience, knowledge and indeed, the reality of their work, is recognised and supported in policy and funding decisions. The current funding models favour large for-profit companies, some international or multinational companies, and marginalise smaller, not-for-profit organisations that are more likely to hold quality of care and decent work at least equal to profit. As illustrated here, in addition to the already poor working conditions pre-pandemic, community support workers increasingly shoulder the risk and cost of their work, in the face of policy decisions that are ignorant of the work that they do and their contribution to society.

Clearly, change is needed, and recommendations that arose from participants' experiences suggest changes that would respond to the poor working conditions of community support workers:

- Advocating for sector wide standards for work conditions and funding, leading to a possible Fair Pay Agreement for the Sector which seeks to settle ongoing issues of hours, safety and respect for the sector's workforce.
- Ensuring the gains of the Care and Support Worker Pay Equity Settlement are not lost when the legislated agreement expires in June 2022; and that pay rates are adjusted to better recognise shifts in the minimum wage and wage rates since it was settled.
- Further building strategic alliances with key stakeholders in order to influence funding models, and regulation of procurement, advocating for a worker voice in accountability mechanisms, making the most of current health system reforms underway.
- Through all of these strategies, fighting to safeguard workers' voice and power, so that workers can speak out without fear of repercussions, have a central place to report safely on their employer's practices, and hold the sector and the funders to account for the long term.

This is a large programme of work however, there are several systemic reforms and regulatory changes underway in Aotearoa-New Zealand that might provide opportunity to bring new worker voice into this sector. Firstly, the Fair Pay Agreements Bill has passed its first reading in parliament and is likely to be passed in 2022. This would provide a framework for collective bargaining to take place at a sector or industry level, rather than workplace-based bargaining. This will potentially strengthen union power in this

sector and reduce the invisibility of community support work. Secondly, and significantly, considerable reform is underway in the health system with a very real opportunity to make change, with several newly created agencies. The first of these is a new national Health structure in New Zealand, represented by two entities Te Whatu Ora and Te Akahai Ora. These organisations oversee national procurement processes, and the funding and employment for community support work which previously took place under the regional District Health Board system.

For workers in this sector, the ongoing work of the Unions has paid dividends. Significant advances have been seen in pay for travel time, pay for sleepovers, equal pay for care workers, and training regimes alongside it. However, while these individual campaigns are successful, there still exists overarching inequities and marginalisation of this workforce, largely as a result of the structure and nature of the work and the sector funding model - the mechanisms that maintain invisibility (Hatton 2017).

The COVID-19 pandemic has put inequality in stark relief, and change is needed – decisions made by policy makers did not reflect the work and needs of community support workers. However, change butts up against systems that maintain the status quo (Howell 2016). Nevertheless, change is necessary, and support workers in NZ have been fighting for improvements – what you hear in the stories captured in this study are the voices of dissatisfaction and women who will mobilise to create change.

Disclosure statement

No potential conflict of interest was reported by the authors. The views expressed represent the views of the authors at the time of writing and do not necessarily reflect the views of the organisations they work/worked for.

Funding

The work was supported by the Health Research Council (NZ) [20/1383].

Notes on contributors

Katherine Ravenswood is Professor of Industrial Relations in the Faculty of Business and Associate Director of the NZ Work Research Institute at Auckland University of Technology. Katherine's research focuses on the examination of power, gender and diversity in the employment relationship specialising in sustainable work and care/work regimes.

Fiona Hurd is an Associate Professor in the Faculty of Business at Auckland University of Technology. She is an expert in gendered experiences of work and wellbeing, and in the qualitative methodologies to provide voice to marginalized groups.

Amber Nicholson is a lecturer in the Faculty of Business at Auckland University of Technology. She is an expert in indigenous concepts of wellbeing, and her research recognises and honours the ancestral landscapes in which business operates.

Dr. Andrea Fromm is a Senior Advisor for policy and strategy at the PSA. Throughout her career Andrea has focussed on understanding, realising and supporting decent work and sound industrial relations. Andrea is a social worker by training.

Kirsty McCully currently works with NZEI Te Riu Roa as their Strategic Lead in Early Childhood Education. Prior to her current role Kirsty was a Director at E tū union with responsibility for care and support work. She has worked for a number of unions, both in Aotearoa and internationally, focused on industry or sector based organising strategies to improve the working conditions and pay for low paid women-dominated workforces.

Melissa Woolley is an Assistant Secretary at the PSA, New Zealand's largest union. Melissa has been advocating on behalf of care and support workers for many years. Prior to working at the PSA, Melissa was a care and support worker.

Tanya Ewertowska is a PhD candidate in the Faculty of Business at Auckland University of Technology. Her doctoral research focuses on young workers' experiences of disadvantage, control and resistance at work. She specialises in qualitative and creative methodologies and methods that empower workers through research.

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