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Caring During COVID-19: A Study of Intersectionality and Inequities in the Care Economy in 16 Countries

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Abstract

Carers were disproportionately harmed in the COVID-19 pandemic. Despite facing an increased risk of contracting the virus, they continued in frontline roles in care services and acted as "shock absorbers" for their families and communities. In this article, we apply an intersectional lens to examine care work and the structural factors disadvantaging carers during COVID-19 through a comparative case study analysis of 16 low-, middle-, and high-income countries. Data on each country was collected through a qualitative framework during 2021–2022. We found that while carers everywhere were predominantly women with low incomes and precarious employment, other factors were at play in shaping their experiences. Moreover, government responses to mitigate the direct impact of the pandemic have created local and global disparities affecting those working in this sector. Our findings reveal how oppressive social structures such as race, class, caste, and migration status converged in contextually specific ways to shape the gendered nature of care within and between different countries. We call for a better understanding of the multiple axes of inequalities experienced by carers to inform crisis mitigations, coupled with long-term strategies to address social inequities in the care economy and to promote gender equality.

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COVID-19 has highlighted the centrality of care work to the health and well-being of individuals, communities, and economies globally. While treating and caring for the lives of others, workers in the care sector, predominantly women, and especially those who are poor and from ethnic minorities, have faced disproportionate risk of infection and death from COVID-19.[1,2] Meanwhile, women have taken on more unpaid care in their homes.[3] COVID-19 has increased the visibility of the role of economic and social systems that depend on the undervaluing and exploitation of care work. It has also highlighted how paid and unpaid care work are intrinsically connected through the care economy, as are the gender, class, migration, and race structures which permeate it.

There is strong evidence that the gendered and intersectional impacts of COVID-19 are deepening existing social and health inequalities[4,5]and setting progress toward Sustainable Development Goal 5 back by decades.[6] Insecure employment, income, racism, and gender norms underpin the persistence of gender inequalities globally, contributing to social and health inequalities.[7,8] During COVID-19 there has been an increase in domestic and interpersonal violence against women, people who are LGBTQ+, and children.[9,10] Women lost more employment and income,[11] and while all children missed education, girls and children in low-income families missed more, especially in poorer countries.[12] Women have provided more unpaid care for children and others[13] and were primarily responsible for home education during lockdowns.[14] There has been a disproportionate increase in women experiencing insecurity of housing[15] and food.[13] Women[16,17] and people who are LGBTQ+[18] have faced disproportionate barriers when accessing health care services,[19] particularly reproductive health care services.

This article explores inequities in paid, unpaid, formal, and informal care work during the COVID-19 pandemic, comparatively analyzing case studies from sixteen countries to better understand how gender, race, class, and other social structures contribute to adverse social and health outcomes of carers. The results and discussion inform strategies to prevent and mediate the impacts of health and social crises on carers.

Theoretical Background

"Care economy" is a concept that describes the social and economic organization of care and generally refers to unpaid or informal care activities.[20] It captures how unpaid care is entwined with "paid" and "formal" economies, not only by limiting a carer's ability to participate in paid work but also by enabling others to engage in paid work, thereby supporting the functioning of society as a whole. Folbre[21] identified four broad categories of care work in the literature: unpaid work, unpaid work that helps meet subsistence needs, informal market work, and paid employment. The balance varies among countries, reflecting social and cultural norms, and between those at different stages of economic development and with other economic systems. We take a wide-ranging definition of care work to account for this diversity, including activities related to meeting the physical, social, and emotional needs of children, older people, and those with mental illnesses and disabilities, as well as daily domestic work like cleaning and cooking.

The unequal division of labor and its impact on women's health has been known for decades.[22–24] Patriarchal traditions see care as "women's work" and severely undervalue the physical, emotional, and psychological labor involved, with economic and health consequences.[21,22] Historical analysis[25] of the conditions that have fostered a gendered division of labor highlight how care work has been assigned as a woman's "natural" role, and part of an ideology of maternal self-sacrifice that has heightened during the pandemic.

These gendered patterns are reproduced in formal and informal care in homes and health systems. For example, in the United States Folbre and colleagues[26] reported how essential care service workers earn less than other essential workers, threatening their well-being and recruitment of new staff. Llop-Gironés and colleagues[8] documented how health and care workers worldwide are at the lower levels of the hierarchy of health-related professions, are overwhelmingly women, and received less government support and less access to personal protective equipment (PPE) and vaccinations during the pandemic. Others[27–29] also found that unpaid carers experienced disproportionately greater social isolation, mental health issues, loneliness, and financial stress during the pandemic.

We view care work within the pandemic's broader structural and intersectional impacts. The concept we now understand as intersectionality was first developed within movements led by U.S. black, Latina, Indigenous, and Asian American women promoting feminist and antiracist agendas in the 1960s and 1970s. They noted the interconnectedness of race, class, gender, and sexuality in their everyday lives.[30] Similar conversations were emerging in communities in Africa, Asia, and Latin America in the contexts of anticolonial struggles and the emergence of a global women's movement.[31] The term *intersectional* was first coined by black legal feminist scholar Kimberle Crenshaw[32] to describe the relationships and interactions that must be understood to

explain the structural dynamics that create privilege and oppression. In health research, intersectionality aids understanding of the complexities of people's lives and how different forms of privilege and oppression contribute to unequal health outcomes,[33] including recent work on COVID-19.[34]

Our analysis of intersectionality and inequalities is guided by Collin's theorizing of intersectionality[35,36] and the "matrix of domination".[37] Intersectionality suggests that oppression cannot be reduced to one axis of social division and that oppressions interact to shape injustice and inequality.[35] The matrix of domination refers to how these intersecting oppressions are organized, including people's social positions within intersecting social structures, and how the nature of oppression is shaped by historical and social context.[37] Using these concepts, we examine the intersections of hierarchical power dynamics operating through care work during the pandemic.

Gendered systems of power intersect with race, class, and other social axes in the labor market and contribute to capitalist modes of production and social reproduction,[38] giving rise to unequal gendered, classed, and racial patterns of wealth accumulation and social capital.[39] Women continue to provide three times more unpaid care and domestic work than men[40] and the International Labour Organization (ILO) and World Health Organization (WHO) note a continuing pay gap in the care economy.[41] Oxfam estimates that unpaid care work by women contributes at least US$10.8 trillion annually to the global economy,[14] enabling capital to accumulate in the hands of the wealthy. Wichterich[38] argues that neoliberal market principles have increasingly shaped and transformed the reorganization of care work, leading to "care extractivism" and the intensified commodification of social reproduction and care work. Care extractivism produces unequal transnational accumulation of capital and care resources away from lower income countries and households.[38]

Ossome has shown how, in many African countries, essential-care activities are excluded from gross domestic product as they operate mainly outside the formal economy.[42] Waged labor plays a minor role in the income of African women, who instead depend on petty commodity production and peasant/subsistence agriculture. Ossome[42] argues that these forms of labor subsidize capital and that "noncapitalist strata" have always been used by capitalists, especially during colonization, to prop up the labor force, resources, and markets. They also point out how in some regions of the Global South, "responsibility for reproduction was never adequately assumed by capital or the state" and, therefore, often remains undocumented. Care work is only one aspect of women's reproductive labor, which constitutes noncapitalist forms of production globally, but especially in low- to middle-income countries (LMICs), operating as a means of survival in the absence of a welfare state and the context of largely unregulated market forces.

This article builds on the small body of scholarship on care work and COVID-19 examining intersectionality and/or country comparative analysis.[8,43–47] Laster Pirtle and Wright argue that during COVID-19, "the erasure of women of color in public health data and public policy efforts only reiterates the need for a comprehensive intersectional analysis of structural disparities".[47] In this article we aim to elevate the experiences of marginalized women who are carers by applying an intersectional analysis to consider how gender, race, class, and other social axes and structures shaped inequalities during COVID-19 in care economies within and across 16 low-, middle-, and high-income countries (Australia, Belgium, Brazil, Ethiopia, India, New Zealand, Nigeria, Peru, South Africa, South Korea, Spain, Taiwan, Thailand, Vietnam, United Kingdom, United States) through qualitative comparative case study analysis. In the discussion, we examine government pandemic responses to care work and propose recommendations for long-term structural change to improve care work conditions and gender and intersectional inequalities.

Method

We employed a comparative qualitative case study design,[48] analyzing 16 countries from 2021 to 2022. A qualitative case study design allowed us to analyze each country's complex contextual conditions that contributed to COVID-19 outcomes. By comparing outcomes and responses to the pandemic, we could explore each country's local historical, geographic, social, economic, and political context and how it interacts with international social and economic structures.

In selecting countries, we sought a spread of COVID-19 outcomes and of low-, middle-, and high-income countries (see Table 2 in the Results section) to counterbalance how most literature on the care economy is from high-income countries (HICs). We were, however, constrained by data availability and, pragmatically, having a country expert in our network whom we could invite to contribute to the analysis. Recruitment included through the authors membership of a global health research network, the People's Health Movement, a global network of health advocates, and snowballing. Most country cases had one or two contributing authors, making a total of 22 experts. These experts were academic researchers with expertise in public health, health equity and public policy research and practice, and in most cases were residents or citizens of the country (see Table 1).

Data collection and analysis followed an iterative qualitative process. Authors one through four created a qualitative data collection framework, which we sent to the country collaborators in July 2021, and responses were received up until June 2022. The questionnaire was developed following a rapid literature review in which gaps in the peer-reviewed literature on topics related to COVID-19 were identified, including political, civil society, and equity considerations. The framework included open qualitative questions on inequities revealed during the pandemic; including population

groups impacted and official responses to those impacts; health and social system weaknesses; political and public health leadership; the role of civil society; and other important contextual factors. We collaborated to develop detailed case studies, including extensive grey and peer-reviewed literature for each country, to find evidence to answer each question. Drafts were developed iteratively with feedback from the central research team. While any study using expert informants has scope for bias in interpretation, we were careful to validate, as far as possible, their responses with other sources of information, including academic and grey literature. The strengths of expert informants are their knowledge of the country's socioeconomic and political context, access to resources and interpretation of literature in different languages, countering bias toward Western and HIC sources, and filling knowledge gaps not easily resolved in web-based literature searches.

The case studies covered from the start of the pandemic in January 2020 to June 2022, when they were completed. The research team identified themes concerning care work as central to understanding the experiences of gender and other inequalities during the pandemic in all countries, but how gendered care work impacted carers depended on other factors such as class, race, and migration status. This intersectionality became a helpful framework for analyzing and interpreting the multiple and complex experiences of caring during COVID-19. The first author triangulated the case study findings through targeted searches on care work in the literature, and the country experts provided more information where required. This included rapid searches and reviews (of Web of Science and Google Scholar, in June–December 2022) about COVID-19, care work, gender, and intersectionality to identify trends and themes within and across case study countries.

Results

Types of Care Work

We found *unpaid work* to be the most common of Folbre's[21] classification of types of care work in all countries, especially care work in homes of family/kin.

Unpaid work that helps meet subsistence needs was present in LMICs (Ethiopia, Nigeria, Thailand, Vietnam, India, Peru, South Africa) where resources and essential services were scarcer, and care work to meet basic needs such as safe drinking water is required.

Much of the care work we documented can fall within *informal market work and paid employment*, depending on the national context and the nature of the transactional relationship. Work in the informal market was prevalent in LMICs and was often considered highly precarious, underpaid, and seasonal.

Time spent on the care of children, older people, and those with a disability in HICs is more likely than in LMICs to be *paid employment* (e.g., regulated by industrial law and waged) by nonfamily members in institutional settings (e.g., aged care residencies) or the recipient's home. In recent decades paid care in middle-income countries (MICs) has become increasingly institutionalized, with correspondingly better state regulation, but it was noted in the case studies that regulation and implementation are uneven.

In some countries (India, Peru, Vietnam), it is commonplace for poorer women to work and live in wealthier homes to perform domestic and care tasks. We confirmed the practice of poorer women from LMICs traveling to middle- and high-income countries to take up paid care employment in institutions and people's homes. In some cases, this work was informal (India, Peru, South Africa), and in others (Taiwan), more likely paid and regulated employment. Still, in all countries, informal care exists in parallel with paid employment.

Essential and Precarious: the Devaluing of Care Work Increases the Risk of COVID-19 and Ill Health

Our case studies highlighted how working conditions contributed to the higher risk of COVID-19 infection among care workers and those they care for. Examples include the United States,[49] Belgium,[50] the United Kingdom, and South Africa.[51] Institutionalized care settings for older people, people with a disability, and children were often underprepared and slow to react to COVID-19. They experienced limited supplies of protective equipment for residents and staff. Just over half of Belgian aged care homes had enough protective gowns, more than one in six care homes had no effective disinfectants, and 64 percent had enough masks.[52] In Spain, Australia, and Belgium, many residential care facilities were forced to carry out the role of hospitals but without the resources to do so.[53] In Spain, residents with COVID-19 in residential facilities were denied access to hospitals.[54] While health and care workers and their clinically vulnerable clients were prioritized for vaccination in most countries, this step did not always translate into higher uptake.

Evidence of the devaluing of care work can also be found in how it is organized. Care industries, to varying degrees in the case study countries, relied on insecure, casual, and low-paid employment contracts, leaving workers in precarious situations. For example, in Spain, South Korea, the United Kingdom, the United States, Australia, New Zealand, and Belgium, where the care of older people is more institutionalized and corporatized, care homes saw some of the deadliest outbreaks, often spread by workers, some moving between different workplaces because of their low pay and limited paid leave. In HICs, care work tended to be more regulated and employment conditions were better than in many LMICs. In Taiwan, recent improvement in migrant workers' status due to labor rights

movements meant all migrant workers in Taiwan were under the same universal health care coverage as its citizens, and they received the same rationing of facial masks. Despite this, labor force shortages increased during the pandemic in all countries, fueled by the spread of COVID-19 among the workforce, who reported overwork, burnout, mental health issues, and effects of long COVID-19.[55]

There were also hierarchies within countries' care economies, such as in South Korea where we found no evidence of support from the government for housekeeping and caregiving work. The more informal nature of workforces, especially those in domestic paid work in countries such as Vietnam, Peru, India, and Brazil, meant workers had no access to sufficient PPE, paid sick leave, or other entitlements. Community health workers who are almost entirely female and low or unpaid workforces provided care work alongside health services in South Africa, India, and Brazil and were exposed to increased risk of infection through lack of PPE and government support.[56,57]

In Nigeria and Ethiopia, health and care facilities and resources were already limited, and care remained the responsibility of families and informal workers. Tigray in the northern region of Ethiopia has experienced a devastating civil war since November 2020, which has caused a "crisis within a crisis" and collapse of the health care system.[58]

Gender Inequalities in Care Work Are Shaped by Class

All countries reported unequal gender and class impacts of COVID-19. The pandemic increased caring responsibilities for unpaid carers and formal and informal workers. Some inequalities between groups in the care economy were particularly prominent. Women and, especially, mothers took on more unpaid caring of family members and domestic and subsistence tasks in all 16 countries. In New Zealand, mothers tend to assume primary responsibility for homeschooling and childcare while juggling paid work.[59] In Thailand, older female caregivers bore the heaviest burden during the pandemic.[60] Similar examples came from South Africa,[61] the United Kingdom,[27] Australia,[62] Brazil,[63] and Belgium,[64] showing that women have been disproportionately affected by the increase in care responsibilities. In South Korea, an increasing "care gap" has developed. A 2021 South Korean survey reported that men's total working hours decreased by an average of 2.2 h due to COVID-19, but hours of caring for their children only increased by 1.8 h. Women's total working hours decreased by an average of 1.6 h, but the hours of care work increased to 6.7.[65]

Gender inequalities in care work were shaped by the relationship with class structures. In India, Agarwal[66] noted how rural and middle-class urban families were affected differently. Under lockdown, urban professional families, who normally employ part-time domestic workers, saw an initial increase in men's contribution to household work before declining to pre-COVID-19 levels; women were spending on average five hours per day on unpaid domestic work and men 1.6 h. In rural and poorer areas, women also faced the unpaid burden of meeting subsistence needs such as gathering water, food, and firewood.

Care responsibilities were heightened in all countries during lockdowns, with the closure of childcare and education facilities disproportionately affecting low-income families. In the United Kingdom, children in poorer households were less likely than wealthier families to get support from their schools.[67] In India, poorer families were placed under greater pressure to provide food for their children, who would typically receive food from schools.[68] People living in poorer and crowded households faced an increased risk of ill health and violence when staying at home, as reported in Brazil,[63] Peru,[69] Spain,[70] and Ethiopia.[71] Care and domestic workers in these groups also experienced violence in their homes and their workplaces.[72] In Thailand, South Africa, and Nigeria, those living in informal settlements and crowded housing could not practice social distancing and had inadequate access to sanitation.

Many women on lower incomes, single parents, and those who headed households could not isolate at home and provided a disproportionate share of the care workforce. In many countries, including the United States, black, Indigenous, and migrant women are also strongly represented in these groups[73] and make up a disproportionate amount of those who continued working outside of the home in essential jobs, including care roles. In South Africa, roughly 23 percent of the jobs occupied by women were directly exposed to infectious disease, compared with 7 percent of the jobs occupied by men.[74] In Belgium, more women than men traveled to work to perform essential frontline jobs and to provide food and other essential products for their families.[75]

In LMICs (India, Brazil, Peru, South Africa, Thailand, Vietnam, Ethiopia), many women provided paid and informal care work in wealthy households rather than in institutions, creating different health and economic risks. In India, around three million women provide informal domestic services in other people's homes. Still, during the initial waves of the pandemic, they were laid off and were slow to be re-employed due to fear of infection.[66] Similarly, in South Africa, 25 percent of women employed as domestic workers were reported to have lost their employment as a result of the pandemic.[72]

Gender, Class, and Race Structures Converge in Care Economies

Our study countries demonstrate how histories of colonization, patriarchy, slavery, and war are manifest throughout the care economy and that these legacies continue through

Table 1. Country Expert Qualifications.

Country Case	Country Experts
Australia	Four academics in public health from Australia, including one professor of health of equity, and three with PhDs and expertise in social sciences, economics, gender studies, public policy, primary health care, SDH, health equity.
Belgium	One director of a global health NGO in Belgium with an MD and expertise in general practice, community health, global development, health advocacy and research.
Brazil	Two academics from Brazil, including one professor with an MD and PhD in epidemiology and expertise in women's, community, and public health, and one PhD candidate in global health and health systems. Both have extensive experience in global health advocacy and research.
Ethiopia	One academic from Ethiopia, residing in Australia, with a PhD in public health and expertise in epidemiology, HIV care in low-income countries, conflict and health, SDH, health equity.
India	Two academics and health advocates from India. One professor with an MD and expertise in health systems, community health and policy research. One researcher with a PhD in public health and expertise in health equity, health systems, and SDH.
New Zealand	One professor of public health in New Zealand with expertise in housing, urban policy and health, SDH, health equity, public policy.
Nigeria	Two academics. One from Ethiopia, mentioned above, and one from Australia with a PhD in economics and expertise in epidemiology, public health, SDH, health equity, and public policy.
Peru	One professor from Peru with an MD and expertise in international health and development policy, equity and SDH, public policy, and poverty reduction.
South Africa	Two academics and health advocates from South Africa. One professor in public health medicine with an MD and expertise in community health, human rights, and health. One academic with a PhD in political studies and expertise in global health governance, politics and economics, social movements.
South Korea	One academic from South Korea with a PhD in public health and expertise in health policy and governance, universal health care, pharmaceutical production, migration, and health.
Spain	One professor from Spain with an MD and expertise in public health, epidemiology, health systems and governance, and international public health.
Taiwan	One professor from Tawain and residing in the United States with an MPH in international health and a doctorate of science in health policy and management. They have expertise in governance in national health systems and global health and health equity.
Thailand	One academic and public policy expert from Thailand with an MD, PhD, and expertise in health systems and policy and international health. Has held positions in the Thailand Ministry of Public Health and global health agencies.
Vietnam	One professor from Vietnam with expertise in health policy, systems, and health equity. They are a national consultant for the Vietnam Ministry of Health, and international global health agencies.
United Kingdom	Two professors from the United Kingdom with extensive global health and health advocacy experience. One with expertise in sociology and public health, health inequalities, SDH, and public policy; one with an MD and expertise in internal medicine, epidemiology, public health, health systems, and policies.
United States	One academic and physician residing in the United States with an MD, MPH, and expertise in public health, health system research and global health, and extensive experience as a global health advocate.

Note: SDH = social determinants of health

the exploitation of care workers, consolidating gender, class, race, and ethnic inequities.

In formal and informal paid care work in countries where data were available, there was a higher representation of migrant women, women from minority ethnicities, and women from lower-class and lower-income backgrounds. For example, in the United States, black women are overrepresented in the lowest-wage and most risky jobs in the health and care systems than any other demographic group, a circumstance that is tied to gender and race divisions of labor established during the period of slavery.[76] In Brazil, historical and contemporary slavery is tied to patriarchal and racist systems which underpin domestic and care work. As a result, black women represent 62 percent of the domestic workers nationwide.[77] In Australia, frontline care work has been shaped by gender, race, and migration aspects of economic and social structures since colonization and is disproportionately provided by non-English speaking migrants.[78]

In South Korea, Taiwan, and Peru, migrant and undocumented women from poorer neighboring countries, employed in both formal and informal roles, make up the most significant proportion of the care workforce. There has been a growing phenomenon of foreign long-term residential care workers in Taiwan and South Korea.[79] Like many HICs, they need more nurses and carers. In Taiwan, migrant care workers come predominantly from Indonesia, constituting 75 percent of total migrant care workers.[80]

Our case studies also revealed poor treatment of migrant and undocumented foreign workers. In South Korea and Taiwan, while pay and conditions have improved in recent

Table 2. Case study countries' COVID-19 outcomes (deaths, cases) in 2021, 2022, 2023.

Country	Income	Excess deaths per 100,000 Jan 31 2021	Excess deaths per 100,000 Jan 31 2022	Cumulative cases per million Jan 31 2021	Cumulative cases per million Jan 31 2022	Cumulative cases per million Jan 31 2023	Gender Inequality Index (GII) 2021
Australia	High	3.73 (3.72–3.73)	15.55 (15.54–15.55)	1100.87	98573.01	431495.93	0.073
Belgium	High	199.19(186.16–235.42)	272.28 (254.47–321.76)	60926.36	270698.34	402499.14	0.048
Brazil	Upper Middle	123.62(111.6–144.92)	339.45(308.28–396.04)	42767.97	118262.58	171027.73	0.39
Ethiopia	Low	49.83 (31.59–76.52)	174.24 (110.44–267.54)	1115.66	3770.13	4048.72	0.520
India	Lower Middle	85.12 (66.9–105.82)	254.87 (199.77–316.79)	7590.89	29262.13	31530.46	0.49
New Zealand	High	0.74 (0.73–0.74)	1.60 (1.6–1.6)	444.33	3205.22	421017.23	0.088
Nigeria	Low	40.95 (28.01–55.93)	78.95 (54–107.83)	600.54	1158.51	1219.28	0.68
Peru	Upper Middle	459.80(346.87–607.81)	900.83(679.57–1190.81)	34120.47	95141.77	131609.4	0.38
South Africa	Upper Middle	226.62(175.49–297.77)	487.39 (377.34–640.26)	24272.28	60193.49	67719.2	0.405
South Korea	High	2.77 (2.68–3.59)	13.12 (12.7–17.02)	1515.14	16675.26	582777.09	0.067
Spain	High	230.18(204.34–264.16)	344.82 (305.85–394.5)	57678.68	209452.05	288727.35	0.057
Taiwan	High	0.08 (0.08–0.08)	3.7 (3.7–3.7)	38.13	786.41	399182.39	0.036*
Thailand	Upper Middle	0.17 (0.14–0.21)	44.7 (35.06–56.29)	261.96	34039.66	65929.99	0.333
Vietnam	Lower Middle	0.14 (0.09–0.19)	75.53 (49.15–110.04)	18.51	23177.51	117393.48	0.296
United Kingdom	High	184.61(183.4–186.94)	268.94 (266.98–272.63)	56543.27	256497.79	359572.56	0.098
United States	High	173.65(154.18–200.02	342.50 (303.62–394.47)	77912.8	222424.27	302486	0.179

Sources: Global Burden of Disease Study. COVID-19 projections: Cumulative deaths. Institute for Health Metrics and Evaluation; 2022 [02 Feb 2023]: https://covid19.healthdata.org/global?view = cumulative-deaths&tab = trend; Our World in Data. Cumulative confirmed deaths per million; 2022 [02 Feb 2023]: https://ourworldindata.org/covid-deaths; Our World in Data. Cumulative confirmed cases per million; 2022 [02 Feb 2023]: https://ourworldindata.org/covid-cases; Our World in Data; *Taiwan Ministry of Gender Equity, Gender Inequity Index for the year 2021 [16 May 2023]: https://gec.ey.gov.tw/Page/B08994C9CFD296BA

years, low-wage migrant workers had fewer rights than citizens, faced harsher public health measures than most other workers, and were more vulnerable to income loss during the pandemic. For example, many aged care residential staff are housed in onsite dormitories, which were high-risk environments for transmission and were subject to mandatory lockdowns. In Taiwan, while the government provided equitable access to PPE and vaccinations, due to its strict quarantine policy, migrant care workers were not able to return to their home countries to visit. In Peru, care work is rarely documented but most is performed at home by personal carers, domestic workers, and nurses who are predominantly Mestizas, undocumented migrant workers, or Indigenous people who serve the minority white and Mestizo upper-class populations. Venezuelan migrants who work as carers within homes in Peru lacked access to social security and industrial rights during the pandemic and have been more vulnerable to exploitation and abuse. Similarly, in Vietnam, pressure to provide care increased during the pandemic, but many employers did not have a paid leave policy or a welfare plan.

In India, care work is organized by gender, caste/class, and colonial structures. Domestic labor is highly feminized and viewed as an extension of women's work. At the same time, tasks that are considered "dirtier" and menial are usually performed by those at the bottom of the caste hierarchy.[81] Workers regularly experience caste- (and class-) based discrimination in employers' homes, and during the pandemic Dalit and Muslim workers, in particular, faced increased discrimination and loss of work. Despite their risky frontline care work, domestic workers and Accredited Social Health Activists were largely left out of early pandemic policy discussions by governments.[57,81]

Government Responses

Early in the pandemic, many public health responses by governments targeted care facilities and clients deemed to be in

high-risk settings and populations. The case studies from Thailand, Vietnam, South Korea, and Taiwan, with lower infections and deaths in the earlier phases of the pandemic, indicate that this was partly due to better pandemic responses, including in acute and long-term care facilities.

Table 3. Summary of government public policy responses to mediate social and financial impacts to carers during Covid-19.

- *Increasing social security payments for people who became unemployed or reduced hours during the pandemic, and recognizing the extra burden for carers*. For example: JobSeeker payment in Australia; emergency cash benefit through Bolsa Familia in Brazil; in Ethiopia cash transfers targeting poor families and women-headed households; increased unemployment benefit in the United Kingdom; in Thailand people were provided 50% of their pay for 60 days and cash handouts; one-off bonuses for poorer families or those living in high risk areas in Peru; Social Relief of Distress Grant payments (SRDG) for unemployed, informal workers, and Temporary Employees Relief Scheme for formal workers in South Africa; financial assistance for vulnerable households and extension of unemployment benefits in Spain; Emergency Disaster Relief Fund for all Korean nationals, Emergency and Temporary Livelihood Support for low income families and employment cost subsidies increased in South Korea; three Economic Impact Payments in the United States; and three Economic Stimulation Payments for all citizens, and payments for unemployed and reduced work in Taiwan.
- *Payments or paid leave for people who took leave to care for someone with COVID-19, or extra welfare payments for parents*. For example: extra days of paid sick leave in Australia and for parents in the United States; special parental leave in Belgium; leave support scheme in New Zealand; living support expenses and paid leaves for whom under the mandatory isolation and the carer of them, and extra paid leave for parents in South Korea; cash bonuses for people on low incomes and who had to isolate or are sick in the United Kingdom.
- *Extra paid sick leave or pay for aged care workers*. For example: bonuses and paid pandemic leave to residential aged care workers Australia; a one-off bonus for aged care workers in South Korea.
- *Informal care workers recognized with special payments* for the first time in Belgium.
- *Childcare and education support*. For example: in Australia childcare was free for a short period; extra emergency childcare provision at home and schools, and community childcare facilities remained open in South Korea; fees reduced or supplemented in South Africa and the United States; during lockdowns in Australia, Belgium, and some U.S. states, childcare and preschool and school facilities remained open for essential and frontline workers, and for vulnerable families; in New Zealand funding was available for in-home childcare for essential workers; the United Kingdome introduced a paid lunch program for children not receiving lunch through schools during lockdown.

In all countries with aged care facilities, it was reported that residents were placed into lockdowns with restrictions on visitors. Still, countries varied in how quickly they reacted and in their ability to secure high-quality PPE. For example, in Thailand, aged care facilities implemented strict measures concerning visitors. Thailand's universal health care system supported coordinated and timely measures providing PPE and vaccinations to staff and residents in the pandemic's first two and half years, contributing to low infection rates.

Beyond the health sector, some government responses recognizing the vulnerable circumstances of carers were designed to mitigate the impacts of employment and income loss for unpaid and paid carers (see Table 3).

The ability of governments to respond to the problems faced by carers varied with the resources available and economic and political contexts. Middle- and high-income governments could more easily intervene through pay and leave entitlements with changes to social security payments, employment, childcare, and education support. UN Women and UNDP[82] report that governments tend to respond to crises by using existing policy instruments and addressing social problems already on their agenda. This risks benefitting privileged groups within countries. For example, in South Africa, the Social Relief of Distress Grant (SRDG) payments intended for unemployed and informal workers (of whom the majority are women) prioritized citizens who were not already receiving government support for care work, therefore disproportionately excluding women from receiving the new grant.[83] The implementation of the SRDG effectively reinforced gender norms and inequalities by supporting women primarily based on their status as caregivers for children, not based on their status as citizens in financial distress. Therefore, existing systems and structures determine how policies and resources are delivered in response to a crisis.

Migrant workers, undocumented workers, workers in the informal economy, refugees and asylum seekers, and international students in all countries were often not able to access government income and other supports due to their visa status or informal employment arrangements. Many of these groups also make up a higher proportion of people performing care work, highlighting a matrix of oppressive systems that compounded people's inequalities and risk of COVID-19 infection.

Discussion

Care workers' experiences in the 16 countries adversely impacted their daily living circumstances, access to health-protecting resources, and put them at greater risk of infection during the pandemic. Our findings contribute new understandings of the intersecting experiences of gender, race, class, and other inequalities and support Collins' "matrix of domination" in the care economy.[37] Firstly, by comparing

multiple countries using an intersectionality lens, our results highlight how these social axes are organized and reflect global oppressive structures with roots in history, operating in and through local contexts of care work. Our results pointed to similarities in the structural inequalities (such as gender, income, and citizen status) that carers faced across countries. These confirm experiences outlined in other studies[9–13] and the consistencies indicate that we achieved data saturation.[84] However, this study reveals how care workers were also positioned differently within the matrix of domination depending on their social position on multiple social axes. This has resulted in different groups of carers experiencing various harms, the starkest being workers in formal paid employment in HMIC countries receiving government support and employment benefits during the pandemic, contrasted with workers in informal employment arrangements remaining uncompensated.

A UNDP report[82] found that nearly 60 percent of countries and territories took no measures to support unpaid care work during the pandemic. Other research concluded that few countries addressed paid and unpaid care work in their policies.[85] The pandemic responses highlighted that even in countries with institutionalized care services and regulated wages and conditions, workers do not receive fair remuneration and take on more risk because the work is viewed as a public extension of the unpaid care by women in homes.

People's social positions within the care economy and beyond have been reasserted in the pandemic. Collins[37] argued that social positions are continually evolving and negotiated and that oppression can be reproduced through the reassertion of, for example, racial hierarchies. Our findings show how COVID-19 disrupted care systems while reasserting the oppressive hierarchies that structured them. The matrix(es) of domination within countries during the pandemic replicated gender, race, caste, class, and citizenship inequalities in private and domestic spaces, institutional settings, and economies, within and between countries. For example, women, especially those from minority ethnicities and poorer women, took on more unpaid domestic care work in every country while also suffering greater rates of unemployment, unsafe working conditions, and income loss.

In all countries, despite differences in economic and government systems, workers who performed informal or unpaid care were the most marginalized and most likely to miss out on government support. The UNDP[82] found that globally, only seven percent of all the labor market and social protection measures adopted by countries up until August 2021 during the pandemic addressed unpaid care, highlighting the lack of political attention to these issues and the contribution of government policy in reasserting the gendered and classed marginalization of carers. The intersection of race, class, gender, and migrant status in the case studies demonstrates how they shaped carers' experiences during COVID-19 and continue to shape an uneven recovery from the crisis.

Implications

Commentators point to COVID-19 as providing a brief window of opportunity for a renewed view of the importance of care workers, as demonstrated by international agencies, national governments, and others calling for a care-led recovery from the pandemic.[14,41,82,86] They recognize that a "gender lens" is important to public policy and health system responses, including more support for care work.[7] However, UN Women and UNDP,[87] through their COVID-19 Global Gender Response Tracker, note how this recognition has yet to be translated into better wages and working conditions. Given that women suffered worse economic and occupational losses during COVID-19, in combination with coming from a lower material baseline compared to men, there are likely to be significant effects in the medium and long term for women who remain under and unemployed. Yet most government responses we looked at were short-term solutions (e.g., cash transfers and time-limited welfare payments). In addition, social protection measures during the pandemic targeted women primarily in their family roles, embedding gender roles,[82] not accounting for the multiple social positions that women hold and how they intersect.

COVID-19 has demonstrated that despite constraints, governments, compelled by civil society and social movements, can and did make rapid changes. Based on our findings, we make several suggestions for long-term structural change to improve the lot of care workers.

Improve Data Collection on Care. A lack of data conceals the extent and nature of care work globally. Much is undocumented and uncompensated and, therefore, overlooked by governments. We need much better data on unpaid and informal care work, as well as the social positions, including gender, race, and class dimensions of care workers, to inform public policy and civil society advocacy.

*Long-term Structural Approaches and Investment in Public Infrastructure for Care.*Public policy responses such as income support and leave entitlements were implemented quickly and mediated the impact of the health and social crisis, especially for people with low incomes. However, many of these responses were short-term and there needs to be more attention to the underlying economic drivers and social organization of gendered, classed, and racialized work, and therefore consideration of long-term strategies for people performing precarious care work. Improving paid parental leave, parenting payments, more affordable and publicly provided childcare, care for older people and people with a disability, better leave entitlements and pay for frontline carers, and citizenship rights for foreign workers are some examples of public policy and infrastructure that could improve living circumstances of carers and access to care for those who need it.

Government Responses Should Address Oppressive Structures. Government responses to COVID-19 must

address the structural determinants of gender, class, caste, and race inequities. An intersectional and feminist analysis exposes the effects of bias within policy responses.[46] For example, when governments have responded to care work, the focus is predominantly on a singular category of "women," disregarding other factors. Many groups of undocumented care workers and migrant women from LMICs performing care activities were excluded from social support. Considering the high levels of informality in the care industry, especially in LMICs, social protection and public policy responses cannot be limited to the formal labor market. Urging governments to include the monetary value of unpaid care work within national accounts can help to counteract its invisibility and undervaluation. It can also provide an entry point for undoing the patriarchal division of care work, and redistributing the responsibility of care work from the private sphere to the collective public sphere.[45]

Highlighting Global Care Work Inequalities. Our analysis has highlighted the inequalities between countries at different income levels and the other considerations needed for LMICs and HICs in response to care work inequalities. Measures to reduce inequalities between countries, including improving the rights and entitlements of migrant and informal care workers and investment in social protection measures, infrastructure, and working conditions for protection from future crises, are needed. Governments must urgently priorities care workers who are most exploited in the care economy if gender, class, and race inequities are to be addressed, as we build back from the pandemic. In addition, more examination of care work and policy responses from those in LMICs is needed as HIC evidence and perspectives dominate the literature.

Limitations

Nordhues and colleagues[88] argue that a lack of comprehensive sex-disaggregated data may lead to our underestimating the gendered impact of the pandemic. Even where data on gender are collected, they rarely go beyond the male/female binary characteristic, excluding the experiences of people who are nonbinary, gender diverse, and trans. Additionally, few countries publish health data by race or ethnicity. Those that do, such as the United States,[89] United Kingdom,[90] and New Zealand,[10] reveal how those in ethnic minorities are at increased risk of infection by COVID-19 and death.

There are also large discrepancies in the statistical data collected between the countries explored in this article, including how informal and formal care work is documented. Most scholarly data on COVID-19 and care is concentrated in higher-income countries. This reality limits our ability to compare countries and draw generalizations.

We have taken collaborative mixed methods and reflexive approaches to data collection and analysis to address bias in the mainstream global economy of knowledge, which we acknowledge is more broadly tied to Western bias in knowledge production and circulation.

Conclusion

The COVID-19 pandemic has profoundly impacted carers and those receiving care and highlighted the often-exploitative way care work is organized. Intersectional paradigms are useful in explaining care workers' experiences in different contexts, and this study provides new theoretical insights into how historical legacies and structural inequality related to race, gender, class, caste, and migrant status shape care. Our comparative analysis of 16 countries found that gender inequalities deepened in all countries and converged with race, class, caste, and other oppressive structures in culturally specific ways. This radically accentuated the precariousness of care workers during the pandemic, whether informal, formal, paid, or unpaid, resulting in a greater risk of health and social inequalities. COVID-19 highlights the continuing devaluing of care work, the people who perform it, and the role of care in upholding society. At the same time, it has sparked discussions in national and global forums for improving care workers' social and economic conditions. In terms of theoretical implications, this study has demonstrated the value of adopting intersectionality to help explain how multiple oppressions can converge during major social and health crises to impact groups and countries differently. We recommend further research into the implications of an intersectionality approach to care work for each country to better understand specific socio-political contexts and appropriate policy responses. These findings can also provide guidance to advocates and policy makers to help identify country specific implications.

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Wim De Ceukelaire was the director of Viva Salud, a Belgian NGO working on people's empowerment for the right to health with partners in the Philippines, Palestine, the Democratic Republic of Congo and Cuba. Wim completed a Medical Degree and trained as a General Practitioner in Belgium in the early 1990s. Wim's previous roles have included work with the Community Based Health Programs in the Philippines as a trainer, researcher end advocacy officer. Wim is a member of the People's Health Movement global steering council and its coordinating commission. He is co-author of the recently published book with David Sanders and Barbara Hutton, The Struggle for Health: Medicine and the politics of underdevelopment, 2nd edn (Oxford, 2023).

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