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# ProGender

A Digital Hub on Gender,
the COVID-19 Crisis and its Aftermath

# Gender, care, and labour during the pandemic

## ProGender Report

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Summary

This report analyses the impact of the pandemic on gender, care and labour. It reviews the literature and examines the analyses of care that have emerged regarding the question of care in Europe and North America, with emphasis on the cases of the three ProGender states, Greece, Iceland and Norway.

First, the report studies the impacts of the lockdowns on gender care and labour. Feminist analyses of reproductive labour argue that the pandemic did not create the care crisis but rather exasperated a care crisis that was already spreading across the world because of neoliberal capitalism. Nevertheless, the pandemic is an important moment in feminist history because it brought to the forefront of public debate the question of care and the relevance of feminist perspectives: on the one hand, the lockdowns impacted on the gendered division of labour within households, that made more visible intersectional inequalities. Even in states like Iceland where gender equality policies were advanced and lockdowns were not restrictive, women were forced to perform traditional gender roles, spending more time than men on care related tasks and this had a profound impact on their professional lives, their physical and mental health and their social relations. On the other hand, the pandemic stretched the limits of healthcare systems, which were in many states, as for example in the case of Greece, already weakened after decades of austerity. Although workers in these feminised and racialised sectors were praised for their selfless contribution to the national efforts to fight against COVID-19, their working conditions continued to be degraded. Labour issues in these sectors include low salaries, devalued labour, overworking, understaffing, lack of protective material, lack of protection and support mechanisms against physical and phycological exhaustion. In both these aspects of care intersectional inequalities played an important role in shaping the needs and the resources available.

Second, the report examines the discourse of the pandemic from a gender perspective. It reviews analyses that argue that masculinist scientific and nationalist discourses that prevailed during this period led to a backwards emphasis on the family and the nation as a intertwined spaces of protection, although both had proven to be very dangerous for women and LGBTQ. Third the report analyses the policy responses to the health crisis, which consisted of special paid care leaves for mothers and fathers, as well as selective openings of public childcare structures for essential workers. As international organisations and feminists NGOs have argued, however, these measures were inadequate because they failed to address the sustainability of critical care infrastructures from a long-term perspective. Fourth, the report concludes with some reflections on contemporary grass roots initiatives of commoning as feminist alternatives to the current care crisis.

# 1. INTRODUCTION

Although feminists have argued for decades that care matters for the survival and reproduction of our societies, care has remained a relatively marginalized issue in public debate for decades. Following the COVID-19 lockdowns, however, care became a popular buzzword. As one analysis noted: “Who doesn’t care, in the midst of a global pandemic, when acts of carelessness—literally—cost tens of thousands of lives?” (Chatzidakis et al., 2020, 889). The exceptional circumstances of the lockdowns have sparked public interest in how care relations impact our daily lives and opened opportunities to revisit and rethink feminist perspectives of care and demands for the radical transformation of care systems. On the one hand, this can be seen in the numerous academic publications on and journalistic analyses of care relations in the pandemic that approach the issue from a feminist perspective (Daly, 2021). On the other, it can be observed in the emergence of various feminist initiatives, which range from bottom-up childcare and neighbourhood cooperatives organised by grass-roots movements to campaigns led by high profile professional NGOs, like the “Marshall Plan for Moms” in the United States of America (USA) (Kisner, 2021, Marshall Plan for Moms, 2022). While this renewed interest in care and feminism is a positive development, it often leads to confusion and ambiguity: the rapid multiplication of diverse social practices to address care gaps and their impact on gender relations during the COVID-!9 healthcare crisis has led to the impression that care is an issue connected only with these exceptional circumstances or with a crisis of compassion and empathy.

Contrary to those who perceive the pandemic as an unprecedented care emergency, feminists have argued that COVID-19 only exasperated the “crisis of care” that developed across the globe. This crisis, according to Nancy Fraser (2016), is manifest in the contradictions of contemporary financialised capitalism, where rising numbers of women join the labour market at the same time as welfare structures are defunded or abolished. The consolidation of as the dual earner model is, thus, intertwined with the commodification and privatisation of care. As access to welfare is cut and more women enter the labour market, real wages are reduced, increasing the working hours needed to support dependent members and pushing a transfer of care work to others. While affluent households can afford to pay for the costs of private care, most workers struggle with time poverty, overworking, deterioration of care relations and physical and psychological exhaustion caused by work-life imbalance. As Fraser argues, care is a class as well as gendered issue: “commodified for those who can afford it, privatized for those who cannot” (Fraser and Jaeggi, 2018, 169). The care gap is then filled through “global care chains” that rely on migrant movements from the Global South to the Global North or from rural to urban areas to provide cheap care labour (Hochschild 2000). Care tasks are, thus, delegated from women of the Global North to migrant women from the

Global South that leave behind their own care responsibilities in the countries of origin (Parrenas, 2005). Care is thus understood within the context of international and intersectional inequalities of gender, class, race, and ethnicity.

From a feminist perspective, COVID-19 pushed already weakened care systems to reach their limits, but the causes of the current care crisis are structural and long-term.

*"What coronavirus does in a way is it shows us the huge costs that we've incurred—let's say the unpaid bill for social reproduction—that has been accumulating for decades, if not longer. Decades of unreplenished energies and costs including those questions about disinvestment in the infrastructure of public health, which is so consequential right now. What was a simmering of a crisis, now it's become really explosive in a way" (Fraser, 2020, np).*

Instead of addressing its structural causes, however, many responses to the crisis of care during COVID-19 identify as its main cause the rising individualism, lack of empathy and compassion that characterises contemporary societies (Dowling, 2021a). These responses to the crisis of care depoliticise the issue and treat it as gender neutral. However, there is very little evidence to suggest that people have become less compassionate and less empathetic to suffering and destitution today compared with the past (Dowling, 2021a). Even in the midst of the pandemic, there were social movements that demonstrated that people across the world are willing to fight in favour of social causes against the fear of infection and the obstacles that lock downs imposed. People showed that they care when they mobilised against police violence and racism following the killing of George Floyd in the USA. People showed that they care when they took the streets protesting gender-based violence (GBV) when the me-too movement erupted in Greece. People cared when they fought against evictions in Serbia (Vilenica, Mentus, & Ristić, 2021). Examples of these social struggles had a strong feminist orientation and addressed issues intertwined with the care crisis. More broadly, the experience of COVID-19 showed that the crisis of care is an ongoing process, rather than an event tied to the exceptional circumstances of the pandemic, that brought to the surface deeply rooted care deficits and intersectional inequalities. Contrary to the depoliticised and instrumental usage of care as compassion and empathy, feminist responses to Covid-19 call for more nuanced conceptions of care that take into consideration intersectional inequalities of gender, race, and class and focus on gaps and deficiencies in national healthcare systems, the unequal

distribution of labour within families, and the feminisation and racialisation of global care chains.

This report is based on desktop research that takes as its starting point the premise that to think about care relations during the pandemic means to problematise care from an intersectional gender perspective against prevailing depoliticised notions of care and labour. Thus, the report address care as a complex and multifaceted concept that requires a gendered analysis (Dowling 2021 b). Care is understood in this context, as a concept that embraces, on the one hand, material tasks that sustain processes of generational and societal reproduction (such as looking after children, the elderly, the disabled, the sick, but also cleaning, cooking, shopping, arranging, and organising the daily lives of households) and on the other emotional and affective tasks that sustain interpersonal relations and community building (such developing protective, affectionate, loving relations, being but also being sociable and caring for others, sharing with them, co-creating, developing social initiatives in common providing for others, protecting others and being protected and cared for). This approach means that the concept of care is not understood solely within the framework of the heterosexual family but extends to broader social relations and political practices (including providing solidarity and support for others, community building, but also working with others to transform dominant relations of power). This follows Joan Tronto's tripartite definition of caring (2013) as a process that includes three distinct yet interrelated instances: "caring for", which involves physical, hands-on care, "caring about", which describes emotional and affective investments and attachments to others, and "caring with", which is related to practices of community building, solidarity with others and common struggles.

This report is based on a review of some of the literature on gender, labour and care during the pandemic and focuses on the European and North American regions. While it draws on the wider studies, it uses examples from the cases of Greece, Iceland and Norway, which are the three partner countries of the ProGender The first section of the report comprises three parts: the first one focuses on the impact of the pandemic on care relations within households drawing on feminist research on unpaid reproductive labour during the pandemic. This strand of the literature analyses mainly the impact that the lockdowns had on the gendered division of labour. The second part discusses the literature on paid care labour as a gender issue and draws on feminist perspectives of what has been termed "essential work" during COVID-19. The third part addresses some of the challenges that emerge when we are trying to explore the gendered impacts of the pandemic beyond the women-man binary. The second section of the report focuses on the public discourses on COVID-19 and care which were in most cases masculinist, nationalist, and focused on the heteronormative nuclear family. These discourses legitimised the exclusion of certain categories of people as others and treated care as a women's sacrifice for the good of the nation. The third section analyses the policies on gender, care and labour during the pandemic. It argues that most efforts to

address the care crisis assumed that it was a temporary phenomenon connected to the health emergency of COVID-19 and failed to acknowledge that the pandemic simply brought to the forefront deeply rooted gender inequalities that were present even in the most advanced states. The final section addresses alternative activist approaches to gender care and labour that emphasize commoning, mutual exchange, sharing, and solidarity as antidotes to the crisis of care.

# 2. HOW HAS CARE CHANGED DURING THE PANDEMIC?

In order to understand how the current care crisis of COVID-19 emerged we need to explore the historical framework in which it emerged. Feminist studies have shown how in different historical periods and in different cultural and geographical contexts different configurations of gender, race, class and ethnicity structure the division of labour and the distinction between the public and the private domain (Glenn, 1992, Duffy, 2007).

In the 19th century in Europe and North America, care became an issue confined to the private sphere, which was reconfigured as the space of femininity, domesticity, and motherhood par excellence while work in public spaces was formally recognised as a male domain. Gradually what came to be called as the “male breadwinner model”, where men provide all the income of the family and women take care of the household and care, was normalised. The male breadwinner model, however, was only possible for affluent middle-class households, where men could earn enough to support their wives staying at home and taking care of the family. In this context, labour unions demanded family wages to keep women at home, rather than higher wages for working class women, while feminist movements demanded participation in political life as mothers and carers (Laslett and Brenner, 1989). During the same period, a process of professionalisation of some sectors of employment led to the exclusion of women who were previously employed there, as for example in medical professions (Laslett and Brenner, 1989). The gradual development of the welfare state, which was partly an outcome of feminist and labour struggles, in the 20th century in some parts of Europe and North America permitted state authorities to take over some care responsibilities from women’s shoulders, including of childcare, healthcare, care of the elderly and the disabled. While welfare systems were gendered providing protective legislation for women that kept them dependent on men, they also opened opportunities for women to enter the labour market and alternatives to the dependency on marriage and motherhood. The new female professions flourished in the care institutions that were set up to cover basic reproductive needs of the societies in question (Laslett and Brenner, 1989).

The demands of feminist movements challenged stereotypical divisions of private and public, emphasising that reproductive work is work too and should be paid and valued. The feminist campaigns of the 1970s on wages for

housewives problematised the distinction between production and reproduction, feminine and masculine, private and public. They argued that unpaid labour carried out in the private sphere is a precondition for paid labour carried out in the public sphere (Weeks, 2019). By the 1980s the massive entry of women into the labour force introduced a new dual earner model, which offered opportunities for women's socioeconomic independence without resolving the issue of reproductive labour that remained a constant problem in women's lives. While the dual earner model was promoted as an ideal by liberal feminists, class and racial inequalities made it less credible for some women, especially women of colour, working class and migrant women, who had no access to the increasingly commodified care provisions (Fraser, 2016).

Since the 1980s, neoliberal policies introduced austerity cuts that hit mostly free care provisions previously offered by welfare states and undermined the quality of services offered. Budget cuts in public expenditure on care led to understaffing and lack of resources in healthcare and educational systems that became permanent features of most neoliberal states, imposing hard working conditions for paid carers, who are in their majority women. At the same time, neoliberal policies encouraged reductions in real wages that forced workers of all genders to increase working hours to ensure their survival and the survival of dependent members. These changes in welfare states led to a gendered time squeeze, which affects both women and men but primarily women who experience the double burden of professional and care responsibilities (Fraser, 2016). While affluent households can delegate care to other women, primarily migrant women, working class households are facing the pressures and dilemmas of work-life balance daily. Easy fixes like neoliberal policies for the creation of flexible jobs for women promoted in the 1990s by liberal feminists as a solution have proven to be inadequate: while when flexible conditions prevail, women continue to face the double burden of combining work with car. For some, flexibilization is a vehicle to spread of precarity in the labour market (Laslett and Brenner, 1989, European Parliament, 2020, Ivancheva and Keating, 2020).

The pandemic exasperated the crisis of care in different ways, which we are going to analyse in more detail in the following sections. First, in order to limit the spread of the virus lock downs were imposed that included closures of care institutions and prohibition of movement of private care workers, which exasperated the unpaid care burden within households. This burden fell mostly on the shoulders of women who faced new challenges in their attempts to combine professional tasks with care tasks. Second, the unprecedented pressure on the healthcare systems caused by the health crisis exasperated the working conditions and work-life balance of care workers, who are in their vast majority women and very often migrant and minority. While the importance of these professional sectors of care for the survival of our societies was publicly recognised, very little was done to deal with the ongoing problems of care systems, which have been devastated after decades of austerity cuts, reductions of personnel and deteriorating labour relations. Third, the pandemic

brought more visibility to the intersectional aspects of care, including the care needs of Lesbians, Gays, Bisexuals, Transexuals and Queers (LGBTQ).

## 2.1 Unpaid care work during the pandemic

Most governments and health experts across the world endorsed lock downs as the best policy solution to pause the uncontrolled spread of the COVID-19 virus. As a result, some workers had to face unemployment, inactivity, and loss of income, while others started working remotely or in dangerous workplaces, where the possibilities of being infected by the virus were high. In parallel with these changes in employment and income, there were changes in private life. To deal with these negative labour market impacts of the lock downs governments focused on saving productivity and employment through fairlough programs and subsidies to retain jobs and keep businesses going. Although many states introduced extra paid maternity and paternity leaves, gender equality and reproductive labour were not part of these programs because they were perceived as being of secondary importance (Batthyány, 2020). Nevertheless, the impacts of the lockdowns were severe on gender relations and reproductive labour, as they increased and complicated the range of activities that caring for dependent members of households involved as both material and affective aspects of care became far more thorny, demanding, and time-consuming than previously. The worsening of the crisis of care has two interlinked aspects:

First, most states across the world implemented closures of day care centres, kindergartens, schools, and care homes for the elderly and the disabled that pushed activities related to care to the private sphere. These closures introduced an extra level of material and emotional difficulty in care-related activities. While in principle parents in general were affected, women became overburdened because traditional feminine tasks were already their responsibility. The emotional pressures of having to spend more time in enclosed spaces with limited social contacts were immense for most individuals irrespectively of intersectional inequalities. However, there were gender and class differences: women in general took more responsibilities at home and women living in low-income households had less material support to carry out the extra unpaid work. These, closures manifested a redefinition of dominant perceptions of children, childcare and motherhood. As children were considered low risk for serious infections and deaths, responsibility for their education and well-being was delegated entirely to the private realm of the family. However, mothers were the ones who had to meet the care needs of their children, without access to state-run care support.

*“[T]here has been a relative downgrading of needs that are typically located within the care system. Children very quickly*

*came to be defined by medical science as non-vulnerable with the result that an entire age group had little visibility or currency during the first 3 months of the pandemic which saw widespread shut-down of childcare and education services. Moreover, if children were seen to have need this was interpreted in educational terms, namely, the channelling of teaching and education resources to families to the almost complete neglect of care resources. In a swift reversal of the public/private care dynamic under social investment perspectives, children's care was effectively reprivatized to the family" (Dali 2021).*

Second, movement restrictions and measures for the avoidance of syncretism prohibited live-out paid carer workers from providing their services to private households. Cleaners, domestic workers, au pairs, nannies, carers for the elderly and the disable, and tutors were forced to stop working, often without payment and access to furlough schemes, leaving households who relied on them without crucial care provisions and support. At the same time, households that were dependent on extended family relatives were severely affected by the COVID-19 restrictions of movement and by the need to protect their elderly relatives from potentially lethal infections.

The gender bias of dominant policies and discourses of COVID-19 obscured the fact that the impacts of the lockdowns on work-life balance were catastrophic for many parents, especially mothers with young children, low-income mothers, and single-parents. In addition to covering for the absence of professional carers, parents had to take responsibility for the extra needs of their children, including home schooling and tutoring as remote education was not always sufficient to cover the knowledge gaps that were created because of school closures. Often parents -especially mothers- had to support children to overcome severe health, psychological and social problems that emerged after being forced to stay indoors for prolonged periods of time during lockdowns (UNESCO, 2021). Similarly, the needs of the elderly, long-term ill and disabled people multiplied, imposing additional burdens on carers. The elderly were a particularly sensitive social group because of its increased risk of severe illness and death that made it imperative for carers to self-isolate to avoid infections. The care of those infected by Covid-19 was also added to the list of care tasks that usually women had to carry out at home during the pandemic.

The increases in the unpaid COVID-19 related workload, worsened pre-existing inequalities in the gendered division of care labour within households (Power,

2020). In response to these transformations, international organisations began to raise concerns about care. According to UN women, in 2021 the contribution of women globally to unpaid care can be estimated at 2,35% of the Global GDP (UN Women, 2021a, 2). In 2020, the International Labour Organisation (ILO) published a brief in which it was recommended that the collection of statistical data on employment and unemployment must become more gendered by including data on unpaid care work (ILO, 2020). In Europe, data on unpaid care work showed that although the hours that men spend on care increased (Alon et al., 2020, Mangiavacchi et al 2020), women continued to carry out most of the labour needed in housework, child and elderly care (Del Boca et al. 2020, Farré et al. 2020). In the European Union (EU), the group that faced most difficulties in work-life balance were parents with children under the age of 12. On average, women spent 62 hours per week caring for children and 23 hours per week doing housework, whereas men spent only 36 hours and 15 hours respectively. Both male and female single parents spent longer hours than average on childcare, but gender differences persisted: 52 hours for women and 36 hours for men (EUROFOUND, 2020).

The same study showed that there were continuities but also differences amongst European states: the gender difference in hours spent on care in countries like Denmark, France, Finland or Sweden were only 2-3 hours more for women, whereas for Greece and Romania, it was 13-14 hours (Eurofound, 2020). Inspite of these differences, however, as research in the Nordic countries showed, gender inequalities in the division of care labour within households was increased even in states, in which gender equality is firmly established in policy making (NIKK, 2021). For example, a study in Norway by Kilden showed that the time women spent on unpaid care work increased much more than that of men and similar findings from Iceland were confirmed (NIKK, 2021). Research has also shown that this unequal distribution of labour had a direct impact on paid work: mothers, much more than fathers, had to reduce the hours that they normally spend on paid labour because of unpaid care burdens, while they also found it more difficult to concentrate on work as they were more troubled with concerns about the social and psychological well-being of their children (Czymara et al., 2020, Andrew et al., 2020, Miani et al. 2022). Also, women were more likely to decrease paid working hours or leave their jobs entirely because of care responsibilities (Blasko et al., 2020, European Commission, 2021).

The significant time squeeze that was experienced by parents of young children during COVID-19 lockdowns has undoubtedly a class dimension. As one study in the USA found, middle class parents go through periods of intense time squeeze because the most demanding periods in their professional lives coincide with the periods when their children need more attention, which means that they have limited options to take time off for family care (Sawhill and Guyot, 2020). The time squeeze is worsened because of idealised expectations of mothers' roles in children's lives. Middle-class motherhood has become extremely demanding aspiring to combine healthy diets and robust exercise

with educational excellence and a consumerist perspective of childhood (Auðardóttir and Rúdólfsdóttir, 2021). In normal times, middle class incomes permit the delegation of care tasks to paid care workers and the purchase of commodified care to achieve much-needed work-life balance without challenging the unequal division of labour. The same, however, is not always possible for lower income and precarious households, which are deprived, even in normal periods time, of access to affordable and quality care. From this perspective it is worth noting that the time squeeze during the pandemic was considered as a much more shocking experience for middle-class women who were used to find solutions to gender inequalities at home through commodified and consumerist practices of care than for working class households, who never had this option. As one study of gender during the pandemic in India concluded, the pandemic brought to the forefront inequalities and interdependencies between women of different classes:

*"Another notable insight, which was drawn from the interactions with the respondents, was the overwhelming dependence of these families on working women from economically weaker classes who had helped them as nannies and maids prior to the lockdown. Without this support system, women such as those surveyed in this study would find it either impossible to pursue careers or would have had their career progression severely stunted. This highlights the class aspect of the gender dynamic" (Hazarika and Das, 2021, 436).*

From this perspective we can argue that unprecedented public interest on the gendered divisions of labour resurfaced during COVID-19 precisely because middle class mothers experienced an unprecedented time squeeze that was commonplace for working class and precarious mothers in normal times (Kanaouti, 2022). In addition to class differences, we can also identify regional and policy differences between states and governments, which also reflects wider gender equality policy frameworks. For example, although the care burden for parents increased across the world because of the lockdowns, the impacts varied according to how long-lasting and severe the measures were. Day care, kindergarten and school closures were much more severe and long-lasting in Greece – a state with a poor gender equality record- than in Iceland and Norway, two states that have shown commitment to gender-sensitive approaches to policy making (Kambouri, 2022, Hjálmsdóttir and Bjarnadóttir, 2020). These differences had differential impacts on gender inequalities, as

class, ethnicity, and race determined the extent to which one could take time off work to take of children or pay for live-ins to carry out the care of children. Moreover, although the relevant literature has shown that the overburdening of women with care responsibilities is a recurring trend in health crises, such as Zica in Latin America or Ebola in Africa (Wenham et al., 2020), the COVID 19 pandemic had made this impact more visible in states, where there were no similar health crises in recent history. COVID-19, thus, provoked increased awareness of the unequal gendered division of labour within households in regions of the world that are considered more advanced in terms of gender equality, exposing invisible aspects of care. Despite differences in the care structures between and within different regions and political cultures, women across the world began performing traditional gender roles during health crises that were delegated in normal period to others -usually the state or migrant care workers- but were never fundamentally challenged. The persistence of traditional gendered roles within households remained unnoticed as long as these others performed their duties but resurfaced when these were no longer able to cover the care gaps created by women's increased participation in the labour market.

However, it is worth noting that the pandemic may has also opened possibilities to question and renegotiate the unequal gender division of labour, in particular to challenge gender stereotypes of motherhood and fatherhood, as well as the prevailing gendered binaries and divisions (Kebert and Hossein, 2014). As lockdowns progressed and remote work became normalised for rising numbers of both male and female workers, the borders between the private and the public, masculine and feminine became more porous and fluid.

*"In this context, COVID-19 lockdowns reinforced existing spatial boundaries between the public and private. At the same time, the lockdowns revealed their contested nature as the workspace and home space became distorted for women in their roles as unpaid care providers and paid care workers. Hence, the way the pandemic was spatially organised through lockdown measures was also a gendered process that necessitates redefining the contested sites of boundary struggles. Because formal and informal care work is further intertwined within the "locked" spaces of the home, the COVID-19 pandemic has caused these boundaries to become more contested" (Akkan, 2021, 34).*

Transforming the home into a workplace was an experience that allowed gendered boundaries to be questioned and renegotiated. Following the contestation of private/public boundaries, it remains to be seen whether fathers that began spending more time caring for their children than previously, would continue to do so in post pandemic times and whether they will also extend their involvement in other types of reproductive labour, such as housework (European Commission, 2021). These contestations of gendered boundaries often appear as seamless and devoid of conflicts, but they require societal renegotiations of gender roles that are not always easy.

## 2.2 Paid care work during the pandemic

The pandemic shed light on paid care work and confirmed the fact that it is "essential" for the reproduction and sustainability of our societies. However, this formal recognition of care work as essential was never really translated into actual measures to improve the working lives of care workers. This became evident when during lock downs a series of public events of clapping for healthcare workers for their heroic contribution to the fight against COVID-19 were organised (Hurst, 2020). These gestures of public appreciation, however, were rarely translated into tangible policies to transform the care system (Wood and Skeggs, 2020). While the selfless sacrifice of healthcare workers was celebrated, their working hours worsened, their low salaries remained low, and violations of labour rights, especially for the migrants working in these sectors, continued. Despite efforts to publicly recognise the contribution of care workers in the fight against COVID-19, labour relations in the care economy remained unchanged or worsened. Chronic problems like low pay, long working hours, workers' exploitation, dangerous and unhealthy conditions, racism, and sexism were exasperated, while very little was done at the policy level to take care of the needs of those who take care of those in need. Although caring needs intensified and got more complicated, the labour of those working in these sectors of the care economy continued to be underpaid and undervalued. Simultaneously many workers that were "essential" for the survival of our societies were silenced because their often unpaid or informal labour is carried out in private isolated spaces. Despite their heroic efforts, these workers were not given decent wages, as their professions still count among the least well-paid in the EU (EIGE, 2020).

A notable example of the silencing of care is that of live-in migrant workers, who remained invisible and unrecognised although their labour in the care of the elderly, the long-term ill and the disable became socially necessary and of crucial importance for the management of the pandemic (de Diego-Cordero, 2022).

*"The pandemic brought to the fore the moral paradox between the crucial importance of care and social reproduction and its systematic and structural devaluation and exploitation. Nowhere was this made more apparent than in the rise of the ubiquitous terms of key/essential workers" (Dowling, 2021b, 4).*

Both recognised and unrecognised essential workers experienced extremely stressful and psychologically challenging working conditions during the pandemic, as well as pressures to overwork. This was especially the case in healthcare systems because of staff shortages and lack of protective equipment that was caused by decades of austerity policies (Dowling, 2021b). Healthcare workers became very vulnerable: one third of all doctors globally are over 55 years of age; 60% of the long-term healthcare workers primarily female suffered from physical risk factors and 44% experienced mental health problems (OECD, 2020). Nevertheless, most of these vulnerable healthcare professionals continued to work throughout the crisis, sometimes without necessary periods-off, without suitable protective equipment and without medical and psychological support (UN-Women, 2020).

Most workers who were employed in the essential healthcare and service sectors are women, including nurses and midwives, health-facility and maintenance providers, cleaners, laundry and catering service employees, child-carerers and elder-care providers, teachers, domestic workers and shop assistants. In Europe women constitute 76% of all healthcare workers, 86% of the personal care workers in home-based settings or institutions, 82% of all supermarket cashiers, 93% of childcare providers and teachers, 95% of domestic cleaners and helpers, and 83% of caregivers for the elderly and people with disabilities (EIGE, 2020). Looking at these statistics makes it clear that the question of "essential work" is gendered. The occupational segregation determined not only working conditions but also the risk of exposure to the virus. This was reflected in the official statistics on infections and deaths from COVID-19. Although the percentages of male deaths from COVID -19 were higher than those of female deaths globally, women's percentages of infections and deaths began to rise because women were over-represented amongst those who were more severely exposed to the virus as they account for a larger share of those working in the health and home caregiving sectors (World Bank, 2020). Thus, while biological factors tended to reduce the risks for women, the gendered segregation of the care economy had an immediate impact on how the risks of infection, severe disease and death were distributed.

Research in Norway and Iceland has shown that the feminisation and racialisation of the health care sector is an issue that requires a more active

approach informed by an intersectional gender perspective. Research in Norway found that gender equality programs implemented to increase the recruitment of males in the health care and personal care sectors have not had the expected results and there are still unresolved issues of pay, status and a culture of part-time that prevail in these sectors, which are dominated by women, especially migrant women (Kilden referenced in NIKK, 2021). Furthermore, research in Norway has demonstrated that increasing numbers of women experienced mental health problems during the pandemic, which may be attributed to the fact that professional healthcare workers are mostly female and also that women took more private care responsibilities on their shoulders (NIKK, 2021). On the contrary, research conducted by the University of Iceland, the teaching hospital Landspítali and Iceland's Directorate of Health on mental health issues during the pandemic showed no significant changes during the lockdowns, which may be attributed to the fact that the government adopted relatively liberal measures of restriction of movement and kept public care structures open (NIKK, 2021).

Overall although during the pandemic, care workers were celebrated as "essential", their labour continued to be devalued as feminised and racialised. Care work requires complex emotional and affective labour, but it is treated as unskilled and poorly paid because it is associated with seemingly "natural" feminine traits (Dowling, 2021). On the contrary, complex emotional and affective labour carried out by men in other sectors of the labour market is valued and considered as requiring high skills (Dursun et al., 2021). The acknowledgment of these double standards led many scholars to the conclusion that we need to go beyond the discourse of "essential work" and revisit feminist approaches to gender, care and labour (Klostermann, 2022) that point out to the fact that beyond the emotional and affective labour needed to care, we must also consider the materiality of infrastructures that unable caring activities to be performed successfully:

*"We've been thinking who has insurance and who doesn't, who can go to a doctor and who can't, who has access to abortion and who doesn't. But what we're now seeing is the infrastructural side and that includes hospitals, clinics, personal protective equipment, ventilators. All of this is part of the material infrastructure that makes care possible, so it's not just the people who we usually think of performing the care, but all those who are keeping the supply chain going or failing to do so…It's not just that care has become visible, which it has. But I think we're*

*starting to see how production and reproduction are so intertwined that you can't care without this material infrastructure. And to the degree that that is organized on the basis of a for-profit production system, there are all kinds of gross irrationalities that cause a breakdown in the supply chain in the need for care. That's the most important insight I've gotten out of all of this. We socialist feminists in particular are always going on and on ad nauseam about the importance of care. You're right, that's becoming crystal clear. But I think we now see the other side of this; it's not just that the production system depends on the care work, the care work depends on the production system. At this moment, that's one of the key bottlenecks and irrationalities in how this all works under a capitalist for-profit system". (Fraser, 2020, np)*

Building suitable care of infrastructures is more important for states that have been through neoliberal austerity programs, like Greece, because they healthcare systems have been damaged and impoverished system to such an extent that the working standards of health care workers and their mental and physical health, as well as the services provided have deteriorated significantly (Markantonatou, 2021). As a ProGender discussion with healthcare professionals and labour unionist in Greece showed, the COVID-19 crisis led professional care workers to physical and mental exhaustion that was not even documented or acknowledged by the management because occupational health professionals and checks were abolished from the Greek healthcare system after austerity cuts (ProGender, 2021). Overall, the pandemic after years of neoliberal governance, the ability of welfare states to provide care has been damaged. Robust public health systems, in which workers enjoyed decent working conditions and recognised the role played by paid and unpaid healthcare workers, have performed better during the pandemic. The question of care in welfare states is on the one hand, a question of valorisation of feminised care labour, and, on the other, of critical infrastructures.

## 2.3 Care beyond binary gender

Feminist critics that have challenged the overwhelming interest in women as carers arguing that the category "women" should not be treated as a unified

and homogenous category. Instead, they have argued for more nuanced feminist perspectives that stress intersectional gender inequalities, especially those of class and race and the ways in which they have influenced how different women experienced COVID-19 (Berkhout and Richardson, 2020). No doubt, intersectional analyses can shed light on the impact of COVID-19 on gender relations than analyses that focus solely on the male/female binary. For example, upper class households who employed live-in care and domestic workers did not face the same pressures to renegotiate work-life balance in more gender equal ways as working-class households that lost access to affordable care structures and support networks. Similarly, the impacts of the lockdowns were not the same on precarious women and women who have stable employment, income and legal status. For example, many migrant domestic workers in Europe, who are usually working through informal and short-term arrangements with employers and may even have no legal residence documents, lost their work during lock downs and were not eligible for Covid-19 relief, fairlough and support funds (Morgan et al., 2021). In the case of Greece, migrant domestic workers who lost their jobs did not have any means of surviving the pandemic other than migrant communities and domestic workers' organisations that provided socioeconomic support (ProGender, 2022). In Norway, migrants who experienced isolation and uncertainty coped by using digital networks to get in touch with relatives and friends in the home country (Arora, 2021). Care in this context was redefined as a community response to exasperated precarity and uncertainty.

LGBTQ also faced specific problems and vulnerabilities that cannot be understood within a binary gender framework. For LGBTQ, the main challenges included access to HIV healthcare provisions, testing and medicines, access to mental health services and participation in community networks to assist with health problems, economic hardship and social isolation. Especially for LGBTQ youth, social isolation in hostile family environments during lock downs was an important issue (DeMulder, et al., 2020). Care in this context was understood mostly in relation to the LGBTQ community rather than in relation to the heterosexual family that was potentially hostile and unsupportive (Morgan et al., 2021).

# 3. PUBLIC DEBATES ON GENDER, CARE AND LABOUR DURING COVID-19

Analyses of the discourse of COVID-19 have noted the prevalence of masculinist approaches to the management of the pandemic that instrumentalised care and treated it as a marginal issue in the broader context of the nationalist fight against the virus. These discourses were characterised by ambiguities and contradictions but shared also some common basic traits. First, by using war analogies and identifying the virus as a lethal enemy threatening the survival of the nation, they tried to install a sense of community, but also insecurity and fear. These feelings were appease, by the usage of rational, scientific narratives aimed at making citizens feel safe and passing the

message that governments were in control of the pandemic (Hasenöhrl, 2021). Although successive waves of infections demonstrated repeatedly that governments were not able to control the spread of the virus, scientific discourse reproduced ethno-centric and nationalist conceptions of care through the usage of statistical data that puts in numbers the management of the national population (Mitropoulos, 2020). This rational masculinist language drew from the authoritative narratives of medical science and statistics but aimed mostly to produce political affects. While it science was promoted as the orthodox approach to the pandemic, community responses were treated as lacking authority and dangerous (Branicki, 2020). This masculinist rational-scientific approach, however, was hardly credible given the uncertainty that surrounded the science of COVID-19 and tended to alienate those who were suspicious of the social impacts of science. The inability to communicate credible scientific findings in ways that would show respect for local communities, as well as for individual fears, and beliefs, often led to a backlash and the spread of controversial information that had a real cost on human lives. Often alienated individuals or social groups fell victims to the conspiracy theories and on-line propaganda that circulated online.

Second, there were strong nationalistic and ethnocentric overtones in the discourse of the pandemic (James and Valluvan, 2020). In this context, the nuclear family was promoted in mainstream discourse as a privileged site for the protection of the health of the nation in a manner that was very close to ultra-right wing ideological constructions of the family and the nation (Laufenberg & Schultz, 2021). Although social interactions were prohibited and treated with suspicion, interactions within the nuclear families were treated as "safe" and favoured as if the family alone could prevent contagion without the support of the broader healthcare system. In fact, very often mainstream nationalist discourse emphasised the protective role of the family, in which traditional masculine and feminine roles could be performed at ease, and at the same time marginalised the need for a robust universal healthcare system and the need to build critical healthcare infrastructures. This appeared often paradoxical as increasingly people in their everyday lives realised that quarantine in a family environment did not prevent infections and was full of tensions, conflicts, and difficult dilemmas.

*"Nuclear households, it seems, are where we are all intuitively expected to retreat in order to prevent widespread ill-health. 'Staying home' is what is somehow self-evidently supposed to keep us well. But there are several problems with this, as anyone inclined to think about it critically (even for a moment) might figure out – problems one might summarize as the mystification*

*of the couple-form; the romanticisation of kinship; and the sanitization of the fundamentally unsafe space that is private property" (Lewis, 2020, n.p).*

Nevertheless, affective relations that developed within the family were influencing all aspects of social life starting from the family and extending to the entire national community. The nation, in turn, was defined strictly in terms of the national territory and its borders.

*"Sought to strike a balance between the technical and financial aspects of the COVID-19 crisis and the repressive measures to tackle it by communicating feelings of solidarity, compassion, and gratitude. The aim was to generate feelings of safety and being cared for among the population – and hence created a "We" – and to promote feelings of belonging" (Dursun et al., 2021, 65).*

While many states organised the return of their co-nationals living abroad and some prevented the export of vital supplies of medical equipment, vaccines and medicine, migrants and ethnic minorities were treated with suspicion and often identified as unsafe (Laufenberg, M., & Schultz, S., 2021, Mitropopulos, 2020). Border crossers such as illegal immigrants were portrayed as dangerous and threatening for the health of the nation and were often "construed as invaders and conflated with the virus" (Ticktin, 2021 np). This ethno-centric conception of the pandemic obscured the fact that many frontline, "essential" workers that kept national healthcare systems functioning in times of crisis were in fact migrants. However, shifting the gaze away from the healthcare system was instrumental in order to hide the fact that many of those who were portrayed as fighting heroically the nationalist war against COVID-19 were not actually part of the nation, most notably many of the nurses and the auxiliary healthcare personnel in global healthcare chains that supply the Global North with specialists from the Global South (Laufenberg, & Schultz, 2021).

From a gender perspective this emphasis on the nation and the nuclear family proved to be rather misleading and biased for a second reason: neither the nation nor the family were especially protective of women and LGBTQ. Rising

gender-based violence and the unequal division of labour made self-isolation in nuclear families especially dangerous for women. Furthermore, homophobia and transphobia in nuclear families made them a particularly dangerous place for LGBTQ who would have been much safer and feel much more protected if they could self-isolate and find support in their communities. Overall, the dominant discourse of the management of COVID-19 exuded and air of paternalism that was described in one analysis as a rare combination of "rational-affective political masculinity" (Dursun et al., 2021).

This rational-affective political masculinity and nationalism reintroduced notions of care as an obligation to the nation, assigning women the stereotypical feminine roles of the heroines who sacrifice themselves for the survival of the nation and the family, either by overworking in caring at home or by overworking in caring at the national healthcare system. In this context care was redefined as a duty first and foremost to protect the health of the nation and ensure the reproduction of the national population (Dursun et al. 2021, 67). This discourse of care was affective in the sense that it mobilises fear, love and shame and organised how affects circulated in order to determine who should be included and who should be excluded from the protective circle of the nation. Thus, who was cared for and who wasn't, in which ways and why became questions that were negotiated discursively on a daily basis (Hasenöhrl, 2021, 102).

For example, at the same time as extreme caution was placed on providing nuclear families with the means to self-isolate safely at home, it became completely legitimate to lock people inside prisons, nursing homes, detention centres and refugee camps, where it was impossible to protect them because of overcrowding and lack of basic hygiene tools to maintain decent standards of protection. People locked in these structured that closed were stigmatised (Ticktin, 2021). In Greece, this discourse of extreme caution and stigmatisation of the other was translated into racist policies preventing the decongestion of refugee camps on the islands, depriving asylum seekers of the right to move in other geographical regions, delaying the asylum procedures and introducing bureaucratic obstacles that prevented asylum seekers from joining the national vaccination program or other health related services. There were severe impacts on the lives of asylum seekers and refugees, including the exclusion of asylum seekers, who were victims of gender-based violence of access to protection, abortion, and financial support (Vougiouka and Liapi, 2021) and the prohibition of children of asylum seekers living in camps from going to school even when these were closed.

# 4. SOCIAL POLICIES ON GENDER, CARE AND LABOUR DURING COVID-19

Across the globe, government policies to contain COVID-19 adopted a familialistic approach to care, pushing the responsibility explicitly to the private sphere and implicitly to women. These policies were "gender-insensitive" because they legitimised the reinforcement of pre-existing gender inequalities, using as a pretext the public health emergency (Akkan, 2021). In a gender-biased policy framework, there was an implicit assumption that women would go back without problems to performing once again the traditional roles of housewives and carers of the sick, the elderly, the disable, as these are natural to them, while continuing to work full time. This meant that care resources were treated as infinite. What COVID-19 showed, however, is that care resources were being extracted in past decades to such an extent that they have become exhausted and had lost their value (Rai et al. 2014; Dali, 2021).

Governments in the more affluents states of the global North addressed the challenges of the privatisation of care labour during COVID-19 mainly through the adoption of two types of policies. First, they addressed issues of care and work-life balance by adopting the selective openings of public care structures to meet the needs of specific households. For example, France has opened day-care centres for a small number of households of essential workers (OECD, 2020). In some states, schools remained open throughout most of the pandemic, while in others they were closed, and classes were moved online for months. Although these responses to the care crisis varied, they mostly targeted essential workers rather than those who were working from home. Second, governments responded to the COVID-19 care challenges by expanding paid and unpaid sick leaves and family leave benefits. Emergency paid leaves, however, were not accessible to all and in some cases, they were only available to those working from home (Rubery, and Tavora, 2021). Precarious workers had no access to those leaves, while in some states, like in the USA, only a very small percentage of working people with care responsibilities were eligible for paid care related leaves. In less affluent states, such leaves were not implemented leaving caregiving entirely to individuals (Bahn et al. 2020). Both categories of policies aimed at dealing with work-life imbalances in the short-term and did not take into consideration the unequal burdens of men and women, nor the special needs of single-parent and low-income families.

Overall, these policies failed to address the crisis of care as a long-term issue manifesting the gender bias and lack of feminist and queer representation in policy making. More specifically they failed to recognise that work-life imbalances were the result of intersectional gender inequalities that persisted despite gender equality policies in place. Moreover, they failed to grasp that care is an issue that cannot be limited only to the male-female binary, but should include also other intersectional categories, such as gender, class, and race. This broader long-term perspective of the care crisis was obscured and rendered invisible even though COVID-19 brought to the forefront invisible gender equalities that were prevalent in both advanced and backwards gender equality policy frameworks. This can be illustrated by considering the examples

of Greece and Iceland during COVID-19, two European countries with completely different gender equality records, which nevertheless both had negative outcomes regarding the division of labour within households during COVID-19.

Greece figures usually at the bottom end of European gender equality indexes but is still ahead of many states in the Global South (EIGE, 2021). Traditionally gender equality policies provided women with incentives to carry out motherhood and other care related tasks, that constitute a highly valued part of femininity in Greek culture. Moreover, harmonization with EU gender equality principles, has led to policies promoting the participation of fathers in care and the removal of gender-biased incentives, like early pensions for mothers. However, after the 2008 economic crisis, welfare structures were systematically weakened by austerity measures that led to privatisation, underfunding, and understaffing of the systems of public healthcare, education, and elderly care (Markantonatou, 2021). Greek women were able to use poorly paid migrant labour to cover their needs for domestic work, child and elderly care but gender stereotypes of femininity and care continued to dominate public discourses. In this context, it was hardly a surprise that as soon as lock downs were imposed, Greek women -especially mothers- were forced back to performing their traditional gender roles as unpaid carers, making more visible the gendered division of labour that has never been truly challenged by the familialistic model of care that prevails in Greek politics (Symeonaki et al., 2020).

The Greek government adopted a gender- biased plan against COVID-19: It closed all day care centres, kindergartens and schools as well as all after school activities, making no exceptions for parents who worked as essential workers. Childcare structures and schools were closed for most of the pandemic and did not re-open immediately after the quarantine was lifted, even though parts of the commercial and public sector had already opened (Kambouri, 2022). To deal with problems that emerged in the online education platform, online classes for kindergarten and primary school children were moved to the afternoon, leaving parents without support during the morning. These measures lasted for prolonged periods of time and impacted mostly on women who could no longer delegate their care responsibilities to state structures, private carers, or extended family members.

Contrary to Greece, Iceland is considered as one of the most advanced countries in gender equality in the world. Yet, studies show that it provides an example of how the unequal gendered division of labour within households resurfaced and became visible once more because of the exceptional circumstances of the pandemic. The case of Iceland is surprising because the government introduced a much more gender-sensitive anti-COVID-19 plan than in most European states. While all after-school activities stopped, pre-schools and elementary schools remained open subject only to some restrictions, including reduced numbers of children in class, small group interactions, limited school meals, alternate days and/or reduced hours of

attendance. Moreover, the care needs of parents whose work was considered as essential (doctors, nurses, teachers, etc.) were given priority regarding these restrictions. Nevertheless, research conducted during the pandemic with parents in Iceland showed that care labour increased at home and that women were the ones who took on their shoulders most of this burden at the expense of their independence and psychological well-being (Hjálmsdóttir and Bjarnadóttir, 2020).

As many public care structures were no longer available, mothers in Iceland were once again placed in a position, where they had to carry out traditional gender roles that clashed with their professional responsibilities and their own personal needs for self-care, as they were too time-consuming, but also too emotionally demanding. The COVID-19 crisis demonstrated that despite progress in gender equality policies caring as mothering continues to be considered as a natural feminine trait that is idealised in Icelandic culture. Moreover, this crisis showed that traditional motherhood in Iceland is being reconfigured in a neo-liberal framework, where caring is no longer solely about addressing children's basic needs, but also about meeting achieving unrealistic goals regarding children's' health, social relations, and educational attainment (Auðardóttir and Rúdólfsdóttir, 2021). These findings support previous research by Icelandic scholars, which demonstrate that official rankings and analyses that present Iceland as a "gender equality paradise" are mostly focused on the public sphere and often render invisible gendered processes of caring in the private sphere that continue to produce gender inequalities (Hjálmsdóttir and Bjarnadóttir, 2020, Einarsdóttir 2020).

These two examples confirm what other studies have argued namely that in all regions hit by COVID-19, women were more likely to spend time doing housework and be the primary caregivers, while they were less likely to have economic independence, adequate access to healthcare, and to feel secure and safe at home (Ladysmith, 2020). Moreover, they demonstrated that policy making during COVID-19 failed to go beyond the health emergency and t make policies that challenge the commodification and privatisation of the care economy. Policy makers did not acknowledge that the crisis of care was a long-term issue that requires more substantial structural changes to have sustainable results. Feminist calls to produce a more equal gender division of labour within households, to create decent working conditions for care workers, to value care beyond the mere rhetoric of essential work and feminine sacrifice and to build decent healthcare infrastructures remained outside policy agendas (Dowling, 2021a).

Policy making on COVID-19 did not include consultation with feminist and queer communities in the planning phase and failed to integrate gender experts in policy making that led to the lock downs and the social protection policies that aimed at mitigating their negative impacts. This was partly because at least in Europe and North America this type of health crisis was unprecedented and partly because of gender biases in the decision-making process that are

prevalent across the world. In that respect it is worth noting that some states that have experienced similar health crises in the recent past have done more effective gender mainstreaming and were more prepared to address the gender challenges of COVID-19 after having learnt the lessons of the past. For example, a program for the relief of caregivers during COVID-19, including informal and precarious ones, in Kerala India was successful mainly because it was based on learning from past crises, including gender experts and consultations with local feminist groups in the design of the program and using gender and sex disaggregated data to assess its impacts (Holmes and Hunt, 2021).

International and European organisations and NGOs have raised the issue of the care crisis in numerous recent publications developing a more substantial critique of the current gender biased economic model of growth and calling for a change of paradigm towards a care economy after the experience of COVID-19 (Gender 5+). This includes the UN Women's demand "to posit care as a public good", which includes three steps: (a) to recognise "the contributions of care work to economic development, social cohesion and human capabilities" in policy making, (b) to "collectively assume the costs of care work, including through the funding and provision of quality public services, time-saving infrastructure and social protection" and the establishment of "a safe and stimulating work environment as well as equal pay for work of equal value, with value being redefined to recognize social contributions, not merely market-based rewards" for private care workers, and (c) "to deliberately seek guidance from those who are most affected by existing care deficits, including those in need of care and those who provide it on a regular basis" (UN Women, 2021b, 39). It also includes ILO's proposal to recognise maternity and paternity leaves as universal human and labour rights and as part of societal collective responsibility as well as ILO's recommendation to states to invest in healthcare infrastructures in order to deal with the childcare and elderly care gaps that have accumulated (ILO, 2022). These approaches are inspired by feminist analyses but go only as far as to argue that reforming the system will contribute to gender equality and growth. Feminist NGOs have taken these arguments one step further making the claim that we should abandon entirely the notion of economic growth and begin to implement a program for a care economy. These proposals recommend shifting resources from military spending and the support of male dominated sectors, such as construction or technology to the care industry, introducing gender budgeting and gender planning at all stages and levels of public decision making. This re-distribution of resources towards care is based on the feminist belief that care is an investment that would contribute to the wellbeing of societies much more than growth (European Women's Lobby, 2019).

These feminist approaches that have been integrated into more mainstream agendas demonstrate that the pandemic had a positive impact in raising civil society's awareness of the significance of gender inclusive responses to crises and a more long-term understanding of the crisis of care as a structural issue.

Our review of relevant policy material and analyses, however, showed that both the policies addressing the care gaps during the COVID-19 health crisis and the feminist NGO proposals that call for a shift from an economy of growth to a care economy fail to integrate intersectionality as an integral aspect of these shifts. While class, race, migration, and disability were mentioned occasionally, they are scarcely treated as integral to the gendering of the paradigm. Moreover, any reference to the specificities of care from an LGBTQ perspective are marginal or entirely silenced reproducing a conception of care as being a binary male-female issue only. This is unfortunate as these feminist mainstreaming has otherwise powerful insights to contribute to current debates about gender, care and labour. One study found that "those that did, mostly discussed these populations individuals in generic terms as a potentially vulnerable group, along with women, children, and people living with disabilities, who might require additional or targeted support" (Asi et al., 2022, 8). This tendency to leave out the care needs and the care practices of LGBTQ individuals and communities, which is shared by civil society actors and by some academic analysts, from the policy agenda on gender, labour and care reproduces normative notions of care as being carried out only within the heteronormative nuclear family context. This in parallel to the familialism of policies, we can observe a "methodological familialism" in relevant research and analysis that only mentions women and men as homogeneous categories and treats the needs and perspectives of middle-class heteronormative families as universal (Laufenberg, 2021).

# 5. SOCIAL MOVEMENTS AND THE CRISIS OF CARE

There have been many gendered -both feminist and queer- social movements that continued proposing alternatives to the current care systems throughout the period of the pandemic. These adopted much more holistic approaches exploring how the crisis of care is intertwined with other crises, the crisis of sexism and anti-gender politics, the financial and economic crisis of financialised capitalism, the political crisis of racism and conservatism, but also environmental sustainability crisis. From this perspective, care extraction is conceived as a broader social problem that include both human and non-human forms of life (Allan, 2020). These social movement approaches go beyond the consideration of the crisis of care as merely a social policy issue to be resolved at the national level. Instead, they envisage care centred perspectives that extend beyond national welfare and work-life balance to endorse different forms of life across national borders, taking account in particular global care chains. In other words, care is addressed in these diverse activist discourses as an issue of collective responsibility and ethos. According to one article, considering care in the period of the pandemic made it possible to accept "that we are all collectively responsible for hands-on care work as well as the work necessary

for the maintenance of communities and the planet." (Chatzidakis et al. 2020, 893).

Many of these movements are continuations of the unfinished feminist projects of the 1970s, 1980s, and 1990s (Hammonds, 2021, np). These include Black Lives Matter, which carry on the tradition of anti-racism and abolitionist feminism as well as different social movements of feminist and queer activism against gender-based violence that have multiplied across the world during the pandemic. In the same manner, Sophie Lewis (2020) has argued that pandemic times are an excellent occasion to revisit the demands for the abolition of the family which has proven more than ever to be a dangerous environment for many women and LGBTQ as it is a dangerous institution in which there are many risks of gender-based violence, unequal reproductive labour as well as the trappings of private property. She gives as an example of such an activist initiative that is in favor of the abolition of the family: the movement Moms 4 Housing in Oackland, which has organized sharing and occupying as a response to the question of how you isolate at home when you have no home (Lewis, 2020). Others develop approaches based on existing efforts to challenge inadequate state structures and extractivism. Instead. they propose commonings of reproductive labour, such as communal kitchens, solidarity squats, urban gardens, shared fridges while endorsing mutual-help and non-hierarchical forms of organising, reciprocity, and sharing of scarce resources (Federici 2019). Such types of commoning interrupt the affective flows that develop around the nation and resist its exclusionary tendencies. As they are based on mutual care needs, they extend beyond the heteronormative family and the national body, to include LGBTQ and migrant families and communities and forms of living together (Hattam, 2020). Such social movements are inclusive of different genders and question stereotypical femininities and masculinities in care. What people who participate in those movements have in common is their shared sense of vulnerability.

*"From the perspective of these movements, care "looks like respect for everyone's fear, anxiety, anger, and frustration. It looks like humility in the face of the unknown and uncontrollable, and openness to new imaginative possibilities" (Ticktin, 2021, np).*

Similarly, there also social movements that challenge prevailing labour relations problematising the strict separation between public and private and conceiving work in terms of a continuum. These focus on demanding less intensive working schedules (for example through shortening of the working week) and higher wages for all. It is no accident that the proposals for a universal basic income have been more widely discussed for their potential in reversing gender

inequalities in care after the pandemic (Lombardozzi, 2020). Moreover, such movements also challenge the existing poverty of caring infrastructures that have been dismantled by austerity policies and propose the construction of infrastructural bottom-up alternatives to cover care gaps beyond the heteronormative family. Social care cooperatives in Emilia-Romagna in Italy, and Quebec in Canada are an example of such "commons-based co-production" based on solidarity and mutual sharing between diverse actors, such as workers, housewives, mothers, neighbours, local community organisers, and activists (Allan 2020). Other examples of such commonings include the struggles for affordable housing during the pandemic, such as the anti-eviction movements that developed in Serbia during COVID-19 which put forward the right to housing as an essential social and political right (Vilenica, Mentus & Ristić, 2021).

# 6. CONCLUSIONS

Most feminist analyses on gender, care and labour during the pandemic emphasise that the crisis of care is not a new phenomenon that rose with the advent of the pandemic but existed before COVID-19 and it will continue to impact our societies in its aftermath. In this context, feminists emphasise that we need to be aware of the broader and more long-term consequences of the crisis and address it in terms of multiple factors that cut across public and private spaces. On the one hand, we need to address the unequal distribution of care labour within households. This includes challenging how we think about the heteronormative nuclear family as a safe place and re-thinking about alternative forms of care that are not tied to the dominant masculinities and femininities assigned to women and men within families. On the other hand, we need to reconsider the importance of care infrastructures and reimagine how we can build more gender equal societies around them. Improving vital care infrastructures includes also recognising the value of care work and care workers, paying them higher wages and fighting against labour rights violations in the private care and healthcare sectors.

The dominant discourses of the pandemic were masculinist and conservative reproducing stereotypical notions of science, the family, and the nation. Many studies have noted how scientific narratives became paternalistic silencing the questions and needs of communities and individuals. In parallel many feminist analyses of the discourse of the pandemic emphasised how it centred around the nation and nationalism. Masculinist, scientific and/or nationalist discourse determined how genders were constructed often assigning caring and nurturing roles to women as mothers and carers at home and potent heroes in hospitals, where they were portrayed as fighting at the forefront of the battle against COVID-19. These gendered discourses have given justification to hyperbolic expressions of feminine caring that did very little to help women and men carry out essential reproductive tasks. The irony was that in some cases while nurses were celebrated as national heroes, nothing really changed in their professional lives, while in many countries, like Greece, even work-life balance were not adequately addressed. When lock downs imposed the closure of schools,

kindergartens, and day care centres, in some countries like Greece, there were no special arrangements for mothers (and fathers) who are “essential workers”. These challenges have prompted feminist NGOs to demand a shift in perspective towards a care economy rather than an economy based on growth in traditional male dominated sectors. The main challenge for the post-pandemic world is, thus, to find ways to utilise what we’ve learnt about care during COVID-19. This includes creating long-term frameworks for the renegotiation of the gendered division of labour within households. At the same time, it is important to challenge the masculinist and nationalist narratives of care and adopt alternative intersectional perspectives and encourage experimentation with feminist social movements proposing alternative perspective and implementing alternative grass-roots care initiatives.

# 7. POLICY RECOMMENDATIONS

To NGOs

- Develop activities providing care for deprived social groups through in a spirit of exchange, solidarity and respect rather than humanitarian protection.
- Focus on developing initiatives against the crisis of care that include local communities and enhance their capacity to provide care beyond the family.
- Challenge gender stereotypes and support new forms of gendering in care-related practices that are inclusive of working-class people, who are struggling mostly with the privatisation of care.
- Support private care workers’ labour rights and develop awareness raising initiatives that promote recognition of their value and challenge the informality and labour rights violations of the sector.

To states

- Address the long-term crisis of care from a gender perspective by re-allocating available funds to public and free welfare.
- Include representatives of feminist organisations, women’s and LGBTQ groups in policy making on care.
- Introduce gender-budgeting in all aspects of decision making.
- Invest and provide state funding for quality healthcare services for all irrespectively of gender, class, race, and ethnicity.
- Create a framework for the protection of the labour rights of health care workers, including migrant ones.
- Promote a more equal division of labour within households by encouraging men to spend more time taking care of their responsibilities through paid leaves and other incentives.

- Organise campaign on care beyond the binaries male/female, private/public and beyond the heteronormative nuclear family.
- Support grassroots caring within communities.

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# ProGender

A Digital Hub on Gender,
the COVID-19 Crisis and its Aftermath

The project is implemented by:

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