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Aging and the Pandemic Care Triangle: A View from a Barcelona

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Abstract

This triangle of care is the result of an ethnographic research conducted with hard pandemic restrictions in Barcelona during 2020. Even if it is based in a bibliography on gender and migration, care and aging, the article is basically empirical. For the interpretation of the debates and discussion groups carried out, we identify here: the elderly person (as we have seen in the interviews in the previous article, Natalia Ribas-Mateos and Herrera (15),"The care debate during the first covid lockout in Barcelona); the caregivers - from family members to hired workers, especially immigrant women- and thirdly, as the third aspect of the triangle, and which remains in this article more blurred, from municipal and health public services. The pandemic highlights the existing systemic inequalities, particularly affecting the elderly, but also migrants and ethnic minorities, people who work in the care sector, and health personnel.

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Introduction

Why to look at the triangle from Barcelona

Westood(17) points out how many works on ageing and care do not consider diversity, when aging, care and diversity conform the key triangle of contemporary changes in sociological aging challenges. She also adds how this 'uncritical reliance' has often led to homogenising narratives. which has often not included questions of diversity in its parameters, has not included representative populations and has not incorporated issues of diversity and/or inequality in its analysis.

Lamas-Abraira(1) provides with a contextual vision of the importance of the debates on care, migration and the elderly in diverse areas of the world. The background context revolves around how to resolve definitional ambiguities on the research of gender and migration and to provide and integrated, synthesized overview of the current state of knowledge. The concept of care has been a main axis of research in migration and gender studies. Fisher and Tronto(10) explain how care encompasses orientation and practices: it permeates people´s lives and seeks to give continuity, wellbeing and or recovery.

Even if the triangle of care has mostly been analysed in Anglo-Saxon countries, we can consider diversity of care of human beings, which involves our everyday life, but it is also inserted in genderised intersectional power systems. Those care systems are of course conditioned by the historical and cultural contexts which lay

behind those systems, in this case referred to the Barcelona case. Of course, such pandemic events were internationally spread. In early 2020, when dominant news reports suggested that COVID-19 was a virus that would target the elderly and vulnerable, many perceived that the brewing pandemic would likely not affect them. For example, the community perception that Black populations in Britain were mostly younger and healthier was compounded by reports- reflective of initial Chinese media channels- that amplified the belief that some people were less susceptible, and would only face flu-like symptoms should they catch the virus. See the exhibition of Open Wounds exhibition | The King's Fund (kingsfund.org.uk)(accessed 12.02.2023).

State of the art: Conceptions of caring for the elderly during the first lockdown (2020)

For this article, we focus on the elderly and how they are cared as a center of reflection. Care work is defined broadly as consisting of activities and relations involved in meeting the physical, psychological and emotional needs of adults and children, old and young, frail and able-bodied. It is understood inside "human capabilities", they mean "health, skills, or proclivities that are useful to oneself or others", which include"physical and mental health, physical skills, cognitive skills and emotional skills". Similarly, Standing defines care work as "the work of looking after the physical, psychological, emotional and development needs of one or more other people".

Two broad kinds of care activities have been defined: first, those that consist of direct, face-to-face, person-care activities, which typically include the work of "nannies", childcare workers, nurses, doctors, teachers, caregivers in nursing homes for older persons and older person caregivers in private households; and, second, those that do not entail face to-face person-care, such as cleaning, cooking, laundry and other household maintenance tasks.

Firstly, we locate care. The meaning of care for the elderly in the context of welfare regimes and migration in Southern Europe opens new debates on the location of the so-called care crisis and its reading from a gender perspective. Certainly, the social organization of care appears as a matter of crucial importance in the world and the European context during the last decades. In this sense, we are not talking about a new phenomenon, the need for care, but we refer to how the problem regains increasingly greater magnitude and intensity. Especially regarding ways of thinking care of dependents and elderly women, in the chainging realities associated to new demographic, political-social and economic changes, which entail a strong increase in demand; at the same time, we are also witnessing a cut and decrease in social benefits. Furthermore, from the elaborations on social care, the place of care in welfare regimes, and the role of the States to regulate and assume it, associating it with labour markets and immigration regulations that unprotect caregivers, have also gained presence.

Care work for the elderly can be paid (in this case with migrant carers) or unpaid (in this article with family carers). As everywhere in the world, the largest amount of unpaid care work in nearly all societies takes place within households, most often carried out by women and girls of the families concerned. But individuals also perform unpaid care for people outside their families, webbed in social networks, such as friends, neighbours, and community members, and within a variety of institutions (public, market, non-profit, community, and even NGOs) on an unpaid or voluntary basis. Paid care work is caring work performed in exchange for payment or remuneration within a range of institutional settings, such as private households (as in the case of domestic workers, who are mainly migrants), and public or private hospitals, clinics, nursing homes, and other care establishments. Marketed care for the elderly is very wide, and it's in constant transformation. As paid care workers may be in an employment relationship, where the employer may be a private individual or household, public agency, a private for-profit enterprise, or a

private non-profit organization; or they may be working on their own account (self-employment), and they are often inside personal arrangements in the informal labour market and with an irregular migrant´s condition.

An easy and graphical way to understand care is through the "care diamond", which proposes a way of conceptualizing the institutional architecture through which care is provided – the four institutions, which are the family/ household, the state, the market, and the non-profit sector, which includes voluntary and community organizations; and the division (and redistribution) of care labour, cost, and responsibility among them. The demand for care services that are "non-familial" (not involving family members) has been on the rise and employed care workers comprise a growing segment of the paid labour force. Care providers in the private sector comprise several kinds. These costs are unequally borne by those who carry the disproportionate burden of unpaid care, i.e. mostly female members of the family and community. In the context of high-income inequality and high poverty levels, families living in poverty provide a steady source of cheap care labour. They can organize and provide care services by care workers employed by the enterprises themselves; or that act as intermediaries, subcontracting care workers or establishments for and on behalf of care recipients; or that simply recruit care workers for private households, individuals, or establishments. The terms of the triangular relationships that involve care recipients, care workers, and these various types of establishments are changing very fast and it is evolving in many different ways.

There is enough evidence to suggest that differentiating care regimes is based on the relative roles of the state in the formal provision of care services and support and of the family in the informal provision of care (18). Two ideal types have been identified: at one end, the Southern European "familialist care model", with high levels of unpaid care provided by the family (particularly women) and minimal public provision of care services; and, at the other end, the "public services model" of Nordic countries, with egalitarian care and gender regime and high levels of provision of public care services.

In this article the context is therefore put into two important evolving preprocesses is on the "marketisation of care" and the other is on "re-familiarisation of care". As regarding the first process, the role of markets in delivering care to individuals and families has expanded especially by (i) direct purchase of service (e.g.families and individuals in a private nursing home, or directly buying such services, (ii) purchase through government care in subcontracting mode or employ care workers (ii) purchase of government to private services to give public services (privatization of care), (iii) partial private financing of public care services, including through user fees and other extra monetary support from care recipients.

As regarding the family setting. Some market-based instruments entail "unburdening the family" or "de-familiarization" of care responsibilities, other measures involve a "re-familialization" of care (bringing care delivery back within the family setting), such as cash-for-care allowances that enable or encourage families to hire caregivers who provide care at home. The types of care in light of the above-mentioned process are very different and give out a different impact on society in distending the social content of the care given, and the relationship between the care recipient and the care provider as well as understanding the economic character of the relationship and the labour involved (e.g. paid or unpaid, employment relationship or another arrangement).

Evidently enough, social relations of care are intertwined with existing structures of power and inequalities of gender, race, and class, Historically and across developed and developing countries, now called North and Global South, women from poorer and disadvantaged racial and ethnic communities have tended to provide the labour (for little or no pay) to meet the care needs (household maintenance,

personal care) of more powerful social groups while their own needs have been neglected. Furthermore, workers generally experienced a wage decline when entering a care occupation and an increase when leaving care jobs, the fact that they were often not unionized, the low cognitive or physical demands of the jobs, or low levels of education and experience among care workers affect their labour trajectories.

In such a triangular setting, we would include the influence of three regimes, the care regime, the migration regime, and the employment regime. As care regimes, influences in support and its conditionality (e.g., direct payments, care allowances, cash benefits, tax credits), characteristics of the care workforce, "care cultures" (i.e., dominant national and local cultural discourses on gender and care, on what constitutes appropriate care, such as familial or institutional care for older people) and mobilizations concerning care. In addition to the distribution of care responsibilities – who pays, who cares, who decides –a regulatory framework that governs these care responsibilities, a care regime has an underlying "care culture" (and sub-cultures) that define what type of care is most appropriate and desirable, including who should provide care. The care regime is intimately intertwined with gender relations (12, 13).

Secondly, we locate migration. As a migration regime, we identify the main elements as immigration policies, settlement and naturalization rights, citizen rights, internal norms and practices in relationships between majority and minority groups, labour market divisions, exclusions and hierarchies, processes of deregulation, deskilling, precarious and flexible labour; forms of social protection (production-related discourses (male breadwinner or dual worker, welfare-to-work schemes, labour market activation), and forms of mobilization.

As employment regimes, they shape the employment situation and working conditions of migrant care workers. At the macro level; institutions and organizations at the meso level; and formal and informal employment arrangements, relations, and practices at the micro-level.

Therefore, because of these arguments, we will use a triangular vision for the analysis of this article based on the different types of caregivers with whom we have discussed. Normally, the care triangle refers to a model adapted for the care of people with dementia - known as the Care Triangle or the Care Triangle - to create a link between the three parties: the person with dementia, the staff member, and the individual carer. This Triangle of Care describes a therapeutic relationship between the person with dementia (patient), staff member, and caregiver that promotes safety supports communication, and sustains well-being. The Triangle of Care seeks a better connection between service users and their caregivers, and organizations. It was developed by caregivers and staff to enhance caregiver participation in acute home and hospital treatment services. It was initially developed to improve acute mental health services in the UK by adopting specific principles: assessing the role of caregivers and their contact with services, contacting caregivers to interact with caregivers more effectively., and see to ensure that policies and protocols guarantee confidentiality and improve the information (https://www.cwp.nhs.uk/about-us/our-campaigns/person-centred-framework/triangle-of-care/).Accessed on 11.11.23.

Thus, because of these arguments, in this general context of the migrant women's work sector, we will also see how the economic crisis of 2008 and the pandemic take on a special role. If the outsourcing of care in society supposes a growing role in society, they are not linked to improvements in conditions in the sector. The role of the elderly in the face of the pandemic is closely linked to the impact experienced by the caregivers during the first lockout. If since 2008 the crisis has been making a dent in society and especially in the migrant community, the pressures have also become much harder during the pandemic: greater risks, greater uncertainty in mobility, and high social costs of immobility

Finally, in our empirical case, in this triangle of care for the interpretation of the debates and discussion groups carried out, we identify here three main social actors. The elderly person (as we have seen in the interviews), the caregivers - in their wide variety, from family members to hired workers, especially immigrant women- and thirdly, as the third aspect of the triangle and showing other social actors, and which remains in this article more blurred, the municipal and health public services. In other words, we focus on the nexus of all the care understanding from a triangular point of view. As we will see in the last part of the article, this triangle is also very affected by the adverse effects of the pandemic. Therefore, in this triangular setting, the pandemic highlights the existing systemic equalities, particularly affecting migrants and ethnic minorities, people who work in the care sector, and health personnel.

A Brief Methodology

25 interviews were conducted with elderly people. The first bulk of the interviews were conducted at the end of August 2020 in Barcelona in the districts-neighborhoods of Sagrada Familia and Ciutat Vella. They mix social classes, ethnic origins and academic- non academic elderly. The first part of the research had completed interviews with the elderly populationin the city, and the second part of the research was related to the carers (see previous article published in this same journal).

Logically, all research comes from somewhere and someone, who manages it. As researchers we must consider where we come from, who we are, the role we have and how we relate to those we meet in the field. In the making, we must constantly negotiate our relationships with the communities studied or collaborate through particular and continuous daily interactions during the field work period. Furthermore, we must also be aware of how our epistemological stances, reflective “care activism”, and different analysis can influence the nature of empirical work. These considerations are important not only to improve our theoretical understanding of power, class, age, gender, identity, and knowledge, but also to address the practical realities of fieldwork and ongoing collaborations.

Through several encounters, as researchers, we build a relationship of familiarity and trust, which probes a series of key issues from multiple angles, explores different facets of the participants' experiences, and learns from the events that take place during the interviews. In that respect, field-work notes have also helped overcome the biases associated with one-time interviews, including a tendency for confident and straightforward responses in which participants flatten out complexity, downplay socio-political conflicts, and put themselves in the centre of the research.

This analysis here follows a "qualitative" approach to *mix methods* as the objectives and research design are thought from a qualitative perspective. We examine from a holistic perspective the joint effects of different care elements of each specific interview. Regarding the anonymity of the interviewees, the ethnographical experience shows that it is difficult to hide the participation of some people in the research, especially in the case of small communities whose members know each other. Even if they share a common guide, each interview can disengage with the narrative itself marked by the interviewee; the rhythm is advanced, delayed, detailed, or ignored depending on how each person feels in relation to the subject to be discussed, as well as in relation to the knowledge / ignorance that may be had.

Qualitative Fieldwork - Analytical Codes of Interviews

1. THE SOCIAL CONSTRUCTION OF OLD AGE

1.1. Selected guidelines

A. Context and life cycle

B. Transnationalization

1.2. Changes and auto- identification

1.3. Categories (from recent retired people to over 100 of age)

1.4. Stereotypes: Pejorative / Dependent vs. Autonomous

1.5. Putting social relationships in the centre

1.6. Crisis perception regarding:

-Frailty

-Identity

-Autonomy

-Psychology and morality

-Technological Gap (Digital Divide)

- Networks (Decrease in quantity and quality)

1.7. Forms of acceptance

1.7.1. Active aging, gender, and empowerment

2. The CITY

2.1. urban inequality

A. District and neighborhood scale

B. Neighborhoods:

1. Aged neighborhoods

2. Neighborhood and diversity

2.2. Covid-19 and urban crisis. Neighborhoods and vulnerability

2.3. Housing typology for the elderly

2.4. Polarization: El Raval / Eixample

3. FAMILIAR STRUCTURE

3.1. Distribution of family responsibilities: Reproductive tasks

3.2. Family mobility /family proximity

3.3. Paradigmatic case: single women

4. SOCIAL NETWORK

4.1.social network and class

A. Friendships

4.2. Social network and gender

4.3. Social network and community strategies

4.4. Socio-cultural activities

5. SOCIAL INEQUALITY

Who is in-charge?

5.1. Gender

5.2. Class

A. Retirement benefits / Circumstances in which the retirement occurred /

B. Professional and labor issues: Still working.

C. Properties

D. Social class and lifestyles

E. Active aging and equal opportunities.

5.3. Ethnicity

5.4. Age

6. VULNERABILITY

6.1. Axes: Affective, gender, social

6.2. De facto: A. Situation of dependency B. Chronic illness

6.3. Counter-concept: resilience

7. SOCIAL SERVICES

7.1. Answers, demands and unmet needs.

1. Contrast of given services with residences

2. SAD services

3. Aid in general

7.2. Vision from the care seeker. Complaints: a) listening, b) lack of communication, c) bureau cratization

7.3. Forms of intervention: a) agency versus dependency, b) socio-community services, c) lei sure and training services

8. DIVERSITY

8.1 Migrations from the biography itself: a) Interiors, b) Exteriors.

8.2.Regularization

8.3.Care outsourcing / Migrations

9. STAKEHOLDER MAP (SOCIAL POLICY)

9.1 Europe

9.2 Ministry

9.3 Generalitat

9.4 Town Hall

9.5 Provincial authority

9.6 NGO

9.7 Foundations

9.8 Religious associations. Parishes, Mosques

10. HEALTH

10.1.Health as a central theme

10.2.Self-assessment state of health

10.3.Emotional health (well-being). Emotional and cognitive aspects.

11. COVID-19

11.1. Essential care and services

11.2 Stereotypes of elderly people and Covid-19. A. Risk group.

11.3. transnational mobilities

11.4. Covid-19 and human rights

11.5. Covid-19 affectation. Specific topics:

-Impact of Lockdown

-Day Care Center

-Caregiver burnout

-"Casals" (open municipal activities)

-Funeral services and diversity

12. RESEARCH METHODOLOGY

12.1-Context. Tracing the ethnographic notes.

12.2. Entrance to the field:

- Regarding research contacts

-. About how to introduce yourself

- On how to ask questions

12.1. On profile based on interviewed files (extraction of generic table)

For example, profiles:

1. Raval , 2. Professional (Eixample) , 3. Academic profile, 4. Encants Market

13. RESEARCH ETHICS

13.1. Anonymity

13.2. Use of the Covid-19 protocol

The return to the field

The city context

Urban aging is an emerging domain that addresses the population of older people living in cities and their new realities and new demands. The aging of society is a positive but challenging phenomenon, as population aging and urbanization are the culmination of successful human development. One could argue whether the city environment is an ideal place for people to grow up and live to an advanced age compared to rural areas. Many interviewees explore the challenges they face in different ways to make their urban environment age friendly.

Fieldwork is truly limited to the central axis of urban life. As we detailed in the attached methodology, it is from the distinction of the neighborhoods and of territories that we go down to the level of the district, neighborhood and staircase. These last two are very clear in the interviews carried out in the Sagrada Familia neighborhood.

As in the city centre, the neighborhood space, the dwelling in which they live and the type of dwelling to which we refer, it becomes central in the daily life of the people interviewed, and of course, in how proximity networks are established; in social relationships, in commerce, in medical care and in civic centres or other meeting places.

This contrast between social classes has been specially revealed in the interviews conducted in the Raval. In the neighbourhood of the Sagrada Familia, several interviews with senior interviewees have been conducted. As a context, they are neighbouring buildings where one can count on certain

amenities as in other parts of the Eixample, but in general they seem to have more space. They have a doorman, elevator, central heating, community patio, terrace. Several interviewees even came to live here from other neighborhoods, choosing a more comfortable place for their old age.

Many of those interviewed in the Sagrada Familia have to do with the Church and so, they identify themselves as very religious women, which precisely makes them live the day to day of the aging process in a much lighter way. For these religious women, faith occupies a central place in their culture, in the way of understanding the disease and in the way of understanding and assuming aging.

In the Sagrada Familia neighborhood, all the interviews have been carried out in the houses and thus, it has been possible to observe the way in which the house is decorated, usually in a bourgeois taste in terms of furniture, decor, books available in the living room, etc.

**The Context of El Raval*

Ethnic diversity is no longer limited to large cities such as the large European metropolises like Barcelona. Mainstream society holds the myth that aging, and disability are abnormal rather than part of the spectrum of human diversity, perpetuating the objectification and disempowerment of *the old and the disabled*, but this diversity has entered directly into the world. Therefore, city spaces are of key importance in public policies. El Raval is one of the key axes in the impact of social vulnerability in relation to social services in the city of Barcelona. It is similar to other more peripheral neighborhoods, but surely here the context of diversity stands out much more. In addition, here in the Raval we find the two key sides of care interplay, the caregivers and the care. It is a good sample of what the changes in the life cycles of the old migrations in the city have meant: the arrival of internal migrants, the arrival of the first flow of foreign domestic women -the Philippines-, the presence of the first public residences for the elderly. In addition, during the covid we also add: the emergency forms of the covid in neglected elderly people, feeling locked up due to lack of freedom, the lack of decision in how you want to be happy as an elderly person (for example, with E5, with respect to women that she cared for), and they also point out how the covid suddenly marks them as a vulnerable group when they had never felt this way before. To what extent are they are risk group?

El Raval has been presented as very deteriorated during the pandemic. On the one hand, during the interviews we have seen an increase in homelessness, an increase in people begging on the streets, and the presence of young drug addicts always without masks. On the other hand, there has been an increase in control, as shown by municipal police in the squares, motorized units of constant surveillance, and chases protagonized by the *mossos d'Esquadra*, the Catalan police. Closed restaurants, closed bars, as in many other places, everything is part of the Covid crisis in Ciutat Vella. Here misery meets art and various forms of culture and the spectre of gentrification.

One of the contexts that best identifies the changes in the Raval is the interview conducted at Associació Surt (with Anna Barbé, deputy director, on August 27, 2020). She narrates how during the 2020 lockdown; they were performing essential services and opened a guard system. She is responsible for a program on families at risk with dependent children, they look for foster families during the week. With them, they manage specific services such as babysitting services, for example, with single women, with immigrant women, and with all families that lack a social network, as are women inmates. Thus, they cover all the neighborhoods of Barcelona. They combine user families with volunteer families. She specifies that in the long term, it is about creating a social network as a collateral objective. Where they are most in demand are the neighborhoods of Nou Barris and Ciutat Vella. However, like so many programs, it has had to stop during the pandemic.

The Surt Association also explained to us about the problems they had to manage during confinement, especially from the food bank. It is basically an association of rights (housing, labour, etc.) but they found that they, then, had to address a situation of first need that they had never had before. They also described the problems of the Raval from the most deteriorated sectors such as the sex workers in Carrer Robadors, the most deteriorated sector of sex work; many of them are linked to trafficking networks. They are one of the groups most affected by the pandemic, says the interviewee, as they are the most stigmatized sector and are seen as the most polluting and contagious people, without the possibility of work and with the stress of having their children to feed.

On the social construction of the old age

The different life cycles that represent getting older may be product of many assumptions about the way we presumably age and the way they are viewed by society. In the first place, the delimitation of age in the selection of the interviewees has put the scale at over 65 years of age, in the awareness that this was really a controverted question, since it is generally considered a very debatable border, which is often surpassed, even when many people continue to work at this age.

Regarding the awareness of entering a new life cycle, the interviewees used to point out this change as a fundamental milestone in their own biographical narrative. For example, in several cases it was seen as an aggravated sense of change, especially based on how the pandemic has affected it and how the pandemic has granted a great awareness of the aging process.

While representations of old age and older people in traditional media have been well documented, examinations of such representations within social media discourse remain rare, so we sometimes know little about these current representations. This is because there is an unfortunate omission owing to the importance of social networks for communication in contemporary society and also due to the cult of youth that misses the aging body: the change of the body and the fact that it has already happened menopause, having gray hair etc.).

In this study, we combine the information we extract from the interviews in order to explore the discourse analysis on the patterns of representation around the terms aging, old age and the elderly. In this analysis of interviews, we found that personal concerns and opinions about health and social care are the predominant general themes. The language often used in general society seems to reinforce negative age and aging discourses that locate older adults as a disempowered, vulnerable, and homogeneous group; old age is seen as a problem and aging is seen as something that needs to be resisted, slowed down, or even disguised. In this way, the interviewees show the different labels imposed around the dominant construction of the elderly and the vulnerable. They perceive how in pandemic times they are constantly labelled, thus also affecting their most basic freedoms, leaving them as an "online subject". Others refer to the feeling of social neglect.

First of all, we must add to this construction, key gender differences. This social construction of old age is based on the distinction by age group, but it also coincides with other aspects of intersectionality, such as gender. It is really in Valentina's interview in which the issue of gender and aging is directly addressed. She even adds the construction of diversity:

"I believe that in the West the construction of age is different and gender differences are also very important. But in other non-Western societies older people are admired, both men and women, but especially women. That is the great contrast between modern Western society in which contempt and invisibility predominate, of course taking into account the variations according to people's temperament" (E23, Valentina).

(…) because of the individualism of our culture… we all have to be young, strong, muscular, and attractive young women" (Dana, E25).

**Regarding the life cycle*

The vision of aging from the relatives' perspective is also important,t as it is often very divergent from the discourse of the older person himself/herself. For example, in the case of Louana, I was able to accidentally speak to her son within a few days of conducting the interview. While I had a very positive view of the construction of the interviewee's aging, her son showed me that it was the opposite, that he had just spent a month in the mountains with his mother and that he had noted a strong deterioration in her: being absent-minded in daily tasks, observing her lack of ability in handling her mobile phone, and ultimately, that greater patience was required on the part of the family member to be with her than before.

Ahmed explains to us how there are many people in the Moroccan community who like to live as adults straddling between two places, as shown also in the case of his mother "My mother likes to be in Nador because we have a house there. She goes upstairs and downstairs continuously, and of course as a Muslim she hears the call to prayer… and there she has the door open, the contact with the people, she is a very open woman… "

"Morocco is good, not bad. But the problem is related to doctors and medicines. You can have there enough to live, but you cannot cover the doctor" (Zahra, E2)

"For health insurance, I prefer to live here than to live in the Philippines, it is that there in the Philippines everything is paid. And of course, I am adapted here" (Rina, E5)

"I believe that in the long run I will return to my land, because there are cheap places there. I have a house there; it is an inheritance from my wife. It has three floors. When this pandemic will pass, we will leave. I leave the apartment to my daughter (…) Now our children are older, even though we are far away, now there are many telephones and many ways to communicate in the long distance" (Franco, E18).

It is within transnationality practice and diversity approach that we also add here a diverse way of getting older, and a diverse way of understanding care, as for example in the case of a woman from Ecuador:

"Well, in my country our parents are always at home, our parents, grandfather, grandmother, and they are dying at home. Then your parents stay because you have to do the same, take care of them, and that of taking them to a residence, because it does not enter my mentality"(Adelina, E 19)

"There are always surprises, right? It takes you by surprise. I had a friend who told me that you have to be very brave in order to grow older. We are not prepared for it. (….) It is a process, but difficult to accept. For example, acknowledging that you are slower, for example, when you get dressed. Until I was 80, I was not very aware that I was growing older. When you see people that do not see you in the same way anymore, they are not much interested in what you are saying…. In contrast, before, the elderly were more valued, but sometimes we even idealise those times. I do not think that they were treated so well. (Louana, E13).

**Regarding Resilience*

Resilience emerges as a central axis of the responses of the interviewees in their awareness of the aging process. In fact, resilience offers you a way to acceptance, to find yourself, to acquire healthy goals, an

active lifestyle and an emotional management of changes based on social participation. It is also resilience that gives the interviewee the tools to be able to order, or at least to be able to be at peace with their own past:

"I thought that having faith was a great advantage. For me, having faith, always gives you hope, it makes you free. I have been very sick. But I have faith and that gave me a spiritual vitality. That really helps, apart from my family, who are also next to me (...) You have to know how to live with sickness, one has to know that also" (Paquita, E15).

**Stereotypes of the elderly*

The interviewees generally coincide in noting how negative age and aging discourses persist in society. Many interviews recall such pejorative visions:

"Old age used to be synonymous with wisdom, and now it is synonymous with waste to be thrown away. I recognize that with the progress of medicine and the mentalities of people, you can become very, very disabled. I have now reached the lowest point I can be, to go lower, it is complicated, it is committing suicide. But you can also do it indirectly, not taking your medications, which is what my mother-in-law did and she died in a month" (Dana, E25).

"Getting older is being very exposed to being disqualified, in your way of being and thinking, that's why we have to learn to live and coexist with those people who we cannot change ... because they are young and believe that the truth is theirs" (Chana, E22).

Pilar (E3) explains within this contemporary construction of old age, how there is a deteriorated vision that is much of our times, but that surely is not generalizable to all places:

"Growing up is looked as a rather deteriorated image of the great people. Apart from the physical fragility, relationships become also more fragile, because you have to experience many losses. This context makes you more fragile. Because, you have your children but the people who are older than you are not here anymore" (Pilar, E3).

Fragility is often used in medicine and social policies; the attribute of "fragility" of the elderly. This attribute stands out above all from the medical perspective and social policies related to geriatrics. This attribute also connects with a broader process of medicalization of aging and with the process of *bio medicalization* of old age. This would be a clinical condition that is intervened with pharmacology. This is how the same interviewee expresses such an implication of fragility:

"(…) The fragility carries tiredness, everything is more of a burden" (Pilar, E3).

Nevertheless, some interviewees fight against such stereotypes in order to find dignity. Dignity together with the concept of care has become a central concern in health policy in many European countries, in the face of the increase representation of the elderly and vulnerable. The empirical and theoretical literature on dignity is extensive and complex both in the field of care (as caring for an elderly person) and in the workplace (here we could include caregivers). There are many questions that we could ask ourselves in this regard and that interviewees also ask themselves indirectly: What does dignity mean? What promotes and shapes dignity? (Pilar, E3).

Clarifying what dignity is it is important. In general, the interviewees give answers that cover a wide range of meanings. For example, implying privacy, courteous treatment, need for care, and consideration for cultural and religious needs. We see how the interviewees recognize the complexity of this dignity concept. It is curious how many interviewees delve into the construction of growing older from feeling

simultaneously an identity crisis and a crisis of autonomy. In general terms, one way to accommodate the constructive response to a deterioration of a life cycle is active aging, despite its limitations.

The world of care

The feminist literature of the 1980s placed the central issue of care in the heart of social policies. Back then, the concept of care was articulated as a central concept of unrecognized informal work, as well as commercialized work. But for us, the important question is to know, who is responsible for care in the community? First, we normally think it is a matter of public policies, especially when thinking about a form of residual public support for families without enough coverage, then NGOs were also included. In such policies we tend to think about community-type social services, where the socio-sanitary was also added, and in the case of Spain and Southern Europe in general we had another important actor of care, the employer family (1).

In general terms, the tendency of public policies to be embedded in the communities has had serious criticisms from feminism. As it was finally evident, care within the community did not support autonomy and cooperation, but rather accentuated dependency, isolation and female overload. In such way, the community became an extension of the private and free space and did not contribute to redefine care in the public's eyes. Thus, in this conception of the community we could not avoid the differences played by gender roles and gender care stereotypes. When regarding housework everything was included, housework as taking care of the household, became very broad. Thus, the debate on care in such terms has become reductionist. The care, understanding the care that one does for others, for their subsistence, for their happiness is often glorified. And in the end, it is only a matter expenditure of time, the time asymmetry, that the productive time of women is greater than the productive time of men.

Certainly, the social organization of care has emerged as a matter of crucial importance in the European context during the last decades. In this sense, we are not talking about a new phenomenon, as if today there was a new need for care, but we are referring to how the problem increasingly recovers greater importance and intensity, in relation to the ways of thinking about the care of dependent people and the elderly, which, coinciding with new demographic changes (both in the Global North and the Global South), which involve an increasing care increase in demand at the same time that we also experience a cut and decrease in social benefits.

If we understand care (in its wide relational sense) as a mixture of compassion and kindness in the family, it is then seen as family affair (1). However, such care is now heavily commercialized when considering the care services for the elderly today. Thus the transformation of the care concept is understood today in a much more relational way than in the eighties. That is that the relationship between caregiver and care receiver is recognized in the analysis of service quality as fundamental, as central when thinking about how to assess the quality of care. This relationship is therefore basic because the quality of the help depends on both technical skills and interpersonal qualities, which especially affect the relationship between the two people, the two figures, both social actors.

It is also important to give a place to this analysis on the changes in elderly care, since the elderly have different needs at different chronological times, therefore, responses from social services cannot act on a fixed plane, but rather they have to flexibly look at the possibilities for long-term changes and adaptations. It is also important to identify the position of older people who are often vulnerable in the process of care decisions; either do not want to opt for services or are unable to make such decisions. In addition, class plays a relevant role, as decisions are often constrained by the purchasing power of the older person.

At a general level, the older people interviewed and more attached to a traditional system who point out how their lives have been characterized by a constant succession of caregiving efforts, particularly emphasizing the role of caregivers of older people within the environment of their extended families.

The figure of the back-up carer

Frequently in interviews I ask about the unconditional figure, the figure of emergency, who to call in case of need. This call of reference has also been very evident in the case of the pandemic. What to do when someone does not answer? What resource do we have? Who is the reference caregiver for each of us?

In the case of Maria Lola, the way she influenced her daughter to learn languages as a child and then to become professionally more international means that she is now out of the network of possible care within proximity, as she is now working in Belgium. However, since she has an older niece who lives nearby, she can be the Maria Lola's emergency contact. It is the figure of the *back-up carer*. Normally when there is a lack of descendants or when the children are not within geographic proximity, it is the figure of the niece that takes relevance in the care or emergency care of the elderly person (e.g. Maria Lola´s interview, Louana´s interview, interview of several Latin American women). We can also distinguish other types of figures of this *back up carer*:

"The children have to live their own life, they cannot take care of their parents and then you think of the senior residences, now the residences are not available (...) My sister has been well provided for, but as her family when we see them, we realize the barbarity of the residences (…) Today everything has taken, in the past parents and grandparents died with their children" (E9, Teresa).

Organisation of the daily care

It is from this indirect inquiry into the daily rhythms of the interviews that we find the organizational structure of care, which underlies the case of the daily description of people. They tell us about a wide variety of activities, from the daily preparations at home, the way of carrying out the shopping, the distribution of tasks among the people at home. And also, of everything that does not have to do with domestic obligations, such as physical exercise through city walks on visits to the park, as well as intellectual exercise.

The activities in relation to their everyday networks are also made explicit:

"I don't hang out with my friends. My friends have been dying, we were four couples, those who worked with my husband. We got together from time to time. They have already died, that's why we don't get together. Only the women remain, they are reaching almost 90, and each one has her story" (Teresa, E9).

Dependency relationships

During the interviews we have also focused on examining the matter of the notion of care, as linked to charity and love that can lead to a relationship of submission of the elderly. On the contrary, we propose an understanding of care in which the elderly and caregivers find themselves in a multifaceted relationship of interjection that implies tensions and possibilities for transformation without losing sight of the ethical background in which both are respected in their idiosyncrasies and differences. But it has also been shown that these relationships of dependency of domestic burden and care fall very differently depending on the social class. Thus, the social class and the burden it poses to women (especially

counted in the active hours of their time) is very different depending on the social class and ethnic belonging.

The importance of family structure and gender in care

It is seen in the analysis of the interviews, especially regarding the identification of the family structure and the role of caregivers. For instance, when they explained to us how in Philippine families the role of the caregiver of the elderly person always falls on the daughter (Rima, E5). Clearly, an interpretation of gender analysis is articulated and intersects with the roles expected, assimilated or rebutted; where not only the gender but also the age structure of the children (relatives) count.

The service provided by family caregivers includes a way to provide unpaid care and support to people who are sick, disabled or frail in the community. The vulnerability of care, and how it affects the vulnerability factors is related to the purchasing power of the family. It is from the social policies that the state should try to deal with the vulnerability before any shortage of family caregivers. Family caregivers are the primary source of care provision for those in need of care due to chronic illness, disability, or frailty in the community. In addition, this demand for home care is likely to increase considerably due to a growing aging population, the abandonment of institutional care for people with greater disabilities and to policies that are directed to put a greater emphasis on home care in most European countries.

These factors related to family caregivers affect women who tend to be main caregivers to a greater extent and affect the stereotyped reproduction of what has traditionally been considered a role of women. In addition, many times the objectives of health policies fall on a greater concern about the focus of care in the home and in the community, where it tends to fall on a higher proportion on women who take care of the family.

The basis of good treatment is always key in the “common sense” meaning of care for all interviewers. This concept includes respect, tolerance, patience and empathy as we would with any other person, because they always refer to human beings with human dignity. A behavior that is disrespectful to the dignity of the person carries only other problems, such as loss and/or low self-esteem, and feelings of worthlessness.

The Outsourced Care Market

The formula of organizing care through home employment responds to a modified family social structure, typical of Mediterranean welfare, where activities are outsourced, but are kept within the home and in female hands, that is, replicating the organizational model of a traditional family. The system began to have a strong presence in the city from the second half of the nineties, with the arrival of Filipino women to the big cities. This outsourcing reached its peak during the first years of this century and maintained its importance during the economic recession that began in 2007, and then with a stronger second crisis in the face of the March 2020 pandemic. It is key in this kind of interpretive scheme of the reality of outsourced care within global care chains. In addition, the concept of "care drain" describes the lack of care resources in sending countries where the migrants left family members behind. They have pointed out the fact that "'care drain” throughout the world raises issues of justice and care that currently are unsatisfactorily addressed at the level of social institutions".

In the case of Barcelona, women with foreign citizenship from the Global South, could be included among the most vulnerable groups in the labour sector for having, in general, less bargaining power, lower support networks (but not always, as it often is really the opposite sense), as well as less specific

knowledge of the socio-labour context in which they are inserted. In addition, the lack of work contract also implies severe difficulties when renewing the documentation required to live and work in Spain. Those women without the pertinent authorizations add to the precarious employment situation a scenario of generalized vulnerability with difficulties defending their rights as citizens.

Furthermore, cultural beliefs about concerns as part of social groups (that is, in how groups are perceived in a given social context), are a compelling analysis of how stereotypes are constructed between different migrant communities as well as between migrant communities, different forms of care and caregivers. This type of stereotype has become evident especially when, for exmple, the stereotypes attributed to domestic workers are analysed: servitude, submission, exoticism, primitivism, etc. When we move them to the care sphere, they are normally grouped into the dimension of professionalism (intelligence, independence, resourcefulness) and human warmth (friendship, kindness, affection, tolerance, etc.). This form of labelling also connects with the content of cultural stereotypes related to different ethnic groups (and considering here the professionalism and warmth in dealing with people).

Conclusion

How the stereotypes of the elderly get reinforced with the first covid lockdown

The image of the elderly during the pandemic has been highly emphasized, more than ever in recent years, especially in these cities that are already aging, such as the big cities of Southern Europe. On the one hand, older people become increasingly vulnerable during periods of emergency, as the pandemic amplifies and highlights the specific vulnerabilities and needs of older people. Older people (defined by the UN as people over the age of 60), are more vulnerable to COVID19 and have a higher death rate.

On the other hand, the pandemic makes the city more aware of the specific needs of older people, especially in generating a type of humanitarian response. However, people also complain of their stereotypical image of vulnerability and of feeling that they are pigeonholed as risk groups and of assuming an awareness that they must be protected daily in public space by the rest of the citizens.

“Those who have affected us the most are the elderly, those with sugar, those with asthma” (Zahra, E2).

**Connecting the lockdown to Transnational mobilities*

Mobility is considered today as a strong hallmark in social inequality. Although before the pandemic we were faced with an appreciation of mobility, today we were facing a devaluation, as well as a disparate way of living mobility (9). On the one hand, many jobs cannot be done at home, while others live immobility at home as a way of feeling safe and with the added status of being able to dedicate themselves to teleworking. Thus, the notion of mobility (applied for many only to a small local scale), and immobility, can be understood today as a double vision of Bourdieu's social capital; creating a new repertoire of privileges.

In March 2020, an extraordinary event occurred: a global shutdown. The current high mobility of people, deeply discussed in social sciences within mobility studies is being identified as an important reason for the rapid spread of the new coronavirus (9). Stopping mobility was a measure recommended by the World Health Organization (2020) and followed to a greater or lesser extent by most countries in the world. This radical change in the daily lives of millions of people was seen as the best way to prevent the spread of the disease, the only feasible way to stop the virus. Cresswell reminds us "that mobility was the

soul of modernity and the virus that threatens to undo it" (2006, cited in 2020). Or more exactly that " mobility is both the lifeblood of modernity and the virus that threatens to destroy it." This author argued that the pandemic and its effects can fit well with the concept of turbulence shaking the "everyday world of mobility" based on order, security and surveillance (9).

**Which rights?*

The global crisis is presented to us as an opportunity to witness how employability and human rights that amplify serious structural inequalities are discarded. Structural crises, such as the current health emergency, easily become an opportunity (intended or unintended) to put pressure on labour demands and human rights, amplifying a situation that is exposing serious structural inequalities.

The pandemic not only highlighted the vulnerability of older people in emergencies, but also witnessed aging cases and worrying accounts of human rights violations affecting older people, particularly in relation to the ultra-elderly, health and long-term care service. It should be remembered that older people have the same rights to life and health as everyone else. Therefore, all social, economic and humanitarian responses must take into account the needs of older people, in particular with regard to universal health coverage, pensions, employment and social protection. These vulnerabilities are further compounded by challenges in accessing information about COVID-19.

In this concern for the human rights of the elderly during the covid we must also highlight the concern for the human rights of people with disabilities, children, and also caregivers of the elderly, the vast majority of whom are migrants. People with disabilities (including physical, mental, intellectual, and sensory) within migrant, refugee and other displaced communities may not be able to socially distance themselves as they depend on other people for many daily tasks.

Certain groups among migrant, refugee and other displaced populations require special attention in the context of COVID-19, particularly when it comes to protecting the right to health, access to information and the prohibition of discrimination. In the migrant group, older migrants, refugees and other displaced persons living in camps, collective shelters and city settlements face particular health risks arising from limited access to health and hygiene supplies and of the least capacity for social distance or personal isolation. To gain their right to health, the policies that are activated must guarantee access to health care, regardless of their legal status, and access to the shelters, water and sanitation centers they need to maintain their health. Furthermore, older migrants in detention, particularly those with chronic illnesses, face particular risks and their continued detention would be disproportionate.

In the interviews, the ethical issue of age discrimination has been raised on several occasions. And there are divergences in this regard, despite the fact that everyone, without exception, has the right to life-saving interventions. It is normally understood that medical guidelines / triage protocols are necessary in countries where healthcare professionals will not be able to provide the same level of care to all due to a lack of life-saving equipment. Triage or screening protocols should be developed to support decision-making by healthcare professionals based on medical needs, scientific evidence, and ethical principles. While some older people will have morbidities that affect their chances of surviving intensive medical intervention, it is always repeated in the respect of human rights that age should never be a criterion for medical triage. Medical protocols that are based on non-medical criteria, such as age or disability, end up denying people their right to health and life on an equal basis with others.

We know that the pandemic amplifies existing inequalities, the global crisis amplifies existing gender dynamics. Gender is here a necessary term to understand the analysis of relationships between men and

women, since it organizes the interaction and constitutes hierarchical social structures between them and structures the care expectations of family members regarding the care of children, the elderly. or other dependent members. The look on gender involves the use of an analytical tool that allows us to expose the forms of care in a clear way. That is, detailing the presence and capacity to organize care, as well as organizing the cultural conceptions of the feminine and the masculine in care roles. This analysis highlights, at a general level, the naturalization of the idea that women are solely responsible for the direct care of children, the sick, the dependents, as well as the elderly, as well as the indirect care that involves housework. food, home cleaning, etc., that is, from the socially, historically, and culturally produced idea that sexual difference implies differences in caregiving roles. In addition, during the pandemic these roles are shown again in a much more evident way. That is why it is evident how the articulation of gender and care stand out strongly in a pandemic context.

This gender division is clear in these pandemic times, but it has also been so in previous pandemics. For example, it had already been noted regarding the specific risks of Ebola; women's traditional roles as caregivers (both within the family and as health workers), and as people who traditionally prepare bodies for burial were at particular risk of exposure to Ebola. Reviewing this past case reminds us of the complexity of health care delivery in an environment where health inequality is high in both communicable and non-communicable diseases. During the covid crisis, while the density associated with poor housing conditions plays a role in the spread of the virus, it is worth noting that death rates are also determined by the capacity of the health system and health conditions. pre-existing in the population (for example, high blood pressure, obesity and diabetes), which in turn tend to be correlated with income and education, therefore, pre-existing health inequalities.

In the interviews, the issue of gender is transversal on many occasions as well as on the subject of COVID. Thus, we know that older women are more likely to be exposed to COVID-19, because they form the majority among older people in need of care, social care personnel, and informal caregivers. Older women are more likely to have only minimal or lower pensions than average and live at risk of poverty and social exclusion, a manifestation of inequalities for life. They are also more likely than men to live alone in their home.

Both for having asked directly and for having asked indirectly, the interviewees have evaluated the impact of quarantines, blockades and measures of physical distancing in people with chronic diseases or not related to COVID 19, as a extremely hard in their lives.

In general, they show an interest in that the current crisis should not be used as a pretext to exacerbate inequalities. They agree that denial of health treatment is a violation of human rights. Thus, they coincide in seeing that older people should be able to receive the necessary integrated health and social care, and it is more when the curve of the pandemic flattens, they indicate that older people should not be deprioritized in the access to health services. On the other hand, other people do not show this negative impact and see the confinement from a more neutral impact. In contrast, other people highlight a positive impact of lockdown, within this more positive view, the resilience mechanisms stand out.

**Covid and networks*

The absence of contact and the complete cut off the most loved or close ones is usually difficult. Reducing visits and reducing care for the elderly becomes very difficult for the elderly. Especially for older people living alone, as older people living alone are at greater risk of isolation and lack of access to necessary services during the pandemic. In this group, older women, who

constitute most of the interviews, are disproportionately affected. In addition, older people who live alone do not always have relatives close by, to share information on adapted sanitary measures, as well as to take care of them in case of symptoms and to ask for help if necessary. That is why it is important to clarify how physical distancing measures should explicitly allow people to leave their home to care for those who live alone and may need help with daily tasks. If we add to that situation of an older woman living alone the fact of aging without children, it becomes even more difficult. As a result, people who are aging childless may be at increased risk of isolation during the pandemic. Typically, until poor health or care needs emerge, people who age without children have stronger and broader social networks. The covid has also affected them in all the cancellation of the activity of the various clubs and charities that have activities with the elderly; thus, people who trust these alternative networks are at greater risk of isolation.

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