The Care Debate During the First Covid Lockout in Barcelona.

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Abstract

The debate of care uses the role of different actors from the interpretation of the debates and discussion groups carried out during the fieldwork. We identify here: the elderly person, the caregivers - here in this article in their wide variety, from family members to hired workers, especially immigrant women- and thirdly, as the third aspect of the triangle, and which remains in this chapter more blurred, from municipal and health public services. This care triangle is also very affected by the adverse effects of the pandemic. The pandemic highlights the existing systemic equalities, particularly affecting migrant women and ethnic minorities, people who work in the care sector and health personnel.

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Introduction.

The care debate in the context of new research on gender and migration

In the new book on a research agenda for Gender and Global Migration, Ribas-Mateos and Sassen 2022, have followed a century´s trajectory as to seek to understand the nature of capitalist globalisation and the relationship between global capital accumulation and the changes on gender and migration paths. Logically, they would be many ways to cut the different periods and their different denominations, particularly in the context of the gender and care debate. For example, Abraira (2022, in the book) [5]. reviews the concept of care as it has been a main axis of research in migration and gender studies and the migration-care nexus. It offers a critical illustration of a striking example the circulation of care within and across borders (in contrast with the dominant global care chains approach): transnational mothering, grandmothering and daugthering. Nieto et.al. (also in the book), show how the context of the prison system and the sexual economies in the Amazon unveils the context which are blended by the movements of people who compose and traverse the *cosmopolitics of care*. In the case of Singh and Sidhu), also in the book, reveal how remittances are seen as a moral good and a currency of care. Remittances have been feted in the migration literature as one of the largest and most resilient international flows, contributing to welfare and development at the household, community, and national levels. In the Indian patrilineal family, it is most often the 'good son' who sends money home fulfilling

his filial duty. However, remittances can become the medium of economic abuse when they are sent without consulting the daughter-in-law. They can deny the wife and children necessities in the country of destination, appropriate the wife's money, sequester money in another jurisdiction to build assets that exclude the wife. The danger of remittances being used as a medium of economic abuse increased during COVID-19 as financial need. Those are the examples that book (Ribas-Mateos and Sassen) [8], uses as illustrations of new research areas on gender, migration and care.

State of the art: Conception of caring for the elderly after the first lockdown (2020)

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 an increasingly greater magnitude and intensity regarding ways of thinking about care of dependents and elderly women, who, coinciding with 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. 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 occurs 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 care work performed in exchange for payment or remuneration in cash or in kind, and may be performed 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, a 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 in 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 from private households, individuals or establishments. Care providers may also be own-account (self-employed). 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 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 (Williams, 2012). Two ideal types have been identified: at one end, the Southern European "familist 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 pre-processes 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 services (e.g. Families and individuals in a private nursing home, or directly buying such services, (ii) purchase through government care in subcontracting mode or employing care workers (ii) purchase of government of 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 [4].

As regarding the family setting. Some market-based instruments entail "unburdening family" or "de-familialization" of care responsibilities, other measures involve "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 by understanding, 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, women from poorer and disadvantaged racial and ethnic communities have tended to provide 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 job, or low levels of education and experience among care workers affecting 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 of support and its conditionality (e.g., direct payments, care allowances, cash benefits, tax credits), characteristics of the care workforce, "care culture" (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, and who decides –regulatory framework that governs these care responsibilities, a care regime has an underlying "care culture" (and subcultures) 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 [6,7].

As a migration regime, the, main elements are immigration policies, settlement and naturalization rights, citizen rights, internal norms, and practices in relationships between majority and minority groups, labour market divisions, exclusion 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); forms of mobilization.

As employment regime, it shapes 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.

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), the staff members, and a caregiver that promotes safety, and 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 seeing 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/)

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. As we have seen in another part of the research (see Ribas-Mateos and Herrera 2024 forthcoming), 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

In our case, in this triangle of care, 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), caregivers - here in this article in their wide variety, 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. In other words, we focus on the nexus of all 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. The pandemic highlights the existing systemic equality, particularly affecting migrants and ethnic minorities, people who work in the care sector, and health personnel.

The Context of the ethnography

From August 2020 to September 2020, I organised various appointments with Pa Lante, Women (Mujeres Pa Lante) and with Madame G. (Sorelas project). Madame G. underlined the importance of always establishing ways to organize a second contact with female caregivers. They are contacts that over time have become more difficult. In their own programs they make contact by going directly to the parks, knowingly being outside the contacts of the NGOs, on the one hand, because in the NGOs they are fed up with having their doors open to research and other activists, and on the second, because there is not exactly a profile of a person as an irregular worker who is out of the loop.

The first part of the research had completed interviews with the elderly population in the city, and the second part of the research was related to the carers. In both part we adapted our interpretation for the following selection of codes that we can see in the table. That table can clarify the reader the main aspects extracted during the research.

Qualitative Fieldwork - Analytical Codes Of Interviews

1. THE SOCIAL CONSTRUCTION OF OLD AGE

1.1. Selected guidelines

A. Context and life cycle

B. Transnationalism

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

-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 labour 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) bureaucratization

7.3. Forms of intervention: a) agency versus dependency, b) socio-community services, c) leisure 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

12.3. On profile based on interviewed files

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

13.RESEARCH ETHICS

13.1Anonymity

13.2. Use of the Covid-19 protocol

13.4. The return to the field

The SAD women who are now working regularly are women who arrived in Catalonia in 2000. Then there is another group of contacts that have to do with Honduran women who have arrived more recently and many are working on the contacts. In this type of tracking of immigrant women caregivers, the association seeks to carry out work to deconstruct the whole issue of "euphemism of care."

The discussion groups of women caregivers had to be organized in a fragmented way to be able to follow the proxiCAT Covid regulations established for the groups that could be formed during October and November 2020. First, we conducted a first discussion group, which we will call here " Colombianas " (October 1, 2020), held inside a Colombian cafeteria in Sagrada Familia. It is made up of Madame M. (from MPL, Mujeres Palante), Madame A., and Madame T. two young Colombian women, together with the person who guides the focus group who works irregularly in care for the elderly. In the afternoon we did the other group at the MPL premises and with the support of the MPL space. In this group we had Madame M. (from Bolivia, caregiver for the elderly), two Dominican girls (they are SAD, professional municipal carers: Madame Ana and Madame MM, and by zoom connection (Alicia, from Uruguay, who spoke to us from a town in Barcelona), (group MLP). This group was very complex to set up since a group had been created (via what's app first) with the support of a SAD that coordinated the group since August 31, and it really only started working with the role of the group coordinator, Madam M, a SAD from the Dominican Republic. We always had cancellations and cancellations of appointments and in the face-to-face case of MPL, it was complicated for us to have pressures to share time and space with other groups. As a return to the field, this same day, we edited a 4-minute video to use in the paper for everyone's campaign for MPL. See the short video made by Rai Ribas for MPL. All this sums up very well the difficulties in the field when there is no direct help for organizing fieldwork contacts.

The group of "Colombianas" highlights the difficulties of young undocumented couples who have just arrived in the city, who combine the tandem of men and women employed, one on the one hand in

construction and they in domestic service. Regarding domestic service, in this type of group, it has been a constant, which is fragmented into many types of tasks and it is considered that caring for the elderly is another extension of domestic work. The problem of mobility for people without paper during the pandemic is also highlighted.

The MPL group also highlights the great variety of profiles in the care of the elderly: The woman who works in domestic work outside the associative network, the woman trained for public service, and the SAD woman who has undergone requalification; who had higher qualification credentials from a SAD (the Uruguayan woman). This last discourse is reflected in the audio that we were able to make a telephone audio of Oct. 2, 2020), where she points out the vision of the SAD union and how different models prevail in it. "We are 70% South American migrants and we are vulnerable women, also at risk of social exclusion, but we are socially resilient women." Many come from SOC courses, "mostly as we are 45-year-old women, it is difficult for us to find a job", "we are also abused by these large subcontractor companies", "the figure of the family worker is not fully dignified" “Users say directly: don’t send *Panchitas*; I don't want people of colour”, or “I'm interested in having people from the same country”. “With all this, it is very difficult to dignify the caregiver's work. “Now in the SAD you are already finding people with more training. But it is important to assert ourselves in front of the company and to assert ourselves in front of the user: “Neither the companies nor the social workers explain well the role within the house. We are not the girl who comes to clean, it is complicated, and we have to visualize and dignify the great task, the worthy task of the caregiver in general, which is done by women, there is only one man in my group and more men are needed. It all depends on making the workers aware of the administration, first from the social workers and then reviewing the entire chain”.

Thirdly, we organized a last fragmented group in the Corte Inglés restaurant with Filipina women (“Philippine group ”). It was formed by the guide of the group and by Madam My and Madam Ri, carers of older people (first as internal care worker and the second as an external care worker).

In the case of family workers, the approach was totally different. The problem of contacts and their activation during fieldwork is so complex that we are forced to make a description that can make people visible: the fear that the covid has placed in people, the distrust of social researchers, and the lack of a culture of thinking that empirical research does not have a visible impact on changes in society.

In the case of family caregivers, the first contact with “Barcelona Cuida't” began through a previous contact with a person from an ECVET network, but it did not work. We sent a formal mail at the beginning of September and received a response within a month. They passed the contact from one person to another, even with a positive reception at some point, but ended up cancelling on the pretext of Covid reasons, even if the discussion group was supposed to be held virtually.

The third way was to go in person with the CAP (Health services) of Gracia Civeles, always with the letter of accreditation of the investigation, to contact the “Grup de familiars de gent gran amb demències”, Family of Dementia patients. They told me that the group had already disbanded and to leave a written note to see what solution they could find. They never responded by telephone message to the request. The secretary told me that they would call the “Germanes Hospitalàries Hospital Mare de Déu de la Mercè. Centre de Sault Mental i Addiccions. Unitat de Memòria, conducta and Demències”, but I never got an answer.

The second route was from the Pascual Maragall Foundation, I got in contact with the therapy groups for

family caregivers. First, it went well but then they left the emails unanswered. Even with the pandemic, they seem to be very active and presented some very innovative programs. From one email to the other we were able to reach out to a social therapist, who in the end also ended up closing the door.

Thirdly, from a contact in the social services of the Barcelona city council, we were able to contact a person from Benestar Social (Welfare), but then we had to leave him because he put too many bureaucratic obstacles on us and we had to quit that source.

The fourth way was from the contacts we had previously during interviews in the Sagrada Familia neighborhood. But the person told us that it was not the right time because she had fallen ill.

The fifth way was from the AFAB carers. The family association in Barcelona, both by phone and by email. They returned the call, but a contact that lasted about 15 days did not come to fruition either.

A sixth route was from the Uszheimer Foundation, establishing a prior appointment in person, but which they cancelled on the same day that I was going to visit. They called me to tell me that, if on the one hand they found that the work we were doing was very interesting, on the other, the director later said that "now was not the time that, in a few months would be better", and they would also reject it after a few months, even if there was the possibility of making it virtual. They justified that now is not the time that now they have closed everything like day centres and then sent me a contact later to write to the Mémora Foundation. I have answered him that here there is a very closed culture towards research and that only pretext of the covid was used to finish closing doors. I have pointed out that it is an essential sector and that it is really needed now more than ever to be able to visualize it, a sector based on the support of the service to the elderly and their caregivers.

The seventh route was through RESPIR, Serveis Residencials d'Estada temporal, but we never had the answer via email.

The eighth route was through the Roure Foundation, to gain access we had to use a personal contact here. In principle, everything went very well and we had a very good reception of the project for a long time. But later, due to the illness of a technician, the first dates were continuously postponed in time until finally, under the pretext of the pandemic, it was also cancelled, even if it was wanted virtually. Finally, a telephone interview had to be conducted to complete the information that we had already begun to collect.

The ninth track was the only successful track. Paradoxically, it was done from an email that was sent to Brussels on the EUROCARE network. From here we were able to have an interview with Madam MM (EUROCARE observer) as well as this same person who gave us contacts for the discussion group of family caregivers and agreed with us to show us that this topic was difficult to research because there is no necessary culture to understand how it is so important to bring this issue to light.

From here, a possibility of contact with MT (Associació Cuidadors Familiars) arose. This association is a meeting point for family caregivers to improve full dedication to a dependent family member, physical and emotional exhaustion known as "the caregiver syndrome, with the support of professionals who facilitate the tasks derived from the care and exchange and manage the adopted material. It also seeks improvements in care (through mutual support) and recognition of the family caregiver at work and social level. They want to facilitate the creation of public day centres and residences given the inaccessibility of private services. In this appointment, MTa highlights four points that will be key in the way in which the discussion group is developed with other participants in the session:

a) Associative wear and tear, for about a year, the dedication granted to the association has decreased, as it is without any support to be able to carry out the associative task.

b) The fact of how familiar to have a specific character refers to "a caretaker wood" for some people, as is the case in his case. She points out that she has always been a caregiver and that she feels good about it, that it gives her something like a note of humanity in her day-to-day work, of being content in some way to be useful to a person who is going to pass. Her own experience has been like this, first she took care of his mother from the age of eight, then he took care of his father-in-law, who had Alzheimer's disease. She has a son, but for her, the sense of motherhood is very different from the sense of caring for the elderly.

c) Thinking care within feminism. MT acknowledges that 99% of people are caregivers, but that she has not experienced this badly in her case, because for her the fact of caring has always had a meaning,

d) The family structure directly affects caregiving. Here, two issues of conflictual inflection are glimpsed in families with several siblings: Heredity and the type of care that parents should receive (model: residence versus home, type of care management organized in care shifts). In families, there are usually tensions between who carries care and who does not, but despite this, she considers that the person who decides to choose the role of the caregiver should not be judged.

e) Political claims. She explains how the disenchantment of her intense and lonely associative involvement had a breaking point in the meeting she had with Ada Colau, the mayor. When she told him that there were so many older people who did not have an elevator at home and that they did not have children to bring them food, the mayor explained that there could be nothing to change this situation. They had previously tried to seek public support for the care of the elderly, but impossible: "In Barcelona, there is no public centre for the elderly."

Contracted Carers. A vision from an NGO of caregivers

In the discussion groups, the typology of caregivers is clearly shown and their differences and working conditions are discussed. This is done based on their position in the labour market, in the absence of social recognition of the role they perform, as well as the different expectations found during the work, the contrast of women who work for the city council –SAD- and the ones that work self-employed.

Latin women mention most of the forms contrasting with the SAD workers contrasting with the rest. As we see below, the contrast between Madam I. and Madam M. is also reflected here. Madam I. works caring for the elderly and arrived a few years ago, while Magnolia has basic education, arrived years ago, and married a Catalan:

"Yes, there are two profiles. There are cases where the family can do it themselves and use the help and they are supposed to give it to her or ask for a family worker and the council pays a subcontracted company, a company I work for (..). And then there are private deals, the ones that work fixed hours 24 hours a day that are in the house all time and do various types of manipulation or do not pay them what they have to pay. This is called modern slavery, it is a way of exploiting that they take advantage of the situation of vulnerability in which they find themselves mostly young girls, there are from different countries of the South"

The ones from the second profile have the problem of regularisation and need to be regularise, but it

costs a lot because it is inside the home. But fear more that regularizes the situation if the person is not difficult to denounce.

In the case of the small group (Colombians in Sagrada Familia, two sisters, the interviewee, and Madam M). They explain how before they did not need a visa, but they did need it now. They say that the quality of life there is very bad and people do not reach 70 and 80 years like here. And that the children don't take so much care of the older parents there either, they wouldn't leave the house for you. A sister first arrived two and a half years ago, when she was 26, and a year later the second sister arrived. They analyse how all foreign women are carers "but I don't think it's a bad job, I don't think it's a degrading job. (….) Of course, you are already very prepared to do what you can, whatever comes out. That I haven't had the opportunity to work hard because I have the child".

In general, from their voices we can detect what it means not to be regularized as a foreign woman working in the domestic service and care sector:

Now it has been complicated because with the covid issue thing they didn't want me to go to their house because it scared them a lot, then, of course, one is out of work and if you don't work you don't make money. (…) Sure, I have 4 or 5 people over the age of 90 who cleaned them and during the covid, they didn't want to. They were afraid. company. Of course, we don't have papers and we charge money in Black (...) It also affected us about mobility as we could not go to work and that with the people we work with it is a population at risk and relatives preferred that we not go. And in lockdown, when you have papers, you have a contract, and when you have a contract you can move and say you're going to work.

Contracted carers: the role of migrant women

There are many works related to "chains of Global Care ", "the deficit of care", "the transnational maternity', the "reproduction of social work internationally", all of them in the context of globalisation and mobility.

The concentration of women from Latin America and the Caribbean employed in these activities in Catalonia and Spain, has a fundamental representation. Many of these immigrant women who are caregivers of the elderly are difficult to account for, as they would fall into the sector of home staff and caregivers of the elderly and children at home who are usually accounted for singly within the job description of the EPA (Labour Force Survey). These activities are considered as personal assistance tasks, with little recognition both labour and social, and do not even occupy a specific differentiated form in domestic service.

Furthermore, this type of employment is characterised to be hidden, unrecognised, uncertain, unprotected, as dependent on a working relationship which can be ended unilaterally. In addition, the person may die or may simply for many subjective reasons get tired of the caregiver, as the bonds are personal and individualized, thus affecting social groups with less bargaining power and more vulnerability. This employment is on the increase, as the cultural and economic considerations that "good care" is at home, contribute on the one hand to the high presence of domestic caregivers (in a group of female immigrants, especially Latin American), and on the other hand to a group of family caregivers who are usually the daughters and wives of the elderly, or in their absence volunteers and NGOs.

The topic of this work is presented as a key thematic axis. Let's look, for example, at how the group of Filipino women put it:

Madam My. who is 62 years old and is working caring for an elderly person, but has just left work now and is the only free time she has from now until tomorrow afternoon… and Madam Ri. who has just found a new job as a caregiver… which is an elderly couple who cares every day, three hours every day. The most important thing is the food. I think I'm the same age as them, 72 (Philippines group, Madam Ri).

In this labour market, it is also important to consider all issues of competition and substitution, as also noted through the Philippine focus group. The impacts of immigration on the labour market critically depend on the skills of migrants, the skills of existing workers, and the characteristics of the economy in which they are inserted. They are also likely to differ between the short and long term when the economy and labour demand can adapt to the increase in labour supply. Immigration affects the supply of labour, as the group of workers in certain sectors of the economy increases. At the same time, immigration is likely to increase the demand for labour, as migrants expand the demand for certain goods and services by consumers. That is, immigration can increase competition for existing jobs in certain occupational sectors, but it can also create new jobs.

The immediate short-term effects of immigration on the wages or employment of existing workers depend on the extent to which migrants have skills that replace or complement those of existing workers. When migrant workers replace existing workers, immigration is expected to increase competition for jobs and reduce short-term wages. In terms of employment, the extent to which declining wages increase unemployment or inactivity among existing workers depends on their willingness to accept new, lower wages. If, on the other hand, migrants' skills are complementary to those of existing workers, all workers experience higher productivity, which can be expected to lead to an increase in the wages of existing workers. In general, workers in low-skilled occupations are expected to face greater competition from migrants because the skills needed for such jobs are easier to acquire and less specialized.

The issue of replacement and competition in the workforce is a recurring theme in the care market. Here, a wide variety of stereotypes related to the submission of Filipino women or the gentleness of Latin women, or the closed rebellion of Moroccan women, often prevail. In many cases, they result from the survival of old colonial stereotypes related to domestic work, as well as stereotypes of miserable views that connected with the internal migrations of Andalusian, Galician, Murcian, La Mancha, and Extremaduran women. Let's see how this theme is expressed in the Filipino women's discussion group: “Yes, everybody prefers Filipinos, they are hard workers”.

Dignification of work is also crucial in the narrative; the issue of the dignification of care and the dignification of the work of caregivers arises. On the one hand, we take care of care here, also adding the concept of dignity, that is to say, from the perspective in which the respect of the person is supported and defended, recognizing its capacity and ambitions, and does nothing to undermine it. It includes respect for what they can do, respect for who they are, as well as respect for the life they have lived. This conception of dignity is considered a fundamental part of quality in care work. On the other hand, decent work also enables the economic empowerment of women caregivers by promoting decent working conditions, addressing the barriers women face in achieving equity in the workplace, and supporting women with take up employment. control of their salaries, as well as from the revaluation of unpaid care work.

**Madam My: a case of multiple caregivers*

It is from the case of Madam My as we can see very clearly how in the same home the hiring of various foreign women for the service of home care and the elderly is combined:

M: It depends… there are very bad children, very bad adults… but when there is work you have to use it patiently and with love… that's better… because we need money and we have to put up and because of the pandemic there are a lot of people who he has no job… and is hungry… then you have to put up with its hay and you have to take advantage of it be children or older… the only important thing is money… so so patiently… my job is not easy… sometimes when I talk to someone for phone escapes the lady

From this discussion, within the discussion group of Filipino women, a whole series of findings of great interest is highlighted: the evidence of the continuity of the problems of domestic service established at the end of the 80s; the hierarchies of discrimination; the preference of the Filipinos over the group of other groups and "we don't want *panchitas*". These are phrases that denote how new forms of ethnic stratification of care are constructed. Therefore, changes are detected as well as permanence. Other themes were also: the pioneering women in the global model of care were the Filipino women, the first domestic workers coming from abroad (possibly together with the Portuguese as well), and the first migrations that indicate a strong feminization of migratory flows, the transformation of the demand in the market and generational change. That is, from child care and cleaning of the home to the care of the elderly and very shortly to the care of the elderly with a presence of 24 hours. See below such differences:

Q: Did you come directly from the Philippines when you were older or younger?

M: If… he came directly here… by family group… he was 18… and we went for a walk and then he got this job in the restaurant… and then to his sister when he came he got another job, but he was far away and didn't catch him… and now they're both working in the call centre… and they've never worked at home…

Other important issues are: maximisation of remittances and visualization of the dependence of the migrants on the extended family, the evidence of the blurring of the services of the Care of women in the house, the different experiences of lockdown according to perception and trajectories (eg.contrasting Madam My and Madam I (MPL group). For Myrna, confinement meant a greater possibility of working hours and maximizing economic benefits and savings, while for Madam I. it meant great suffering. To sum up, confinement creates strong differences in the mobility/immobility of people, depending on where you live and how the older person lives.

On Training

Non-formal and informal skills acquired in professional or private activities are often hidden in official training courses and are rarely recognized. However, these skills can be essential in working life. Therefore, it is not correct to think that people without formal qualifications are deprived of the possibility of career or career development, although they may have developed many skills and abilities through other paths and itineraries. This "competence" approach we propose here is based on the concept of "lifelong learning", promoted by the European Union and its specific programs. This is the case of the Erasmus Plus program, within which the VALUE + project has been developed (directed by Amado Alarcón, URV), which focuses precisely on this concept of training and skills from an ECVET perspective. The project presented here responds to the need to recognize and validate the knowledge and skills acquired in the informal / non-formal environment by family caregivers (France, Spain, Italy, and

Romania, we have used a generic category of *home carers*), to ensure the conversion of certified Learning Outcomes into ECVET credits (by the ECVET Recommendation) which can be implemented in all countries participating in the project to achieve transnational labour mobility of women workers and workers in the sector.

There is a growing demand, a growing need in Europe for skilled workers across the EU who can be employed in the home care sector. This requirement is linked to the progressive aging of the population. The phenomenon is common to the whole of the EU but takes on different characteristics in different European countries. For example, if the countries of central and northern Europe have a public and private social and health services organization capable of responding to the growth in the need for home care, this is not equally true for the countries of Central and Northern Europe. Mediterranean area, or the European region of southern Europe, where this need was only marginally covered by institutional services and the labour force employed is mainly immigrant and low-skilled.

The main problems facing training in the care of the elderly are: the growing demand for skilled workers to be employed in the home care sector; the massive presence of workers without qualifications and/or certification of skills that feed the undeclared labour market; the difficulty of the family care without qualifications.; the difficulty of recognising certification of skills/learning outcomes acquired in their country/region autonomy, as well as in other European countries.

For the Filipino caregivers, affection is for them the basis of care. This is how we often detail the concept of care. That is, in the way they show the little tricks that one applies to understand subjectively what the basic aspect of caregivers is. That is, f, we understand how to give affection as a service, as a sale of a service that may or may not be remunerated. In the case of the Latina group, they all agree on the importance of training, on the need to acquire training for greater professionalization in the sector: “Of course you have to have a lot of empathy for the situation in which the eldest is, you have to understand it very well right? In this regard, we must detail that we often find difficulties in relationships with families. That is, in the relationship between caregivers and management of the family, the divergent views they have about each other in regard to seeing the person being cared for, and weighing the care.

Mobilities

The general context in which to understand the model of care is the social change that has occurred in Southern Europe in recent years, especially concerning socio-economic transformations, as well as about the rethinking of the Welfare State from a gender perspective. From the early 1990s to the last few years, there has been a significant increase in the immigration of non-EU women to these countries, especially in the service sector of the local markets of the major cities of Southern Europe. This context of reception in Southern Europe is characterized by several key elements (with their variants by country and region) such as the heterogeneity of origin of migratory flows (especially for the Italian and Spanish cases), the strong feminized character flows, the dynamic role of the informal economy and a strong concentration of immigrant employment in the tertiary sector, as well as a segmented structure of labour demand. The arrival chronology of migratory flows (accompanied by large pockets of irregulars), the weaknesses of immigration policies (both control and integration), the informality of certain typically female jobs, etc., could also be considered common elements of this. Reception context: domestic service and sex work. These niches are linked to the strong expansion of the services sector, especially in the area of domestic and personal services, jobs that refer us to relations of subordination in which the interaction of social class relations, gender, and ethnicity are presented. More pronounced form. Likewise, the nature of

these niches is linked to the more typically "feminine" tasks: caring for homes, caring for people, and prostitution.

Mobility is examined based on key axes of analysis (global care chain and relocation of care services, technological changes, marriage strategies, circularity, and transnational practices, also within South-South mobility). This represents an engine that generates social inequalities that cross the spheres of gender and/or ethnicity, intergenerational. Despite the rationalization effort developed in the late twentieth century, most southern European governments continued to be characterized by a limited level of institutionalization in certain areas of public policy and based care, primarily on the family. In a triangle such as well-being, family, and market, it is becoming increasingly difficult for families to take on the tasks and responsibilities of caring. It is then in this context where we see the connection between the crisis of well-being, which means a crisis of care and the commodification of care through migratory chains. This informal solution seems to help resolve the care crisis in the short term but may call into question the development of a formal and professionalized dependency care system. Thus, the emergence of an informal care market, covered mainly by immigrant women in labour, poses sustainability challenges to the welfare regime, the sharing of responsibilities, the integration of immigration, and social justice.

In the case of Filipinas, most of the time we witness a type of migration project in which women are left alone (both married and single). Married women leave behind their children and descendants in the care of their sisters, mother, and husbands. It is the clearest paradox of the global care crisis: they had to take care of other children who were not their own and the elderly could not take care of their own elderly: Myrna could not take care of her daughters and now care for the elderly.

The health of the carer

It is well known that certain handicrafts are linked to physical ailments that tend to become chronic with age. This is also a very broad and very complex subject. The repercussions of overload on caregivers often involve problems in their mental and physical health - depression, anxiety, psychosomatic illnesses, etc. - as well as economic, work, family, social, and leisure relationships.

In addition, the caregiver's overload would have strong consequences for the person being cared for, when he or she sometimes behaves reactively toward the dependent person. The caregiver's burden, as a process of stress, can have important consequences on the caregiver's physical and mental health and well-being, as well as on the care given to the person, and has a direct impact on the relationship with the caregiver. the caregiver.

This topic is covered in both parts of the article, both in terms of immigrant caregivers and in terms of the part of family caregivers. Let's look at this first part for now, both for the group of Filipinos and for the group of Latinas:

M: The problems come to hotels… and legs… everything… before when I worked in hotels for four years… my legs hurt a lot and then I stopped, it's over… and now I don't want any more… not even children… it's not… it's much worse… everything hurts a lot… and now it hurts too because sometimes she doesn't want to get up too… and then I have to get her up…

Q: Has the crisis changed the issue of work for the elderly much?

Madam M.: Well they talk a lot about body problems; that is the stress, that is the wrist, the tendon is that immediately from a very young age begins to hurt you when you do so much work.

Here we are in the context of activist struggles for “Dignificació del Treball de Cures. Regularització already" in the MPL to participate. We refer in particular to the debate that has also been related to a campaign that began as "a hashtag has ended up being a political force representing the voices of migrants." The organizations involved estimated that about 600,000 migrants were severely affected by the impact of the health crisis, referring to the situation of immigrant women who had to live in a situation of dehumanized conditions, excluded from basic human rights, health rights, decent housing, and full protection in a time of health crisis.

Family Carers: The vision of an NGO

In this different typology of care models, the model of Southern Europe has relied on the charitable sector, where volunteering also has its weight. We have in mind first of all the context of Southern Europe, as we have already pointed out in the first part. Southern Europe shows us the world of care for the elderly, under a context of precariousness, defamiliarization, privatization, a dual and highly informal labour market, and ultimately, a strong organization of services.

We must also add here that there is some confusion in the various definitions of informal and formal support for the figure of the volunteer. Some authors state that informal care also includes “independent volunteers, as well as volunteer work organized through organizations such as religious groups. The issue of informality is also strongly mixed with the working conditions of immigrant workers in the domestic work and care sector. The development of undocumented immigration must be seen as an integral part of the increase in immigration from the countries of southern and southern Europe. As a structural phenomenon, its origin is relatively recent, if we consider, from a historical point of view, the whole evolution of international migration in the field of the world labour market: its birth dates to the eighties, and did not become in a massive mass. phenomenon until the 1990s. Only recently has this issue been addressed more critically, beginning, for example, with the replacement of the monolithic opposition between "informal economy" and "formal economy" with the more dialectical concept of "informalization process." and seeking to create model theories and analytical instruments capable of explaining the complexity of the connections between formal and informal, continuous and discontinuous forms that fully touch the world of care.

The words "caregiver" describe a person who means amounts of help over long periods to a family member, friend, or neighbour who is sick or disabled. This economic saving is considered important economically, saving a great expense for the services of health and social attention. "Caregivers" are those who take care of the basic needs of care and attention of other people who, due to an illness or old age, have a certain degree of dependence. In addition, in many cases, the caregiver shows a feeling of social asylum, because the time spent on social relationships and leisure time are greatly reduced.

There is a family member and the informal caregiver. The relative already says very well the word, the relative. But the family member can also be informal, because of course, he is not prepared for that. The informal caregiver is the person who comes from another country, you know, who are hired here. They come from Venezuela or I don't know where Venezuela is saying. And these are not familiar, but neither are they professional (interviews with caregivers).

It's much more complicated. Well, first they have to declare the degree of dependency, if they don't have it, it has to be processed, then the social services, because then it will depend on the income. Then they will look at what grade they give you because there is a ladder. Because of course, there is grade 1, grade 2, grade 3, grade 4, dependency. Of course, there are some dependency protocols, which go well but go

slower. And how families go about work and things, because they do, because they call and take company. And of course, companies like everything, there is only one market, there are companies that are very aware, there are companies that are not so much.

Family Carers: Visions of the Elderly

In the case of the Roure Foundation, there is a strong critique of Eurocentrism in the eyes of the elderly, especially focused on strategies for valuing, making visible, and empowering the elderly:

The elderly are invisible to the eyes of our society. There is loneliness too and many people have been evicted because of the small pension they have they cannot get to. (…) We are used to being the centre of the world. In the South is not as strong. We are learning from cultures that do not discriminate against older people wisdom, resilience, etc., teach us. Yes, we have seen examples of real discrimination during the pandemic. Think of closing day centres or finding the most vulnerable people. We have to take things home, medicines, etc. The flats are occupied by *narcos.* It is a continuum that shows us in the neighbourhood the whole situation of the elderly who are not worth it on their own. Yes, they are worth it at the level of reasoning. But in other places where they have more resources, they can do better. There is a kind of idea of separating others because "we have the habit of overprotecting; we think with the ethics of risk".

To us, they can never take away the fidelity of the great causes, but we always treat them as active subjects. The role of volunteers is essential and the strength of volunteering is endless. There is also volunteer training. What's important is always to listen to them, that's what older people need, it's not to entertain them, it's active listening that is needed. The main issue we have is the management of the beloved new loneliness.

This way, in the Roure foundation, the issue of caregivers is questioned again, as we mentioned in the previous part.

Family carers. Classic roles and new roles

We reiterate here again the importance of situating fundamental changes in the model of care, based on the opposition to those cared for by caregivers and on their urgent need for recognition, as expressed below:

** EUROCARES: socio-labour recognition of the figure of the caregiver*

(..) Not at the level of a professional caregiver, but to give it the name of a caregiver who is as recognized, and as loved and valued as a teacher.

That he is a recognized person, with a salary, with a social security benefit, and clearly you have a job. With a job that is very hard, because you will have certain aspects that you support. As you think, for example, in the case of a nurse.

It has already been seen, for example, in the case of the pandemic, that this type of professional needs a type of support rinsing, but it needs recognition, which is a recognized profession. And if it is to be recognized, there will be proper training, because now training. They tell you yes, in a care company, they answer you yes: "they have trained me. (...) Training needs to be regulated. Because there is the psychological part of the elderly, there is dignity, respect, the issue of culture, and the issue of health (it

is different to care for a diabetic or a person with a stroke, a person who is physically disabled, or a person with Alzheimer's).

In short, the need for social recognition is expressed here, referring to recognition through: economic remuneration, a professionalization of the regulated formation, and on the other hand, from the recognition of the dignity of the person caring for its values, his or her culture and the ways considered as "well treatment". In summary, it is also a question of seeing how the lack of recognition entails social spending and system inefficiency.

In the face of universal reality, a search for rights that go beyond the vision of a family conception policy is pursued. That conception that is criticized in the quotation that we will show next, where it expresses some forms of lobbying that are divergent between familism and individualization of the policies of the carers.

The issue of care lobbying also needs to take into account the perspective of the groups, such as whether or not they have a more feminist view. Thus, while classical feminism was based on the fact that most informal care work was done by women, and that there was then an unpaid informal contribution, all of this must have had a strong impact on their lives. It is also important to consider the perspectives that include criticisms of the controlling nature of caregivers' care and lobbies need to be considered. As we will see from the discussion groups, these critiques take into account how the concept of care serves to dominate and manage our lives, starting from the idea that the relationship of care is a relationship of power and discipline in which the cared-for person often does not have an active role, with a voice of his own. This type of criticism should be taken into account by caring adults and their caregivers. As for users of social services, there are also key differences in their use, as many immigrant communities prefer to use their kinship and community networks than those provided by formalized social services, as we have seen in interviews conducted. to the elderly (a total of 25) (Ribas-Mateos-and Herrera 2024).

** EUROCARERS: recognition of the caring family*

I have been an observer for many years. What interests the European Parliament most now is to try to get the figure recognized, to give it some rights, you know? Before there was very clearly the model of the two-speed Europeans. But now all countries of the East are very present. They are more religious and more traditional and this is noticeable. Now, the Europe is more liberalized, I speak in terms of answers, although the needs are the same everywhere. These are very universal needs of the elderly. There are many associations there as well as large, more traditional families. In recent years, these types of associations are putting more pressure and blocking a bit, but well, it's getting done.

As regarding the elderly, the problem is great as occupying a weak position from the care perspective:

In addition, there are other problems for the elderly. If you grow up as a person, you become a person of no interest. Moreover, this is already seen even at work, and if you are a woman even more so. A person who is already starting to be a certain age, you see, and women more. Well, if you're a 55-year-old man, he may even look good, look he's a senior. Now we don't talk so much about caregivers anymore but in general.

As we have indicated about demographic changes and those affected by the care crisis, we see how they question the public management system:

What is happening now, as a result of demographic change, is the population is getting older, people are living longer, the birth rate is going down. There is an imbalance that does not fit. And this is

costly. First, because if we want public or semi-public health, we eat because there is much more demand. And there are also more diseases, MORE things, as more people live, more things also happen. Therefore, there is much more spending on health. (...) Many people have not contributed enough, and there are more crises as this affects them and they have little pension left. If it is not the minimum. And how there is also poverty. All comfort systems that are needed are left behind. When I say comfort, I don't say luxury, they are the minimum of a quality of life, and all this is lost, and therefore, and for a person to be well, you also have to have good housing (EUROCARERS).

From the EUROCARES group we see how the active strategies for the elderly are detailed, a strategy of independence of the person in which a whole series of requirements is accommodated, on the one hand, related to the direct care (location and presence of the care network) and basic forms of infrastructure (at home and in the neighborhood).

Certainly, the social organization of care appears to be a crucial issue in the European context in recent decades. In this sense, we are not talking about a new phenomenon, the need for care, but we are referring to how the problem is gaining increasingly magnitude and intensity concerning the way of thinking of the care of dependent people and the elderly, which, coinciding with new demographic changes, means a sharp increase in demand while we also experience a cut and decrease in social benefits.

Traditionally, it was a care that meant to the family a mixture of compassion and kindness but that was difficult to commercialize in the care as the services of care for the elderly are conceived today. This concept is relationally understood today, so it is recognized in the analysis of the quality of service relationship of the caregiver and care 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 the technical skills and interpersonal qualities, which have a special impact on the relationship between the two people.

It is also important to identify the position of older people who are often vulnerable to decisions, whether they do not want to choose services or are unable to make such decisions. In addition, elections are often constrained by the older person's purchasing power and the type of family caregiver he or she can count on; from very limited public services, from a small family, and a highly informalized care market.

On the other hand, what does remain in different ways in this figure of the caregiver is perhaps its feminization, its continuity with a conception in which the ideology of domesticity implanted in society still survives.

a) Good treatment as a basis

Besides the concepts of general care and significance of "burn out care," we can also add the conception of “subjective good care”. This concept includes respect, tolerance, patience, and empathy as we would with anyone else because we always refer to human beings with human dignity. Behaviour that disrespects a person's dignity leads to other problems, such as low self-esteem, loss of self-esteem, and feelings of worthlessness.

b) Human rights as a vehicle

We are referring primarily to changes in care-related changes about human rights and the right to choose. The changes in families in this age of aging with long-term care, as well as the need to recognize the rights of family caregivers, questions a whole series of questions about human rights, human rights that are increasingly taking up more space. important in care policy. For example, if we referred earlier to

the issue of the right of caregivers (it can include many aspects that also have to do with privacy and the right to family life, to the services being offered with respect, quality and good practices), on the other hand, the world of caregiver recognition and their rights also stands out. These caregivers may also be affected by discrimination as caregivers, or they may manage discrimination against the caregiver through a system of complaints.

b) According to the way of understanding care

The first point, the approach to change, is about the emerging and classic views of caregivers. To address how this figure of the family student has changed is about the change in the mind set. What it was before and what it is supposed to be now. The role you have to play; which family member depends on him. Why does it depend on this member? Why does it depend on women? And what is a caregiver today? Is it just the caregiver? Is he the manager? Because we have to look for residences and everything, it's all bureaucracy. What are the dimensions of this care? It is also difficult to understand everything that comes with care and meaning. Well, this point would be all that were before and after the way of thinking about care, within the caregiver's experience. The contrast is also seen in how our own grandmothers had worried, what are the differences in these care figures? Before, we may not have had to care so much about people because people didn't live that long and families were older and therefore could share the care. It may now be that everything is more individualized in terms of burden for new family structures. It seems that one of the fundamental changes is that they are more caring than their own parents.

d) socio-economic context

Of course, there is an economic impact of unpaid care delivery on family caregivers of older adults who need help due to functional or health limitations, and it explores which caregivers are most at risk for severe financial consequences. Older caregivers can suffer significant economic consequences to both direct expenses over their own expenses, as well as long-term economic and retirement security. In addition, spouses who are caregivers are at special risk. Likewise, some caregivers are also employed, but the family leave is not remunerated, which makes it difficult for many employed caregivers, in particular low-wage workers, to take time off to provide care.

Continuing with the issue of caregiver payments, it is added that it is very little money, with very obscure information and that it is also criticized how the dependency, graduation, and tempos work (because the assessments take six months). According to the dependency law, they explain how the caregiver's pay needs to justify the last two years. People seek a self-employment relationship with the family caregiver, which can affect their own retirement, as well as their own family reconciliation problems (in a way that is done for the reconciliation of parents with children). They also refer to caregiver recognition, respect, and good treatment.

e) According to the presence or absence of a caregiver (Fundació Roure)

Caregivers, as well as caregivers themselves, are diverse. Clearly, caregivers belong to diverse populations, as we have also analysed in the previous article. Thus, this importance of diversity is also key to future research, which should explore the experiences of caregivers from different demographic groups. As an example, we can differentiate between young and older caregivers, who are not a homogeneous group, and diversity in, for example, ethnicity and sexuality should not be ignored. In general, older people in black minority groups are more likely to be caregivers and caregivers of black minority ethnic groups and may also have different experiences of receiving and accessing care

support. Some caregivers are lesbian, gay, bisexual, and transgender (LGBT). Therefore, these people are less likely to be identified in the changing world of families and to be able to find the right services available. In these family changes we must also consider the absence of the figure of the caregiver, that is, not having a caregiver at all as we see here:

That is the problem, knowing who he is, asking ourselves who he is. I can talk to you at the beginning about a case we have with a lady in the day centre, the case of an abused elderly woman who comes here and uses the service of data, nursing, think about these situations of these people because during the state of alarm they closed everything to us. But we were able to set up a team that went from house to house, checking: medication, overhauling, the kitchen, washing, etc., where hours of work. And here again, the question of where is the caregiver? It is confirmed in all cases: the absence of a caregiver and the abandonment of the elderly.

This absence of a caregiver responds to a real situation or also responds to seeing who the caregiver is in each case. For example, in the case of a woman's cognitive impairment, she has a child in prison, an 87-year-old person. She has a son. The only way out is to visit the day centre. The woman comes with physical assault. The daughter denounces her father. He thinks his father also comes to this centre. Who is the caregiver in this situation? The husband who beats her?

The Context of the Family Structure

Most care within families is performed either by the spouse or by the adult sons, especially daughters. However, in many European societies, contemporary changes in families must be seen as a central factor in changes in care. Either because families have drastically reduced the number of children, or because separation and divorce are much more common than in earlier times. These two factors lead to complexity in care, because there are fewer people available for care and because there are also more geographically dispersed families. On the other hand, as we have seen, both in the interviews and in the discussion groups, we also find isolation among the immigrant population, but also at the same time a greater availability of family and community care networks. Thus, for example, the typical situation of an elderly woman alone in Barcelona without a network of proximity linked to care is much more recurrent in non-immigrant populations, but who have other patrimonial resources and social capital to deal with old age.

Although it is well known that the macrosocial impact of society's aging has not been sufficiently considered, there has been a tendency to address in more detail the changes in family and care. In studies with older people in the city of Barcelona, we have seen how much of the care research has addressed issues in the context of the traditional family structure. This is how we see in the discussion groups how the organization of care is described. Most care for the elderly is provided by children, although with different modes of commitment and responsibility depending on the various family structures.

If on the one hand, it is made explicit how the model of the conventional nuclear family is increasingly rare, less answered, as new pluralistic models of family life appear in contemporary society, new forms of care are also sought. Thus, we see from these debates how conventional and pluralistic families face great challenges in meeting the need for the care of their older members, leaving some older adults at risk of not meeting their needs. However, if multiple changes are usually shown, on the other hand, we also detect important continuities regarding the role that women play in community and family care networks. In this model of Barcelona, as in the rest of Southern Europe, the family, in particular the

woman, is one that has traditionally assumed attention to the dependent people in the domicile, given the sociological character of the Mediterranean societies, and this is the fundamental aspect of survival.

A second aspect of the change that has occurred in these societies about care is that, the lack of children is an increasingly common condition in many European societies. The consequences that this demographic phenomenon could have on welfare systems, and in particular long-term care policies, are widespread. This is particularly the case in the family welfare states of southern Europe. Thus, shortly, they are likely to lose the forms of support they need most in the event of ill health. Children without children are then more likely to receive help from non-family and non-profit organizations and, to a lesser extent, from the welfare system.

Feminisation of care is part of the awareness of care for famílies, we see here the burden of women within this care structure in the group of family caregivers:

I had three more brothers. Two sisters and a brother. The brother came to see them once a month and that's it. To tell you something, caregiver or assistant or whatever. Instead, the man thanks you for coming, "the child has come." That I guess happens to everyone.

The way in which how the family rotation system works, the role of care management, the obligation of care concerning marital status, how care is shared among the family, and the different styles of children are detected. Each one has a well-tended, the socialization of the care of youngest are all considered.

Dignification of Care

Experience teaches us that economic growth alone is not enough. We must do more to empower people to appreciate decent and decent work and to support them through social protection. Promoting equality in employment, guaranteeing rights at work, and expanding social protection and dialogue on gender equality as cross-cutting issues are essential for sustainable development. Ensuring access to equality in employment and training for all men and women, in particular migrant women, is not only a human right, but also for sustainable progress, economic growth, and poverty reduction. In addition, the absence of any kind of violence and gender-based violence at work is a basis for ensuring human security and dignity. This dignity is basic in the world of care as we have pointed out above. This analysis of dignity also involves the review of other key concepts for the project: intersectionality in discrimination practices, the connection between employment, training, and accreditation, and the connection between temporary and non-temporary work. This context of dignification also implies a contextual setting in metropolitan and rural areas of southern Europe.

Next, we will show how care policies are guided here through a cross-cutting policy, promotion and in-depth work with NGOs and associations, and ultimately with an urgent need to recognize and encourage the creation of associations. of family caregivers.

Conclusion: visibility of care through the pandemic

In general, it is from EUROCARER S that we best identify here the impact that the pandemic has had on the issue of care at a more generic level:

a) visibility:

As a result, more sensitivity is beginning to be felt, more importance is being given to the issue of caregivers, and even more so since the pandemic. We have taken a *tremendous* step forward because

everything has been evidenced, with the pandemic, a giant step has been taken. People now when he talks to you, he tells you, for example, I my father used to not see him in isolation, but now I have seen him. And that lady, who has no one, oh, how strong! I guess it has helped raise awareness. And it also serves you that you have been isolated, there are many things. And look at how home care has increased, because it is becoming clear that home care is much better, and it is also much cheaper. In addition, you avoid displacement, you avoid movements by the person taken care of. The person when he receives you at home is much calmer than according to which place, right? Hospitals are more uncomfortable, there are no spaces, that's all. Housing is becoming increasingly important. I always say it's like pizza, dough, the base, the minimum of everything.

And with family caregivers everything is also going up. Because with the economic crisis, let's say, look to take care of you at home and I'll take care of you. It's also going up a lot and it's shocking it's the family's minor caregiver. In Scotland, in England, in Ireland, because all of a sudden you have an impoverished father, or who is diabetic or who has had some chronic illness or who has cancer. In many single-parent families, because of course, if he gets sick, who cares for him? Imagine you are isolating them socially and with a duty that is not understood. And you are also socially unacceptable, you are socially despised. If you can't go to friends and you have to take care of your dad it's a *pringat (worthless person)*, right?

b) Eurocarers: learning the pandemic: the human factor in care technology

On a technological level, I'll tell you that he's a subject of caring robots, people loved him five years ago. But those who do are big companies like google or Canon, very big and very powerful multinational companies that have the domain. Thus, some components of mechanism are O are used. Well as they have the market, then if they want to stop producing it and leave everyone thrown. In Europe, what is being done is to subsidize companies that leave these products open. Because then, of course, the cheapest is the production of China, but of course then it all depends on China. Well, what happens is that as they do not see the investor is difficult, they prefer to invest, for example, in an electric car. They have to wait for people to get used to it because it will be a medium long term.

Yes, they are doing many hubs for creators, both here and in Europe. But the problem then moves on to product industrialization, you have to pay a lot, and then there is no industry here. Investors only want the short term. What is being done here is for public institutions to do it, to start teaching it, as the city council does. So the investor is at least sure that he has insured part of the initial purchase of the city council.

The same thing happened with telecare, first it was public tele assistance, and then it was already in private. The same route. In other words, technology also has this problem, but now with the pandemic, the need for technology for these things has become clear. That public is shouting at her. Now they say in Europe that they will give a lot of money to projects that are focused on that.

c) Direct effect on caregivers

We have also been able to see how it has affected people near caregivers. Overall, shows how the impact of Covid has affected the deaths restriction and showed the problem in the residencies, solitude of people, and the death of social relations. Many have lost the people they were caring for. Others have died. With the first covid episode, Joan and Miquel died, you! Good people and look at your women.

M.T: Yes, poor thing

M-T husband: First that. And then look with covid what happened? Let's Make Coffee

- closure of day centres

We refer directly to the covid impact: the closure of day centres and pressure on family caregivers (family group).

Anna: Some people are afraid of residence, of contagions and such. Many people want to get their grandparents out, but they can't.

Natalia: What do you think about this topic? Face to the caregiver, how can this be resolved? How is this handled?

MT: Well in some cases it must be very difficult. The fact of having a family day centre lets you work; you can live life. Well, live life, do your duty. The fact that the family member does not go to the centre, because it forces you to stay at home. I'm sure a lot of people will have had to leave work to take care of their grandfather.

M.T husband: And all residences have a day centre. And they are all closed.

Marta: And how it affects the affected person. A whole day in a centre where they do cognitive stimulation, you spend a few hours, you get distracted and socialize, and then, all the day locked up at home. This person must be losing faculty every day. By force, they are emotional, physical descents of all kinds. It affects both sides, the dependent person and the caregiver. The caregiver and caregiver, both. (...) I think it's to drive you crazy, to be up all the day, 24 hours a day with a person who has Parkinson's, Alzheimer's, a degenerative disease. It's to drive you crazy. No wonder it comes out of everything later. And housing. Moreover, of course, the type of housing. If the person had a space with a terrace to go out and walk a bit, and the others had nothing. Of course, this is essential.

d) Intensification of essential services: assistance and absence of a caregiver

** COVID (Roure)*

They explain to the Roure association how they have been in place as essential during the pandemic.

"During the pandemic we have always been on the move. We brought food and were alert for the follow-up".

But as we have pointed out above, they point again to the issue of the difficulties involved in the absence of the caregiver:

We need to think about covid and post-covid. Now more difficult situations arise more heterogeneous situations because on the one hand we face a lack of social resources and on the other, we face a casuistic complication of all kinds about the elderly. The resources are not there, they are not enough, if we don't have them, we have to put them ourselves.

It needs strong support in the face of brutal fragility. We are at the forefront, there is a reality that is expressed very crudely. We must be able to respond immediately. We face ongoing cases of indignity and abuse. So, in such cases I could tell you!

I give you as a first case, Josep, a 79-year-old man, single who lives alone in the neighborhood. who helped us after having a stroke. He lives in his grandfather's house, an old rented house. A very old house. Of those portals that you have to throw the key to be able to open low. A gloomy smoking space, an interior space of full authority, without a sofa. For two years we helped him with cleaning the house and he used our laundry and we ironed it. Now, what exactly happened during the lockdonw? Well, Josep didn't go down anymore, he didn't go down to make coffee anymore.

Because we coordinated with social services, we decided to bring him food during confinement. Nathalie (who had already been there before), accompanied her with the doctor and they saw an arm on the floor. He does not wear a medal. They alerted the fire brigade here at the hospital, here at the health partner. But at the beginning of October, we pass by the house and see that there are two flags. That is, the house has been occupied. So we contacted the social worker and then the young men's devices and sent Josep to the house by taxi. There was a lot of commotion, they didn't want to go out, even the neighbours were coughing to try to convince the squatting couple. They destroyed the whole house, in the end they left. Josep no longer had any of his belongings. On Josep's return, everything had to be processed again, the DNI, the cash card, managing an emergency SAD. Well, this whole example is so explained to tell you that this is taking care of a person in all possible dimensions, and it's just one person. You see, it's a lot of work.

Therefore, the problem is not who the caregiver is. The problem is how to deal with its absence, How do we manage when there is no caregiver?

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