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RESEARCH ARTICLE

Race, gender and class under COVID-19: narratives of care, caring and carers

Jayanthi Thiyaga Lingham, j.t.lingham@sheffield.ac.uk
University of Sheffield, UK

Shirin M. Rai, sr86@soas.ac.uk
SOAS University of London, UK

Shahnaz Akhter, Shahnaz.Akhter.1@warwick.ac.uk
University of Warwick, UK

It has been well documented that the COVID-19 pandemic and policy responses in the UK had discriminatory effects on racially minoritised communities, older people and carers. While separate studies have investigated outcomes for these groups, few have brought them together. This article shares findings from a qualitative study undertaken during the pandemic that investigated impacts on the everyday lives of three racially minoritised groups in the UK: older people and unpaid and paid carers for adults. Situating the data in a wider context and viewed through a feminist lens of everyday political economy, we argue that the pandemic both reflected ongoing crises in and of care and intensified life-making practices of social reproduction. As revealed through narratives of everyday care experiences at the 'peak' moment of the pandemic, the crisis was characterised by depletion through care and caring, reinforcing and deepening existing racialised, gendered and class-based hierarchies of inequality.

Keywords care • caring • social reproduction • racism • COVID-19 pandemic • depletion

Key messages

- The COVID-19 pandemic exposed and was a part of an ongoing crisis in and of care in England.
- Racialised, gendered and class-based inequalities in care deepened through the pandemic.
- A feminist lens focusing on the everyday reveals depletion through care and social reproduction.
- Individuals and communities resisted depletion and called for a focus on life making, not profit making.

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Introduction

The COVID-19 pandemic caused a global death toll of at least 20 million before it was declared by the World Health Organisation to no longer be a global health emergency (BMJ, 2023). Although it may now seem well behind us, the pandemic's impacts remain – a reminder that crises do not have discrete end points and that earlier crises shaped the trajectory of COVID-19. Earlier crises and state responses to them meant that the pandemic left population groups differentially positioned in its wake. In this article, using findings from a qualitative study on care and caring undertaken in England, UK, during the main phase of the pandemic (2020–22), we put this peak emergency point in a wider context than the pandemic itself. We situate our analysis and understanding of care and caring during the pandemic within a feminist political-economy understanding of care, social reproduction, the everyday and crisis. The pandemic not only laid bare pre-existing class-based, gendered and racialised inequalities in the UK care ecosystem; it also revealed how care was managed in the context of neoliberal capitalist socio-economic policy frameworks, further deepening these inequalities (Rao, 2021).

The study that forms the basis of this article, 'Care, Caring and Carers', was part of a larger consortium formed to investigate the combined impacts of the COVID-19 pandemic and racial discrimination in the UK.[1] The consortium consisted of five workstreams, each focusing on different aspects: the emergency powers; children, young people and families (Barnard et al, 2024); care, caring and carers; physical activity and nutrition (Gafari et al, 2024); and creative outputs (Rye, 2023). The 'Care, Caring and Carers' workstream investigated the impacts of the pandemic and lockdowns on the everyday lives of three racially minoritised groups in the UK: older people and unpaid and paid carers for adults. This article contributes to the literature on care and caring during the pandemic by bringing the following together in analysis: (1) the experiences of older people, who were disproportionately affected by the COVID-19 pandemic and are a fast-growing demographic in the UK's chronically underfunded care system; and (2) the labour experiences of both paid and unpaid workers in that system. Through this, we are able to chart the intersectional impacts of the pandemic on the wider regime of care/social reproduction in the UK and raise some issues of the social relations of care and caring. We also consider how racially minoritised research participants and communities were differentially positioned in the aftermath of COVID-19 as the pandemic health emergency gave way to other crises, most notably the cost-of-living crisis (Harari et al, 2024). We ask: how did they (individually or collectively) push back against crisis conditions, and what are the implications of these dynamics for care and caring?

We adopt two conceptual frames to analyse our findings. The first, 'depletion through social reproduction' (Rai et al, 2014; Rai, 2024), allows us to reflect on the human costs of caring because of the undervaluing and mal-recognition of care and care labour. The second, feminist everyday political economy (Elias and Rai, 2019), helps frame the rhythms of care and caring and consider their socio-economic and depleting effects, especially when these rhythms were disrupted as they were during the pandemic.

In the article, we explore how COVID-19 reshaped the everyday rhythms of racially minoritised and gendered individuals, households and communities and, depending also on their class relations, how they negotiated their way through this landscape. We understand class as a process and relation of appropriation and exploitation within capitalism, which is both gendered and racialised, rather than as a category of identity or subjectivity (Mojab and Carpenter, 2019: 281). We centre the relations of care of research participants with a range of migration histories and globalised care relations, taking into account the multiple kin, households and family forms that proliferate across the world and shape diverse care arrangements (Moore and Price, 2023). While focusing on the depletion that resulted through care and caring, we also pay attention to the agency involved in caring and surviving, both during and beyond the pandemic.

Contextualising care during the COVID-19 crisis

This section provides a necessarily brief review of the literature on the racialised outcomes of the COVID-19 pandemic, on care and on 'crisis'. We explore how these have been framed and identify some gaps that we seek to address.

COVID-19: not all in the same boat

It was identified early on that racially minoritised groups – also called Black, Asian and minority ethnic (BAME) by policymakers – were disproportionately affected by COVID-19 (PHE, 2020; McCarron and Webb, 2020). Selected analyses are attentive to the structural inequalities that shaped these disparate health outcomes in Europe and North America. The US saw excessive harm and deaths among older Black and Latinx adults, through the unequal risk of disease exposure, unequal access to (quality) healthcare and the damaging consequences of racism across lifetimes of 'weathering' (Garcia et al, 2021; Geronimus, 2023). In the UK, unequal and devastating health outcomes for racially minoritised populations were also documented, though analyses largely focused on health rather than social care settings.[2] In the early months of the pandemic, reports showed that COVID-19 mortality rates for people from Black African backgrounds were 3.5 times higher than those of White populations, while mortality rates among those from Pakistani and Black Caribbean backgrounds were 2.7 and 1.7 times higher, respectively (Otu et al, 2020; White and Nafilyan, 2020; Wheatle, 2021). Another analysis found that of the 106 UK health and social care staff who died, at least 60 per cent were from a BAME background (Cook et al, 2020). A parliamentary investigation detailed the complex intersection of disadvantage, marginalisation and risk/exposure that drove higher levels of illness and death among racially minoritised populations (House of Commons, 2020). Like other reports, it highlighted the role played by pre-existing racialised inequalities (Runnymede Trust, 2020; Bailey and West, 2020).[3]

Jacobs (2021: 57) frames the outcomes of COVID-19 as occurring within intersecting structures of oppression, within which 'the lives of people of color are devalued in order to extract labor and the lives of disabled, immunocompromised and elderly people are treated as disposable, viewed as unproductive and incapable of producing profitable labor for capitalists'. Other research has emphasised how pandemic-related social and economic harms did not establish a 'new normal' but flowed along existing trajectories of gendered and racialised inequality, exacerbating damages and inequalities already wrought by pre-pandemic conditions (Choonara, 2021; Faraday, 2021: 240; Neely and Lopez, 2022).

As the pandemic struck and lockdowns were put in place, feminist political economists (re-)articulated an urgent need for a socio-economic and political reset that recognised the key role of care and social reproduction in enabling the wider economy and society to function and, indeed, survive (Kabeer et al, 2021; Stevano et al, 2021; Wenham et al, 2020). That said, the research on care and the COVID-19 pandemic in the UK generally focuses on either the pandemic's impacts on specific demographics (for example, older people, younger people and so on) or its impacts on broader trajectories of care and social reproduction within the economy. There is limited research examining the impacts of the pandemic and lockdowns on both older people and carers (Bear et al, 2020; Tujit et al, 2021; Akhter et al, 2022), very little on those from racially minoritised communities (Webb, 2020), and none that analyses all together these groups and the associated implications for trajectories of care. This is a gap our article seeks to address. We turn, first, to the research on care, which informs and adds specificity to our social reproduction approach.

Recognising and valuing care

Feminist political-economy research on care and caring is multifaceted and extensive. At its core is the concept of the care economy, which brings together different aspects of caring, such as 'unremunerated care and domestic work performed in the household or community, remunerated domestic work, childcare, elder care and disability care services (provided by the market, state or civil society) and, more broadly, education and health care' (Mahon, forthcoming: 1). The literature also spans various debates between those using the term 'care' and those framing this work as social reproduction. Although we use the term 'social reproduction' in this article, we are not unsympathetic to the framing of this work as care. Care, as Dowling (2021) has noted, has its etymological roots in the Greek word '*caru*', or worry, anxiety, sorrow and grief. The weight of caring, then, can be seen reflected here, even as care and caring are also about the labours of love (Rai, 2024). As a 'species activity' (Fisher and Tronto, 1990), care is needed and given by everyone, and yet as feminist political economists have long pointed out, most care work is done by women, reflecting the 'male breadwinner' model of paid employment (Williams, 2011). This unequal distribution of care work leads to many other inequalities: health inequalities (Harman, 2024), and specifically racialised health inequalities (Geronimus et al, 2006); immigration care chains and North–South inequalities (Kofman and Raghuram, 2012; Lutz, 2018; Mahon, 2020); ageing (Buch, 2015), and the crisis of care (Fraser, 2016); and the ethics of care (Hochschild, 1979; Bookman and Aboulafia, 2000; Gilligan, 2014; Raghuram, 2016).

The care literature, furthermore, alerts us to how care relationships affect democratic rights, norms and dispute resolution, challenging settled understandings of democracy and representation (Tronto, 2013; Gilligan, 2014). Therefore, the research on care is expansive and focuses not only on the intimate, the domestic and the everyday but also on the public political questions so central to democracy at the national and global scales. Fundamentally, the point made by much of this literature is that the unequal distribution of care labour is hidden and that care is valorised but not valued in society (Dowling, 2021). This is the jumping-off point for our adoption of the framework of depletion through social reproduction (Rai et al, 2014; Rai, 2024), through which we chart the unequal costs of the under/mal-valuing of care. These unequal costs intensify through crisis, as discussed next.

Framing 'crisis'

The gendered and racialised impacts of the undervaluing of care and unequal distribution of its labour shaped the context within which our study's research participants experienced the COVID-19 pandemic. This context was exceptionally fraught after a decade of economic austerity in the wake of the 2008 financial crisis (Harries et al, 2019; Warren, 2022). There is evidence that voluntary services providing care for racially minoritised groups were more vulnerable to funding cuts (Lipman, 2014), while institutional racism further undermined social care policy and delivery (Liu et al, 2017; Zaranko, 2018). Furthermore, like all populations in the UK, racially minoritised groups are ageing (Lievesley, 2013). Thus, care for racially minoritised groups was already under stress before COVID-19 struck.

While their care needs are under-resourced, racially minoritised populations are heavily over-represented in a crisis-wracked social care workforce and its most precarious segments. Around 14 per cent of England's[4] working-age population are from racially minoritised groups (UK Government, 2020), yet in 2022, the adult social care workforce was made up of 23 per cent racially minoritised workers (Skills For Care, 2022). Moreover, minority ethnic workers in the independent care sector are more likely than their White British peers to be on zero-hours contracts (EHRC, 2022). In other words, the system relies on undervalued and hyper-exploited racialised labour to function, enabling it to continue on the backs of workers in an enduring socio-economic crisis.

Of course, as detailed earlier, care under capitalism requires more than wage labour: the 'hidden abode' of unpaid care work is integral to the system's functioning (Fraser, 2014). Under austerity, gendered unpaid care loads increase: care provision is necessarily undertaken by families and communities as welfare state support is withdrawn. In the UK after 2008–09, racially minoritised women were disproportionately disadvantaged, as they are more connected to state services due to unpaid care responsibilities (Emejulu and Bassel, 2015; Women's Budget Group and Runnymede Trust, 2017). The hostile immigration regime deepened these racialised impacts, driving migrant families further to the margins (Erel et al, 2017; Bassel and Emejulu, 2018). At a moment when pushback and resistance to class-based and racialised policies were urgently needed, communities and activists were undermined in their capacities to organise such collective care (Emejulu and Bassel, 2015; Fraser, 2016). Thus, care and caring are both racialised and gendered, generating a double discrimination.

What we are arguing here is that the intersection of persistent forms of structural discrimination with emergency spikes demands that we pay attention to how 'crisis' is framed: how it gets defined and who is (and is not) made visible through studying it (Emejulu and Bassel, 2015). We understand 'crisis' as a political process in itself: a mode of governmentality that both reflects the prevailing socio-economic power structures and reproduces them, discursively, institutionally and structurally (Strolovitch, 2023). The period 2008–09 was a crunch point for global capital, a systemic crisis in capitalism (Saad-Filho, 2011). Yet, in the sphere of care, there is a persistent inclination towards a rarely acknowledged everyday crisis: the ongoing drive to accumulate surplus under capitalism undermines the abilities of individuals, households and communities to socially reproduce and care (Katz, 2001; Hoskyns and Rai, 2007; Rao, 2021). For marginalised groups, 'crisis' is everyday and endemic, being normalised until, as during the pandemic, dominant social groups are affected

(Strolovitch, 2013; Emejulu and Bassel, 2015). This discursive framing of crisis can be understood as a form of violence (Rowley, 2020). The 'resolution' of a crisis is also deeply political and can reinforce this violence and deepen existing socio-economic hierarchies (Piscopo and Walsh, 2020: 275).

Thus, the COVID-19 crisis took on unique dimensions in 2020 because of the nature of the health emergency and national and global policy responses. However, it was also affected by an ongoing, multidimensional crisis that started well before the pandemic itself and has continued within regimes of care since (Allen et al, 2020). A crisis such as the pandemic, then, is a 'moment of revelation' (Townsend-Bell, 2020: 87) of these deep inequalities pervading the whole of society (Rowley, 2020; Walby and Shire, 2024). Our study investigated how these inequalities were experienced and navigated in the everyday.

Understanding care through depletion and the everyday

Against this backdrop of enduring and deepening racialised and gendered crisis, we adopt the framework of depletion through social reproduction to understand how the everyday rhythms of care and caring were reconfigured, experienced and negotiated during the pandemic. The depletion framework uses social reproduction rather than care as its framing device. As Rai (2024: 8–9) says: 'Social reproduction approaches are embedded in historical debates on labour within Marxism; its reproduction and value, and how reproduction and production, exploitation, oppression and accumulation are intertwined.' This allows for a more expansive understanding of crises in and of care, not only historically constituted but also sitting within wider social relations (Mezzadri, 2019). Within these social relations, racialised and gendered structures of exploitation and oppression loom large (Crenshaw, 1989; Collins, 2000). At the same time, survival in the face of racism and crisis can be understood as a mode of care (Hartman, 2016: 171), with transformative, even liberatory, potential (Neely and Lopez, 2022).

Depletion allows us to understand the costs of maintaining these everyday rhythms, especially in the context of the non-recognition of care labour/the value of care work and in the context of pre-existing crisis. Depletion occurs when human resource outflows (time spent caring, social-reproductive labour and so on) exceed inflows (such as medical care and support networks) beyond a sustainable threshold, making it harmful for those engaged in it (Neely and Lopez, 2022: 4). These harms include physical and mental fatigue, discursive violence, and harms to citizenship (Rai et al, 2014). Harm and damage within the social reproduction sphere accrue over time rather than only in immediate response to one-off, visible and damaging events. The process is entangled with inequalities of race, gender and class, deepening those inequalities and leaving individuals, households and communities from marginalised groups disproportionately depleted.

In understanding the pandemic not as an isolated event but as an unfolding crisis of care, we further frame our analysis through the lens of the everyday (Dowling, 2021; Akhter et al, 2022). COVID-19 and the lockdowns that followed, we argue, reconfigured the everyday lives of people: their public and private spaces and temporal rhythms, as well as their experience of multiple forms of violence (Broom et al, 2023). We share the empirical findings in the following by deploying the space, time and violence (STV) framework developed by Elias and Rai (2019) as an intervention into the study of the gendered nature of the everyday political economy. They argue that social reproduction *is* the everyday and the costs of social reproduction *in* the everyday are experienced as depletion and its harms. Space is the gendered terrain of care, both in private and in public locations, where the home can be a site of both production and social reproduction; time is both commodified – clock time – and unrecognised (unpaid labour) as work; and violence manifests in regimes of labour as well as through law and policy, entrenching unequal and marginalising systems and (re)making and (dis)embedding relations of class, gender and race (Elias and Rai, 2019: 21). Entwined with each other, the rhythms of space, time and violence in the everyday are also resisted, and depletion can be reversed through the exercise of critical agency, both individual and collective. Such a framing of care and caring in the pandemic allows us to reflect on the disrupted temporal rhythms of everyday lives in specific locations and the violence that is and can be attendant upon such disruption. Such a holistic approach to the experience of COVID-19 also allows us to analyse how depletion was experienced and challenged as people negotiated reconfigured space, time and violence.

Doing research in COVID-19 times

Doing research in pandemic times was not easy, either for research participants or for researchers. The research was located in two cities in the Midlands (England) of comparable size and with sizeable Black, Asian and other minority ethnic populations. This demographic profile has consequences for a range of policies that affect care and caring, including policies relating to language and religion. We also worked in London and the West of England to expand our participant pool because of a degree of research fatigue in both cities at the time of the fieldwork due to academic and media interest in these locations. As detailed in Table 1, all participants self-identified as being from a racially or ethnically minoritised population; most were women and differently positioned in a care system mediated by class relations. All research participants were living in England, but they or their older generations originally migrated to the UK; for this reason, we refer to both England and the UK as relevant contexts in this article. We interviewed three subgroups: older people (over 60 years) who receive care and unpaid and paid carers for older people. There was, of course, overlap between these categories; for example, paid care workers were also unpaid carers for family members, and older people often both received and provided care for the family.

As researchers, our positionalities enabled us to engage with participants and communities. We are all women from racially minoritised groups, though with different familial histories: two are second-generation immigrants born and brought up in England, and one is a first-generation migrant. With our own histories rooted in Global South geographies formerly colonised by Britain, we were familiar with the diverse forms of kin and caring relations that exist across the world. Two of us have also experienced the challenges of navigating austerity-damaged and pandemic-affected local council services as unpaid carers. We understood worries about extended families across borders, the intergenerational occupation of space and the importance of religious and other community institutions in everyday life. Participants felt comfortable speaking with us on such matters as 'insiders', even though we were 'outsiders' in terms of our researcher status, and we recognise that

Table 1: Research participants

Participant category	Number of interviews	Ethnic identities (self-identified)	Gender
Older person	16	Black African – Somali British Asian British Pakistani Asian	16 female
Unpaid carer	19	British Indian British Pakistani British Asian Asian British Black African – Somali Indian	17 female; 2 male
Paid carer	22	Asian Indian British Asian British Indian British Pakistani Indian Pakistani Black African – Somali/Black British Black British Black African Black Caribbean Black African – Cameroon Black African – Kenyan	20 female; 2 male

researchers with 'insider/outsider' positionalities can make unjustified assumptions about shared experiences between themselves and research participants.

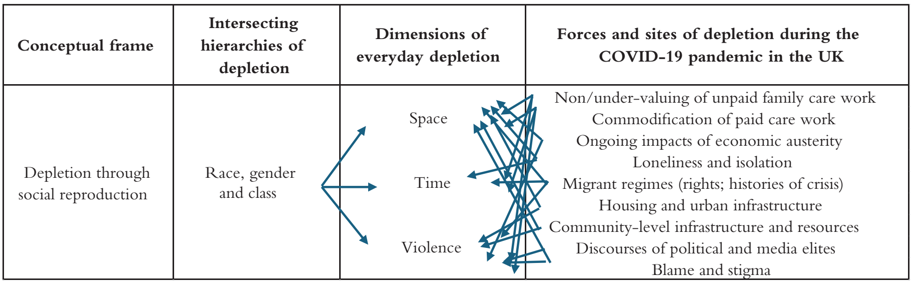
We worked with local community organisations to recruit research participants. This approach enabled us to develop trust with research communities, which was especially important given the investigation of sensitive issues, the short time frame for the main study and participants' linguistic needs and preferences. It also helped us overcome the aforementioned issue of research fatigue. Informed consent was obtained by introducing the research at group gatherings before fieldwork started, providing potential participants with a one-page information sheet in advance (translated into their preferred languages) and actively ensuring time for questions and discussion with each individual before the interview began. The full research information was provided to community organisations in advance, which were also points of contact for research participants. As the research took place during the 'main phase' of the pandemic, social-distancing requirements and the health needs of participants and researchers posed additional challenges and had to be considered.

In-depth interviews were carried out in five languages: English, Punjabi, Pothwari, Gujarati and Somali. In addition to English, two of the researchers speak Punjabi and one also speaks Pothwari, and we worked with interpreters for interviews undertaken in Gujarati and Somali. Our choice to carry out research in the first languages of participants – rather than English, which might be their second or third language – further built trust. Eight pilot interviews were carried out via online platforms (MS Teams or Zoom) between May and June 2020. From these, a set of research themes were identified, and these shaped the development of the topic guide for the main research. These interviews were carried out face to face, via telephone and online between August 2021 and June 2022, determined by, first, government social-distancing restrictions and, second, according to participant preference. Interviews were audio-recorded with participants' informed consent and turned into anonymised written transcripts for data analysis. During the main phase of research, interviews lasted between 1.5 and 3 hours each and were composed of (1) a short (20- to 30-minute) structured questionnaire to collect basic demographic data and (2) a longer narrative interview, in which participants were asked open questions about their experiences of care, caring, the pandemic and lockdowns, as well as their views on local and national policy responses in the present and future. The two sets of data (demographic and narrative) were collected in one setting, and each formed one transcript per research participant, which facilitated data synthesis. Participants were thanked for their time and contribution to the study with high street vouchers to the value of £20 per interview hour.

The research team combined both inductive and deductive approaches to the identification of themes and analysis. Transcripts were quality checked against the original audio files by the two researchers who carried out the fieldwork. The three researchers then separately annotated transcripts to identify materials related to themes already identified from the pilot interviews. Important among these were the shifts in the everyday rhythms of individuals, households and communities, experiences of depletion, experiences of racism, and desires for the future. New themes, such as the different migration statuses of research participants, were also identified at this stage. The research team compared and discussed findings, carrying out ongoing, iterative analysis at fortnightly meetings and updating, sharing and reflecting on emerging findings. Emerging findings were also discussed with our advisory board at the University of Warwick and with community engagement partners. In May 2022, we also held two 'knowledge exchange' workshops with research communities to share and sense check findings. These were attended by community organisation representatives, research participants and service users within the communities. Discussions confirmed the findings and also deepened our understanding of how individual experiences manifested at the community level.

In the next part of the article, drawing on the theoretical and methodological discussions outlined earlier, we examine how, in the sphere of care and caring, space, time and modalities of violence were configured and reconfigured during the pandemic and with what depleting effects, as well as how these were negotiated. Figure 1, to accompany the empirical data, attempts to illustrate the complex and intersecting ways interlinked forces and sites drove depletion.

Figure 1: Hierarchies, dimensions, forces and sites of depletion



Conceptual frame	Intersecting hierarchies of depletion	Dimensions of everyday depletion	Forces and sites of depletion during the COVID-19 pandemic in the UK
Depletion through social reproduction	Race, gender and class	Space Time Violence	Non/under-valuing of unpaid family care work Commodification of paid care work Ongoing impacts of economic austerity Loneliness and isolation Migrant regimes (rights; histories of crisis) Housing and urban infrastructure Community-level infrastructure and resources Discourses of political and media elites Blame and stigma

Study findings

Reconfigured spaces: locking in and emptying out

The pandemic contributed to the reshaping of both public and domestic spaces. As per Elias and Rai (2019; see also Smith, 1987), in our research, spaces reflect intersectional social relations where class, cultural and social norms, and gendered separations of private and public are important. Travelling across spaces – for care and caring, both paid and unpaid – is as much affected by location, infrastructure and resources as by emotion and affect.

COVID-19 produced fundamental shifts in the rhythms of everyday life within participants' homes, communities and workplaces. In some cases, lockdowns meant the 'locking in' of multiple generations of families in relatively small spaces. Class mediated the access to and reshaping of household space. Compare, for example, the experiences of two unpaid carers, both with ageing mothers with health needs. One, from a high-income household, had spacious living arrangements that supported the mother's care needs when she had to isolate:

> She's got her own toilet; she's got her own shower; she's got her own walk-in wardrobe; she's got a TV in her room, with all her channels that she wants … the fact that she had to spend ten days in there without leaving the room, it's kind of, everything's catered for in there. All we had to do was leave the food outside.[5]

The other, having come to the UK as a refugee, lived for the first seven months of the pandemic in a two-bedroom house (social housing) with her mother, husband and four children:

> The living room, [we] used to make it a bedroom, so we had beds, singles, two beds on top of each other, and that's, yeah, we used to sleep there as well. We had a TV there, so when we go to sleep, we'll turn it off. So, it was like a living room, but in the night-time, we'd be sleeping in there as well. Mum had her own room. It was not easy at all.[6]

For some research participants, lockdowns meant an 'emptying out' of spaces, as casual but regular visits of family and neighbours ceased, with consequent effects of loneliness and isolation. The 'emptying out' of roads and supermarkets was also traumatic for those who had come to the UK to escape war and conflict. For one interviewee, a single parent living alone with her child, the empty spaces triggered terrible memories of fleeing war as a child, when it was 'like the whole world collapsed':

> She went to buy food and there was no food on the shelves at Tesco … you know, back in our country as well, when people were rushing through the country, all the shelves and everything were gone, so she remembered. … 'The roads were empty', she said, 'there', and she came back home with nothing. 'And I was scared', she said, 'really scared'. (Interpreter)[7]

These experiences demonstrate how the reconfiguration of space through both 'locking in' and 'emptying out' had distinct impacts for those minoritised by (racialised) migrant experiences, connecting to their historical experiences of violent crisis and compounding the depleting effects of this one.

'Locking in and emptying out' also took on particular forms for men and women, as well as for different generations. Unpaid care labour, which is predominantly undertaken by women, became more complex and depleting, as they had to traverse the same space but under conditions of lockdown:

> [I live in] a flat. It's so high up. Not many floors but many stairs. I'm on the top [floor]. And at that moment in the start of COVID, my daughter was still one-and-a-half, two years old. So, I have to carry her; I have to carry the shopping with my son's help. My husband was stuck in a different country.[8]

Paid carers, who were often simultaneously negotiating these reconfigured spaces as unpaid carers for children and older relatives, had to grapple with other urgent issues, such as the adequacy of personal protective equipment (PPE) provision within their workplaces, as well as inadequate everyday supplies, such as uniforms. A domiciliary care worker described fears for her own health and the safety of those she was caring for:

> Wearing my uniform from this house to another house, I didn't feel comfortable with it because I felt, like, if I've put– if something's come onto my clothes, I'm going to then take it into that house, and then that whole house is going to get it. And it's that little fear, that– even though you didn't want to do it that way, but you had no choice. Like, for two days, three days, [I would have to wear the same uniform]. Myself personally, I didn't feel safe, and I didn't feel that my service users were safe.[9]

For paid carers, the everyday negotiation of space was already prone to crisis conditions. For domiciliary workers who might spend several hours a day travelling between home visits, travel time is typically unpaid and is physically depleting on top of the demanding work of care. During COVID-19 lockdowns, racial abuse and violence also reportedly increased towards those seen to be mobile (see later). Therefore, depletion through reconfigured spaces occurred through the constraining of space and the lack of available and safe open spaces and familiar places. Anxieties about this reconfiguration of space intensified depletion for carers and those receiving care.

Time use and timeliness

Being locked in meant that the day stretched ahead of older participants, without the welcome social interruptions by family members or local outings with friends that many were used to. One interviewee described how, despite her limited mobility due to ageing, she was not used to the isolation:

> [It is] difficult. Nothing to do, just to sit down to watch TV, to look what's going on in our country. That's it.… Lonely, yes.… Everybody says, 'Don't go outside because older people especially, you have asthma, you have diabetes, no good for the health, sit down, at home.' And I am not used to sitting down at home; that's why it feels difficult.[10]

The resulting loneliness is very much part of their depleting experiences of COVID-19 (see Akhter et al, 2022).

The already protracted time that older people and carers spent navigating health and social care systems lengthened further during the pandemic, as services became 'emergency only'. This was particularly time-consuming and depleting for those unfamiliar with the care system and without English as a first language; once again, racialised conditions of crisis, already present, were now exacerbated. Furthermore, the intimate care of older people and children that is largely undertaken by women meant that the challenging experiences of caring during reconfigured spaces were deeply gendered. One interviewee recalled juggling childcare and home-schooling for her five young children while also caring for her mother who had advancing dementia:

> If I remember, I feel like crying. It was really difficult because I had to look after them [the children], make sure they were doing their work. Yeah, and I had Mum with me as well, who wanted to be in and out, you know, outside all the time, and I'd got the kids here. It was not easy at all.… There was no time for myself at all.… It was really, really difficult when he [husband] was [working] in the warehouse and I was with the kids by myself.… But as a mother, you need to just get on with it. You can't say, well, you know, 'I'm just not going to do this'; you have to.[11]

The council finally provided an in-person care needs assessment for her mother in the autumn of 2021, but they were still waiting for a follow-up months later.

The depleting effects of caring during a public health emergency emerged strongly from interviews with unpaid carers, who were often caring for both older relatives (parents or parents-in-law) and children. One research participant was told by local health services that her mother, with mental health needs, would not receive any extra help because it was assumed that she could step in and provide unpaid care,[12] a withdrawal of formal care that draws on the racialised and gendered trope that minority ethnic families 'look after their own' and pushing her deeper into already crisis-laden conditions of caring. Her young son caught COVID-19 and subsequently suffered serious health complications, so she had to juggle emergency care for him as well as ongoing care for her mother. The gendered expectations within her household that overlooked her needs meant that her own time contracted enormously during the lockdowns:

> There was never any help and I remember, you know, I'd go to my mum's, take her shopping, my whole day would just go doing that, and I was flat out when I got back, and then I had the kids, and obviously there was no going to the gym for me then either because it was all lockdown. I couldn't run away from my house.[13]

The disruption to rhythms of life and work has continued past the emergency phase of the pandemic, as health services struggle to cope. For example, the same research participant now had to juggle follow-up hospital care for both her mother and son with appointments in different hospitals because of the lack of availability in her preferred locations.

Paid care workers consistently expressed deep concern for the well-being of those they cared for. However, they already faced significant challenges with their time use, having to balance caring for older and vulnerable people, often with diminished mental and physical capacities, with the profit-focused demands of the adult social care system. As discussed earlier, the drive to accumulate profit undermines capacities to care, creating an ongoing crisis and driving depletion in the social reproduction sphere. The squeezing of time for carers has been criticised for many years, without much change (UNISON, 2013). When this is combined with zero-hours contracts and poor pay, the depletion of carers becomes rapid. One carer reported how the care agency managers would get angry with her for spending extra time with clients. She and others expressed the view that the extremely low pay was 'disgusting' and 'a trap' to get carers to work longer hours.[14]

During the pandemic, even more than usual, paid carers had to navigate the distressing additional time demands of a public health emergency while still facing backlash from employers:

> Any work involving personal care, it's one of the most difficult jobs you ever find yourself doing. Never mind about going into people's houses and finding them already dead [voice agitated, distressed]. It happened to me twice. And they [employers] say to you, 'If the police have arrived, you should leave the scene and go.' No, you can't, because sometimes, in some cases, you have to wait for the coroner to arrive before you can go. I've told them this, [but] all they're interested in is, 'It's this time, why are you not there?'[15]

For paid carers, a combination of paid and domestic work within their own families also became more complex to negotiate. During the pandemic, fluctuations in carers' hours may have been more extreme than usual, especially at the start, leaving them even more economically precarious than usual. Some reported having several weeks where work was cancelled because patients were afraid of the risk of COVID-19. On zero-hours contracts, such carers' working hours dropped at short notice; they simply did not get paid and risked falling into debt, causing economic, psychological and physical depletion. One carer reported stress that manifested in hair loss, while her friend suffered severe anxiety due to the debt.[16] Time, therefore, reconfigured the everyday lives of both those who were cared for and those who provided care.

Gendered and racialised violence in care chains

Violence – individual, institutional and structural – can be understood as a framing concept for the everyday regimes of care and depletion, affecting the well-being of individuals, households and racially minoritised populations. Older research participants' narratives revealed the long-term and intergenerational effects of structural and gendered violence across their transnational histories. While some older participants expressed gratitude to the British state for providing them with support, younger family carers reported how their older relatives were receiving poor-quality care in England well before the pandemic. This drove distress and fear that their older relatives were now 'doubly disposable' to the British government and state health and care authorities due to their age and ethnicity:

> I remember watching when Boris [Johnson] said something like, 'Everybody will lose a loved one', which scared the hell out of me because literally it's almost like someone telling me, 'Somebody in your house is going to die.' Everybody kept saying BAME communities are more likely to get it. And then obviously, if you're BAME and you fall into that category of old people that are not going to be cared for as much, it makes you feel like, well, that's it, bottom of the list. Not only are you more likely to get it, you're also in the category that is not going to be cared for, so it's like a double whammy.[17]

Older participants' narratives also included household stories, for example, of younger family members facing everyday racialised violence and microaggressions and of structural violence faced by family members who, working in the paid care sector, had not been provided with adequate PPE or regular pay when the pandemic started.[18]

Paid carers already faced racism during their everyday working lives: in interviews, Black women workers described experiencing regular verbal and physical racist abuse from those they cared for and dismissiveness and a lack of support from employers.[19] However, the pandemic drove new, virulent expressions of racism, and it increased everyday violence – of abuse, stigma and blame – and, for some, physical violence.

One research participant, for example, recounted how she and her colleague, the only two Black people at work, both suffered racist abuse, being told by a workmate that 'It's only the Black people who have contracted Covid and brought it to work'; her colleague was then ordered to go and 'bleach herself from head to toe' to avoid catching the virus.[20] Carers reported feeling unable to turn to workplace unions and had to deal with such violence individually, which intensified their depletion.

For research participants, the national government and media discourses enabled this racism by failing to clearly communicate what was driving the disproportionate risks of viral infection among racially minoritised populations at that time:

> I've lived in [city] 32 years, and it's [racist attacks] never happened [till now]. So, I just think sometimes it's how the media, or Boris [Johnson] or everyone words it.[21]

> It was like, you know, the kind of hype that the Chinese got, that only the Chinese were transmitting the disease, and the way the backlash that they got. That's how I felt. I don't know if they felt they were helping the BAME community, but it wasn't good for us.[22]

The pandemic, as well as generating new forms of racism, exposed and exacerbated the entrenched socio-economic insecurity and structural racism experienced by paid care workers. All interviewees emphasised that the pay (£9–10/hour) was insufficient. The economic insecurity driven by the low pay is made worse for workers with migrant backgrounds by the UK's hostile immigration environment; for example, it limits the number of paid hours certain migrant carers can work while still receiving working tax credits (see Webber, 2019).[23] Research participants, most of whom were on zero-hours contracts, explained that it was only possible to survive economically by living with family who could financially support them or – for those not restricted by visa conditions – by working extremely long shifts, seven days a week.[24]

Against this already highly insecure backdrop, individual workers and their families had to bear additional risks to their health and well-being during the pandemic. One care worker had to take time off sick after suffering asthma flare-ups from wearing the PPE mask. Her short-staffed employer was unsupportive, and she was threatened with the loss of more shifts and pay unless she returned.[25] There was no increase in statutory sick pay – then £96.35 a week if the worker had been sick for more than four consecutive days – despite the higher risks to care workers of catching COVID-19. A single-parent care worker with five children recounted how she had to isolate for ten days with her clinically vulnerable daughter after her daughter's classmate tested positive for the virus. As she was on a zero-hours contract, she was not paid for those days and her employer refused to support her application for the £500 Test & Trace support because she did not have COVID-19 herself (see UK Health Security Agency, 2022). These poor working conditions, combined with unpaid care demands, had serious economic and depleting impacts:

> I didn't get anything. No payments, no payment. It does, it does [have a huge effect], yes. And they are so demanding, very demanding, the children. Yes. Shopping is three times a week when they are at home.[26]

Thus, structural and interpersonal violence are a permanent feature of the everyday landscape for research participants and significantly added to their depletion during the pandemic through material, financial and psychological harm.

While we have separated out time, space and violence as a heuristic device in the empirical analysis, research participants' testimonies demonstrate how these aspects are overlapping and intertwined. Paid carers already depleted by long working hours experienced additional harms due to extreme fluctuations in these working hours (and pay) and heightened everyday racism as they navigated reconfigured spaces in lockdown. Unpaid carers' time to recharge and replenish contracted as they were locked into crowded home spaces, caring for both younger and older generations without additional resources. Racially minoritised older people, deemed doubly disposable in both state policy and discourse, experienced loneliness because they were isolated and 'locked in' for long periods. Participants sought to resist these depleting conditions, however, and this formed an important segment of the research, discussed next.

Navigating COVID-19 and beyond

Research participants individually and collectively did what they could to survive and cope; they were the shock absorbers for the health crisis despite the fact that their access to resources, especially under COVID-19-induced lockdowns, was limited. Interviewees 'self-cared' by carving out 'time for themselves', for example, to exercise, to counterbalance the effects of the depletion caused by the combination of the pandemic and care work. One, an unpaid carer for her parents, described the paradox of feeling 'healthier and better' from taking long walks while, at the same time, 'more consumed at home trying to take care of them'.[27] Others had to navigate gendered power structures within the extended family to carve out time for themselves to cope with care-related depletion.[28] Some participants saw these individual actions not as acts of agency but as acts of survival. For example, one carer who would go to the supermarket 'as a pressure cooker release' simultaneously described this act as 'quite surreal and rubbish'.[29] Another, a paid carer, describing how she and her workmates coped with everyday racism, reflected: 'Coping? It's not coping.'[30]

While technology was mobilised by research participants, not all found it an adequate or desirable substitute for human contact. An older participant travelled to her home country in Africa to be with family and friends in person rather than be alone in England.[31] Others emphasised that more human interaction was needed for older people rather than increasingly sophisticated digital technology to track their physical safety.[32]

Responding to how to address pandemic-related and future care needs, participants called for the transformation of care system structures. For example, there were calls for the creation of 'care hubs':

> I think the onus is always left on us to reach out and almost know what exists out there for us, if anything exists at all. A lot of people have registered as carers, so employ people to make contact with all the registered carers … health and social care-based hubs can … [help] to signpost to organisations, OTs [occupational therapists], physios, carer centres, other organisations etc.[33]

Others described how support for family members through local channels would ultimately support them too:

> I would just love to know my mum is in a group somewhere with people her age, having a laugh. That makes me feel amazingly good.… I think it's just having that reassurance that they're okay because it means then we can emotionally focus on other things.[34]

The importance of financial support for unpaid family carers was emphasised, not only by carers themselves but also by older people receiving care:

> I would love if the government could give [my kids] payment or something because they are supporting me. Because they are not paid workers; they're unpaid, and they're just helping me voluntarily now.[35]

Participants also called for much more widespread, systemic change to austerity-driven politics, in particular, for a national social care system that is needs not profit oriented:

> We need change, we need real change, we need real ground change … provide vouchers that families can use for activities, learn from other countries, neighbouring countries. Go to Holland, go to all the Scandinavians and see what they're doing. Just focus on the right side of things, focus on the people [rather] than the money.[36]

Recognising that the ongoing and everyday racism that was heightened during the pandemic was driven 'from the top', carers demanded that the government address its own (structural, everyday and political) racism:

> I would tell them to start sorting things from up there before it gets down [to us]. How can I say it? They start it. Because it's discrimination or racism starting from above; that's why the little people who are normal people are carrying it on.[37]

In the two knowledge exchange workshops organised at the end of the research project, participants called for financial support for chronically underfunded local community organisations, which act as conduits between the government and minoritised groups. During the COVID-19 pandemic, these groups set up food banks, were sources of information and support in multiple languages, and organised vaccine drives. Participants also challenged defeatism, demanding active engagement from local councillors and members of Parliament to help access care-related services and challenging themselves to harness collective agency and recognise that they are not 'second-class citizens': 'Know your rights and know the system.'[38]

Discussion and conclusions

Arundhati Roy (2020) wrote that, 'Historically, pandemics have forced humans to break with the past and imagine their world anew. This one is no different. It is a portal, a gateway between one world and the next.' We read the demands from our research participants – for the transformation of care, for a 'focus on people rather than money' – in this same vein: as calls to break with the past and imagine the world anew.

Through bringing together paid and unpaid care labour with experiences of older and younger generations and communities during COVID-19, we have shown how analysing care and caring through the overarching frames of depletion and the everyday enables us to fully understand the care-related costs of the COVID-19 pandemic. While other studies have documented the unequal and devastating health outcomes of the pandemic for racially minoritised populations in the UK, analyses have mainly focused on health rather than care settings. Adopting a feminist political-economy approach, we situated our analysis in the context of the hidden, valorised but un/under-valued care economy. We adopted the concept of depletion through social reproduction (Rai et al, 2014; Rai, 2024) to explain how the everyday rhythms of care and caring were experienced and reconfigured during the pandemic. This approach enabled exploration of how harm and damage – the costs of caring – had been accruing over time before the pandemic struck as part of an unfolding crisis of care in the lives of research participants. By documenting the everyday rhythms of care and their spatial, temporal and violent dimensions (Elias and Rai, 2019), we could detail how the pandemic unequally reconfigured the lives and labour of those who cared and were cared for.

Our research has shown that the COVID-19 pandemic held up a mirror to society, laying bare existing regimes of inequality and discrimination along the axes of race, gender and class for individuals, households and communities in England (Allen et al, 2020; Townsend Bell, 2020). The ongoing impacts of neoliberal austerity, combined with economic precarity and multiple forms of racism, intensified human depletion at a time when the public health crisis was at its most acute (Faraday, 2021; Garcia et al, 2021). The crisis of care in everyday lives took on unique dimensions during the pandemic due to the nature of the health emergency and national policy responses, but this was not the first or last crisis point. Rather, it was part of an ongoing crisis in the everyday lives of the most marginalised that started well before the pandemic itself and has continued since (Strolovitch, 2013; 2023; Emejulu and Bassel, 2015). The compounding of racialised and gendered inequalities due to the neglect of care, caring and familial and community lives is a feature of other crises too (Erel et al, 2017; Bassel and Emejulu, 2018). Moreover, as seen in our study, it is normalised through gendered and racialised discourses by political and media elites, taking for granted the care labour of women and racially minoritised people at the same time as contributing to 'misinfodemics' that led to an increase in hate crimes against minoritised communities (Rowley, 2020; Yasmin, 2021).

Our study shows how structural discrimination was further embedded through pandemic times, intensifying depletion. Older people were deemed disposable (Jacobs, 2021), leaving them isolated and lonely while already stretched unpaid carers and community groups struggled to support them as the pandemic took hold. The labour of unpaid carers became a shock absorber for the crisis as health services became 'emergency only' and social care was minimised. With little or no respite, their depletion intensified. In the disproportionately feminised and racialised paid care sector, workers became simultaneously essential and more disposable. The reconfiguration of everyday life deepened the depletion of racialised individuals and communities (Crenshaw, 1989; Collins, 2000; Elias and Rai, 2019), while interlocking structures of gendered and racialised violence functioned to manage the crisis for the capitalist care system (Rao, 2021).

Thus far, the portal of the pandemic has not opened the way to progressive, radical change to address care and caring in a gendered and racialised political landscape. Our research has revealed the compounding effects of everyday depletion through caring; the task of merely surviving in the gendered and racialised hierarchies of capitalist crisis is so immense that it depletes capacities to organise and resist these conditions (Bassel and Emejulu, 2018).

Yet, individual and collective survival in the face of multiple crises is itself an achievement and a mode of resistance (Hartman, 2016; Neely and Lopez, 2022). Depletion was not passively accepted; rather, research participants and communities navigated and challenged these harms in their everyday lives. Albeit within constrained circumstances, critical agency was and continues to be exercised to mitigate against and struggle to reverse depletion. Our research revealed participants' deep care for one another, whether as unpaid carers meeting multiple care needs in locked-down spaces, as paid workers insisting on time and pay to properly care, as older people calling for more human interaction and for the financial valuing of family and community care, or as community groups organising through the emergency. Looking to the future, research participants decried existing structures of inequality. Their calls to transform long-standing conditions of crisis remind us that justice and real care are unlikely to materialise within existing socio-economic structures (Piscopo and Walsh, 2020; Rowley, 2020; Rai, 2024). They demanded a different care system: one that cares and does not deplete and focuses on their human and collective needs – on their 'life making' rather than on profit making. Future studies would do well to incorporate their demands for justice and equality, for reversing depletion, and for centring care when imagining alternatives for a caring rather than a care-less society.

Notes

[1] 'Co-POWeR: Consortium on Practices of Wellbeing and Resilience in Black, Asian and Minority Ethnic Families and Communities', 2023 (ESRC Study Number 856500).

[2] Adult social care in the UK is governed and delivered separately from healthcare. Healthcare is governed through the centrally funded National Health Service, which is free at the point of use. Adult social care is delivered through local government (councils) and private providers and is funded through a largely privatised system. Social care includes both domiciliary (in-house) care, that is, helping people to independently stay in their homes through home visits, and residential care, whereby people live away from their homes in staffed 'care homes'.

[3] At the time of writing, the UK COVID-19 public inquiry has not reported any specific findings around unequal outcomes. Such findings may yet emerge in Modules 6 (the care sector; hearings in mid-2025) and 10 (impacts on society; hearings in early 2026). For the full schedule, see: https://covid19.public-inquiry.uk/news/inquiry-update-final-investigation-announced-module-10-impact-on-society/.

[4] The study's fieldwork was carried out in England.

[5] Unpaid carer UC-005, 5 October 2021.

[6] Unpaid carer UC-006, 2 December 2021.

[7] Paid carer PC-003, 28 October 2021.

[8] Paid carer PC-009, 8 December 2021.

[9] Paid carer PC-001, 26 October 2021.

[10] Older person OP-014, 10 November 2021.

[11] Unpaid carer UC-006, 2 December 2021.

[12] Unpaid carer UC-008, 15 December 2021.

[13] Unpaid carer UC-008, 15 December 2021.

[14] For example, PC-001 (26 October 2021) and PC-012 (1 December 2021).

[15] Paid carer PC-012, 1 December 2021.

[16] Paid carer PC-001, 26 October 2021.

[17] Unpaid carer UC-002, 17 August 2021.

[18] Older person OP-004; Older person OP-006.

[19] For example, paid carer PC-013, 21 January 2022.

[20] Paid carer PC-011, 4 January 2022.

[21] Paid carer PC-001, 26 October 2021.

[22] Paid carer PC-009, 8 December 2021.

[23] Paid carer PC-006, 19 November 2021.

[24] Paid carer PC-001, 26 October 2021.

[25] Paid carer PC-001, 26 October 2021.

[26] Paid carer PC-002, 28 October 2021.

[27] Unpaid carer UC-002, 17 August 2021.

[28] Unpaid carer UC-008, 15 December 2021.

[29] Unpaid carer UC-003, 20 August 2021.

[30] Paid carer PC-011, 4 January 2021.

[31] Older person OP-015, 1 December 2021.

[32] Older person OP-014, 10 Nov 2021.

[33] Unpaid carer UC-003, 20 August 2021.

[34] Unpaid carer UC-002, 17 August 2021.

[35] Older person OP-015, 1 December 2021.

[36] Paid carer PC-009, 8 December 2021.

[37] Paid carer PC-011, 4 January 2021.

[38] Workshop, 10 May 2022.

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Author biographies

Jayanthi Thiyaga Lingham is a research associate in the Centre for Care at the University of Sheffield, UK. Her interdisciplinary research focuses on: the international political economy of gender, violence and conflict; care and social reproduction; and research at the intersection of crisis and development.

Shirin M. Rai is Distinguished Research Professor of Politics and International Relations at SOAS University of London, UK. She is a fellow of the British Academy. Shirin is an interdisciplinary scholar and has written extensively on issues of gender, governance and development, and gender and political institutions.

Shahnaz Akhter is a postdoctoral researcher and widening participation officer for the Department of Politics and International Studies at the University of Warwick, UK. Her current research looks at the relationship between silencing and securitisation of South Asian women, focusing on historical medical experiments.

Conflict of interest

The authors declare that there is no conflict of interest.

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