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Care, Inequalities, and Conviviality

The Impacts of the COVID-19 Pandemic in Berlin, Buenos Aires and Mexico City

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Care, Inequalities, and Conviviality: The Impacts of the COVID-19 Pandemic in Berlin, Buenos Aires and Mexico City

Raquel Rojas, Juan I. Piovani, Laura Flamand, Sérgio Costa, Carlos Alba

Abstract

Care, long overlooked by mainstream political and academic actors, seemed to have become one of the most urgent issues of our time amid the COVID-19 pandemic. While recognizing that the crisis of care is far from a new phenomenon, we use the pandemic as a magnifying glass to analyse its impact on both social inequalities and patterns of living together, i.e., conviviality. Our empirical analysis focuses on the cases of Argentina, Mexico, and Germany, based on original surveys conducted in the largest city of each country: Buenos Aires, Mexico City, and Berlin. We provide an analytical framework that assesses the impact of the pandemic by comparing diverse social groups and societies in which care is organized differently. The analysis shows that different models of care provision translated into heterogeneous levels of support for the population during the crisis, and that unequal access to care services determined, to a large extent, the unequal impact of the pandemic and its containment measures on specific social groups.

Keywords: care provision | COVID-19 | inequalities | conviviality

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Contents

1. Introduction

Care activities are essential for the reproduction of society and the maintenance of life. When the capacity to raise and educate children, cook meals, care for the sick, or maintain clean homes, healthy environments and strong communities is diminished, the entire social order crumbles. Feminist scholars and activists have long advocated for the valorization of these activities and the recognition of care as a crucial component of the economy. And while discussions of the crisis of care are not new in feminist literature, it was in the midst of the COVID-19 pandemic that care seemed to become one of the most urgent issues of our time.

In this text, we approach the COVID-19 pandemic as a magnifying glass to analyse the distribution of care and its impact on both social inequalities and the patterns of living together that we refer to as “conviviality”. Our empirical analysis focuses on the cases of Argentina, Mexico, and Germany, drawing on a comparative survey conducted in the largest city of each country: Buenos Aires, Mexico City, and Berlin.

The theoretical starting point of our discussion is the research program of the Maria Sibylla Merian Centre Conviviality-Inequality in Latin America (Costa 2019; Mecila 2018). Accordingly, conviviality and inequality are reciprocally constituted insofar as inequalities shape social interactions but only acquire meaning and produce social impacts in concrete social interactions. Following this logic, we understand conviviality in this paper not as a normative category, e.g. as a synonym for peaceful cohabitation, but in a strictly analytical sense: a situational category that refers to the interactional moment of social relations. The co-constitutive link between conviviality and inequality appears abstract at first glance but becomes tangible in concrete webs of interactions referred to in this article as convivial configurations. These can refer to both social microspheres (e.g. families) and macrospheres (a city, a country), as well as to the connections between these different levels.

There is a dynamic relationship between care, inequalities and conviviality. In this sense, the social organization of care – the ways in which societies organize the provision of, and access to, care – is a central constitutive element of convivial constellations, that is, the way how people live together in a certain society. This can be observed at the level of the household, where there is a gendered division of care work that disproportionately burdens women and girls, with implications for roles and relationships within the family and beyond. However, depending on their position in the social structure, some households have sufficient resources to pay for care services, thus commodifying care and transferring at least part of the burden to others, and freeing up time for (female) family members to participate in the labour market. This process exacerbates inequalities between households, not only because some are able to outsource care responsibilities

and free time for their members to generate income, while others are not, but also because those who provide care to the former group tend to belong to the latter and receive significantly lower wages for their work, as in the case of domestic workers.

Moreover, depending on the context, domestic workers tend to be of different ethnicity, class or citizenship than their employers. In Latin America, for example, they are disproportionately black and indigenous, while their employers are mostly white or creole elites (Valenzuela et al. 2020). Accordingly, in contexts where their employment is common, this practice generates complex convivial configurations (Rojas 2022), both at the micro level of the household and throughout the social structure. For example, a wealthy family that hires someone to do domestic work in Brazil or Mexico may have a more equitable gendered distribution of care within the employer couple, but at the expense of more intersectional inequalities, as the likely Afro-descendant or indigenous woman they hire accumulates care responsibilities in her own household and that of her employers. At the macro level, these imbalances reinforce existing inequalities, as the children of domestic workers face care deficits that may limit their life chances. Care inequalities, i.e. the hierarchical distribution of both care responsibilities and care benefits, show not only a strong gender bias, but also a bias in terms of ethnicity, race, region and class. In sum, care inequalities are intersectional.

In this paper, we aim to examine how the COVID-19 pandemic has affected care inequalities and, consequently, convivial configurations in different care provision models. There is a large body of literature on the impact of the pandemic on the (already inequitable) distribution of care responsibilities (Batthyány and Sanchez 2020; ECLAC and UN Women 2020; Stefanović 2023; Rojas et al. 2024; Strevano et al. 2021). We want to go one step further: our goal is to comparatively analyse the effects of the pandemic on the restructuring of convivial configurations at the micro and macro levels, comparing not only diverse social groups but also societies in which care is organized in different ways. In short, we want to examine how the pandemic has affected the relationship between conviviality and inequality within different modes of care provision.

The paper is organized in five sections, including this introduction. The next section elaborates on the different ways societies organize care, engaging in a dialogue with literature from both Latin America and other contexts to offer a typology that allows us to compare different cases without reducing them to monolithic care regimes. In the third section, we apply the typology of care provision to our case studies. The fourth provides further details on the methodology for data collection and analysis. In the fifth section, we examine the impact of the pandemic drawing on original data and highlighting the heterogeneous impact of the COVID-19 crisis on different social

groups and contexts that offer a particular matrix of care provision. The final section interprets the findings vis-à-vis the analytical framework used.

2. Care and its Social Organization: Building a Typology

There is a long tradition in the European welfare literature of developing typologies to classify and compare institutional arrangements for the provision of social welfare. Of these, Gøsta Esping-Andersen's welfare regimes has been the most influential (Esping-Andersen 1990). Feminist scholars have also drawn on Esping-Andersen's classification, although it has been criticized for its gender blindness. As Jane Lewis and Ann Shola Orloff have pointed out, this typology focused mainly on male workers and ignored women's role in providing welfare within the family and through their unpaid work (Lewis 1992; Orloff 1993). Thus, "gendering" the analysis of welfare regimes became an urgent matter early on.

In the context of this debate, the first efforts to describe different "social care service regimes" (Anttonen and Sipilä 1996) emerge. Care regimes, described as "the institutional and spatial arrangements (locations) for the provision and allocation of care" (Kofman and Raghuram 2009: 4), then appear as a new object of study and typology. Complementing the idea of regimes is the metaphor of the *care diamond*, which Shahra Razavi describes as "the architecture through which care is provided" (Razavi 2007: 21). The diamond shape is given by the four institutions involved in the provision and distribution of care: the state, the market, families/households, and the community.

Latin American debates, on the other hand, have focused on the notion of the "social organization of care", drawing attention to the lack of consolidated care policies in the region and the prevalence of rather fragmented state interventions. Eleonor Faur asserts that in highly unequal societies, an analysis in this regard should identify the many "diamonds" that emerge through differentiated access to care services, depending on the position that actors occupy in the social structure, their geographic location, or their occupational status (Faur 2011).

Analysing childcare in Argentina, Faur points to the existence of a complex mix of care models that combine a myriad of fragmented social policies: while some state provision is universal, other benefits are means-tested and targeted only at the low-income population; still other services rely on formal labour market participation; and the rest are privatized options accessible through the market for those who can pay. Not surprisingly, the results are highly heterogeneous. Thus, in Argentina, as in other Latin American countries (Esquivel et al. 2012), there is no homogeneous care regime "with a uniform and somehow predictable configuration" (Faur 2011: 992).

While we agree with Faur's critique of a monolithic concept of care regimes, we still see typologies as useful in that they facilitate comparisons between various contexts, highlighting differences and commonalities, which can ultimately lead to the development of new theories (Giordano 2022). Also, in a Weberian tradition, we consider ideal types as abstract models – i.e., conceptualizations that will never exactly correspond to what is empirically observed – to which reality can be compared to better understand social phenomena. From this point of view, we interpret the critique of Faur and other Latin American scholars not as a resistance to the construction of typologies, but as a call to consider the degree of fragmentation that each care regime contains.

Indeed, as austerity measures gain ground and welfare states retrench, analyses from the "Global North" have increasingly drawn attention to the dualized organization of care: those who can pay for care services externalize – and commodify – social reproduction, while those who cannot must bear the brunt to the detriment of their ability to generate income (Fraser 2017). Thus, regardless of the geographical location of the analysis, fragmentation should be considered when describing the organization of care in a given society.

Bringing these different streams of literature into dialogue, we propose a typology that builds on previous attempts to classify care regimes. We start from Jane Jenson's three questions for framing care practices in different welfare regimes: who cares, who pays, and where care is provided (Jenson 1997). Answers to the first question consider the institutions that make up the care diamond: it considers how much care is provided by private institutions, by public institutions, by families and by the community. The distinction between who cares and who bears the cost is important because even if most care is usually provided by the family – especially if we focus on the case of children of preschool age – it is not the same if parents have access to paid maternity/paternity/parental leave and protection, or if it is assumed that a family member (most probably, the mother) must do this work without any compensation. In addition, it is important to clarify that "paying" for care does not always involve monetized transactions: family or community members also contribute by devoting their time and energy to care activities.

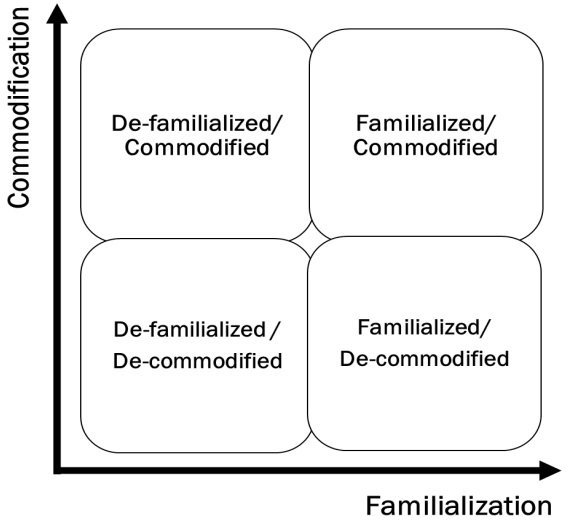
Regarding where care is provided, we consider households or extra-domestic spaces, which in turn can be classified as private institutions, and public or community settings. Analysing the location of care provision also offers important information about its institutionalization. Take the case of Latin America, where most of the middle and upper classes hire domestic workers to meet their care needs. This means that, even if it is private care, it takes place within the home and is therefore less institutionalized than, for example, sending children to a nursery or day care centre, where care activities tend to be professionalized. This has implications not only for the characteristics of the care provided, but also for the working conditions of the care workers. As the extensive

literature on domestic workers' rights (Blofield and Franzoni 2015; Valiente 2016) shows, this has historically translated into informal and precarious working relations.

Our typology has two main indicators: First, the degree of commodification, and second, the degree of familialization. Following Esping-Andersen's classic proposal on welfare regimes, we classify societies as having a high degree of commodification when care needs are overwhelmingly met through the market (Esping-Andersen 1990). On the other side of the spectrum, de-commodified care regimes are those in which access to care is not entirely dependent on the market but is guaranteed – at varying levels – as a social right. Familialization, in turn, has been one of the main criteria for analysing and classifying care regimes from the very beginning (Giordano 2022). The main aspect considered here is how much of the care responsibilities fall within the family and, conversely, how much care is provided by the other actors that form part of the care diamond.

Based on the degree of commodification and familialization in the social organization of care in different contexts – that is, the answers to the questions of who cares, who pays, and where care is provided – we identify four ideal types of care provision, as shown in Figure 1.

Figure 1. Matrix of care provision: Four ideal types



Source: elaborated by the authors.

Now, as noted above, these are only ideal types. In light of the aforementioned critique by Faur and other Latin American scholars (Faur 2011), the analysis of real cases should take into account the degree of fragmentation in each typology. As a rule of thumb, less government involvement means more fragmentation: if families are the ones paying for and providing care and knowing that households in different positions in the social structure have different levels of resources to do so, it is evident that

access to care services will be unequal. Another relevant aspect to consider is the dominant patterns of gender relations It is well known that, when care is provided by the family or the community, women tend to be the main providers. In this respect, familialization generally means feminization of care.

The characteristics of the labour market in a society can also have a strong impact on the fragmentation of care provision. For example, contributory care policies such as maternity/paternity leave and health insurance tend to cover only those who work in the formal economy. People who are not part of the labour market (mostly women) or who work in the informal economy (mostly from the lower income groups) do not have direct access to these benefits and are therefore either excluded from them altogether or depend on family members who are primary policyholders.

Thus, by considering fragmentation, we not only recognize that access to care services varies according to the position that groups or individuals occupy on the social scale, but we also introduce an intersectional perspective to the analysis. In other words, depending on certain criteria – gender, social class, migration background and/or ethnicity/race – the model of care provision will have different impacts on different groups of people. As we will see, this became even more noticeable during the COVID-19 pandemic.

3. Care Provision Models in Argentina, Mexico and Germany

Care encompasses the different activities and practices that are essential to meet people's basic needs and provide them with the physical, emotional, and symbolic elements necessary to live in society (Rodríguez Enríquez 2015: 36). Care is thus an inherently broad concept, allowing for rich analysis but making it difficult to operationalize. This means that we must make some choices when constructing a typology of care provision, as we cannot include all aspects. Given our focus on the COVID-19 pandemic, we will concentrate on two dimensions: childcare and health services.[1] Childcare is not only a dimension typically considered when classifying care regimes (Giordano 2022), but also became a critical point during the lockdown mandates that dictated school closures for almost two years, and an important vector in the reproduction of inequalities. Health services also emerge as a key aspect in the context of the global spread of an infectious disease and is thus important for our typology.

To answer the questions that will help us build our typology of care provision as described in section 2, we have selected several indicators for each dimension (early

1 However, we recognize that there are many other elements to consider when discussing care services and policies. For a more comprehensive overview, see Bango and Cossani (2021).

childhood care and health services) and for each actor in the care diamond, as shown in Table 1 and described below.

Table 1. Selected indicators for classifications into types of care provision and their sources

	Early Childhood Care	Health Services
State	- Statutory childcare service system (0–2 years) and national pre-primary education system (3 years and above) (ILO 2023a) - Maternity cash benefits (ILO 2020)	- Universal Health Coverage Index (WHO 2024)
Market	- Maternity, paternity and parental leave (ILO 2023a) - Percentage of paid household workers in total employment (ILO 2021)	- Health private spending (OECD 2024)
Family	- People outside the labour market due to care responsibilities (ILO 2018) - Children not enrolled in early childhood education and care services (0-2 years old) and pre-primary education (3-5 years old) (OECD 2023)	- Population with household spending on health greater than 10% and 25% of total household budget (WHO 2024)
Community	- Communitarian care experiences (secondary literature)	- Communitarian care experiences (secondary literature)

Source: elaborated by the authors.

So, who cares, who pays, and where is care provided in the three cases we analyse in this paper? In Mexico and Argentina, the state has a rather small presence in the provision of care. Argentina does not have a statutory system of childcare services for children between the ages of 0 and 2 (ILO 2023a), and even if such a service exists in Mexico, it does not seem to be very effective, considering that 96% of children in this age group are not enrolled in public or private childcare and early education centres (OECD 2023). are thus the main providers of care, a that falls disproportionately on the shoulders of women, who are much more likely than men to be outside the labour market precisely because of their care responsibilities. Not only is the gender gap in labour market participation much wider in these countries – 30.2 percentage points in Mexico and 19.6 in Argentina, compared with 10.5 in Germany, according to ILO (ILO 2023b) – but, in the case of Mexico, 67.3% of women cite care responsibilities as the main reason for not participating in the labour market, compared with only 9.4% of men. In Argentina, the figures are 30.4% for women and 4.5% for men (ILO 2018).

In addition, households in these countries are forced to spend a high proportion of their income on health care. While 9.57% of households in Argentina and 4.44% in Mexico reported spending more than 10% of their budget on health, this was the case for only 1.53% of households in Germany. In a more difficult situation, 3% of households in Argentina and 1% in Mexico reported spending more than 25% of their total budget on health. No household in Germany reported such a level of expenditure (WHO 2024).

Maternity, paternity, and parental leaves are rights mediated by the labour market. According to ILO data (ILO 2023a), only Germany guarantees the 14 weeks of maternity leave established by the ILO Maternity Protection Convention 183, while Argentina and Mexico do not recognize this "maternalist floor" (Blofield and Franzoni 2015), granting new mothers 13 and 12 weeks of leave, respectively. Paternity leave provisions are far more limited: fathers receive 5 days in Mexico and only 2 days in Argentina, reflecting the absence of policies that actively promote paternal involvement in childcare. Germany, by contrast, grants up to 312 weeks of job-protected parental leave per child, shared between both parents and inclusive of the 14 weeks of maternity leave.[2] However, only a portion of this period is paid: under the parental allowance scheme, parents can receive benefits for up to 61 weeks in total, of which 9 weeks are reserved exclusively for fathers to promote their participation in caregiving (Bundesministerium der Justiz 2024; Bundesministerium für Familie, Senioren, Frauen und Jugend 2023).

It is also important to ask what the eligibility criteria are for access to these benefits. For example, while self-employed workers in Germany and Argentina are covered by mandatory maternity leave cash benefits, this is not the case in Mexico, where only wage earners are guaranteed this right. In addition, self-employed workers in Germany also have access to parental cash benefits. Moreover, if we consider that informality in the labour market is 4.2% in Germany, 51.2% in Argentina and 56.3% in Mexico (ILO 2023b), we can also conclude that the proportion of the population with access to maternity and paternity/parental leave varies widely, as it is well known that those who work informally – disproportionately women and the lower classes – are excluded from these benefits.

Another indicator of market participation in childcare, and one that is particularly relevant for Latin American societies, is the percentage of the female population in the labour market that reports working as a domestic employee. The figures are 17.8% in Argentina, 10.1% in Mexico and 1.1% in Germany (ILO 2021). Although household workers may not be hired (exclusively) to care for children, we use this figure as a proxy for this service, since it is well known that in highly unequal societies, "the hiring of

2 Under the *Bundeselterngeld- und Elternzeitgesetz* (BEEG, Federal Parental Allowance and Parental Leave Act), each parent is entitled to up to 3 years (156 weeks) of job-protected parental leave per child. These entitlements are independent, so in principle both parents could take leave simultaneously, amounting to a combined total of 312 weeks.

mostly female personnel for work in familial settings is an alternative to public provision [of care] in institutional settings" (Blofield and Franzoni 2015: 45).

Now, when access to the market is not an option due to low income, government services are not available, and family members cannot take on the responsibility of caregiving, community care practices meet the need. This is the case for many families living in impoverished areas of Latin America. In Argentina, for example, many communitarian organizations have emerged in response to the hyperinflation of the late 1980s, the high unemployment of the 1990s, and the crisis of 2001 (Sanchís 2020). Despite the great heterogeneity among them – some are linked to religious groups, others to social movements or political associations, some receive some government funding, and all have varying degrees of institutionalization – there are common features: the key role played by women, the importance of territorial inscription, and the relevance of these services to social groups from the lower income brackets (Sanchís 2020; Zibecchi 2020). Among the many experiences in Buenos Aires and its metropolitan area – the area to which we applied our survey – a wide variety of heterogeneous projects and interventions have been analysed by scholars, such as those that focus on the health of children and pregnant women, on nutritional aspects, on the situation of the population with drug problems, on the prevention of gender violence, on school assistance, and also on community care services for preschool children (Fournier 2017; Rosas and Araujo 2021; Rosas 2018; Zibecchi 2015). In Mexico, too, communitarian practices that had been in place for decades (Lomnitz 1973) became much more visible during the COVID-19 pandemic. Challenging the idea that communal care practices are something to be found predominantly in rural and indigenous communities, a variety of groups organized in Mexico City to provide food, childcare, and even emotional support and physical activity (Villanueva Gutiérrez 2023). In a context where state support was perceived as inadequate and needs were growing; community solutions were a means of alleviating hunger and despair.

With this constellation and considering the ideal types described above, we classify the cases of Argentina and Mexico as familialized/commodified: the family is the main provider of care,[3] and the market also plays an important role for those who can pay for care services. At the same time, the lower presence of the state makes the model more fragmented, since access to (quality) care services is strongly mediated by family resources.

In Germany, on the other hand, the state is much more present: there is a universal and free system of childcare services for children between the ages of 1 and 2, and a national system of preschool education for children between the ages of 3 and 5

3 The fact that, during his presidential mandate in México, Manuel López Obrador declared that families are the main social security institution, illustrates this quite clearly (Yahoo News 2020).

(ILO 2023a). In addition, virtually all women with children under 1 have access to cash benefits, which reach only 10.4% of mothers with newborns in Mexico, and 31.7% in Argentina (ILO 2020). In terms of health services, Germany scores 88 on the Universal Health Coverage Index (WHO 2024), meaning that most of the population receives the health services they need without incurring catastrophic health expenditures. Mexico's score is 75 and Argentina's is 79.

Nevertheless, the family is still a key player in Germany, especially female family members (Eggers et al. 2023). This is even more evident when we look at the situation in other European countries: while 46.4% of women in Germany who are not in the labour market say that care responsibilities are the main reason, the average in high-income countries is 19.6% (ILO 2018). And the fact that 61% of children up to the age of 2 are not enrolled in childcare or early education services in Germany (OECD 2023) underscores the importance of the family in caring for young children. The market, on the other hand, is not a key player in this case: childcare services are largely financed or subsidized by the state, and the participation of household workers is significantly low, considering that only 1.1% of the female population in the labour market reports working as a domestic employee (ILO 2021). According to the typology developed in section 2, with a strong family and state presence, Germany is then classified as a familialized/de-commodified model of care provision.

4. Data Collection and Analysis

The following analysis is based on surveys conducted in Berlin, Buenos Aires, and Mexico City, including their metropolitan areas. In each of these cities, a telephone survey was carried out with a probabilistic stratified sample (n=2,500) of people aged 18 and over, based on parameters such as gender, age, education level, household size, and total population per district. The survey period in Buenos Aires and Mexico City was between June and August 2021, while in Berlin there were three different collection periods: January-February 2022, March 2022, and April-June 2022.[4]

Building on previous analyses of these cases (Costa et al. 2023; Flamand et al. 2023; Piovani et al. 2023), we aim to provide an analytical framework that assesses the impact of the pandemic on inequalities, comparing not only different social groups but also societies where care is organized differently. Focusing on these three cities allows us to highlight similarities and differences in terms of household and population composition and government responses to the crisis. Among the five largest cities in Europe, Berlin is a multicultural city with about 23% foreign-born residents in 2022

4 As the implementation of the Berlin survey required a comprehensive international call for offers, it could not be conducted in the same periods as the Buenos Aires and Mexico City surveys.

(Amt für Statistik Berlin-Brandenburg 2024) and a high proportion of one- to two-person households (about 72%, according to our survey). México City and Buenos Aires, two of the largest cities in Latin America, are located at geographical antipodes. While in Buenos Aires there is also a significant proportion of international migrants, in Mexico City it is important to consider the indigenous population. Also, while the number of single-person households in Buenos Aires is closer to the Berlin case, households in Mexico City tend to have more members, highlighting the importance of the extended family in their care strategies.

Similarly to what is discussed by Piovani and Baranger, although the questionnaire applied in each city was basically the same, some adaptations were necessary to account for local specificities, that later affected the possibilities for comparing its results (Piovani and Baranguer 2023). This means that we had to find alternative ways to make the data comparable and equivalent. For example, to assess the impact of the pandemic on different groups, we needed to classify the population according to socioeconomic characteristics. As we have done elsewhere, we decided to use education level as a proxy for social class (Rojas et al. 2024). We believe that this variable is more suitable for cross-country comparisons, as the measurement of income and the construction of the social class variable differ greatly between countries.

A first methodological issue, as we are comparing societies with different characteristics, we had to adjust the classification, since educational level is a relative concept that takes on meaning in the context of each society. In addition, the educational systems are different, as are the relationships between formal education, labour market integration, and income.

A second methodological issue was whose level of education to consider. In Latin America and other societies where intergenerational and larger households are the norm, it is customary to ask about the primary earner, as this person's situation is considered more representative of the household. In Germany, this question is not usually asked because households are much smaller and the process of individualization is much stronger, meaning that young people usually move out of their parents' house around the time they finish school. In fact, our survey data show that 72% of the households surveyed in Berlin are either one- or two-person households, usually consisting of the two members of a couple. In other words, while the level of education in Berlin draws on data from the individual respondents to the survey, regardless of their position in the household (primary earner or not), the education level in Mexico City and Buenos Aires reflects that of the primary earner.

5. Covid-19 and Care Provision Models: Impacts on Inequalities

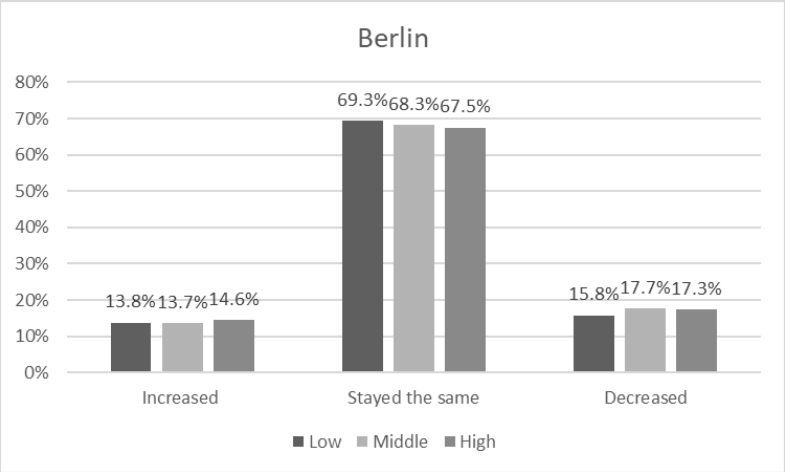
In this section, we use data from our surveys to analyse how the different models of care affected the relationship between conviviality and inequality during the COVID-19 pandemic. We begin our analysis by looking at the extent to which the pandemic has affected household income. While Latin America is known as a region where income inequality is a persistent problem, Europe's average level of income inequality is much lower, and Germany's is actually below that average (Eurostat 2024; Statista 2024). The impact of the pandemic on household income, according to our survey data, fits into this broader picture: While most households in Berlin, regardless of their socioeconomic position, reported income stability during the pandemic, this is not the case in Mexico City, where the negative impact was greater for all socioeconomic groups, and even more so in the lower strata. In Buenos Aires, the picture is more nuanced, with more households reporting income stability, but still a marked difference according to socioeconomic position, as shown in Figure 2. This points, as other studies have already done (ECLAC 2022), to a worsening of income inequalities in societies that are already unequal.

The different impact of the pandemic on income in these three cities may be explained by the governments' response to the crisis, but also by their labour market. In this sense, it is noteworthy that in Berlin, unlike in the other two cases, it is the group of people with lower levels of education that experienced more stability in their income and were less affected by income losses. As Costa et al. have pointed out, this highlights the role of the government in providing financial support to the poorest in times of economic instability (Costa et al. 2023).

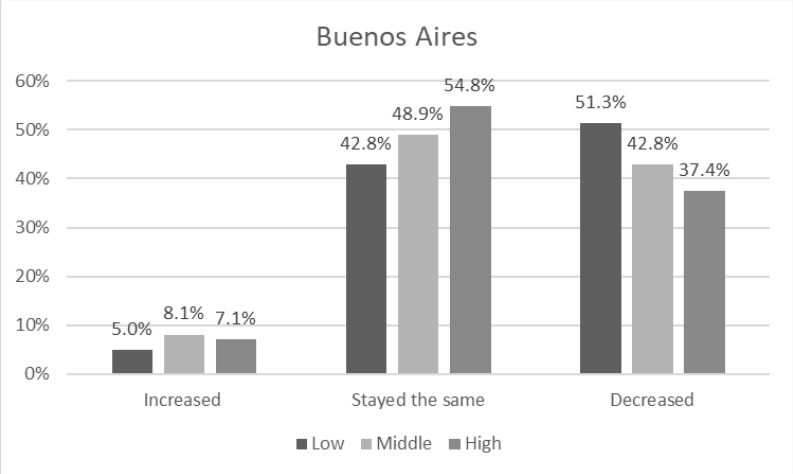
In contrast, the high proportion of Mexicans from lower socioeconomic backgrounds that experienced a reduction of their household income can be attributed to the informal economy, which accounts for around 60% of those who are active on the labour market.

In addition, the Mexican federal government decided not to expand social assistance during the COVID-19 crisis. The Buenos Aires data, in turn, reflect the stabilizing effect that the expansion of social assistance introduced by the Argentine government has had in offsetting the negative consequences, even if its effects were significantly milder than in the case of Berlin (Lustig et al. 2020). Another aspect that explains the differences, and which we will focus on below, has to do with the options available to working parents during periods of lockdown. In this respect, when governments kept school/daycare closures to a minimum or offered income replacement to parents who could not work due to childcare responsibilities – as in the case of Germany (Eggers et al. 2023) – the negative income effects were smaller.

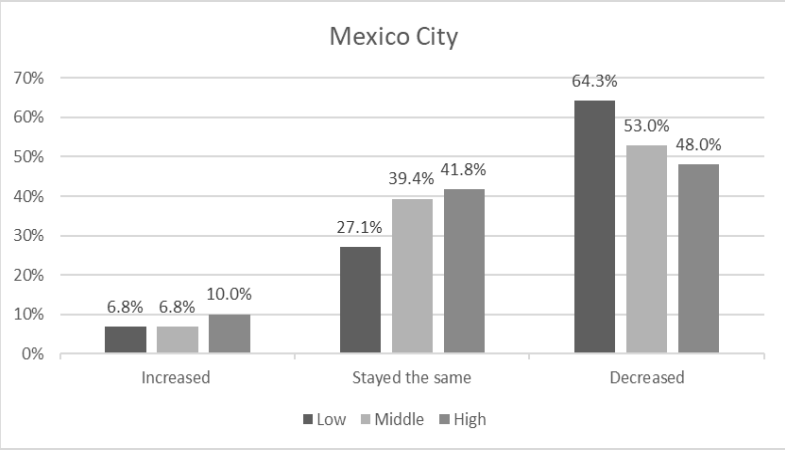
Figure 2: Impact of the pandemic on household income, by level of education



Source: Authors' elaboration based on FU Berlin (2022).



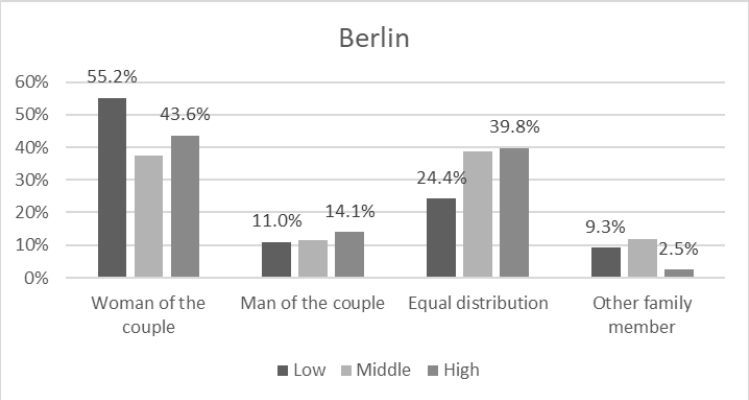
Source: Authors' elaboration based on UNLP (2021).



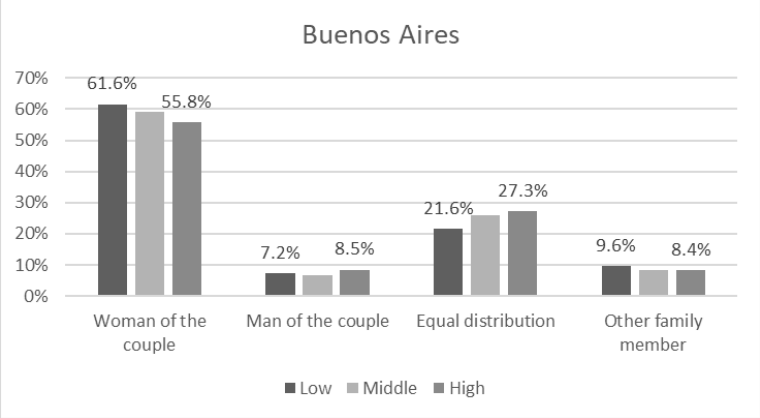
Source: Authors' elaboration based on COLMEX (2021).

The link between the position of the household in the social structure and inequalities in the distribution of care and housework responsibilities is clearly observed in our survey data. In all three cities and in all social groups within them, women were the main providers of this work before the pandemic. This is hardly surprising. What is striking, however, is that in all three cases, the higher the socioeconomic status of the household, the more likely it is to report an equal distribution of these tasks (see Figure 3). And while this trend repeats itself in all the cases we analysed, the proportion of households reporting an equal distribution of domestic tasks is higher in Berlin across all social groups.

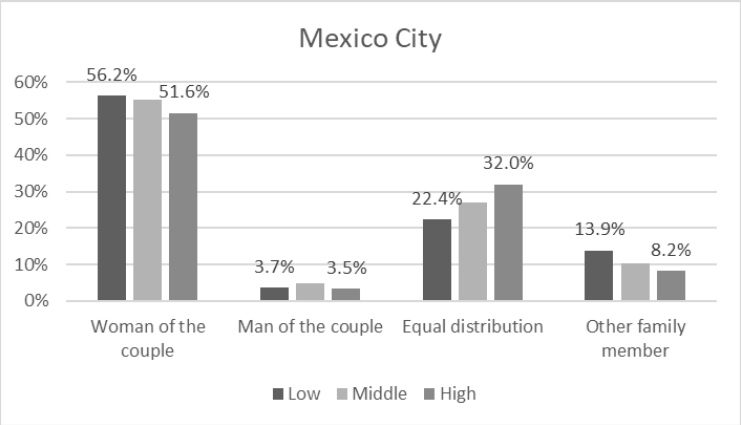
Figure 3: Household member that did most of the housework before the pandemic, by level of education*



Source: Authors' elaboration based on FU Berlin (2022).



Source: Authors' elaboration based on UNLP (2021).



Source: Authors' elaboration based on COLMEX (2021).

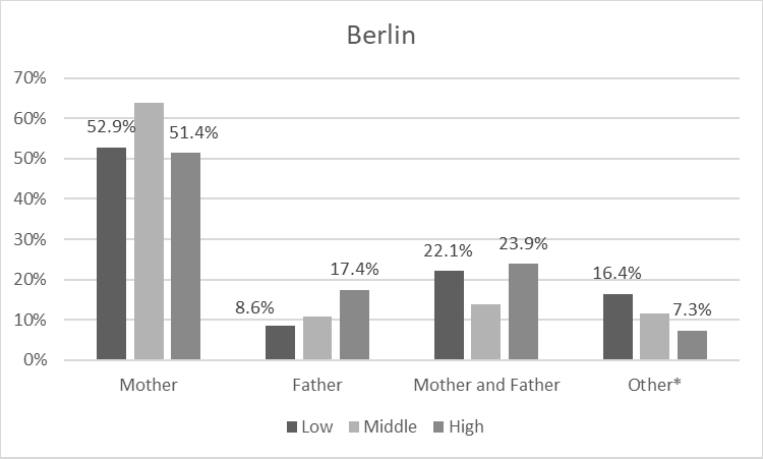
*Excludes single-person households in all cities and, in the case of Berlin, excludes also housing arrangements that are not considered households, such as shared accommodation (*Gemeinschaftsunterkünfte*) and apartment shares (*Wohngemeinschaften*).

The pandemic exacerbated these pre-existing inequalities. As is well known, our survey data show that household care work increased significantly during the lockdown period. This was due to the closure of schools and day care centres and/or the inability to rely on the work of domestic workers, among other reasons.

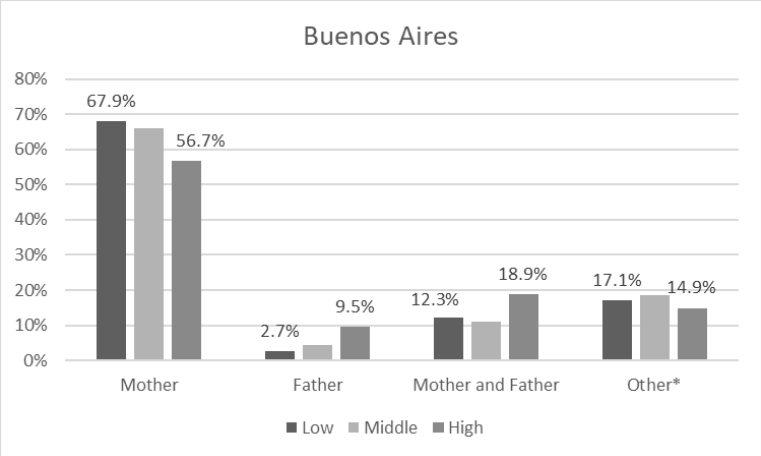
Nevertheless, large proportions of survey respondents reported no change in the distribution of housework (66% of households in Mexico City, 75.5% in Buenos Aires, and 82.4% in Berlin), suggesting that those who previously did the lion's share of care work were overburdened. But even though most households in all education groups maintained their previous arrangements for care and housework, those that reported a change towards a more equitable distribution were again those with higher levels of education.

Following the same trend, the case of households with school-age children who had to switch to homeschooling is particularly striking. Significantly more mothers than fathers were reported to be the primary helpers of children and adolescents during the periods of online instruction. Again, our data indicate that there were some differences by social class, as shown in Figure 4. We suggest that this should be read in terms of the fragmentation of care services. The data show that those at the bottom of the social structure, who have fewer options available to them, also have a more limited ability to negotiate the allocation of new responsibilities. This highlights a clear link between the macro and micro levels of analysis: even though negotiations over the distribution of domestic and care work within households may appear to be a private matter, they reflect the access that households have to services at the macro-social level. Thus, while gender inequalities in the allocation of care are found in most households, regardless of their position in the social structure, they are exacerbated in the case of those with lower socioeconomic backgrounds and fewer options.

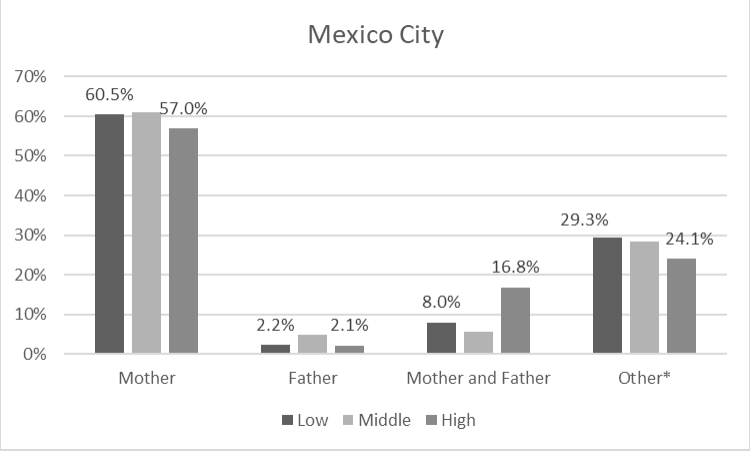
Figure 4: Household member responsible for helping during homeschooling, by level of education



Source: Authors' elaboration based on FU Berlin (2022).



Source: Authors' elaboration based on UNLP (2021).



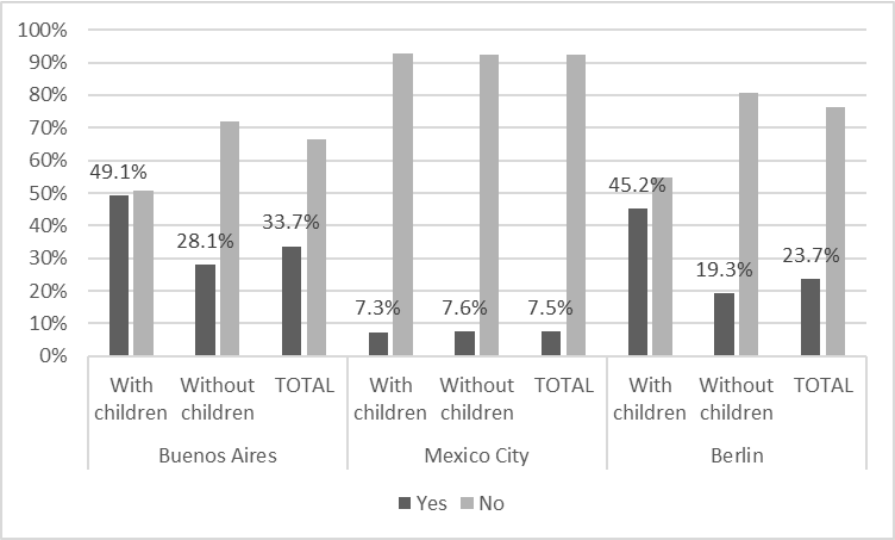
Source: Authors' elaboration based on COLMEX (2021).

Regarding homeschooling, it is necessary to note an important difference between the three cases studied: the length of the period of school closures. While UNESCO recorded a total of 82 weeks of school closure in Argentina (22 weeks of total closure and 60 weeks of partial closure) and 81 weeks in Mexico (53 weeks of total closure and 28 weeks of partial closure), schools in Germany were closed for a much shorter period: 38 weeks in total, divided into 14 weeks of total closure and 24 weeks of partial closure (UNESCO 2022). This shorter period was possible thanks to the implementation of a reduced schedule, with half of the students per classroom alternating in daily or weekly shifts, accompanied by strict hygiene rules and other similar measures imposed by the federal and local governments (Freundl et al. 2021). When asked about the person responsible for childcare during periods of lockdown – including preschool children – the picture repeats itself: We see higher participation of fathers in Berlin and in households with higher levels of education in all three cities. But it is important to note that about 12% of households in Berlin had access to official alternative arrangements for the children of "essential" workers, which were not available in the other two countries. Again, we see that a more equal distribution of tasks within the household is easier to achieve in contexts where care responsibilities are also better shared with other institutional actors, in this case, schools and daycare centres.

According to our survey data, and in line with what was mentioned earlier, while 23.7% and 33.7% of the population in Berlin and Buenos Aires, respectively, reported having received support from the government during the more difficult moments of the pandemic (participating in at least one of the different support programs), the percentage drops to 7.5% in Mexico City. Another aspect to consider is that while in both Berlin and Buenos Aires there is a marked difference in access to government support in favour of households with children, the difference is almost non-existent in Mexico (Figure 5). This points to the application of policies targeted at families with children.

Now, when asked about support received from non-state actors, the incidence is much higher in Mexico City and Buenos Aires, and in all three cases it is also higher among households from lower socio-economic strata. For example, 4% of the population in Mexico City reported receiving donated medicines, compared to 2.7% in Buenos Aires and 1.4% in Berlin. This also reflects differences in access to healthcare: While virtually the entire population of Berlin is covered, with household members having access to either public health insurance (85.5%), private health insurance (8.9%), or a combination of both (4.7%) – and only 0.2% reported being uninsured – 31.7% of households in Mexico City reported having no health insurance. In Argentina, on the other hand, there are 20.9% of households whose members are not covered by either employment/retirement or private health insurance, but who have access to the universal health system available to everyone in the country.

Figure 5: Households that received government support during the pandemic, by presence of children under 12



Source: Authors' elaboration based COLMEX (2021), FU Berlin (2022), UNLP (2021).

When the state is not the one providing assistance, other actors take on this role. As discussed earlier, the importance of neighbourhood and community initiatives is striking in the context of Mexico City and Buenos Aires. Now, when community organizations had to provide meals and other types of support, this also resulted in increased exposure to the virus and thus increased risk. In addition, while community care alternatives such as soup kitchens were often already stretched thin, the increased demand during lockdown periods – due to the important number of people whose incomes were adversely affected – again placed a strain on community caregivers, mostly women from lower socioeconomic strata (Almeda Samaranch and Batthyány 2021; Zibecchi 2022).

6. Concluding Remarks: Inequalities between Social Groups and across Care Provision Models

Although the pandemic and its containment measures affected people virtually all over the world, the severity of the impact varied according to different elements such as socioeconomic position, gender, ethnicity, or household composition. In this text, we have discussed the interactions of these aspects with the models of care provision in different social contexts. We have shown that in societies with already high levels of inequality, responses have not been sufficient to prevent a widening of the social divide along class and gender lines. Moreover, the level of preparedness of care services and the existence of more universal and less fragmented care options not only determined how the health crisis was managed (Esquivel 2023), but also had a direct impact on the containment of increasing social inequalities.

Looking at the cases of Mexico City and Buenos Aires, we confirmed what other analysts have already pointed out, namely that in Latin America the pandemic exacerbated the gender, class, and racial/ethnic inequalities that have long characterized the region's care regime (Martínez Franzoni and Siddharth 2023). As our data show, in societies with less state involvement in care provision and reduced government support during the pandemic, not only were income inequalities exacerbated, but pre-existing inequalities in the distribution of care responsibilities were deepened. This was clearly seen in terms of gender – as women, who already did the lion's share of care work, had to take on even more responsibilities – but also between different groups of women: when analysing the distribution of childcare and homeschooling support, it became clear that households occupying a lower position in the social structure not only saw inequalities between family members worsen, but also in comparison to other households, as they had fewer resources to cope with the new situation while often also facing higher care demands due to a higher presence of children. The longer periods of school closure in Latin America, the lack of childcare alternatives for essential workers and single parents, and the absence of income replacement for those who could not work because of childcare responsibilities also had an important impact.

In contrast, the welfare model established in Germany, which explains the lower level of inequalities compared to Latin American countries, has guided government policies to mitigate the negative effects of containment measures and has achieved a better result in avoiding a deepening of income inequalities. And while greater support for working parents has also been central to a more equitable sharing of care responsibilities, it has become clear that Germany still has some way to go in closing the gender gap. This reflects the important role that families, and women in particular, play in providing care in German society. This type of care model, although less fragmented thanks to greater state involvement, still tends to reproduce a traditional gender division of labour, and as we have seen with our survey data, mothers still tended to take on most childcare responsibilities during the pandemic and spent significantly more time helping with homeschooling than fathers.

The classification into different models of care provision, i.e. familialized/commodified in the case of Argentina and Mexico and familialized/de-commodified in the case of Germany, highlighted that lower levels of state involvement in care provision are directly related to higher levels of fragmentation in access to care services and, in turn, to higher levels of inequality in the distribution of care responsibilities. In this sense, the higher level of government involvement in Berlin was key to avoiding an increase in income inequalities, in contrast to what we observed in Buenos Aires and Mexico City. However, the family aspect of the German care model has not been able to prevent an increase in gender inequalities in care responsibilities. The familialization of care leads

to feminization, as our data showed. However, because of the greater participation of the state, the gendered impact of the pandemic, even if present in the case of Berlin, was still less than in Buenos Aires and Mexico City.

In other words, using the pandemic as a magnifying glass to analyse the care crisis by comparing different societies has highlighted the fact that inequalities have undermined the response to the crisis, deepening the gap between men and women and among women with different socioeconomic characteristics. Moreover, the pandemic has affected not only inequalities but also patterns of living together, i.e. convivial arrangements. This text has illustrated these dynamics through an analysis of household responses to increased care needs, showing how segmented access to care services translates into deeper inequalities within and between households. Care, analysed as a convivial realm, reveals how interpersonal negotiations at the micro level are embedded in broader dynamics at the macro level. The changes brought about by the pandemic have made this relationship even clearer, highlighting the differential impact of the COVID-19 crisis on different social groups and contexts that offer a particular matrix of care provision.

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