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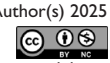

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Long-term care workers in Spain as *contaminating agents* during the covid-19 pandemic

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Abstract

During the covid-19 pandemic, long-term care workers played a crucial role in ensuring well-being. Despite this, they came to be seen as bearers of discomfort, harm and even death. Long-term care workers themselves accepted that, notwithstanding their assigned role and their own best intentions, their presence brought with it a risk of contagion. In this article, we interrogate how these care workers came to be perceived and perceive themselves as a threat to those they cared for. We also describe their strategies for risk management and the responsible provision of care. We used a qualitative methodology centred on 36 semi-structured interviews carried out with long-term care workers in Spain. We found that both official measures designed to reduce transmission and informal practices of control played an important role in the emergence of the perception that these workers constituted a threat and ultimately reinforced the preexisting marginalisation that they faced. In addition, we saw that strategies for covering, removing and cleaning the body aimed at ensuring well-being were simultaneously practical and symbolic. The article makes a contribution to the relatively unexplored nexus between care, the body and risk.

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Bodywork, contamination, covid-19, long-term care workers, risk

Introduction

On 11 March 2020, the World Health Organization declared the SARS-CoV-2 (hereafter covid-19) pandemic. Days later, on 14 March, the Spanish government decreed a state of alert and implemented measures to prevent transmission including home confinement, mobility restrictions and social distancing. The sense of widespread anguish during this period was documented in media coverage such as El Mundo with headlines like 'The new panic society: how the coronavirus has transformed our fears' (Benítez, 2020). As well as disrupting the daily lives of the general population, this context had an especially significant impact on long-term care (hereafter LTC) services.

The Spanish LTC system is characterised by underfunding and generally insufficient levels of support, a dependence on the largely unpaid labour of family members, and the privatised delivery of care (74.1% of residential centres were private at the time of the pandemic) (Martínez-Buján et al., 2022). As a result of structural factors, the sector is characterised by minimal training requirements and low wages. The Spanish care workforce includes a much higher share of workers classified as unskilled than in other European countries (Geerts, 2011). It is highly feminised (around 90% of workers are women), and migrants are overrepresented (25.6% in residential care homes and 49.2% in-home help services) (Martínez-Buján et al., 2022).

In this context, the measures taken to mitigate risk of contagion in LTC were not effective (Zalakaín et al., 2020). The initial lack of information and the delayed establishment of protocols led to chaos and uncertainty (Comas-d'Argemir and Bofill-Poch, 2022; Del Pino et al., 2020). In addition, during the first wave of the pandemic (12 March to 21 June 2020), adequate and sufficient personal protective equipment (PPE) was generally unavailable (Salas-Nicás et al., 2020). Spain was not unique in terms of its crisis management. Throughout Europe, the response of health care systems was insufficient, uneven and inconsistent, slow, late and inadequate, and this placed the burden of care on families (Daly, 2022). Also in the United States, protocols shifted constantly (White et al., 2021) and there was not enough PPE equipment, nor training in how to use it effectively (White et al., 2021). A similar reality was also documented in the case of Australia and the United Kingdom (Hussein, 2020), Italy, Peru and Mexico (Sarabia-Cobo et al., 2021).

Even before the crisis, many health workers faced exacting physical and emotional demands in the workplace. The pandemic, which increased both the workload and the incidence of violence and harassment (International Labour Organization, 2020), further impacted their physical and psychological health, exposing them to increased risk of burnout, moral distress and compassion fatigue (Blanco-Donoso et al., 2021). Gender, class and ethnicity have been identified as key variables in terms of LTC workers' risk of contracting covid-19 (Nguyen et al., 2020), making the low-paid migrant women prevalent in the Spanish context especially vulnerable. The covid-19 virus thus confronted LTC workers with a paradox: while their primary responsibility was to ensure well-being, they could also potentially bring discomfort, harm and even death to those they

were supposed to care for. We use the uncomfortable term *contaminating agents* in this text to refer to LTC workers deliberately, as it compels a reflection on the stigmatisation they faced even while making a vital contribution to the crisis response. We confront this tension in order to achieve a twin objective: (1) to analyse the construction of LTC workers as *contaminating agents* during the pandemic and (2) to describe the strategies that these workers developed in response with respect to risk management and responsibility for care. We used a qualitative methodology to approach the experiences and perceptions of LTC workers and interpret them in the context in which they occurred. This centred on collecting the testimony of 36 Spanish LTC workers gathered through semi-structured interviews.

Existing research provides quantitative data on covid-19 contagion and its consequences (see Blanco-Donoso et al., 2021; Greene and Gibson, 2021; Zalakaín et al., 2020 among others). Some qualitative research also exists on the social construction of risk in context of the pandemic (Bhanot et al., 2021; Moctezuma, 2020 among others) and the impact of covid-19 on LTC services (see for example, Del Pino et al., 2020). Risk is also the subject of significant attention in the field of public health (Fine, 2005; Lupton, 1993), and some papers specifically address the psychosocial risks faced by LTC workers outside the specific context of the pandemic (Blanco-Donoso et al., 2021; Cohen and Wolkowitz, 2018; International Labour Organization, 2020). However, the topic has received little attention in work on care within the discipline of sociology. One contribution of this article is to demonstrate the importance and legitimacy of engaging with the social perception of risk and contamination from a sociological perspective. To this end, we bought together disparate lines of research. Specifically, we found it necessary to integrate literature addressing the social construction of risk, understandings of contamination and care as bodywork.

Care work, risk and contamination

Care as bodywork

As emphasised by a number of authors, care is a form of bodywork (Cohen and Wolkowitz, 2018; Fine, 2005; Lhuilier, 2005; Molinier, 2008, 2011; Twigg, 2000; Twigg et al., 2011). It involves work not only *with* the body, but also *on* it (Molinier, 2008). Twigg et al. (2011) argue that 'social care is in fact centrally about body care' (p. 175), an assertion that reflects the intimate and physical nature of caregiving tasks. While the body is at the centre, the current consensus in the literature is that care is multifaceted, requiring '*both* emotional labour and body work' (Cohen and Wolkowitz, 2018: 7). In addition, care is traversed by power relations, which is why some authors argue that 'issues of abuse, violence and oppression should be conceptualised as part of rather than in opposition to care' (Kelly, 2017: 98). The increasing medicalisation of care, particularly in residential settings, adds a further layer of complexity (Comas d'Argemir et al., 2022).

Dealing with the bodily dimension of care brings its own set of challenges. As the body is indivisible (Cohen and Wolkowitz, 2018), it demands the co-presence of the caregiver and care recipient. This can bring caregivers face-to-face with their own vulnerability (Fine, 2005), exposes them to risks such as sexual harassment and physical

violence (Cohen and Wolkowitz, 2018) and confronts them with social taboos (Twigg, 2000: 399). Research observing bathing and washing emphasises that care work involves negotiating nudity and dealing with human waste, dirtiness and disgust (Twigg, 2000). For this reason, occupations closely linked to the physical and bodily dimension of care fall within a category loosely defined as 'dirty work' (Lhuilier, 2005; Molinier, 2011; Twigg, 2000; Twigg et al., 2011). Twigg (2000) argues that measures taken to maintain bodily distance such as gloves, commonly used in England among community care workers during bathing, can imply that the person being cared for is contaminated or subhuman. As a result, some workers feel guilty for wearing them.

It is important to recognise that not all emotions linked to the bodily dimension of care are negative. In fact, this work is often experienced as worthwhile, meaningful and rewarding (Twigg et al., 2011). These contradictory emotional engagements with care work are not mutually exclusive (Kelly, 2017). Holroyd and Holroyd's (2015) research on tub bathing in a nursing home for elderly people in Canada concluded that most workers found it to be a stressful but nevertheless intimate bonding activity. Comparable emotional experiences also surfaced during the pandemic. Studies conducted with nurses in nursing homes in Spain, Italy, Peru and Mexico (Sarabia-Cobo et al., 2021) and in hospitals in Sri Lanka (Rathnayake et al., 2021) and Indonesia (Siregar et al., 2022) also show that while providing care during covid-19 was a demanding experience, it was also satisfying and motivating.

Experiences of giving and receiving care work are shaped by social hierarchies and inequalities. Paid care work is often perceived as unskilled and is rewarded with low wages and precarious working conditions (Fine, 2005; Molinier, 2008, 2011). Lhuilier (2005) notes that, in care-related bodywork, a division of labour operates not only technically and socially, but also morally and psychologically. For this reason, the greater the prestige and privilege associated with a role or position, the greater the bodily distancing of those who exercise it (Lhuilier, 2005; Twigg et al., 2011). A focus on the bodily dimension of care helps explain the lack of recognition and the precarious working conditions that characterise LTC work, as well as its feminisation (Cohen and Wolkowitz, 2018).

The social construction of risk, purity and contamination

Risk is multidimensional and context-dependent. Douglas (1986) describes it as a socially constructed phenomenon shaped by cultural values. Moctezuma (2020), to give an example, documents how a section of the Mexican population saw exposure to covid-19 as relatively low risk in the context of their everyday lives marked by precarity and violence.

Focusing specifically on the issue of LTC workers being perceived as *contaminating agents* in the context of a global health crisis, the work of Lupton (1993) and Kavanagh and Broom (1998) provides a number of insights. Elaborating on ideas introduced by Douglas, Lupton (1993) identifies two ways of understanding risk in public health discourse. The first, 'environmental risk', includes external threats to health over which individuals have little control (e.g. environmental hazards such as pollution and toxic chemical waste). 'Lifestyle risk' is perceived as a consequence of an individual's 'lifestyle choices' (e.g. tobacco or alcohol consumption). Kavanagh and Broom (1998) add a

third category: 'embodied or corporeal risk', which refers to risk situated inside the bodies of individuals that expresses 'something about who the person is' (Kavanagh and Broom, 1998: 437). Their research with patients who received abnormal Pap smear results suggests that embodied risk can cause a person to conceptualise themself as separate from and threatened by their own body.

Lupton (1993) also shows that definitions of risk can operate as tools used to maintain social hierarchies. She argues that different understandings of risk can harden the separation between the self and 'the other', and that 'the notion of external risk thus serves to categorize individuals or groups into "those at risk" and "those posing a risk"' (Lupton, 1993: 428). This moral distinction reflects a differentiation between harm caused by external forces beyond an individual's control, and that caused by individuals themselves. Her conclusions support the idea that the concept of risk is used in public health discourse for political purposes and that, in a significant number of cases, purported concerns can be attributed to ideological objectives rather than genuine consideration of health or well-being. In their research addressing stigma and discrimination over the course of the covid-19 pandemic, Bhanot et al. (2021) similarly noted that uncertainty and fear of the unknown guided by the adage 'better safe than sorry' fermented othering and encouraged not just caution but also negative behaviours directed towards people suspected of being contagious, including medical professionals.

The framework of social risk can be complemented by theories of purity and contamination, which offer another lens through which to understand societal responses to the bodily dimension of care. The body is an ideal space for analysing conceptions of purity and contamination (Cortés Campos, 2010), since control of bodies is another form of social control (Douglas, 1970, 1975). Johnson (2023) engages in analysis from this perspective when she reflects on the symbolic meaning of wearing gloves for some care activities, such as changing nappies, showering or feeding. Gloves are a barrier between dirty and clean matter, and represent a boundary that has become contaminated and should therefore be disposed of. In many contexts, an imperative exists for bodies to be less visible in social relations. In the specific context of care work, Molinier (2008) observes that nurses must conceal their bodies and avoid revealing signs of fatigue, vulnerability, irritation or suffering in order for their presence to be reassuring. Douglas (1970) designates this process 'disembodiment'. The disembodiment of relationships can also be understood as a strategy for maintaining purity. In the face of the threat of contamination, bodily expression and the physical body are progressively removed. Le Breton (1991) describes this phenomenon as the 'ritualized erasure of the body', which includes practices that reduce bodily presence through concealment, silence, and discretion to maintain a sense of order and purity. Wearing masks and social distancing, widespread practices during the pandemic, can be understood as symbolic actions as well as practical tools to mitigate the risk of contamination.

The above review of the literature brings together the centrality of the body in care work, the stigma sometimes attached to the bodywork of care, and the politicisation of risk. Taken together, this offers a framework through which to understand ways that social values shaped both the practice and perception of care work in the LTC sector in the context of a global health crisis.

Method

The fieldwork for this research is drawn from two qualitative projects aimed at analysing the impact of the pandemic on the working conditions of people who, paid or unpaid, were engaged in caring for dependents and the elderly in Spain. This specific article is based on 36 semi-structured interviews with a diverse sample of professional LTC workers that were carried out by different members of the research team, including the authors.

Sample selection took into account gender and specific role in care. We interviewed LTC workers providing direct care on the lowest rung of the care work hierarchy. Our sample was generally representative of the general population of LTC workers in Spain across the variables of gender, migration history, age and level of education (Martínez-Buján et al., 2022). 30 respondents were women and 6 men. Twenty-three were born in Spain, while 13 were immigrants. Seventeen were aged from 20 to 44 and 19 between 45 and 64. Most, but not all, had relevant formal training. Twenty-two had completed certified vocational training, while eight had completed a certificate. Of these eight, five were immigrants who held university-level qualifications in an unrelated field. Of the remaining six interviewees, four had completed secondary education and two had completed further education in an unrelated field. Seventeen interviewees were geriatric assistants working in nursing homes for elderly people, 13 were home care assistants working for home help services and 6 were personal assistants providing personal assistance services.

Initial participants were recruited from among existing contacts established during earlier research projects, and the sample was subsequently expanded through the snowball technique. We would like to highlight the willingness of the LTC workers that we approached. In general, our respondents desired to share their experiences and believed that it was important for their efforts to save lives to receive the visibility they deserved. As a result, most of the interviews were extensive and involved a degree of emotional connection. This rich and rewarding fieldwork process facilitated detailed accounts and deep reflection.

The prepared interview script focused on caregiving practices before and during pandemic, and was organised into four blocks: caregiver, caregiving context, cared-for person and alternatives or possible improvements that could be made to the existing care system. This article is limited to addressing testimony gathered in the first three blocks. Early interviews were conducted during the period of home confinement (April–July 2020), although most were held between September 2020 and February 2021. They lasted from 60 to 120 minutes. We ceased interviews when the team consensus was that saturation had been achieved. While some interviews were conducted face-to-face, the pandemic forced us to conduct a majority remotely in order to ensure safety and to accommodate the preferences of the interviewees. For online interviews, we used the digital platforms Zoom, Google Meet, Skype and WhatsApp video-calls. Our research did not constitute a project of virtual ethnography (Hine, 2000). Instead, digital platforms simply offered a means for us to conduct interviews while respecting the covid-19-related restrictions on mobility and physical gathering that were in place at the time (Hamui and Vives, 2021).

All the interviews were audio-recorded with the prior informed consent of each participant. They were then transcribed verbatim for analysis with the support of *Atlas.ti*

software. We used sociological discourse analysis (Ruiz, 2009) as this allowed us to identify and understand the narratives of the LTC workers in the context in which they were produced.

LTC workers as *contaminating agents*

Below we present the results obtained from our analysis of the interviews. First, we describe how the perception of LTC workers as *contaminating agents* emerged and was materialised in the implementation of protective measures and mechanisms of social control. Second, we describe the strategies developed by LTC workers to protect themselves and the people they cared for, while also continuing to carry out their work as caregivers.

Protocols, protection measures and social control mechanisms

The pandemic was a dynamic, unfolding event during which information about the virus and the tools available to respond to it emerged unevenly and unpredictably. LTC workers were a focus of attention throughout, as they provided care to an especially vulnerable population, and because the physical intimacy of care work itself was an additional risk factor. The way that the perception of risk changed over the course of the pandemic was related to but not determined by objective conditions.

The lack of information and personal protection equipment. During the first wave, there was a general lack of protection against the virus, due to both insufficient availability of PPE and limited awareness of the seriousness of the situation. The widespread shortage of PPE drew comment in virtually all of the LTC workers' accounts. Nerea (geriatric assistant) reported: 'Nobody had masks, nobody had safety glasses, nobody had FP2 masks, nobody had PPE . . . nothing'. Similarly, Karina (home care assistant) recounted: 'We didn't have the equipment we needed, masks, screens, any kind of protection (. . .) we felt unprotected'. This situation worried LTC workers because it exposed them to a high risk of being infected and of transmitting the virus to the people they cared for, including their own families. Karen (geriatric assistant) recounted: 'We were afraid of getting infected, of infecting the people we had at home'. In addition, the lack of information led to uncertainty about what was happening and this resulted in confusion and a lack of organisation on the part of service:

> There were maybe three changes in policy in a single afternoon. That is, we started our shift at 3pm and at 3pm we found out, well, what we were expected to do with the people in isolation and how we were supposed to organise ourselves, and that was the first plan. At 5pm there was a different policy and at 8pm maybe another one again. And when we arrived at work the next day there had been another change. (Raquel, geriatric assistant)

During this period, some nursing homes prohibited the use of what little protective equipment they had, mainly so as not to alarm and distress the residents. Even the

existence of covid-19 and its seriousness were denied. All of this put both LTC workers and service users at risk:

> We were very ingenuine in the circumstances, because we thought we were untouchable, right? Because visits continued, despite the fact visiting had already been cancelled in other centres we continued to allow them. We couldn't wear masks, the workers (. . .) because it might frighten the users, right? (Nerea, geriatric assistant)

Vivian (geriatric assistant) reported that, in the nursing home where she worked between March and April 2020, there were officially no people infected with covid-19, despite the fact that there had been deaths among residents every night since March of that year. There were also cases where home care assistants were not informed that the care recipients that they were working with had tested positive.

The establishment of protocols and protection measures. As time went on, alarm spread through the health system and wider society. LTC workers became a particular focus of concern, and protecting them was directly tied to protecting the people they cared for. This dynamic is clear in Damian's (geriatric assistant) account: 'the nursing home had to find ways to make workers protect themselves and, really, if a worker protects themself, they are protecting residents'. Workers came to be perceived as vectors of contamination. José (a geriatric assistant) acknowledged that 'we were the biggest transmission vector there was, involuntarily'. Thus, along with supplying PPE, rigid protocols were implemented on the basis of WHO guidelines. In the case of home help services, a technical document detailing recommended practices was published by the Spanish Government (Secretaría de Estado de Derechos Sociales, 2020). This protocol was also adopted by personal assistance services, while in the case of nursing homes, specific legislation was enacted (Royal Decree-Law 21/2020, of June 9). Workers found these protocols exacting:

> It was very meticulous (. . .) there were protocols for changing clothes, for putting on the PPE that the company allocated us. And washing our hands all the time and all the proper protocols. Quite strict in that sense. (Luciana, personal assistant)

The main objective of the protocols was, in general, to minimise or eliminate bodily contact. As care work involved physical proximity, more protective barriers were added to compensate for this closeness: 'They gave us hospital gowns, which were single-use gowns; gloves, three types of mask, surgical masks, so that we could work one-on-one' (Bárbara, home care assistant).

LTC workers were covered in layers and layers of protective equipment to the point that they resembled 'astronauts', to cite a simile that many interviewees used in their stories:

> There were astronauts all over the place. That's what it was like with the suits from top to bottom, triple gloves and things like that. I wore a second suit, of the same type, the suit, overshoes (. . .) triple gloves, we often had to wear long plastic gloves as well, all the way up

> here, to protect against water or when we were bathing someone, so that everything [the rest of the PPE] wouldn't get wet. A cap, overalls, everything covered up, [he gestures to the parts of the body that were protected] the hood all the way up to here. Then a N95 mask, another mask on top, then goggles and a visor. (Jose, geriatric assistant)

These layers protected users and prevented transmission but, at the same time, erased the bodies of the LTC workers. This, together with physical distancing, implied a depersonalisation of care work: 'Of course, that meant colder treatment, we couldn't offer that human contact. (. . .) Now it's all coldness, keeping a distance' (Rosa, geriatric assistant).

LTC workers as vectors of transmission. Even though the use of PPE did dramatically reduce transmission, people receiving care demonstrated fear and resisted workers coming close to them, precisely because they represented a focus of contagion. Bárbara (home care assistant) remembered: 'They were afraid of me touching them, they often said "no, no, I'll do it, even if it's slower", "I'll try and shower myself"'. During this period, LTC workers began to feel more protected at work. However, the perception that they were responsible for the spread of the virus did not diminish, but perhaps even increased. To some extent, this concern was based on the reality that, unlike workers in other sectors, care providers faced increased risk of exposure when travelling to and from work in order to be physically present with their care recipients. This fear of responsibility was magnified for those working in nursing homes, because their coming and going undermined the protection that highly restricted social interaction otherwise afforded this vulnerable section of the population. Home-based care providers drew attention to this when comparing themselves to their nursing-home based colleagues:

> Obviously, [there was] much less fear, much less fear and much less pressure than for workers in residential homes, I'm sure of that, but well, in the period when you weren't allowed to leave your house as a precaution, when any contact with the outside world was a risk, we had to keep going out . . . (Iñaki, personal assistant)

In home help care and personal assistance services, we identified three phenomena that showed how the feeling of responsibility increased even as increasing knowledge and resources reduced the probability of transmission.

First, in home care, protection measures were obligatory for LTC workers as well as users and their relatives. Many users and relatives did not, however, always follow protocol, comply with guidelines for social distancing, or use masks consistently or correctly. Marina (home care assistant) reported: 'When I went to this person's house [infected with covid-19] I used a mask, disposable gloves, but he didn't'.

Second, in some cases, care recipients and/or their relatives demanded to know about workers' doings outside their responsibilities as carers. This illustrates that they were seen as vectors of transmission, a dynamic demonstrated even more clearly in cases in which families imposed measures beyond the established protocols, restricting workers' movement within homes and demanding constant cleaning and disinfection:

> Well, they'd ask you: 'the other places you work, tell me . . . what's happening there? Or, 'what's going on in the other homes you visit? Where do their sons and daughters work?' I don't know, they were a bit worried in case, by going from one house to another, we might spread the disease. (Mariana, home care assistant)

Third, cleaning, which was already part of care work, gained special symbolic significance as an act of disinfection and, thus, safety and protection:

> Things we used to do, filling the hot water, bring the food in . . . now they kind of don't want you to touch it, in some places. In others they say 'go on with your normal life and then I'll disinfect it'. But, more or less, you might find that in two cases out of eight. In the other six: 'Have touched this? Then go and clean it with bleach. (Mari, home care assistant)

The above examples provide evidence as to how the perception that workers were a 'contaminant' developed and persisted throughout the pandemic, even once protective materials were available and protocols were in place.

Risk management and LTC workers' strategies to protect themselves and others

LTC workers felt afraid from the outset of the pandemic: they feared becoming infected and infecting others, including both service users and their own relatives. This was accentuated during the initial weeks due to misinformation, the shortage of protective equipment and the lack of diagnostic tests. In this period, LTC workers began to see themselves as vectors of transmission of the virus:

> The initial feeling was fear. I mean, we were all afraid, I personally was afraid, for my grandparents and for myself. That is, of everything (. . .) We were afraid and, well, we didn't know what might happen to us, because, if you got infected you might be a carrier, or not, because, of course, testing wasn't being done either. (María, geriatric assistant)

> You worry when you go in [to service users homes] because you don't know if you are bringing it [the virus] with you or if you are going to leave with it, and then we also had to deal with the fact that it's not just one home, we went from one to the next, and maybe it would be me who set off another cluster. And then, of course, you have to go back home to your family. (Miguel, home care assistant)

This fear of infecting, harming and even killing care recipients remained even once PPE became available, as LTC workers continued to perceive themselves as vectors of covid-19. Damián (geriatric assistant) reported,

> It was more the fear of 'what if I really am the death, going into nursing homes, missing some small detail, leaving my mask a little bit too low, not securing it properly, or whatever: If I scratch my eye with my glove on and then touch somebody'. . .

To cope with the context in which they operated and to minimise the risk of contagion to both themselves and others, LTC workers developed responsible practices for the care

of service users and their own families. While based on the official protocols mentioned earlier, they sometimes took measures to an extreme and interpreted them in particular ways. We identified three strategies that LTC workers used to protect their bodies. The first two aimed to remove the body, and the third to purify it.

Removing the body. The first strategy was to physically cover up as much as possible. During the onset of the pandemic, given the lack of material, there was a generalised process in which workers themselves tried to secure material by accepting donations, buying it, and using home-made alternatives. This included home-made cloth masks and gowns made from rubbish bags, among other improvised solutions:

> I went out, I bought masks, I bought my own gloves and gel and I had it, because I also had to have it in my own house. (Valentina, personal assistant)

> Workers were wearing rubbish bags (. . .) we had to bring our own safety glasses from home: snow goggles, these safety glasses for use in factories that don't really work, but well, they're better than nothing. (Irati, geriatric assistant)

Even after supplies of certified equipment became available, the perception that LTC workers were *contaminating agents* continued and, in fact, increased. Some LTC workers implemented additional procedures beyond those established in the official protocols: 'The gloves we use, we wear two pairs one over the top of the other, and I consume a lot of them' (Mercedes, home care assistant).

A second strategy workers used was to try to physically isolate themselves from others. Many made drastic changes to this end that affected their personal lives. To give some examples, they curtailed their leisure activities, limited their social contacts and restricted family gatherings, even physically separating themselves from their loved ones. Alejandra (home care assistant) described her practices as follows: ' . . . during the State of Alarm, you didn't interact with your colleagues or anyone else, you went to the service users' houses and that was it'. Along the same lines, Raquel (geriatric assistant) stated: 'My mother lives here in the city and I stopped visiting her, because I was very afraid of infecting her'.

Purifying the body. Finally, a third strategy was related to cleaning the body. In addition to the measures imposed by official protocols, some workers created their own purification routines that they followed when returning home after work:

> Here at home, I live with my children (. . .) we take off our shoes and clothes in the hall, in the entrance, and I usually go straight into the shower. I disinfect the doorknobs, well, we've been taking our [clothes] off, putting [disinfectant] on everything, the keys, everything. (Mercedes, home care assistant)

Within the logic of seeing themselves as *contaminating agents*, some LTC workers went as far as to implement 'purification rituals', as understood in the sense described by Douglas (1966). That is, they engaged in rituals which for them were synonymous with disinfection and purification, ensuring that they eliminated any contamination:

> You go to the changing rooms and, well, to shower and shower and shower. I really cleaned myself; I even washed my glasses and sometimes there was this sensation of being covered in filth and washing yourself was like a way of purifying yourself a bit. (Carmen, geriatric assistant)

Some LTC workers even went so far as to expand their cleaning practices to the point where they became obsessive:

> Look, I'm not saying that we used to wash ourselves in bleach all over, but using it on ourselves was only just outside the limits. We disinfected our PPE from top to bottom, we were a bit over the top about cleaning and disinfection. Excessively. (Juana, geriatric assistant)

Fulfilling the duty of care. In addition to protective strategies, LTC workers engaged in other practices linked to fulfilling their responsibility for the well-being of the people they cared for. They tried to lessen the negative effects that depersonalisation imposed by PPE and social distancing had on the emotional health of the people they cared for in a number of ways. To give an example, Raquel (geriatric assistant) explained that in her nursing home they opened the windows and doors so that the residents did not feel 'like they were in prison'; she also said that she sang and 'clowned around', 'to bring a little bit of joy'.

As to more extreme measures, some respondents reported considering a strategy of isolating themselves inside the nursing homes where they worked, in order to protect their families while also continuing their work as carers. This actually occurred in a nursing home that we visited as part of our fieldwork in early April 2020. Here, almost all residents and LTC workers had tested positive. Ignoring the government's decision to concentrate infected people in a few nursing homes, the director decided to confine herself in situ alongside the residents who had contracted covid-19, while transferring those who had not been infected to another facility. Other workers supported her stance and joined in her quarantine confinement together with the residents. These workers' decision to undertake this confinement at their workplace indicates both the high risk they perceived and their commitment to the people they cared for.

The strategies that LTC workers employed, including routines and rituals, show that the body was understood as both a vector of transmission and, at the same time, fundamental to carrying out the work of caregiving. Moreover, these strategies demonstrate the sense of responsibility that LTC workers felt towards all the people they cared for.

Discussion and conclusions

Our article makes a contribution to the literature addressing care as bodywork and the social construction of risk by bringing to light LTC workers' capacity for agency and their responsible attitude towards care, thus improving our understanding of care work. We highlight how the bodily contact involved in care work put both LTC workers and care recipients at risk and argue that while care recipients were seen as potential victims, LTC workers came to be seen as embodying danger. We show that these workers largely

internalised this distribution of responsibility, and responded by developing strategies to ensure that they were able to provide care while minimising risk and discomfort.

First, understanding risk as social construction has enabled us to describe how the perception and self-perception of LTC workers as *contaminating agents* emerged and consolidated over the course of the pandemic, and the consequences this had on their social position.

External perception materialised in the obligation placed on LTC workers to strictly comply with protective measures, even in cases where, as other studies have also pointed out, service users and their families did not (Siregar et al., 2022). Despite this compliance, workers were subject to additional practices of social discipline, comparable to those documented for health personnel in India (Joshi and Swarnakar, 2021), but not extending to physical violence as Moctezuma (2020) observed in Mexico. In many cases, workers' self-perception mirrored the way they were seen by others. One indicator of this was the fear they expressed of infecting the people they cared for, in both the workplace and their homes, even in spite of their rigorous application of best practices for risk reduction. This experience of fear has also been documented in other research (Sarabia-Cobo et al., 2021; Rathnayake et al., 2021; Siregar et al., 2022; White et al., 2021). Fear also produced negative psychosocial impacts on the mental and emotional health of LTC workers (International Labour Organization, 2020), in a sector already characterised by a lack of recognition and precarious working conditions prior to the pandemic (Fine, 2005; Geerts, 2011; Hussein, 2020; Martínez-Buján et al., 2022; Molinier, 2008, 2011).

At the time the pandemic broke out, the LTC workers in our study occupied a subordinate social position as entry-level workers in a feminised sector with a high representation of migrant workers (Geerts, 2011; Martínez-Buján et al., 2022). Despite the acts of public acclamation that recognised the dedication and sacrifice of essential workers, the perception and self-perception of LTC workers as *contaminating agents* resulted in further marginalisation. This observation is supported by Lupton (1993) and Cortés Campos (2010) who warn that, where hierarchies exist, the attribution of risk can serve as a tool to maintain power structures in society. Work by Bhanot et al. (2021) specifically about covid-19 confirms this interpretation. An aggravation of their lack of social recognition occurred through the differentiation of people involved in LTC into the two categories identified by Lupton (1993): 'those at risk' and 'those posing a risk' (p. 428). This distinction inverted the logic of care, as LTC workers came to be seen as a threat to the people they cared for, insofar as care service users were identified as *being at risk* and those providing care as *being a risk*. Applying an idea developed by Lhuilier (2005), providing care (doing something *for* someone) was transformed into potentially endangering care recipients and negatively affecting their psychic and somatic integrity (doing something *to* someone).

Second, understanding care as bodywork has allowed us to show how and why, as the pandemic progressed, the body became central to the development of the perception and self-perception of workers as *contaminating agents*.

Over the course of the pandemic, the risk of contracting the virus went from being perceived as an external or 'environmental risk' (Lupton, 1993), to being understood as a 'corporeal or embodiment risk' (Kavanagh and Broom, 1998), as the identification of LTC workers as *contaminating agents* became more established. While fear of contagion

expressed by the LTC workers, as anticipated by White et al. (2021), can be partially explained by the direct bodily contact that the work demands, this does not account for the distribution of responsibility shifting towards LTC workers as the pandemic progressed. A greater understanding of the virus and the availability of protective equipment heightened antipathy towards the body as a source of contagion, leading certain bodies to be identified as foci of embodied risk.

Linked to the concept of bodily risk, the protective measures that LTC workers had to comply with and the strategies they developed were intimately connected to the bodily presence that care work requires, as highlighted by Twigg et al. (2011) and Cohen and Wolkowitz (2018), among others. In response to the threat posed by this bodily presence, LTC workers became subject to a process of 'disembodiment' (Douglas, 1970) and 'the ritualised erasure of the body' (Le Breton, 1991). Practical measures were imbued with complex symbolic value. They mitigated the perception of the body as a source of contamination, but also reinforced dynamics of depersonalisation (Del Pino et al., 2020) and reinforced existing social hierarchies. While limiting bodily contact to avoid contagion was not new as a concept or practice in the sector (Johnson, 2023; Twigg, 2000), in the context of the pandemic it became more extreme and more visually evident and thus took on new significance.

Up until the covid-19 outbreak, the person in need of care was often identified as the *contaminating agent*, and certain practices, such as wearing gloves (Twigg, 2000) acted as 'symbolic boundaries' (Johnson, 2023). Over the course of the pandemic, this logic was reversed and barriers were instead understood as serving to protect others from LTC workers themselves. Even while physical co-presence remained central to the act of caregiving (Cohen and Wolkowitz, 2018; Twigg, 2000; Twigg et al., 2011), the bodies of LTC workers had to be held at a distance, covered and cleaned, and otherwise removed. As a result, these workers came to experience an ambivalence towards their bodies similar to that identified in the case of other groups facing embodied risk as described by Kavanagh and Broom (1998). As did health professionals in the Netherlands (Van der Molen and Brown, 2021), LTC workers in Spain developed cleaning routines and rituals. These were practical measures that ensured the safety and security of themselves, their families and their patients, and also expressed feelings of responsibility.

In a way consistent with the work of Rathnayake et al. (2021), our results highlight the agency of LTC workers, understood as their capacity to cope effectively with crisis and adversity. Their attitude exemplifies an ethic of care based on the development of moral disposition, which facilitates contextual responses (Molinier, 2008, 2011) As compared to risk society theories that read the pandemic through a lens of danger, threat and distrust, this offers a fairer and more egalitarian basis for designing public policies and LTC models, as well as for managing social and health crises (Branicki, 2020). Therefore, by concentrating on LTC workers' perspectives, this article appeals to a conception of social relations based on an ethics of care. In parallel, centring the paradox experienced by LTC workers, who faced stigmatisation even as they made enormous efforts to fulfil their responsibilities while managing fear and uncertainty, constitutes an approach to the analysis of care work that recognises the inherent tensions and apparent contradictions identified by Kelly (2017).

To conclude, while this article provides insight into the relationship between care, the body and risk; it also has its limitations. First, it does not address a number of variables including the sector in which individual workers were employed (public, private for-profit and private nonprofit), their working conditions, or the impact of sociodemographic factors such as gender, ethnicity and citizenship. It would be valuable to include these and other questions in future research in order to add further nuance, especially with respect to understanding the experience of workers. Second, the research was conducted early in the pandemic, before vaccines were available. This does facilitate the comparison of similar experiences at a global level, but also reflects a state of exception that changed from 2023. Despite these limitations, by bringing together care, the body and risk, we have made a contribution to academic debates that we believe is also relevant to the design of public policy that would address the complexity of care work and grant it the recognition it deserves.

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Availability of data

Due to the sensitive nature of the research, supporting data is not available. The participants of this study did not give written consent for their data to be shared publicly.

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Résumé

Pendant la pandémie de covid-19, les travailleurs du secteur des soins de longue durée ont joué un rôle crucial pour assurer le bien-être des patients. Malgré cela, ils ont été perçus comme vecteurs de malaise, de préjudice, voire de mort. Eux-mêmes ont accepté que, en dépit du rôle qui leur était assigné et de leurs meilleures intentions, leur présence comportait un risque de contagion. Dans cet article, nous nous interrogeons sur la manière dont ces professionnels de la santé en sont venus à être perçus et à se percevoir eux-mêmes comme une menace pour les personnes dont ils s'occupaient. Nous décrivons également leurs stratégies de gestion des risques et de prestation responsable de soins. Nous avons utilisé une méthodologie qualitative sur la base de 36 entretiens semi-structurés menés auprès de travailleurs du secteur des soins de longue durée en Espagne. Nous avons constaté qu'à la fois les mesures officielles destinées à réduire la transmission du virus et les pratiques informelles de contrôle ont contribué de manière importante à créer la perception que ces travailleurs constituaient une menace, ce qui a conduit au bout du compte à aggraver la marginalisation à laquelle ils étaient déjà confrontés. Nous avons par ailleurs observé que les stratégies pour couvrir, retirer et laver le corps, destinées à assurer le bien-être, étaient en même temps d'ordre pratique et symbolique. L'article permet de mieux comprendre le lien relativement peu exploré entre les soins, le corps et le risque.

Mots-clés

contamination, covid-19, risque, travail corporel, travailleurs des soins de longue durée

Resumen
Durante la pandemia de covid-19, las trabajadoras y los trabajadores de cuidados de larga duración desempeñaron un papel crucial para garantizar el bienestar. A pesar de ello, llegaron a ser vistos como portadores/as de malestar, daño e incluso la muerte. Ellas y ellos aceptaron que, a pesar de su rol asignado y sus buenas intenciones, su presencia conllevaba un riesgo de contagio. En este artículo, se analiza cómo estos/as trabajadores/as de cuidados llegaron a ser percibidos y a percibirse a sí mismos/as como una amenaza para quienes cuidaban. También se describen sus estrategias para la gestión de riesgos y la prestación responsable de cuidados. Se utiliza una metodología cualitativa basada en 36 entrevistas semiestructuradas realizadas a trabajadoras y trabajadores de cuidados de larga duración en España. Se ha hallado que, tanto las medidas oficiales diseñadas para reducir la transmisión como las prácticas informales de control, desempeñaron un papel importante en el surgimiento de la percepción de que estos/as trabajadores/as constituían una amenaza y, en última instancia, reforzaron la marginación preexistente a la que se enfrentaban. Además, se observa que las estrategias para cubrir, eliminar y limpiar el cuerpo, destinadas a garantizar el bienestar, eran tanto prácticas como simbólicas. El artículo contribuye al nexo relativamente inexplorado entre el cuidado, el cuerpo y el riesgo.

Palabras clave
contaminación, covid-19, trabajadoras y trabajadores de cuidados de larga duración, riesgo, trabajo corporal