

COVID-19 and female immigrant caregivers in Spain: Cohabiting during lockdown

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Rocío de Diego-Cordero 

Lorena Tarrío-Concejero 

University of Seville, Spain

María Ángeles Lato-Molina 

University of Barcelona, Spain

M^a Ángeles García-Carpintero Muñoz

University of Seville, Spain

Abstract

From a gender perspective, female immigrant domestic caregivers have been particularly impacted during the COVID-19 pandemic: first, as female immigrants, and second, due to their work within the domestic care sector, which has been so badly affected in this pandemic. This study investigates the emotions and experiences of 15 female Latin American immigrant domestic workers, caregivers in five Andalusian cities (Seville, Cádiz, Málaga, Huelva and Córdoba) (Spain) who were cohabiting with their employees/patients during the COVID-19 pandemic lockdown, using qualitative research through in-depth interviews and life stories. The results show the moral debt accrued by the caregivers with the family who employ them, while worsening the physical and psychological health of many of the caregivers, due to both work overload and fear of the global pandemic.

Keywords

Caregiver, COVID-19 pandemic, emotional and physical health, immigrant women

Corresponding author:

Lorena Tarrío-Concejero, Research Group PAIDI-CTS 1050 Complex Care, Chronicity and Health Outcomes, Faculty of Nursing, Physiotherapy and Podiatry, University of Seville, C/Avenzoar, 6.41009, Seville, Spain.

Email: ltarrino@us.es

Introduction

The crisis originating from the current COVID-19 pandemic has reopened the feminist debate about work division and gender roles, in which women continue to play the role as the main caregivers, thus situating them on the front line of exposure to the pandemic. According to the United Nations, women make up 70% of the workforce in the health sector, and the United Nations (UN) has appealed to governments and society in general to evaluate the role these women are playing as caregivers during the COVID-19 pandemic (UN Women, 2020). Women tend to be at greater risk of health vulnerability, as confirmed by experiences in past pandemics, such as the Ebola and Zika crises, in which gender proved to be a determining health factor (Fassin, 2020). During the COVID-19 pandemic, women have also been the most affected, making up 54.8% of the total infected (Ministerio de Sanidad, Consumo y Bienestar Social, 2020). Women who have continued to work during the pandemic have done so under increasingly hazardous working conditions, often without the necessary personal protective equipment (PPE), many being exposed to great risks due to their direct personal contact with patients with COVID-19 (Bezerra et al., 2020; St-Denis, 2020).

To help stop perpetuating these gender gaps in caregiving sector, we need to analyse the consequences of the COVID-19 in relation to the gender variable and to pay special attention to the risks posed to caregivers (Kamalakaran and Chakraborty, 2020; Wenham et al., 2020).

This research focuses on immigrant women of Latin American origin who work as domestic caregiving workers in Spain, who have provided care during the COVID-19 pandemic lockdown, as key actors enabling many individuals and families to cope with the pandemic (Carrasco et al., 2020).

The population in Spain, as in most other European countries, is ageing, and more work is therefore required on the part of caregivers to meet the needs of this population (Carrasco, 2009). In fact, the dependency ratio in Spain is expected to rise from 29.6% in 2018 to almost 50% in 2040 (Mestres, 2019). This highlights the growing need for paid care workers who provide essential assistance (Reckrey et al., 2020). This workforce tends to be female and immigrant. Caregiving is generally seen by society as an innate capacity of women which is socially developed, defined, distributed and learned, rather than as remunerated work (García-Calvente et al., 2004; Pérez and Agenjo, 2018). In Europe, over half (51.4%) of the immigrants are women, with an average age of 40.8 years. In Spanish province of Andalusia, where this research is conducted, the figures for the average age and sex are similar: of the 813,787-strong immigrant population, 48.11% are women, mostly from Latin America (Altuna, 2019).

Spain is the second country in Europe regarding the number of domestic workers: 619,600 people. This represents almost 30% of the European total, only behind Italy. Spanish domestic employment represents 3.32% of the 18.6 million employed. In terms of the weight that domestic employment has over total employment, Spain is in second place, behind Cyprus (Eurostat, 2017). In most European countries, this rate is below 1%.

Spanish figure for caregiving as a formal employment in residential establishments (such as those for elderly, disabled and dependent persons), is 499,200 workers, only half that in France or Germany, where formal caregiving sector reaches 1 million jobs. In Spain, the formal employment generated by this type of care represents only 2.6% of the

total, while in countries such as Denmark, it represents 11%. However, the number of domestic jobs in Spain is twice as high as in Denmark. This suggests that domestic work in Spain is covering caregiving and dependency care needs that should be met by public services and formal employment. Thus, families have to resort to domestic work to cover these types of needs (Agencia, 2019).

The caregivers in Spain are 95% women, most of them migrants, who in many cases work in precarious conditions (León, 2010). Majority of these women are Latin American: thus, we must add the variable of ethnicity to the gender variable, which acts as a double vulnerability factor (Altuna, 2019; León, 2010) as it brings the added risk factor of immigrant women's poverty (St-Denis, 2020).

Regarding the COVID-19 pandemic, Spain has had, until October 2020 (when this text was written) the second highest number of cases in Europe, after Russia: 405,436 confirmed positive cases and 28,872 deaths (European Centre for Disease Prevention and Control, An Agency of the European Union (ECDC), 2020).

Thus, informal and precarious conditions of domestic care work in Spain places immigrant women domestic workers in especially vulnerable position regarding the COVID-19 pandemic. These women have often come from previous precarious work situations which may have worsened during pandemic, and although some of them are in a situation of legally registered employment, the type of contracts that they have does not make them eligible for unemployment benefit.¹ Others are working illegally and so are not eligible for the minimum labour protection.²

The immigrant caregivers who participated in this research are live-in domestic workers who remained confined in the homes with the people they care for during the lockdown, between 14 March 2020 and 28 April 2020. This often meant working longer hours and in most cases, without a clear distinction drawn between their work and their free time. These circumstances have triggered both physical and psychological health consequences in the caregivers (Bezerra et al., 2020), and have left emotional scars in their lives. Thus, the focus of this study is to investigate their feelings and experiences of caregiving during the COVID-19 pandemic lockdown, with specific focus on their emotional and physical well-being regarding two aspects of their lives: the live-in working conditions and the separation from their families.

Material and methods

Design

We used a qualitative descriptive design, which makes the subject matter easier to understand by gathering a rich, literal description of the insiders' views and perspectives (Bradshaw et al., 2017) and generates a comprehensive summary. A phenomenological perspective (Neubauer et al., 2019) and ethnographic approach (Álvarez-Gayou, 2003) were also used.

Population and setting

The sample consisted of 15 Latin American immigrant women aged between 27 and 62, who were able to communicate in fluent Spanish or English and had cohabited in the

workplace with the person they took care of during lockdown. At the time of the interviews, the women lived in Seville, Cádiz, Málaga, Huelva and Córdoba. Almost half of them ($n = 6$) came originally from Nicaragua. There was a wide variety in the number of years women have been living in Spain, from 1.5 years to as much as 22 years. Most of the women ($n = 13$) had children, some had up to four. The educational level was very diverse: five had had a university education, three a high school education and seven a primary education. The majority of the women ($n = 14$), were in employment at the time of the interview, but nine participants did not have a work contract at the time of the interview. In relation to the perception of their salary, nine of them believed that they received a low salary considering the work they did and according to current Spanish law.

The sampling was intentional, and saturation criteria were used, as it was unlikely that new data, such as new categories or concepts, would be obtained in subsequent interviews (Urrea et al., 2013).

Procedure

Purposive sampling and the snowballing effect were used to select the participants. First, baseline interviews were conducted: a 50-minute semi-structured interview was conducted with 61 female immigrants between April 2019 and September 2019 (de diego-Cordero et al., 2020). This was followed by phone interviews and life stories. One year after the baseline interviews, all the female immigrants were contacted by phone to find out which of them had lived-in with the people they had cared for during lockdown. Of the total, 18 women had cohabited, 15 of whom agreed to participate in a second semi-structured telephone interview. In addition, 3 out of 15 interviewees were asked to tell us their life stories, from the time they arrived in Spain up to the COVID-19 pandemic, in order to learn about any factors which could influence their then current (cohabiting) situation (Figure 1).

All of the participants had lived with the person they cared for, and all the interviews and life stories were conducted by phone or by videoconference by a specialist research assistant (a sociologist specializing in gender studies) and, as before, these were audio-recorded and transcribed verbatim.

Instrument

The interview guide included information on sociodemographic characteristics (sex, place of residence, social and labour profiles, and education level) and focused on two main themes: *conditions of habitability while caregiving* (working conditions, employment situation and health status) and *relationships and feelings during cohabitation* (caregiver's relationships with the family for whom she provides care, main concerns and experiences, and communication with her family of origin).

For the life stories, the participants received the following instructions:

This part is about your life story in Spain. Please decide which events are most central to the story of your life since you arrived in Spain. There are no right or wrong answers. You could

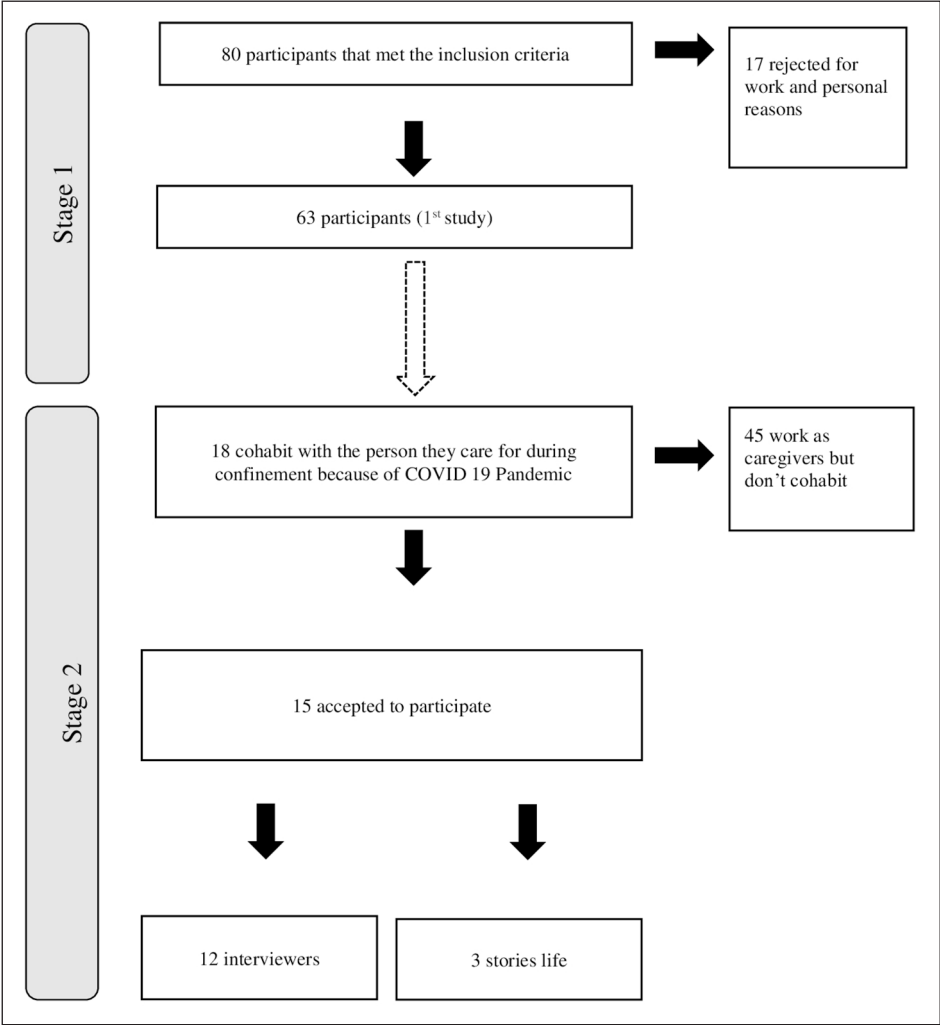


Figure 1. Process flow of participant selection.

describe the events, from your arrival to Spain until now, that you believe have most influenced your life story in Spain. Describe what you thought and felt during the COVID-19 Pandemic.

Data analysis

The qualitative analysis was carried out following the steps proposed by Braun et al. (2019): (1) familiarization with the data; (2) generation of categories; (3–5) search, review and definition of themes; and (6) the final report, which was prepared with the statements from the informants, each marked by an 'I (interviewed) number' or 'LS (life

story) number' and the length (in years) of residence in Spain. Transcription, literal reading and theoretical manual categorization were carried out and the NUDIST NVivo (version 12) software was used.

Reliability

This research followed The Consolidated Criteria for Reporting Qualitative Studies (COREQ) (Tong et al., 2007). For data triangulation, Aguilar and Barroso (2015) proposed five different methods of triangulation in studies: of sources, of researchers, theoretical, methodological and multiple. In this case, we are referring to methodological triangulation, which enabled us to test the level of consistency and resolve discrepancies. In this way, the methods used for guaranteeing quality were data triangulation, including participants with different sociodemographic characteristics, and triangulation of the data analysis via different researchers.

Ethical considerations

All the women included in the project agreed to participate voluntarily. They received verbal and written information about the study, as well as a letter of confidentiality signed by the research team before the interviews. The information included potential risks of the study, voluntary participation and an explanation of their right to refuse to answer any questions and terminate the interview at any point. In addition, the participants were informed that the interviews would be recorded on audio files and quoted anonymously in publications, and that all personal identifying information would remain blinded. The study was approved by (Code: 0731-N-19).

Caregiving in the time of lockdown

Cohabiting while caregiving: Insecurity, workload and isolation. The migratory experience of the interviewees conditioned their situation as caregivers and, in many cases, accounted for the situations of vulnerability we found. The lockdown measures imposed by the Spanish government to fight against COVID-19 led many female migrant caregivers to accept working situations in which cohabitation with the person cared for was a prerequisite for keeping their job, in some cases to the detriment of their personal freedom and health. This is what they said:

LS1: We fled the country because of the crisis that affects the country – life there is hard and there's no other option but to emigrate to another country. I'm currently caring for a person over the age of 85. I'm working as a resident – they give me two hours off a day when I can go out a little to relax. They pay me a pittance and they've told me that if I report them, they'll send me to immigration who will deport me back to my country.

LS2: I came to Spain because of my economic situation, because I was alone, I'm divorced and my son needed help for his studies. I was working when the lockdown started and my employers told me I had to stay here at home and if I left, I'd lose my job because they wanted a person to stay with their father during the lockdown. I look after the man and do things around the house, and I also get up at night to attend him.

LS3: I've been in Spain for 18 years now. I came here to improve my economic situation and help my 3 children with their studies. I looked after a person during the lockdown, and it was an extremely difficult situation, because I couldn't communicate with my family and it was difficult for me to send money back to my family in Bolivia.

Despite this, issues such as the security felt by the interviewees regarding conserving their home and employment and protection during the lockdown have mostly been reflected in a positive light by the participants.

As regards the habitability and housing conditions during lockdown, most of the interviewees work in flats or large houses, where they have their own room and private space with good conditions of habitability. This is what they comment:

I4: This house has 3 bedrooms, 2 bathrooms – it has the living room, dining room, an internal courtyard and another courtyard that overlooks the room where the lady lives and there's a terrace . . . Yes, I even have a room to myself – right now I'm in the room. It's a very large room – it has a bed, television, Wi-Fi and everything and I even have a separate bathroom.

However, in other cases, there are worse living conditions, including small houses where the elderly person they care for lives alone:

I5: The house has 2 floors, but the grandmother and I both live on the ground floor, which is very (small) . . . and I sleep in the same room as she.

Regarding working conditions, we wanted to know the tasks they performed as carers during the period of lockdown. All the participants stated that they were completely responsible for looking after the person and the home, and in most cases, they reported that the responsibilities and working hours had increased during that period:

I6: Apart from the things in the house, I had to take care of the man and the things they brought me – I had to pick them up and take them into the house – I had to clean things, put things away and everything else.

I8: I work a lot because usually I'm working right up to about 11.30 pm finishing cleaning up in the kitchen, and I go to bed very late . . . I had to do everything in the daughter's house and upstairs, we were upstairs, in two rooms with a kitchen and bathroom and everything.

As for the salary and the contractual relationship, the participants gave different answers: there were situations where they considered that they received a fair salary and others where they were unhappy with their salary and regularity of employment:

I1: Well, since I've been living here, I normally work for 8 hours. I suppose it's around 8 hours because the truth is, in the afternoon, I no longer do anything (. . .) I get paid like for a normal employment.

I4: I get paid far too little. I work all day until 6 in the afternoon and then from 8 until 10.30 pm and I only have one weekend off a month – so I work a lot and don't earn much.

Similarly, we wanted to know the working conditions they had, especially regarding the availability and use of PPEs. In this regard, gloves were the commonest protective measure; only two of the participants acknowledged having a mask, while one participant stated that she did not have any protective equipment at all.

I4: With gloves, yes, because they're essential to be able to wash the lady, to be able to change her when she relieves herself and all that – but no masks or suits.

I11: Nothing. I used to buy my own masks and all that.

As regards working conditions during the COVID-19 pandemic, the safety and health of these workers have become a shared concern, since the participants in this study are categorized within the group of *essential workers*, a list of essential infrastructure workers designated by the Department of Homeland Security (DHS) who 'protect their communities, while ensuring continuity of functions critical to public health and safety, as well as economic and national security' (Agencia de Ciberseguridad y Protección de Infraestructura (CISA), 2020). In the case of Spain, the annex to Royal Decree-Law 10/2020, dated 29 March 2020 defines the activities that are considered essential services in the COVID-19 health crisis and includes the caregivers of dependent people in this category (Boletín oficial del Estado (BOE), 2020).

In the specific case of caregivers of dependent people, they have been exposed to possible contagion with the virus in the workplace, since they live with the person they care for and the virus is easily transmitted between people. As a result, the probability of infection in these essential workers, and those they had contact with, increased (Rothan and Byrareddy, 2020). The task of caregiving, as seen in this study, includes not just the complete care of the person, but also of the house, and therefore government measures such as physical distancing, changes in schedules and loss of other services in the house, such as help with cleaning and housework, negatively affect caregivers, whose workload is often increased (Dennerlein et al., 2020).

The National Institute for Occupational Safety and Health (NIOSH, 2020) has made specific recommendations to protect workers' health and safety during the COVID-19 crisis. However, the irregularity of the working conditions of cohabiting caregivers highlights the difficulty of applying these measures.

When we asked about the self-perceived value of their work in this special situation, women's opinions were divided: some participants said they felt appreciated and described the relationship with their employer's family as a 'family relationship' rather than simply a working relationship. But others had different experiences. Their views on this subject were related to regularity/irregularity of employment:

I1: Here in this house, I really feel appreciated and loved. I'm like a member of the family in this house.

I4: Everyone says I do an excellent job with her. However, I've been working for the family for 3 years – practically since I arrived in Spain – and they don't want to give me a contract, which would enable me to apply for legal residence, despite the fact I've offered to pay my own social security costs.

Regarding the interviewees' own health, none of them stated that they had had symptoms related to COVID-19, nor that they had had a diagnostic test for COVID-19. Only some of them said they went to the doctor for routine check-ups.

Most of the interviewees do not self-medicate: they go to the doctor if they have health problems. Only three of them said they were self-medicating, because they did not have time to go to the doctor.

I5: I take the medicine without it being prescribed by the doctor . . . I don't have permission to go to the doctor during the week.

I9: I've been to the doctor for normal things, but not for work, and I haven't had any tests. I've been, because I have my normal doctor with my normal treatments and my medications and all of that, but not for work.

Although the general health of the interviewees is good, the main health problems detected in these caregivers are psychological problems: anxiety, stress, fatigue and depression, which got worse during lockdown:

I2: I'm in the house 24/7 (. . .) and I have problems psychologically because maybe physically, I look after myself, but psychologically I don't.

I5: Stress and stuff, tiredness from work, my head hurts a lot, I feel like crying sometimes and I lose my appetite.

In our study, the self-perceived health of these women was generally good, coinciding with the data on the good levels of health of the migrant population living in Spain, reported by the latest National Health Survey in Spain (Ministerio de Sanidad, Consumo y Bienestar Social, 2018). However, half of our interviewees reported physical and psychological health problems manifested in anxiety, insomnia, depression and a worsening of osteoarticular problems, among others, related to the change of habits due to lockdown coinciding with recent research (Dubey et al., 2020; Rubin and Wessely, 2020). Their quality of life was also inferior to that of the local population, and this worsened even more during the lockdown (Liem et al., 2020; WHO, 2020), as has been shown in past pandemics (Truman et al., 2009).

This worsening of health during the lockdown was shown by some of the interviewees:

LS1: In the lockdown, I felt worse. Now that I can go out a bit more, I feel I can rest a little and clear my mind – because when I walk a little and get out, I feel I've rested a little.

LS2: During the lockdown my health has worsened, because being in lockdown with a person suffering from Alzheimer's, without talking to anyone, and with everything that has happened to me, it's really affected my mental health.

This is in line with research from other countries, such as the United Kingdom and the United States (Public Health England, 2020). However, in Spain, there is no available data differentiated by nationality of origin or ethnicity.

Thorn between here and there: The cared for and the left behind. The burden of caregiving in this pandemic has a clear gender bias, as warned by the United Nations Population Fund (UNFPA, 2020). In our study, with immigrant Latin American women, this gender bias is exacerbated by the factors of ethnicity and immigration. These women, during the COVID-19 pandemic health crisis, have attended to the care needs of elderly people, a highly vulnerable population, while being confined to their homes (Agenjo, 2020; Pérez, 2012). This global care chain involves women overwhelmingly from poor households in Latin American and Caribbean countries (Comisión Económica para América Latina y el Caribe (CEPAL), 2020) moving to European countries – especially to Spain, due to the cultural affinity and common language (blinded author). On the contrary, for the majority of Latin American women, employment in the domestic sector is the sole opportunity to access the labour market, and many see it as a stepping stone towards a better job and the attainment of permanent residence status (León, 2010).

These women constitute specific labour force in the capitalist system; care work is not provided by the native population, since it is not an attractive choice for workers who may have other work options (Durán, 2012; Fuentes and Agrela, 2018).

When analysing the relationships that the migrant caregivers have with the employer's family, there is clearly a moral debt, which increases the obligations towards the person cared for, since there are many elements of emotional bonding, which are more characteristic of a family member than of a person hired to work (Parreñas, 2014). They are expected to do domestic work and provide care for the elderly in a relationship in which they are 'quasi-family members'. This increases the psychological pressure, since they feel responsible for the care and well-being of the elderly as a moral imperative (Giordano, 2020), with all the characteristics required of domestic work and caregiving: it is a 24-hour routine, carried out by the woman, calling for abnegation, affection, patience, empathy, affection and tenderness (Bover et al., 2015; Larrañaga et al., 2004). The emotional ties and 'quasi-family' relationship between the caregiver and the person cared for make the employment relationship ambiguous (Parreñas, 2014), which is sometimes defined by the employers and in other cases by themselves, as 'a member of the family'.

The interviewees also valued positively the security provided by having a house to live in, food and work during lockdown:

I4: I've felt protected because, since I never had to go out, I wasn't afraid of getting infected.

I10: I felt good, I felt protected and I didn't feel afraid . . . the truth is this, here they've really appreciated my effort and dedication in staying with her throughout the lockdown and all of that.

In most cases, they have not had to go outside the house, a place which was seen as hostile territory and a source of contagion. The family provided them with groceries by having them delivered from the shops or bringing them themselves:

I3: No, they didn't let me go out, they sent us everything – it was them who ordered everything online.

I8: Before, I used to go out to the supermarket to shop maybe once a week and then after that they wouldn't let me go anywhere or even go for a walk because the lady's daughter was afraid that she'd catch the virus and come and infect them.

For most of the women interviewed, the relationship with employees has also been an element of protection against the external situation of pandemic (Moré, 2018). They have not had to go out of the house: in the most critical moments of lockdown, 'outside' was considered hostile territory, while the home was considered the 'safe space' that isolated them from the external pandemic (Chow, 2020). This was seen positively, because in many cases, staying in the house of the person they were looking after meant considerable savings in terms of food and housing, and was therefore seen as a *refuge value* (Giordano, 2020).

In much the same way as the native population, there have been two main concerns for these caregivers: fear of contracting the disease and the health of their family of origin (Orellana and Orellana, 2020). Regarding the concern for the family of origin, the global care chains put these women under extra pressure, since they are responsible, through the savings they send back home, for the maintenance of their family of origin (children, spouse, parents and other family members) and for providing the main financial support for the children's studies and household expenses. This involves a double load of responsibility, and they are afraid of losing their job because the safety and livelihood of their family is at risk (Orozco, 2007; Pérez, 2010; Pérez and López, 2011). As for the fear of catching the disease, much of it was due to the lack of PPEs, especially masks, which has been a generalized problem in Spain and other countries of the world, where, at first, not even health professionals had these PPEs and they were totally unprotected during the most virulent weeks of the pandemic (Carville et al., 2020; Lázaro et al., 2020).

The main experiences during lockdown have been of uncertainty and fear of catching the disease and even of transmitting it to the person they look after, as well as anxiety for being so far from their countries, and not knowing how to cope with possible bad news about the family back home:

I8: The truth is that what worried me most was my family in Bolivia, because things are not like here as regards medical care and medicines.

I9: My main concern was about getting infected . . . Because as well as infecting myself, I could infect the person I was looking after.

I12: I worried about my family. Because of the economy too, because I'm afraid that if something happens to me at work they'll sack me or if something happens to the woman I care for, I'll end up without work – things like that worry me a lot.

LS3: I worked a lot – I usually went to bed very late and only rested a couple of hours each day . . . my head hurt, my brain hurt. I don't know if it was the stress or also the worry, because one of my brothers caught the virus in Bolivia – all of this aggravated my health, especially the headaches.

In most cases, communication with their family of origin has been very easy during lockdown, and most mentioned the social media application WhatsApp as the one they most used – social media was valued very positively compared to the past:

I1: We communicate by video calls or direct calls through WhatsApp. I'm in constant communication with my family. Thank God for social media, because the truth is when I arrived 17 years ago, I could only speak with them every 20 days, which was when I could go out. I couldn't go out much and I couldn't move around much either.

I9: I communicate by phone calls or video calls.

Social media proved to be the most important means of social contact (Castells, 2006; Chopik, 2016; Padala et al., 2020), which has allowed caregivers to maintain fluid communication with their family and friends. The use of social media, as shown by research both before and during the pandemic, is linked to greater subjective well-being and fewer depressive symptoms (Chopik, 2016; Padala et al., 2020).

Conclusion

Women have been the main providers of care and domestic work in the homes where they have been confined during the COVID-19 pandemic, helping to sustain the lives of families and vulnerable elderly people they have looked after. To do this, they have had to renounce their own freedom of movement and social interaction to a greater degree than the rest of the population also affected by the restrictions imposed due to the pandemic – in many cases, at the expense of losing their jobs.

The emotional debt and the relationship as 'quasi-family members' have contributed to increasing the work overload, since as well as the usual care, they have been responsible for all the domestic work, resulting in a non-stop working day during the lockdown, without any personal free time and being separated from the social group of their friends who live in Spain. On the contrary, the security they have felt in the family home is also significant, and has been valued positively by both the workers (who appreciate having the security of a home and a job) and the people cared for (who have benefitted from their labour), although these circumstances have not been valued in the same way by all the interviewees.

Finally, it must be stressed that different international institutions (UN, World Health Organization (WHO)) have shown their concern for this sector, the main concern being addressing the consequences of COVID-19 for public health. Consequently, the authorities must identify vulnerable groups, such as immigrant caregivers, through adequate detection, timely referral and the specific promotion of early interventions.

Our study contains certain obvious limitations. First, the size of the self-selected sample ($N = 15$) was small. Future studies should ensure that more women are represented in the sample. Second, some of the interviewees preferred not to use calls for fear that something they said could be used against them and would affect them in their work. Furthermore, an added difficulty was that most of the interviews were conducted during working hours in the workplace with the person they care for, so some of the answers

were very brief, through fear of losing their job. Finally, most of the women participating were of Latin American origin, and therefore some of our findings may be less applicable to immigrant women from other regions.

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ORCID iDs

Rocío de Diego-Cordero  <https://orcid.org/0000-0002-3453-003X>

Lorena Tarrío-Concejero  <https://orcid.org/0000-0003-0158-5744>

María Ángeles Lato-Molina  <https://orcid.org/0000-0003-0515-5864>

Notes

1. Only two-thirds of all Spanish domestic workers are registered with the Social Security (Instituto Nacional de Estadística, España, 2017). It is important to point out that already in 2011, the International Labour Organization (ILO, 2011b) stated that ‘domestic work is work. Domestic workers, like any other workers, have the right to a decent job’. But Spain has not yet ratified the ILO (2011) Agreement on the Working Conditions of Domestic Workers, which came into force in 2013.
2. Employment policies have been proposed to improve market conditions and promote fairer working conditions for women, with special attention to migrant domestic workers (CEPAL, 2020). States in Southern Europe have introduced migration systems to facilitate the entry of migrant women in their territories, who are given temporary working visas exclusively for the domestic service sector. In the case of Spain, a quota system was applied in 1994, granting 20,000 annual work permits to non-EU nationals to fulfil the need for domestic work services (Escrivá, 2000: 204).

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