Building community-centered social infrastructure: a feminist inquiry into China’s COVID-19 experiences

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Abstract
The global COVID-19 pandemic has revealed the essential role of care work in sustaining life, health, and maintaining the basics of everyday existence. It has also made visible the disproportionate burden of care work on women that existed before the outbreak, which has intensified rapidly and been gravely exposed during the pandemic. In this article, we take China as a case study to investigate the gendered impact of this pandemic and further problematize the landscape of care provision. With a feminist political economy perspective, we introduce China’s provisioning of care prior to the outbreak and investigate how the care crisis has further deepened in the pandemic. Drawing on the most recent data available on China’s experience, we explore the role and function of community-centered social infrastructure, an assemblage of state, family, and local resources, in effectively combating the virus and providing care. We further provide comparative international evidence to demonstrate the essential role of community care infrastructure in this pandemic. Building social infrastructure to deliver care at the community level presents important policy implication, especially for many developing countries. Therefore, a critical reflection and discussion on pandemics and women is not only more vital than ever, but also sheds light on the endeavour to develop long-term solutions for the care crisis that will almost certainly outlive the current pandemic.

Keywords The COVID-19 pandemic · Care work · Women · Community · Social infrastructure

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1 Introduction

As the COVID-19 pandemic deepens, it has been increasingly acknowledged that many essential care activities have been undergoing a far more calamitous crisis than any other in the recent history of capitalism (for example, Bhattacharya, 2020; Dattani, 2020; Mezzadri, 2020). Yet, the tension between the essential role of care work and the rising burden on care providers, particularly women, was anything but new. The care crisis predated the outbreak and only rapidly intensified and was gravely exposed after the lockdown policies constrained a significant part of social activities.

In this article, we investigate the gendered impact of this pandemic and further problematize the landscape of care provision. A feminist analysis is not simply a matter of recognizing women’s work, but of asking what the current care provision model is and what better alternatives we should envision and strive for. Therefore, we focus on the actual effectiveness and potential capacity of community as a crucial site for care provision, especially in this Covid-19 pandemic. More specifically, we take China—where the virus was first detected and then at least temporarily contained—as a case study to examine, through a feminist economics lens, the impact of pandemics on women, the role of community-centered social infrastructure, and the broader implications for care provision.

In the care economy literature, care work can be conceptualized and categorized in different ways. Work done primarily by women to care for family members such as cooking, cleaning, shopping, and care of children, the sick, and the elderly in a daily basis and intergenerationally, are typically unpaid care work. Unpaid subsistence production such as collecting water and firewood is also viewed as providing indirect care. Care work also encompasses certain work within the paid economy, particularly jobs that provide market substitutes for services women once provided in the home (Folbre, 2006). One of the key analytical concepts in articulating the provision of care in society is the “care diamond”. The four corners of the ‘care diamond’ each refers to a different supplier of care: families/households, markets, the public sector, and the not-for-profit sector. Within the not-for-profit sector, there is a spectrum of care provisioning formats, from completely uncompensated voluntary work, to the sometimes negligibly compensated yet still informal community organizations, to the more formal not-for-profit organizations that “receive funds from a variety of sources” (Razavi, 2007). This architecture embraces human services requiring personal and affective engagement (including but not limited to childcare, healthcare, eldercare, social work), and explains the relationship among these four actors. The components of the care diamond are interconnected with each other while the boundaries between them are flexible (Tolstokorova, 2013). It is in the critical examination of the Chinese experience, as well as other similar country cases, that we consider the manifestation of the “care diamond” framework in understanding care provisioning, and a more essential role for community-centered social infrastructure.

Our study shows that the engagement of communities in care provision during the COVID-19 pandemic has proved effective in combating the virus and
assisting social reproduction. Moreover, we stress the distinctive features of China’s community-centered social infrastructure representing an institutionalized assemblage of state, family, and local resources with a public employment scheme, as opposed to some ad hoc community-level arrangement elsewhere. We argue that a critical reflection and discussion of the pandemic experience with a focus on community-centred social infrastructure sheds light on the endeavour to develop long-term solutions for the care crisis that will almost certainly outlive the current pandemic.

The reminder of this paper is organized as follows. Section 2 examines the landscape of care provision on the eve of the COVID-19 pandemic in China, showing that a tenuous balance between unpaid housework by women across generations and the care services provided by the market, such as paid childcare, elderly care, etc., was already hard to maintain. Section 3 describes the gendered impact associated with the pandemic, highlighting the relatively higher exposure of women in different social classes to the overwhelming burden and risks. Further, in Sect. 4 we focus on the prominent role which community-centered infrastructure has played as a key component in mitigating the hardship faced by individual families during the pandemic, both in and beyond China. Section 5 discusses the broader policy implication of building community-centered care infrastructure and concludes.

2 Privatizing and commodifying care in China

Globally, neoliberal capitalism—the resurgence of economic liberalization and free-market capitalism since the 1980s—has generated what Nancy Fraser termed as a “dualized” organization of social reproduction. That is “commodified for those who can afford to purchase it as a market service and privatized as household work for those who cannot, as some in the second category provide care work in return for (low) wages for those in the first” (Fraser, 2017, p.32). Such a shift of care responsibility back to individuals and households also took place in the post-reform China. The gendered and classed division of labor in the care economy, as found elsewhere in the world, has conditioned the care crisis people have faced in the pandemic. To make sense of the experience and impact of the COVID-19 pandemic for care provisioning, one must understand the landscape of care provision prior to the pandemic.

2.1 Family

Families in post-reform China assume a dominant role in the provision of both eldercare and childcare. A rapidly aging population has intensified the need for eldercare. According to the One Percent National Population Sample Survey in 2015, more than half of the elderly—64.7% of those age 65 and over—live with their working-age family members (CPDRC, 2015). About 94% of older adults primarily rely on family caregivers while 9.9% of them still take care of their own parents (NSRC, 2015). At the same time, rising competition in the educational system and labor market intensifies the need for childcare, despite a declining fertility rate.
The Third Survey on the Social Status of Women in China found that care for children from birth to three years of age is fulfilled largely within households. Among care providers, 63.2% are mothers who serve as primary daytime caregivers (NBS, 2011). About 67% of the elderly are providing grandchild care at home. The elderly between 65 and 74 years old spend the longest amount of time on housework, with men working 81 min per day and women 179 min (NBS, 2019). While mutual support within households across generations does enhance the resilience of the extended family whenever care is most needed, it also reflects the heavy care burden on families.

Much of the care responsibility has fallen on women, as the recent time use survey reveals. Chinese women on average spent 2 h and 16 min per day more than men on unpaid household chores and care work, as Table 1 shows. The gendered gap is particularly pronounced in the time spent on household chores and caring for family members. Combining all the time for care-related unpaid labor, on average, women spent almost 2.5 times more than men every day. This is partly explained by the rising percentage of stay-home mothers China has witnessed in the past decades. A national survey on Chinese household childcare arrangements shows that 82% of mothers under 25 years old choose to stay home (ISSS, 2019). For a country with a progressive history of full employment of women and the resonating campaign of “Women Holding Up Half the Sky”, such radical transformation in women’s career choices could be explained less by a persistent cultural factor than the changing economic relations following the massive privatization of social services in the 1990s.

With day care services affiliated with state-owned enterprises in the socialist period completely halted after privatization, mothers, and sometimes grandparents (often grandmothers), became the default caregivers of young children. Even if many women choose to stay on the job after becoming mothers, they are under pressure to play the role of the more “flexible” parent in different-sex households. Women are expected to take on childcare work when children are sick or babysitter arrangements fall through, as well as tutor children if they are unable to catch up with schoolwork.

The rising workload for care has contributed to the continuous decline in China’s female labor force participation rate, from 73.2% in 1990 to 59.8% in 2020 (NBS, 2019). The persistent gender discrimination in the labor market reinforced the gender norm that women should be more accommodating the intensified care need at home.
While many women must rely on support from extended families, housework has also been increasingly outsourced to the market.

### 2.2 Market

The market for domestic service has expanded rapidly in China with a roughly 10 percent year-on-year employment growth and a total increase in income of over 20% during the 2010s. In 2016 more than 25 million workers were employed in the domestic service sector, including maternity matrons, elderly care workers, nannies, and nurses. Nearly 30% of them work in the maternal and childcare sectors, 16 percent work in elderly care, and 26% as general domestic workers (Ministry of Commerce, 2017). Various studies find that more than 95 percent of workers in China’s domestic service sector are women (for example, Liu, 2017a, 2017b; Tong, 2013). General domestic workers, on average, work 12.9 h every day, with those specializing in maternal and childcare working even 16.4 h daily (Liu, 2017a, 2017b). Domestic work, therefore, is vital for Chinese families, communities, and the society.

Subsidized childcare through employers and free public space for childcare have been shrinking since the market reform in the 1980s, and the shrinkage accelerated along with the large-scale privatization of state-owned enterprises across the country in the 1990s. The intensification of outsourcing care to the market is largely a result of both the offloading of care responsibilities to the private domain afterwards and the aggressive expansion of the commodification of entertaining and educational activities from the 2000s.

The family and market dynamic in the care economy is not only gendered, but also classed (Laurent & Wen, 2020). Most domestic workers are either rural migrant workers who do not have a sufficient income from farming, or former urban workers who were laid off during the privatizations of the state-owned enterprises, with some exceptions for Filipino domestic workers in Hong Kong and Macau (Constable, 2020; Hall et al., 2019). These domestic workers are willing to accept demanding but low-paid domestic service jobs in the hope of securing a better life for their families. Many rural migrant women had to leave behind their own young and elderly family members in order to earn a wage through providing care to the urban employers’ families. Oftentimes, the husbands of rural migrant domestic workers were also migrant workers in the same towns and cities, which leads to the lack of sufficient care to both the elderly and the young back home. The “left-behind children” and “elderly suicides” are two examples of severity of the care insufficiency in the rural sector (Wen & Xie, 2019; Zhou et al., 2019). When rural migrants do take their children to their adopted cities, the burden of care work still falls onto the families. Sometimes it is more difficult for them to handle because migrant families don’t have access to public education system or related care provision in their adopted

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1 We thank the anonymous reviewers for pointing out the existence of Filipino domestic workers in China. Whether Mainland China will loosen international migration control and offer work visas to them is still under debate.
cities, hence the “migration children problem”. The 2020 China Migrant Workers Monitoring Report by China’s National Bureau of Statistics shows that rural migrant parents view “access to local schools”, “high living expenses” and “lack of care for children” as their top three concerns, with agreement rates at 29.6%, 26.4% and 21.5% respectively (NBS, 2021). Overall, the care burden does not go away regardless of whether rural migrant families take their children to cities.

While the care burden has become increasingly privatized and commodified in recent years, the capacity of ordinary households in providing care is diminishing, largely due to the increasing deregulation of the labor market and therefore the rising precariousness of income-generating work. The pressure and tension of providing care has intensified to the level that makes many families, especially the poor, quite vulnerable in overcoming the economic hardship brought by the pandemic.

3 Gendered impacts of the COVID-19 pandemic in China

When the already fragile system of care met the COVID-19 health crisis, it revealed that care work, most of which is performed by women, is essential to the functioning of society. However, due to pre-existing gender inequalities and social norms, the COVID-19 pandemic not only directly caused income loss, but also indirectly brought additional hardship to women, especially those from poor households in the Global South (Agarwal, 2021; Al-Ali, 2020). In this section, we focus the gendered impact of the pandemic on three groups of women: urban women, female rural migrant workers, and female healthcare professionals. Urban women mostly saw themselves shouldering more household reproduction responsibilities after the lockdown. Female migrant workers, in addition to extra childcare and household chores, had to also endure economic hardship due to job losses, since most of their jobs concentrated in the precarious informal sector. Female healthcare professionals, risking their health, provided care at the frontline and at the same time bore the mental pressure of possibly transmitting the virus to family and loved ones.

Care responsibilities already occupied most of urban working women’s leisure time before the COVID-19 crisis. With school closures, commercial food services shuttered, work-from-home practices for adult family members, and the abrupt inaccessibility of services provided through domestic workers during lockdown, the amount of childcare work, homeschooling, cooking, cleaning, and other household chores immediately surged, most of which falls upon women’s shoulders. This gendered division of labor is present regardless of the nature of women’s jobs. As found in a recent study in the US, even when women’s jobs are equally telecommutable, they end up performing more care activities while working from home than their male partners because of the gender norm (Alon et al., 2020). The same holds in the Chinese case: having the option to work-from-home became less of a privilege for women than men in married households with children. Zhang and Liu (2020) find that working mothers in China, compared with male workers and female single workers, were least likely to return to work. Even when they did return to work, working mothers were most likely to remain working from home.
While many urban women could still protect themselves from the economic hardship or potential health risks through working from home, rural migrant women, accounting for 35% of the entire rural migrant population of 290 million people, are facing high-stake choices (NBS, 2020a). A 2013 survey conducted in Beijing suggested that more than 80% of female migrant workers work in low-paid service sectors (i.e. sales, hotels and restaurants, domestic service, and cosmetics) and labor-intensive manufacturing sectors (Hao, 2018). Most service jobs require in-person interactions and cannot be operated on virtual platforms during the lockdowns. As a result, many of these workers lost their jobs during or even after the lockdowns due to employers’ health concerns (Hu, 2020; Si, 2020). Manufacturing jobs, especially those in the export sectors, were also hit hard as a result of their reliance on the world market. When crisis hit the rest of the world, many orders were cancelled, and workers were laid off. Although employment statistics provide some signals that a recovery is underway (a 0.5-percentage-point decline in urban unemployment from February to March 2020), the process is slow (NBS, 2020b). When the relatively stable income from previous jobs was lost due to the crisis, many rural migrant women had to accept more precarious and exploitative jobs to cover daily expenses. Women taking up waitressing jobs reported that they had to accept lower wages while working longer hours. Similarly, female domestic workers who were fortunate to obtain jobs now found their employers setting higher standards for cleaning and childcare, knowing that these workers are afraid to lose the jobs (Li et al., 2020).

Oftentimes when urban middle-class households hire domestic workers, it is the urban women, due to the gendered division of labour, whose care burden was alleviated with the help of domestic workers. This fact suggests the complicated power structure as a result of class differences. Even though there is sufficient incentive for domestic workers to stay healthy, employers still take extra caution in rehiring them after they came back to work once the lockdown was lifted. In most cases, employers prefer to keep live-in domestic workers, while furloughing the non-live-in ones, to avoid any potential risks (Xing, 2020). Accepting the live-in arrangement implies subjecting oneself completely to the supervision of the employers. Compounded with employers’ requirement of not going outside, many domestic workers had to endure the truncation of personal free time, causing severe mental pressure. Prior to the crisis, married women among the migrant population were already stretched between gainful employment and unpaid housework (Hao, 2018). Now they had to sacrifice more personal leisure time to secure the meager income needed to facilitate household reproduction.

Female workers in the healthcare sectors also have played tremendously important roles in fighting against this crisis. Throughout the country, 97% of registered nurses are female. Amongst the 42,600 healthcare professional volunteers who left their hometown for Wuhan, the epicenter of the crisis, 70% are women, and 90% of nurses are women (State Council, 2020a). These female health workers were risking their own health to provide treatment and care services to patients at the frontline. When personal protective equipment (PPEs) was still in shortage in January and early February, long-time exposure to large numbers of infected patients led to 3387 healthcare workers becoming infected with COVID-19, with 22 deaths by the end of February (Wang et al., 2020).
Although 17 of the 22 healthcare workers who died were men, women still faced high risks given their larger share of the healthcare labour force (Zhan et al., 2020). The risks they had to bear at work may have relieved them from some household work, which was picked up by partners and the elderly. Yet the psychological distress was prevalent due to stress from work and anxiety about carrying the virus and spreading it to family members (Chen et al., 2020).

The uneven gender impact of the pandemic, on the one hand, reflects the fact that this recession differs from many previous ones in terms of increasing, rather than decreasing, gender inequality (The Economist, 2020; Financial Times, 2020). On the other hand, it further reveals the essential weakness of our existing care provision regime due to the increasingly heavy reliance on family and the market as well as the lack of coordination within the regime. It urgently calls for an alternative to our care provision framework, a discussion of which we start with the observation of community-centered social infrastructure in China.

### 4 The role of community-centered social infrastructure in the pandemic

Before the outbreak of COVID-19, the privatized and family-based care provisioning system was already under heavy burden, with women shouldering almost three-quarters of the time spent in unpaid care time (see Table 1). The gendered impact of the COVID-19 pandemic further illuminates the fact that the family is too institutionally weak to fight against a health crisis on a large scale. For instance, without coordination and collaboration at the community level, each household needs to do grocery shopping separately and spend more time waiting outside the stores, which is risky health-wise and inefficient time-wise. Therefore, organizations at the community level are conceptually desirable to complement the care provision from families and the market.

It is worth noting that the concept of “community” is often understood to be a source of social support in parallel with the state and the market, implying that community only exists in the civil society network independent of the state. In this paper, we question this artificial boundary between the state and community and argue that the complex global environment requires us to acknowledge the heterogeneity of community organizations and community services in reality. In China, for instance, community organizations refer to the neighborhood-based governing units in urban areas and villages in rural area. They are financially sponsored and organizationally supported by the state, yet at the same time, their important role in the fight against the pandemic is too significant to be overlooked only because they do not fit the conventional conceptualization of community. We maintain that the functions of these communities in the pandemic offer a crucial analytical lens for us to advance the theoretical understanding of the potentially significant role of community in care provision.
4.1 China’s experience

In the context of China, community organizations and services assemble resources from various levels of governments and local civic organizations. They are largely funded by the state, coordinated with other local organizations, such as volunteer groups, and staffed with publicly employed community workers. They are established as social infrastructure to supplement informal civic networks and family/friend helping. In normal times, community organizations—including but not limited to, neighborhood committees, community care centers, clinics or hospitals—are already in place handling household registration and supplementing basic care. Combining centrally dispersed and locally mobilized resources, they are formed by a fine division of responsibility between existing urban or rural units. During the pandemic, community organizations served as the cornerstone of national governance and the most basic units of prevention and control (Wei et al., 2020). This is not only because they had already been familiar with the neighborhood and residents, but also because they harnessed direct state support and local trust to deliver social services for the last mile. This institutional feature of care infrastructure ensures a relatively equal coverage of social service across neighborhoods with existing uneven distribution of income and wealth.

It is important to note the historical specificity of the notion of community. The rise of communities in contemporary China can be traced back to the withering of the danwei (work-unit) system—state-owned enterprises employing majority urban labor force—under the urban reform in the 1990s (Lu, 1989; Shue, 1988). For decades, danwei was not only the physical site for production, but also served as the employment-based social infrastructure for care provision. It used to provide free or affordable on-site childcare, schooling, and healthcare services, all of which have now been pushed back towards families as individual responsibilities following the demise of danwei. Care work for urban populations became spatially separated from production and are now mostly performed in newly commercialized residential compounds.

It was in the context of the collapse of the employment-based social infrastructure that the “community building” project was launched nationwide in the 1980s. Studies have demonstrated that the central government was building communities in the hope that they could address the massive scale of social problems emerging from the rapid social transformation, so that governance efficiency, coordination and capacity could be improved (Tang, 2019). Community-based health and social services were provided for residents “within a certain geographical parameter per official administration” to compensate, in a very limited way though, for the loss of social service provision previously taking place on-site at danwei (Shen, 2014; Zhu et al., 2018).

Starting at the end of the 2000s, “community” is designated by the government as the basic unit of urban social, political and administrative organization (Ministry of Civil Affairs, 2020a). Since then, “community” in China has started to acquire its physical and institutional outlook: community centers have been erected to serve the neighborhoods and community workers have been incorporated into a public employment scheme with low-yet-stable salaries from the local government. The building of institutional infrastructure at the community level via public
employment is as much about constructing new forms of physical space as it is about building new kinds of organization (Bray, 2006). At present, there are 650 thousand residence-based rural and urban communities in China, formally hiring about four million community workers (State Council, 2020b).

The provision of care work by the communities was particularly crucial during the COVID-19 pandemic. First, communities-level organizations were able to guarantee the provision of necessities when human mobility was restricted. During the Wuhan lockdown, community councils provided basic subsistence for people who were not able to sustain their basic needs on their own. They were also responsible for disseminating virus-control tips as well as delivering food and medicine to every household in the neighborhood so that the unnecessary movement of people could be reduced. By doing so, community workers and volunteers partly shared care responsibilities and reduced stress in the quarantine time. According to a recent study on residents’ living conditions during the pandemic, more than 70% of people nationwide received direct service or help from community workers when they encountered difficulties during the lockdown (See Fig. 1). In the city of Wuhan, the epicenter of the crisis that experienced the earliest and the strictest lockdown, 79% of residents reported receiving direct help from community workers, even higher

Source: CSG Report on Residents’ Living Situations in the COVID-19 Pandemic 2020.

**Fig. 1** Survey Responses to the Questions regarding the source of help received during the COVID-19 Pandemic

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2 Among the total 4 million community workers, 1.5 million are women so women’s share is 37.5 percent which is not the majority. This pattern implies the possibility that once care work is de-marginalized and formally compensated, more men will likely assume their fair share of care work in society and that the traditional gendered division of labor will be challenged.
than the percent from families and friends (76%). As high as 53% of residents in Wuhan think the community-level support was very important for them to get through the most difficult time during the longest lockdown in China for 76 days. People outside the city of Wuhan echoed this sentiment. Hubei, the province where Wuhan locates, also implemented strict quarantine policies due to the severity of the pandemic and being adjacent to the epicenter. Therefore, 80% of the residents there benefited largely from help at the community level, higher than the anywhere else in China (73%). Nationwide, roughly half of the people surveyed received direct help from community workers and deemed it very important in this pandemic (CSG, 2020).

Second, community-level organizations were indispensable in providing and coordinating health services during the crisis. The most prevalent task at the community level was health screening and contact tracing, which is crucial in containing the virus. Community workers and volunteers were able to keep close contact with families, screen febrile patients in the communities, and transfer them to quarantine sites for medical observation or send them to fever clinics for diagnosis. In Wuhan, community clinics and public health centers also provided care to affected patients with severe symptoms. In addition, community councils in Wuhan also took the responsibility of providing psychological comfort to neighborhood residents. In places like Shanghai with only imported cases, all 246 community clinics remained open during the lockdown to guarantee unaffected patients’ access to basic healthcare services. For people coming back to China via international flights, the community also took the lead in the entire process from pick-up to the end of the quarantine. In Shanghai, for example, people arriving from abroad were picked up from the airport via designated transportation accompanied usually by two people from the community council, one doctor from the community clinic, and one public security worker. This four-person group would then send those arrivals for testing, then to hotels while waiting for the results, and finally for home-quarantine if the results were clear. They also established close contact with the people during the 14-day home-quarantine, exercising monitoring but at the same time providing needed assistance to make it possible for the arrivals to stay housebound. Family members were largely relieved from all the health-risky responsibilities throughout the process. This process proved helpful particularly for those family members who have pre-existing conditions and are immunologically weak.

Third, the community centers in the neighborhoods served as a platform through which various kinds of actors could be organized and coordinated in fighting COVID-19. In addition to receiving help and food delivery, many residents volunteered to help with contact tracing and health monitoring daily. Moreover, community infrastructure in different parts of China, despite sharing the same goal of combating the pandemic and providing care, has shown noticeable local variation and adaptation (Liu, 2020; Zhu et al., 2020). For example, it was widely reported that organizations such as the Real Estate Owners’ Committees and other self-help organizations also coordinated with the community centers to deliver food and services during the health crisis (WHTV, 2020).

Nevertheless, community-level institutions in China do not perform equally well across regions, and their levels of development also vary greatly. Part of the
variation can be attributed to the legacy of the *danwei* system. For example, the “post-*danwei* communities” have relatively homogenous residential composition, consisting mostly of those employed in the same work-units. These work-units have often survived the privatization waves and remain state-owned or state-controlled, such as public universities, natural resources, and some transportation industries. Residents in these neighborhoods often show strong solidarity and actively participate in neighborhood businesses. While the “mixed residential communities”, being the product of housing commercialization, usually have a diverse body of residents and rather loose internal connections. These differences have strong ramifications in the process of mobilizing human and materials resources during the pandemic crisis, with the post-*danwei* communities performing significantly better than the mixed residential ones (Zhang & Xu, 2020).

After the new infection became stabilized in China, the role of communities is further highlighted in recent policies (Ministry of Civil Affairs, 2020b). On the one hand, the government has a strong incentive to restore the economic and social order and has gradually reopened different sectors. On the other hand, there remains the risks of a reappearance and resurgence of COVID-19 cases. Under such circumstances, the government has implemented “delicacy management” 3 with specific guidelines for areas of different risk levels (Ministry of Civil Affairs and National Health Commission, 2020). Communities in the high-risk areas are expected to regulate and monitor the movement of people, disinfect cars, deliver food and other necessities, and coordinate deliveries. In the low-risk areas, communities should focus on services such as opening service stations and coordinating deliveries.

4.2 International experience

China is not the only country utilizing community or other forms of social infrastructure to enforce and coordinate isolation and quarantine operations, which have proven to be the most crucial step in stopping the spread of the virus (Sjödin et al., 2020). A few other countries and districts, for example, Taiwan, Singapore, Cuba, Venezuela, and the state of Kerala in India among others also share this community-level care experience in this pandemic.

Some countries struggle to use limited public resources to provide ad hoc support. In Taiwan, for example, in addition to big data and cell phone signals which are used for contact-tracing and quarantine monitoring, the borough chiefs, the lowest-level elected officials, were made to check on people daily “to make sure they are not fooling authorities by leaving their tracked phone at home while they go out” during the quarantine. They also need to assist people with grocery shopping and provide psychological comfort occasionally, which has overwhelmed these borough chiefs mobilized only in an ad hoc manner (Sui, 2020). In Singapore, community centers were assigned to distribute masks and monitor

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3 Delicacy management is the concentrated expression of modern scientific management theory and the inherent requirement to realize the modernization of national governance systems and governance capability (G. Chen et al., 2021).

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quarantine with temporarily increased staffing during peak times. Yet places where community resources were lacking for strictly enforcing and coordinating an effective quarantine, such as the immigrant worker dorms, experienced outbreaks (Han, 2020).

Given their relatively small sizes of population, Taiwan and Singapore’s ad hoc community structure proved to be effective in enforcing quarantine when they only had to face imported cases at the early stage. Yet their weakness is also salient. Singapore’s community centers were set ad hoc with temporary staff, and Taiwan’s Covid-19 policies at the community level only imposed extra work on the already heavily burdened borough chiefs. Both suggest that communities there had long suffered from chronic insufficiency in human resources and the lack of experience and preparedness becomes a barrier for mobilization and implementation. Therefore, their performance is less impressive compared to countries or regions which were more prepared with such social infrastructure already in place.

In Cuba, for example, as early as mid-March, some 28,000 medical university students joined a campaign to offer in-person check-ups to each neighborhood in the country, and managed to visit six million Cubans within one week. Their work helped narrow down the number of people that needed follow-up testing, a decision ultimately made by family doctors in the respective communities (Prashad, 2020). This massive mobilization of human resources played an acute role when testing kits were not in full supply and anxiety was still spreading. Medical professionals reaching out to households, rather than people crowding at hospitals for testing, also helped curb the spread of the virus, as witnessed in many other countries hard-hit by the pandemic.

In Venezuela, communes work as part of the community infrastructure and played crucial roles in imparting knowledge on COVID-19 prevention and coordinating quarantines. Commune doctors had already gathered information on individual households prior to the pandemic, which helped them to quickly identify the most vulnerable members with extra physical and psychological needs. Before the pandemic even hit Venezuela, doctors had already started to make house-to-house visits to inform residents about the nature of the virus and ways to avoid catching it. Such preventative methods might not appear efficient from the economic perspective, considering the time and labor involved, yet in the context of a pandemic, it has proved to be an extremely prescient method of saving immense amounts of resources in the treatment stage.

The case of Kerala in India is even more exemplary. The existing institutional structure Kerala has in place since 1998 connects women in neighborhood groups at the village level and is scaled up to Community Development Societies at the village council level (Agarwal, 2021). Its cooperatives not only effectively facilitated quarantine, as in the cases of Cuba and Venezuela, but some of them even assumed essential production function such as producing masks and hand sanitizers, in addition to farming in groups (Dennis & Prashad, 2020; Kudumbashree, 2020). With state government commitment, as well as support from NGOs, this network of 295,000 neighborhood groups with 4.4 million members began community kitchens, delivered home meals to the needy, coordinated with community health workers for contact tracing, and so on (Agarwal, 2021).
All the above-mentioned examples suggest that countries with pre-existing community infrastructure were able to act rapidly to take advantage of its affiliated human resources. It proved effective in enforcing quarantines during the pandemic, and in reinforcing the prevention of infections in the first place. Moreover, it helped protect people’s right to food, health, and livelihood, especially for the poor in the pandemic. Instead of individualizing the responsibility and cost of “flattening the curve,” community service in the age of COVID-19 socializes the cost and maximizes the effectiveness in combating the virus.

5 Discussion and conclusion

The global COVID-19 pandemic has revealed the essential role of care work in sustaining life, health and maintaining the basics of everyday existence. It has also made visible the disproportionate burden of care work on women. Such tensions developed under neoliberalism and have been exacerbated by the public health crisis. With care work externalized onto families and the suspension of market channels during the lock-down, individuals and households are fundamentally weak in combating the crisis. The actual extent and scale of the crisis is far more calamitous than what has been directly observed.

Reviewing the COVID-19 experiences in China, we find the nature of response to COVID-19, like elsewhere, is indicative of the centrality of a care crisis in the pandemic and the long-term conditions leading to it. While countries globally have been searching for effective ways to respond to and recover from the crisis, we discover community-centered infrastructure, representing an institutionalized assemblage of state, family, and local resources, at the center of China’s overall response and relatively successful result. This assemblage is also found in successful experiences beyond China, such as in Cuba, Venezuela, and India’s Kerala, where community resources were organized and institutionalized prior to the pandemic and thus could be quickly and effectively mobilized in this public health crisis.

What the communities in China exemplify is not just emergency relief—though more of that would have been needed for many countries—but rather a more socialized response and reinvestment in formal preparedness for imminent public crises that families are intrinsically weak in responding to. Our focus on the landscape of care provision reveals the necessity to institutionalize the community’s function as a social infrastructure to deliver essential care services. Just like we need physical infrastructure, such as highways and airports, to deliver our goods to market, we also need social infrastructure such as community organizations to deliver social services to local recipients. The comparison between mainland China, Venezuela, Kerala and Taiwan also suggests that effective social service delivery is more likely to occur with the support of a long-existing social infrastructure that coordinates locally non-exclusive care provision, and less so from community organizations that are mobilized in an ad hoc fashion.

In addition, we stress the crucial importance of the collaboration between the state and the community in constructing a new normal in which privatized and marketized care can be, at least, partially re-socialized as a public service. Leaving local
communities alone without government support thus tends to exacerbate existing inequality. While local community independence has some merits, overemphasizing it to the extent of completely ridding the involvement of the state will only lead to further polarization of community development, with the best services available to communities endowed with rich resources in the first place. For example, neighborhood communities with abundant educators could form collectives, taking turns to provide after-school enrichment programs for local kids, relieving other parents from daily care work or purchasing market-rate services. Yet children living in poor neighborhoods are denied such opportunities, just like their parents who can hardly take a break from either wage-work or housework. At the same time, even for communities endowed with resources to spontaneously assume care services, the stability and permeance of these services is also in doubt. Fluctuations in human or material resources could lead to the collapse of the formed community organizations, especially in a pandemic or an economic crisis. This weakness of exclusiveness and instability originating from the spontaneous nature of community work could be addressed by a more cohesive state-community partnership in the realm of care provision. Development, as Amartya Sen (1983) advocates, should be seen as expanding the ‘entitlements’ of all people and the ‘capacities’ these entitlements generate. Community-centered infrastructure as a non-market process can serve this goal, not only in managing a public health emergency, but also to truly promote human development for all.

Nevertheless, our analysis of community does not take community as a natural, taken-for-granted category nor as an object of state policing. Rather, community acts as a platform to mobilize state and local capacities and resources, to develop its potential to provide decent jobs, improve gender equality and promote long-run human development. For instance, building a community-centered social infrastructure could attenuate the negative impact of COVID-19 on employment and income loss, but also serve as a social platform to reset public agenda and reclaim public spaces. Expansion of social infrastructure beyond health is also a job creation process in which care work is not only made visible, but also decent, secure, and rewarding.

To find ways to socialize the cost and maximize the effectiveness of disease or disaster prevention and control will be increasingly important when capitalism, under the current global system, tends to self-produce more ecological-epidemiological-economic emergencies. Hence, we believe building community-centred social infrastructure is of great value and call for more policy attention and initiatives. The crucial role of social infrastructure in combating the pandemic has provoked an opportunity to explicate the solidarity basis of care and shape collective imagination and efforts to create a better alternative through which people survive and thrive.

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