

Making the City Livable: Caregiving and Health in Gentrifying Boston

by

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Abstract

How does the urban environment shape everyday caregiving practices? How does care mediate the relationship between cities and health? What are the planning ingredients of urban environments that support caregivers and viable caring relations? I answer these questions by analyzing data from interviews with caregivers conducted as part of the Healthy Neighborhoods Study, a longitudinal Participatory Action Research project exploring the relationship between gentrification and community health in nine Boston-area neighborhoods. First, I find that the strategies respondents employ to fulfill caregiving goals are shaped by the availability and adequacy of specific components of the urban environment, which I argue comprise the urban infrastructure of care. However, this infrastructure may be unavailable, inaccessible, inadequate, or poorly connected. Caregivers compensate for these shortcomings by securing, connecting and maintaining the components of the urban infrastructure of care to ensure satisfactory background conditions for caregiving. By shaping the extent and nature of this “infrastructural labor,” cities influence what forms of care are possible and what the work of care demands from caregivers. Second, comparing caregivers’ experiences at different stages of gentrification, I find significant differences in their perceptions of changes in local urban infrastructures of care, and in what the work of care entails. I argue that gentrification produces “care insecurity” for respondents: diminished confidence in the ability to provide satisfactory care in the future and to adapt to neighborhood changes that impact caregiving. Finally, I explore the hypothesis that changes in the urban infrastructure of care could produce caregiver stress, and that stress might thus be a pathway through which the relationship between caregiving and the urban environment becomes embodied by caregivers. I find that the challenges of performing infrastructural labor necessary to care can be physically, mentally and emotionally depleting for caregivers with negative consequences for their health and wellbeing. I conclude by proposing a framework for “planning for care” focused on the intertwined priorities of alleviating and equitably distributing the burden of care work, proliferating the possible forms that care can take, and maximizing people’s freedoms to give and receive care in ways that they value.

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1 Introduction

1.1 Right here, running

“A lot of people always tell me they admire how I do a lot with my kids in the sense of anywhere I go, my kids is right there,” said Nina, a Black woman living in Dorchester, MA, during an interview in the summer of 2018. I conducted Nina’s interview as part of the Healthy Neighborhoods Study, a longitudinal Participatory Action Research project investigating the relationship between community health and urban development in the Boston region, which I have helped to design and lead for the past six years since we began in 2015. Nina explained to me that she cares for her three children and elderly mother, while also working full-time as a nanny. Providing care to so many people amounts to a tremendous amount of skilled work, with constantly shifting demands. But, Nina explained, “I feel static. I feel, honestly, standing still. I’m not moving...In the sense of like I’m trying to be more independent, myself, but it’s hard to be a single parent and have to take care of your kids and still support yourself in a sense. So yeah. I feel like I’m not moving from one spot. I’m just right here.” A year later, much had changed – her father had passed away, one job ended and another began, and her eldest son joined her in Boston from her home country in the Caribbean – and she still felt like she was running on the spot. “I want it to slow down, but not with the cost of living. I can’t... I want to go to the gym, but I can’t. I want to do a lot of things, but I can’t. I want to go home, but I can’t. I can’t so I just – it’s a big sacrifice... It’s huge.”

Why does Nina feel simultaneously stuck and unable to slow down? What does being “on the run at all times” mean for Nina’s health and wellbeing? What role does Nina’s neighborhood, and the rapid urban development and rising economic inequality in the region her family lives in, play in producing this paradoxical, yet common, experience? Urban planners are increasingly seeking to apply planning tools, ranging from zoning to housing development to community engagement, to improve public health. As this area of our field’s practice expands, we must start to consider how we will attend to the wellbeing of caregivers in cities, those who do the work that everyone’s health depends on, day in and day out? What is the nature of urban planners’ responsibility to Nina, and how might

planning researchers and practitioners make it possible for Nina to “slow down”? These questions are at the heart of this dissertation, which explores the relationship between the everyday work of caregiving and the urban environment, as well as how the relationship between care and the city becomes embodied by caregivers and influence community health. What is possible in terms of care, what the experience of caregiving is like, and what freedoms Nina and others have as caregivers, are shaped by their neighborhoods and the city at large.

Care is, and has always been, ubiquitous in cities; cities are teeming with as many forms of care as there are life. Nina’s life revolves around caregiving, and she is far from alone. We all depend on the care of others, in different ways, from the cradle to the grave. Whether or not we have the care we need is another matter entirely. But when care is there, someone is doing it. Sometimes, that person may be paid; if they are, it is almost certain that they will be underpaid relative to the value of their labor. Most of the time, though, the work of care goes unnoticed, unpaid and under-valued. Nevertheless, the work gets done. For many people, caregiving is one of the most important things they do in their lives. For many caregivers, this work is also psychologically, emotionally and physically taxing. All of this work, on which our lives and livelihoods literally depend, takes place. Care depends on place; it takes place to make care possible. As planners, we see ourselves as the field that makes place; the field that intervenes in the built environment so that we can live together and benefit from one another’s presence.

Care is “everything we do to maintain, continue and repair our world so that we can live in it as well as possible” (Tronto, 1993, p. 103). Care is the work of making life livable. It is “life’s work” (Katz et al., 2015). The present era is characterized by a crisis of care – “an acute expression of the social reproductive contradictions under financialized capitalism” – which is the latest in a long historical pattern of social-reproductive crisis tendencies in capitalist societies (Federici, 2004; Fraser, 2016, pp. 21–22). Social reproduction refers to the forms of work that are socially and biologically necessary for maintaining life and reproducing the next generation (Laslett & Brenner, 1989). Care is the engine of social reproduction. The history of capitalism – and thus, as I show in Chapter 2,

the history of U.S. cities – has been characterized by the exploitation of social reproduction in service of ever more profitable forms of production.

Under neoliberalism, the political rationality that has dominated economic and social policymaking in the U.S. since the 1970s, responsibility for meeting and fulfilling everyone's needs for care has increasingly been pushed away from the collective and on to individuals like Nina. At the same time, people's capacities to fulfill these responsibilities has been undermined by the hollowing out of the welfare state, the rise of workfare, and ever-greater labor market insecurity for all but the most privileged few (Fraser, 2016). Demand for care has skyrocketed since deindustrialization and the economic crises of the 1970s, as women entered the labor market en masse while retaining responsibility for the "second shift" of household work, and advances in health and medicine mean more and more people are living well into old age (Hochschild, 1989; Winant, 2021). Care has increasingly been commodified to meet this rising demand in the absence of state support, but the labor of people like Nina who are involved in producing care as a commodity – mostly women, mostly people of color – is economically marginalized and structurally under-valued, even though care is the largest and fastest-growing sector of the U.S. labor market (Budig et al., 2019; Dwyer, 2013; Folbre et al., 2021; Pietrykowski, 2017; Winant, 2021). While the wealthiest can fulfill their care needs by purchasing care as a commodity, everyone else must sacrifice ever more resources and energy to accomplish care, working more and spending more time trying to make it work, less able to provide care and less able to receive it (The Care Collective, 2020). All of the patterns that comprise the crisis of care reproduce racial and gender inequality at the societal level (Bhattacharya, 2017).

The crisis of care has tremendous implications for urban life. By increasing the burden of unpaid care work on individuals and by rendering the fastest-growing part of many urban labor markets under-valued and vulnerable, the crisis of care is a vector for the reproduction of structural inequalities across multiple social axes including race and gender, which threaten health, wellbeing and the livability of cities. Constraints on individuals' and communities' abilities to care and be cared for threaten to thwart our efforts to overcome the most pressing urban challenges of our time like climate change,

global migration and public health crises. Urban governance and real estate are at the heart of the process of the racialized financialization of capitalism that is fueling the contemporary crisis of care (Aalbers, 2020; Fields, 2018; Fields & Raymond, 2021; Fraser, 2016). Inspired by the urgent need to center the crisis of care in conversations about the scope and purpose of urban planning, this dissertation shows how planners can understand the ways that everyday, unpaid care – and the uneven distribution of its burdens - is shaped by the urban environment; how the work of care is transformed by the increasing competition for the benefits of urbanization brought about by patterns of disinvestment and gentrification; and how the impacts of urban space on the work of care come to be embodied by caregivers and impact their health, wellbeing, and freedoms to care for themselves and others in ways that they value.

Figuring out how to answer questions about the relationship between care and urban environments opens up a crucial new dimension of understanding planning's role in protecting and creating health. If health is indeed the ability to adapt to one's environment (Huber et al., 2011; Lancet, 2009) then care is necessarily crucial to this task. Moreover, if care is indeed a defining element of what it is to be human and a necessary condition for life itself (Bellacasa, 2017; Kleinman, 2015), then it should concern not only planners focused on health, but all planners for whom livability "matters" (Sanyal et al., 2012). For planners, focusing on care is essential for advancing health, wellbeing and livability because: (a) care modifies our embodiment of the social, material and ecological contexts in which we live; (b) we directly embody the socio-material relations of care and neglect that we have been embedded within; and (c) care is a central way in which people attend to, engage and negotiate one another's embodiment of the worlds around them. By ignoring the role of care in the production and achievement of health, as well as the ways that care is undermined or supported by urban environments, I contend that urban planners and public health practitioners face a high risk of both failing to fulfill our scientific efforts to link health and its distribution with changes in social context and structure, and failing to succeed in our practical efforts to enhance health and wellbeing. Thus, this dissertation also seeks to link questions of care to questions of the relationship between health and place.

Though improving health is a core motivation for this research, it falls within a broader aim of developing approaches to planning research and practice that take care as their object are necessary to make planning – and planners – adequate to the challenges of our time. Because the production of urban space is central to the crisis of care, and because the consequences of the crisis of care will mostly be borne by urban dwellers, how is our field responsible for ensuring that the built environment of cities supports the everyday work of caregiving rather than undermining it? What is our role in alleviating our contemporary crisis of care? How will attending to and supporting cities' infrastructures of care advance planners' efforts to enhance public health and make cities more livable? These are not "if" questions: there is no doubt that changes in the built environment and how we inhabit it result in changes to the means of social reproduction and the work of care (Hayden, 1983; Markusen, 1980; Morrow & Parker, 2020). They are "how" questions: how is care dependent on the built environment, how do changes in the built environment affect caregiving practices, how has planning contributed to our contemporary crisis of care, how might planning help us resolve this crisis? To answer these questions, we must make space for care in planning thought. To date, care has for the most part been missing from urban planning conversations, an omission that devalues the lives and livelihoods of the vast majority of people like Nina from whom care is a central part of life, and that threatens to thwart planners' efforts to secure more livable urban futures. The purpose of this dissertation is to help rectify this error, and establish care as a pressing priority for planning research and practice.

1.2 Missing and Finding Care in Urban Planning

So: where is care in urban planning? This question comes from a place of concern and frustration, because something so central to life as care shouldn't be hard to find in how planners make sense of cities and in how they try to change them for the better. But, until very recently, care has received scant attention in planning research and discourse. While planners have lately begun to talk about how planning can be more caring in disposition, we have yet to seriously consider how to value, cultivate and support the work of care as

it exists in cities through our research and practice (Jon, 2020; Lyles et al., 2018; Lyles & White, 2019). An equally important question to ask, then, is: why is care so absent from our understanding of how cities function and what they are for?

To answer this question, it is useful to return to the concept of social reproduction, which originates in the work of Friedrich Engels and Karl Marx (Engels, 1884; Marx & Engels, 1848). They observed that under capitalism, social reproduction is structurally subordinated to the imperatives of production and accumulation. The concept was later expanded upon by feminist political economists to refer to “the activities and attitudes, behaviors and emotions, responsibilities and relationships directly involved in the maintenance of life on a daily basis and intergenerationally” (Laslett & Brenner, 1989, p. 382). Or, as Cindi Katz (2001, p. 711) puts it, social reproduction is “the fleshy, messy and indeterminate stuff of everyday life.” Necessary and messy, every day, so that we can live. In recent decades, feminist scholars and activists have explained that the intertwined processes of de-valuing care and obfuscating care’s role in how economies and societies function have been central mechanisms through which life’s work has been subordinated to production and capital accumulation (Dalla Costa & James, 1975; Federici, 2004; Fraser, 2009, 2014, 2016). Some among them have also shown how these patterns of devaluation and obfuscation have been accompanied by forms of racist coercion and exploitation, and have been crucial to the maintenance of durable, structural racial inequities in U.S. society (Bhattacharya, 2017; Glenn, 2012; Roberts, 1998).

I argue that one answer to the question of why care is missing from planning: because it had to be for planning as a professional field to expand, gain legitimacy, and maintain its place as an arm of the state that exists to mediate the turbulent and harmful effects of the capitalist mode of production on people’s homes, communities, livelihoods and wellbeing. Since its modern inception as a means to manage and control the unruly, unhealthy and rapid growth of many cities during the industrial revolution, planning as we know it – at least in its mainstream and institutionalized forms - has served as a tool of the powerful for the production of urban space in ways that encourage capital accumulation, manage the contradictions inherent to capitalism, and perpetuate heteropatriarchal white supremacy (Goetz et al., 2020; Goh, 2018; Harvey, 1978; Hayden, 1983; Lefebvre, 1992;

Miraftab, 2019; N. Smith, 1984; R. A. Williams, 2020). In the development of planning as a professional field under capitalism, the de-valuation and obfuscation of care and social reproduction were necessarily central to the field's ability to serve capitalist ends and thus maintain its standing vis-à-vis organized capital. And, similarly, the perpetuation of racist inequities in who is empowered or disempowered to reproduce and care for one another has been central to the development of the contemporary capitalist city, as have many other mechanisms of racial – and class, and gender, and sexual – subordination. Urban renewal and suburban sprawl exemplify these processes, as planners sought to increase real estate values while safeguarding the interests of white property-owners. Stein (2019, pp. 16–17) argues that planning's has been characterized by a tension between pragmatic efforts to ensure that people have the means to survive, and “a crude commitment to capital...[by] turning everyone's space into someone's profit.” Though many planners are undoubtedly motivated by the former, when these two imperatives come into conflict, it is typically the latter that prevails.

Undermining care is not the only way to live with one another, not the only way to organize our society, and not the only way to plan. Confronting our field's neglect of care to date, and the imperative of bringing care to the center of planning research and practice, is essential to the pursuit of racial, gender, and health equity in cities, as I will argue throughout this dissertation. But first, I want to stake the claim that planning for and with care is also essential to the future of planning itself – if, that is, we seek forms of planning that can help bring about the demise of racial capitalism, participate in repairing its harms, and foster alternative forms of collective survival and growth. A tall order, to be sure, but there is no more urgent task to ensure that those of us who live in cities, those of us whose lives are shaped and structured by the motions of urbanization, can live as well as possible now and in the future. As planners, one way we can meet this challenge is by expanding our understanding of what planning is and where planning happens, of who planners are and who can be empowered to plan on behalf of others, of the forms of knowledge that plans and interventions are informed by, and of the sources of power we have at our disposal to build more just and livable urban futures. And one way we can do that is by acknowledging and affirming that social reproduction *is* planning, that

caregiving *is* planning, and thus seeing our work as one, not so as to coopt caregivers' efforts but in order to act in solidarity, together.

In *The Undercommons: Fugitive Planning & Black Study*, Stefano Harney and Fred Moten draw a distinction between 'policy' – "the new forms command takes as command takes hold" – and 'planning' – "not an activity, not fishing or dancing or teaching or loving, but the ceaseless experiment with the futural presence of the forms of life that make such activities possible" (2013, pp. 74–75). They situate 'planning' as they define it not within local bureaucracies, private sector firms, think tanks, or the halls of academia, but instead in "the undercommons of the social reproductive realm" where people, themselves the means of social reproduction – "for instance, the republic of women who run Brooklyn" – are the planners and are "still part of the plan" (2013, pp. 37; 74). Here, in life's workshop, planning takes a different form than professionalized planning researchers and practitioners are most familiar with: here, planning is the "ongoing experiment with the informal, carried out by and on the means of social reproduction, as the to come of the forms of life." Planning, Harney and Moten elaborate, "is self-sufficiency at the social level, and it reproduces in its experiment not just what it needs, life, but what it wants, life in difference" (2013, p. 76). These forms of planning resist the effort of the state, of policy, "to impose a compulsion of scarcity through seizing the means of social reproduction." Instead, "the plan is to invent the means [of social reproduction] in a common experiment launched from any kitchen, any back porch, any basement, any hall, any park bench, any improvised party, every night" (Harney & Moten, 2013, p. 75). The innovative strategies of such "kitchen table planning" are informal, decentralized, gendered, and crisscross what we might distinguish as public and private spaces (Sweet, 2015).

Planning, as Harney and Moten define it, is the force of social reproduction's potential, the means through which care is made possible. In comparison, *urban* planning, as most of us know it professionally, seems but a technical artifact at best. And at worst, urban planning is and has been a tool of 'policy', in Harney and Moten's terms, through which capital seeks to break up the means of social reproduction "as a way of controlling

them, as once it was necessary to de-skill a worker in a factory” through the proliferation of “contingency [and] risk... as imposed consensus, which both denies and at the very same time seeks to destroy the ongoing plans, the fugitive initiations, the black operations, of the multitude” (2013, p. 76). In the U.S., redlining and segregation, the destruction of Black neighborhoods via urban renewal and the development of the interstate highway system, and the organized demise of public housing are but a few examples from our profession’s harmful past (Crockett, 2018; Fullilove, 2005; Rothstein, 2017; Sugrue, 2005; Vale, 2019). Some planning scholars have sought ways to reckon with and repair such harms, exemplified by approaches like abolitionist, reparative and antisubordination planning (Goetz et al., 2020; Steil, 2018; UCLA Abolitionist Planning Group, 2020; R. A. Williams, 2020). But to date the reckoning in practice, and not just in theory, has been led by the planners of the undercommons, organizing one another to proliferate the means of care and social reproduction through efforts ranging from the free breakfast programs of the Black Panther Party to Moms 4 Housing’s occupation of vacant homes (Heynen, 2009; Ho, 2020). From this vantage, then, another answer emerges to the question of where care is in planning: it’s everywhere, and we as professional planners just need to learn to see it and to value it on par with our own skills and practices.

We as urban planners are but a small part of the vast enterprise of trying to make urban life livable. Scholars and practitioners in our field have long grappled with the manifold limitations on our power to act, the question of our role and agency in spite of them, and the frustrations of political impotence; entire schools of planning theory have emerged in response to these very questions. The choice before us as planners, as we strive to preserve and nurture urban life as the contradictions of racial capitalism accelerate and we face the twin crises of care and climate, is whether we serve as ‘policy’s’ deputies, or align ourselves with the planners in the undercommons of the social reproductive realm in the effort to proliferate possibilities of social reproduction. Whose power will we be an instrument of? To me, the choice is clear: to stand in solidarity with, rather than opposition to, the ‘kitchen table planners’ of the world. And so, the question becomes, how do we marshal our skills and capacities to plan with and for them? How do

we plan for – by which I mean plan in service of – social reproduction and care, maximizing their potential and the forms they can take, in ways that do not coopt, control or command these ongoing experiments in living life as well as possible? This question drives my dissertation.

In the chapters that follow, I endeavor to construct key building blocks for the effort to plan for care by exploring how the work of care is dependent on the urban environment, how changes in the urban environment impact caregiving, and how the evolving relationship between the urban environment and care comes to be embodied and influence wellbeing. To answer to these questions, I turn to caregivers themselves. Care is skilled work, and it does not take place in a vacuum: caregiving involves adapting to the attributes and limitations of one's context, and leveraging the material and social affordances of one's context in the service of care itself. Thus, through this work, caregivers possess knowledge about cities and processes of urban change, as well as visions and desires for cities that can be more conducive to care. As a planning scholar trained in and committed to Participatory Action Research, I see my task as learning from their experiences and insights in ways that serve their empowerment and control over the conditions of care and the means of social reproduction, so that people like Nina can slow down and be free.

1.3 Research Questions

In this dissertation, I ask three research questions about the role of care in the co-production of health and place. First, I ask: How do characteristics of and changes in the urban built environment shape everyday caregiving practices? Caregiving activities are shaped by the spatial contexts in which they take place, as geographers have demonstrated in depth. By asking this question, I will seek to understand how the urban built environment comes to matter for caregiving from the perspective of caregivers, and how the urban built environment figures in caregivers' understanding of their roles. Thus, I will explore how the built environment constrains or expands possibilities for caregiving, and how it intensifies or eases the burden of caregiving work on individuals. Similarly, I

will explore the impact of changes in the built environment – in particular, those related to gentrification – on residents’ caregiving practices, and seek to understand how these changes afford or withhold the means of providing good care.

Care is a central factor shaping both health outcomes and the lived experience of health. This is true both for dependents and for caregivers themselves, for whom the work of caregiving has psychological, emotional and physical benefits and tolls. Since caregiving is central to health, and since caregiving is shaped by its context, my second research question will explore whether attending to caregiving can help planners understand the relationship between the built environment and health by asking: How does care mediate the relationship between the built environment and individual and community health? Many of the ways that the built environment shapes health – for example, by affording different degrees of access to resources, by shaping exposure to and risk from sources of illness and harm, by shaping how and whether people can move through space, or by supporting or taxing one’s mental health – are negotiated and managed in day-to-day life through caregiving practices. How do caregivers navigate and negotiate the ways that the built environment impacts their health and wellbeing and that of their dependents, and how do these efforts shape the lived and observed impacts of the built environment on health? Understanding these efforts promises to shine new light on planning’s understanding of the relationship between the built environment and health.

The final research question builds on the first two to ask: What are the planning ingredients of urban environments that support caregivers and viable caring relations? This question is grounded in the imperative to link planning research back to practice, and as such seeks to understand the steps planners can take to support caregiving practices as part of a strategy to fulfill the field’s goals of ensuring health, well-being and the livability of urban spaces and the built environment. To answer this question, I will consider both the “inputs” to planning interventions – what and how we know about places and their inhabitants, what we value, and how these values shape the outcomes we seek – as well as the “outputs” of planning interventions – physical, social, economic, and policy changes that shape the built environment and how it is inhabited. This question can be answered through empirical analysis, as caregivers are often explicit about what types of

changes to their circumstances would allow them to be more effective caregivers with less stress and strain. By linking the results of this analysis to findings from prior research in planning and public health, I will be able to consider how planning for care might be salutogenic, and how to incorporate care into planning efforts to improve community health.

1.4 Gentrification and displaceability

Urban space is constantly changing. Though planners of both the professional and kitchen table variety have a hand in shaping these changes, the underlying force driving these changes is capital. The production of urban space is a central mechanism of the creation and accumulation of value under capitalism, and the uneven development of urban space at scales ranging from the city block to the planet itself serve as both the expression of and temporary “fixes” for the crisis tendencies inherent to capitalism, including the tension between production and social reproduction described above (Harvey, 1978; Lefebvre, 1992; N. Smith, 1984). Today, one of the most significant patterns of socio-spatial transformation underway in cities around the world is gentrification (Lees et al., 2016). I focus on gentrification in my analysis of how changes in the urban environment impact the work of caregiving not only because of its prevalence, but because via the privatization of the commons and the destruction of connections between people and place it threatens to exacerbate the contemporary crisis of care (Curran, 2017; Elliott-Cooper et al., 2019; Luke & Kaika, 2019). Below, I define gentrification and explain some of what we know about its causes and consequences to date.

Gentrification is broadly understood to refer to the ascent of a neighborhood’s socio-economic status via the production of urban space for more affluent users. Academic definitions of gentrification vary, and scholars operationalize neighborhood ascent differently (Brown-Saracino, 2017). For the purposes of this study, I define gentrification as “the transformation of a working-class or vacant area of a city into middle-class residential and/or commercial use” (Lees et al., 2007; Slater, 2009). Specifically, this process of

transformation involves “change in the population of land-users such that the new users are of a higher socio-economic status than previous users, together with an associated change in the built environment through a reinvestment in fixed capital” (Clark, 2005, p. 258; Lees et al., 2016). The mechanisms underlying this process – including real estate development and costs, patterns of migration and displacement, and state sponsorship – remain broadly debated, as do their causes (Brown-Saracino, 2017; Ellen & Captanian, 2020; Hwang & Lin, 2016). Scholars have identified many different forms of gentrification, such as ‘green gentrification’ driven by urban greening and climate adaptation interventions, and ‘tourism gentrification’ driven by the explosion in short-term rental properties (Anguelovski et al., 2018; Cocola-Gant, 2018).

Due to historic patterns of residential segregation and economic inequality, such that race and class are intertwined in the American urban landscape, gentrification in the United States is concentrated in low-income communities of color (Hwang, 2019a; Hwang & Sampson, 2014). Though gentrification is commonly portrayed as a process whereby white people gentrify Black neighborhoods, some studies have found that historically, gentrification has been more likely to occur in racially mixed neighborhoods, and that patterns of immigration also influence where gentrification takes place (Brown-Saracino, 2017; Hwang, 2020). One study noted that predominantly Black neighborhoods face higher barriers to reinvestment due to racism, echoing findings that show how racial hierarchies shape patterns of neighborhood selection such that people in the U.S. favor Black neighbors the least (M. B. Anderson & Sternberg, 2013; Hwang & Sampson, 2014). Nevertheless, as gentrification advances, especially in places like Boston where it has been underway for decades, it is increasingly occurring in historically Black neighborhoods (Freeman & Cai, 2015). While some studies have identified emerging patterns of Black- and Hispanic-led gentrification, the fact remains that in the U.S., regardless of who is moving in to a gentrifying neighborhood, gentrification leads to the dispossession and displacement of the racialized poor. (Delgado & Swanson, 2019; Moore, 2009).

Recently, scholars have argued that we are in the “fifth wave” of gentrification, driven by financialized capitalism (Aalbers, 2019). In a recent assessment, Hyra et al

(2020) specify that this fifth wave is primarily about rental market real estate speculation, a process that has disproportionately affected low-income communities of color in Boston due in part to long-standing racial wealth disparities (Hwang, 2019a; Muñoz et al., 2015). Rising rents are leading to various forms of displacement – residential, political, cultural – and popular fears of long-time residents being pushed out (Hyra, 2015; Hyra et al., 2020; Versey et al., 2019). Displacement is not only physical but also cultural and psychological, an experience of “the destruction of phenomenological attachments to place and home” (Elliott-Cooper et al., 2019, p. 498; Fullilove, 2005; Slater, 2009). Scholars have called attention to the need to understand the stressors experienced by low-income people living in gentrifying neighborhoods, along with the health consequences of displacement anxiety and the feeling of being pushed out (Anguelovski et al., 2019a; Elliott-Cooper et al., 2019; Hyra et al., 2019).

While many gentrification scholars argue that gentrification contributes to displacement, the current evidence about whether gentrification causes residential displacement suggests that residents of gentrifying neighborhoods are not necessarily any more likely to be displaced than residents of non-gentrifying low-income neighborhoods (Brown-Saracino, 2017; Ellen & Caplanian, 2020; Hwang & Lin, 2016). Nevertheless, displacement remains a core concern for residents and community organizations in gentrifying neighborhoods – including those involved in the HNS (Arcaya et al., 2018; The Everett Community Health Partnership et al., 2019). This is perhaps because, as Yiftachel (2020, pp. 154–155) argues, *acts of displacement*, which he defines as “the involuntary distancing of residents from the full right to the resources and opportunities of their metropolitan region,” are increasingly overshadowed by an expanding *condition of displaceability*, a growing form of vulnerability characterized by susceptibility to “involuntary distancing from these rights and resources.”

Today, gentrification and the condition of displaceability characterize the site of this research, metropolitan Boston, and form not only the backdrop for the experiences of caregivers who I study, but as I will show, increasingly jeopardize their ability to give and receive care in ways that they value, with consequences for the wellbeing of both the caregivers and their dependents. The impacts of gentrification on social reproduction, and

the broader social, economic and health consequences thereof, have received little exploration to date (for an exception, see Curran, 2017). To date, researchers evaluating the harms of gentrification have predominantly focused on displacement, though this focus is broadening in part through efforts to explore the relationship between experiences of displacement and health (Brown-Saracino, 2017; Schnake-Mahl et al., 2020b). This dissertation contributes a new dimension to our understanding of the consequences of gentrification by exploring how this process of urban transformation is reshaping the means of social reproduction in cities with consequences not only for health but for social inequality, collective wellbeing, and urban livability more broadly. In doing so, I heed recent calls for more research that explores and centers the experiences of residents of gentrifying neighborhoods, analyzing qualitative data about experiences of caregiving amidst destabilizing neighborhood changes that has been collected as part of a Participatory Action Research project led by residents of gentrifying neighborhoods across Boston (Anguelovski et al., 2019a).

1.5 The Healthy Neighborhoods Study

I answer my research questions about the relationship between caregiving and the urban environment in the context of gentrification through analysis of qualitative data collected from interviews with nearly 70 caregivers living in the Boston metropolitan area. These interviews were conducted as part of the Healthy Neighborhoods Study (HNS), a longitudinal, multi-site Participatory Action Research project that I have helped design, manage and facilitate for the past six years. The HNS explores the relationship between urban development and community health in nine gentrifying neighborhoods across the Boston metropolitan area. A central aim of the study is to produce research on gentrification that more closely corresponds with the lived experience of living in a gentrifying neighborhood (Arcaya et al., 2018; Binet et al., 2019). We do this by involving community residents and partner organizations in all phases of the research, and focusing our research on asking and answering the questions that are most imperative to residents' efforts to plan for and work towards the future they desire for their communities. Resident

leadership in, and control over, our research is important for two reasons. First, because it helps build a shared understanding of the experience of gentrification across academic, policy and community circles. Second, because it helps correct for the power imbalance with respect to the production of knowledge upon which planning and policy decisions are made that emerges when communities are not afforded the “right to be heard” and have their experiences considered valid by mainstream institutions like universities and government agencies (DataCenter, 2013; The Everett Community Health Partnership et al., 2019).

1.5.1 The HNS Participatory Action Research model

Participatory Action Research is an approach to inquiry that centers the lived experiences of those individuals and communities most affected by the phenomena under investigation in each phase of research, and seeks to use the knowledge co-created through this research to act on and improve the community’s social and material conditions and the power relations that shape them. With diverse origins ranging from John Dewey’s pragmatism to Paulo Freire’s liberation theology, PAR-like modes of inquiry have been employed in non-academic settings ranging from organizational development to social movements (Dewey, 1954; Freire, 2000; Greenwood & Levin, 2006). Within academia, PAR-like approaches to research exist across the social and health sciences, in some cases under different names such as Community-Based Participatory Research or Participatory Epidemiology (Greenwood & Levin, 2006; Israel et al., 2012; Wallerstein et al., 2017). PAR is an epistemology rather than a specific research methodology, and PAR studies like the HNS use a variety of qualitative and quantitative methods as appropriate for the research questions and action goals of the community being studied (McTaggart, 1994).

The HNS PAR model is centered on a team of about 45 Resident Researchers who work in collaboration with a local partner organization in each community (*Table 1.1*). Resident Researchers are recruited by community partner organizations, and participate in all aspects of research design including research question development, instrument

design, data collection, data analysis, sharing research findings with various audiences (e.g. academic publishing, conferences, community meetings) and using study findings to develop interventions addressing the health impacts of development. Resident Researchers range widely in age, education and familiarity with research, and life experiences. Resident Researchers are trained in PAR methods and research ethics, and are registered as IRB-approved study personnel. To compensate them for their efforts, Resident Researchers are paid a stipend of \$15-\$18/hr. for all HNS activities.

Table 1.1: HNS Communities and Partner Organizations

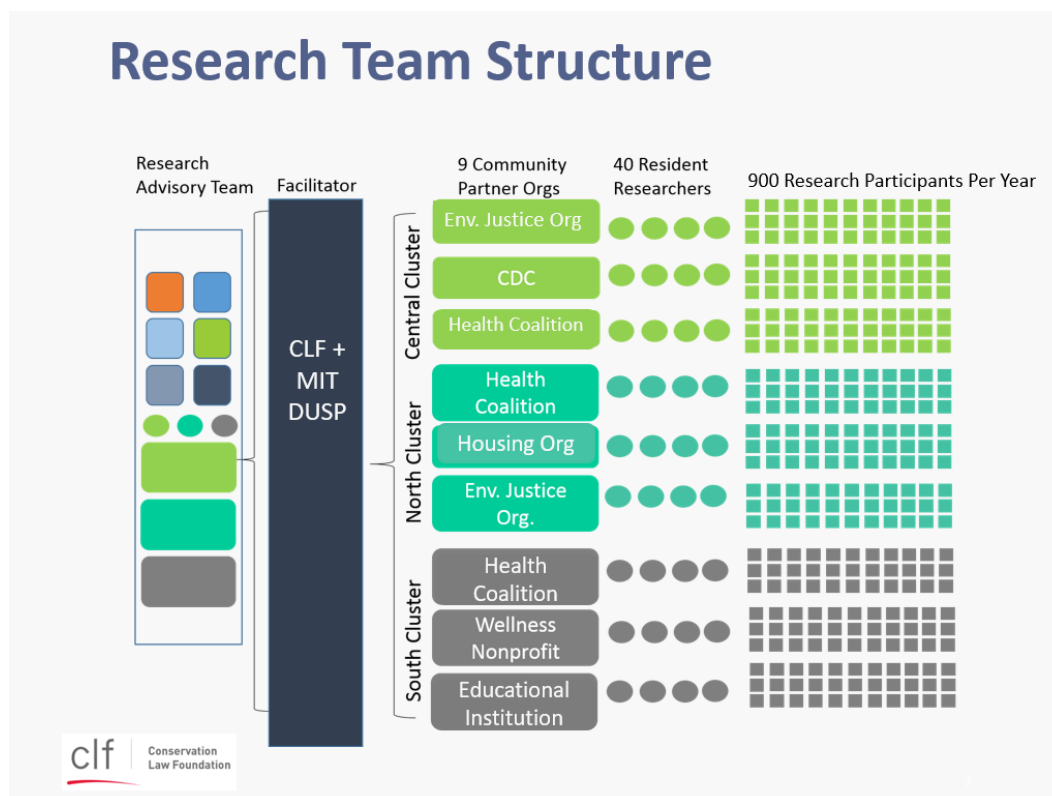
Community	Current Partner Organization	Prior Partner Organization
Lynn	Lynn United for Change	
Chelsea	Greenroots, Inc.	
Everett	Everett Community Health Partnership	
Roxbury	Alternatives for Community and Environment (ACE)	Dudley Street Neighborhood Initiative (DSNI)
Dorchester	Codman Square Neighborhood Development Corporation	
Mattapan	Mattapan Food and Fitness Coalition	Action for Boston Community Development (ABCD); Redefining Our Community (ROC)
Brockton	Massasoit Community College	City Life/Vida Urbana
Fall River	Greater Fall River Partners for a Healthier Community	
New Bedford	Voices for a Healthy South Coast/ YMCA SouthCoast	

HNS community partner organizations were identified based on overlaps with their work and the focus of the study, and their ability to mobilize community residents. Partnerships were established after discussions with organizations about how to ensure that the research would be aligned with and beneficial towards their work. Coordinators

from partner organizations support the Resident Researchers in carrying out their roles, and also provide input on research design, data gathering, analysis, and acting on findings. The process for community selection, and more information about the HNS communities themselves, is presented in *Section 1.6* of this chapter.

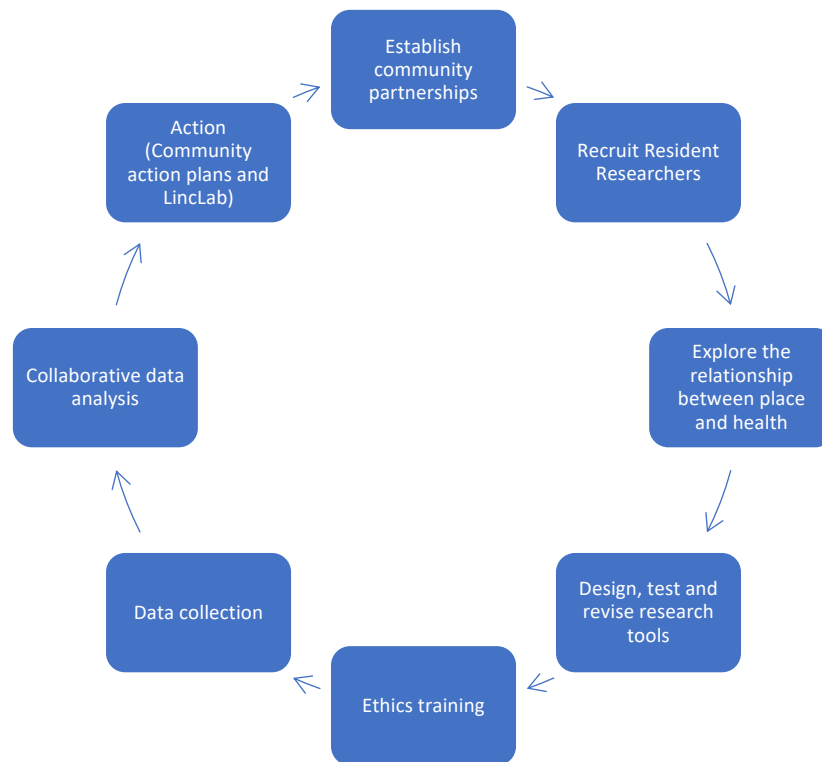
The HNS Resident Researchers and community partner organizations form the core of the broader Healthy Neighborhoods Research Consortium, which also includes academic partners, partners from non-governmental organizations like the Conservation Law Foundation (CLF), and partners from state and local government agencies like the Metropolitan Area Planning Commission (MAPC) and the Massachusetts Department of Public Health (MDPH), all of whom are directly involved in using urban development as a tool for improving health and achieving health equity (*Figure 1.1*).

Figure 1.1: The Healthy Neighborhoods Research Consortium Structure



Our PAR process is cyclical, running on roughly an annual basis (*Figure 1.2*). I designed the first iteration of this process during our baseline year in 2016, and over the years since have been involved in co-leading each of the phases in this process for various periods of time. The first phase of our PAR process is establishing partnerships with community organizations in each of the study communities, and recruit Resident Researchers. Then, we conduct “Collaborative Research Design” workshops, during which Resident Researchers participate in facilitated discussions about core study themes, and co-design, test, and revise research instruments. Next, Resident Researchers practice data-gathering and participate in research ethics training. Then, we conduct fieldwork, which involves Resident Researchers conducting community surveys and academic staff conducting semi-structured interviews with the study’s nested longitudinal cohort. Fieldwork is followed by “Collaborative Data Analysis” workshops where Resident Researchers are engaged in various aspects of analysis including model-building, hypothesis testing, qualitative coding, and meaning-making. Finally, Resident Researchers collaborate with community partner organizations to share data and findings back with their communities through individual community action projects as well as a collaborative research-to-action process called LinLab, and endeavor to use our findings to advance equitable development without displacement through building community power and engaging in advocacy. In 2020, we published a public-facing guidebook to PAR based on our process, which is freely available online (The Healthy Neighborhoods Study, 2020). The process for designing and facilitating the initial rounds of collaborative research design and data analysis workshops is also described in greater detail in Binet et al. (2019).

Figure 1.2: The HNS PAR Process Cycle



1.5.2 Dissertation Community Advisory Committee

The HNS leadership team, comprised of personnel from MIT and CLF, strives to involve Resident Researchers in all aspects of the research process. As a member of the leadership team, I believed that it would be appropriate for Resident Researchers to play a formal role in advising my dissertation. This reflects, on the one hand, the enormous amount of work they have put in to the study that the proposed dissertation draws from, and on the other hand, the high value of the contributions they stand to make based on the skills and knowledge built through their involvement in the study thus far and their experience living (and in many cases, caring and/or establishing the supports that enable care) in the study communities. Accordingly, I submitted a proposal to the DUSP PhD Committee to have a Community Advisory Committee (CAC) co-supervise my dissertation along with the traditional academic committee, which stated two goals. First, to establish and maintain a structure that allows Resident Researchers to constructively shape the

dissertation – as they did the data-gathering tools, other findings, etc. – and share control over this aspect of the research process as they would any other. Second, to develop a model for resident input on scholarly products that I will be able to build on over my career, and that will be replicable in and compatible with other projects and contexts whether by myself or other researchers. The proposal was approved prior to my dissertation colloquium in November 2020.

The CAC is comprised of five Resident Researchers from the HNS and one of the study's co-Principal Investigators, who serves as chair. The Resident Researchers were recruited via an open invitation to all Resident Researchers and Site Coordinators. CAC members received \$300 stipends for their service.

CAC members have provided feedback and guidance on the progress of the dissertation through four facilitated meetings in addition to the colloquium and defense: one in advance of the colloquium, and three over the remaining timeline to completion focused on each of the analytical chapters of the dissertation. To design and facilitate each meeting, I drew on my experience developing collaborative research design and data analysis workshops for the HNS to build facilitation guides and materials that make the process engaging and accessible for with varying levels of formal education. Agendas for each meeting involved a presentation of updates on analysis and findings, and structured discussions and interactive activities designed to solicit feedback on progress to-date and advice for moving forward. The CAC Chair provided feedback on the materials in advance of each meeting. Written work relevant to each CAC meeting was shared with CAC members one week in advance of each meeting. At the colloquium and defense, the CAC offered its own determination about the proposal and dissertation. In the conclusion, I offer reflections on the contributions the CAC made to my findings and argument, and the nature of their role in the dissertation process as a whole.

1.5.3 HNS research questions and theory of change

During the first year of the HNS, as we began to explore the relationship between place and health through workshops with Resident Researchers and site coordinators from

community partner organizations, we collaboratively developed a set of three overarching research questions to guide us through our research-to-action cycle. These research questions are:

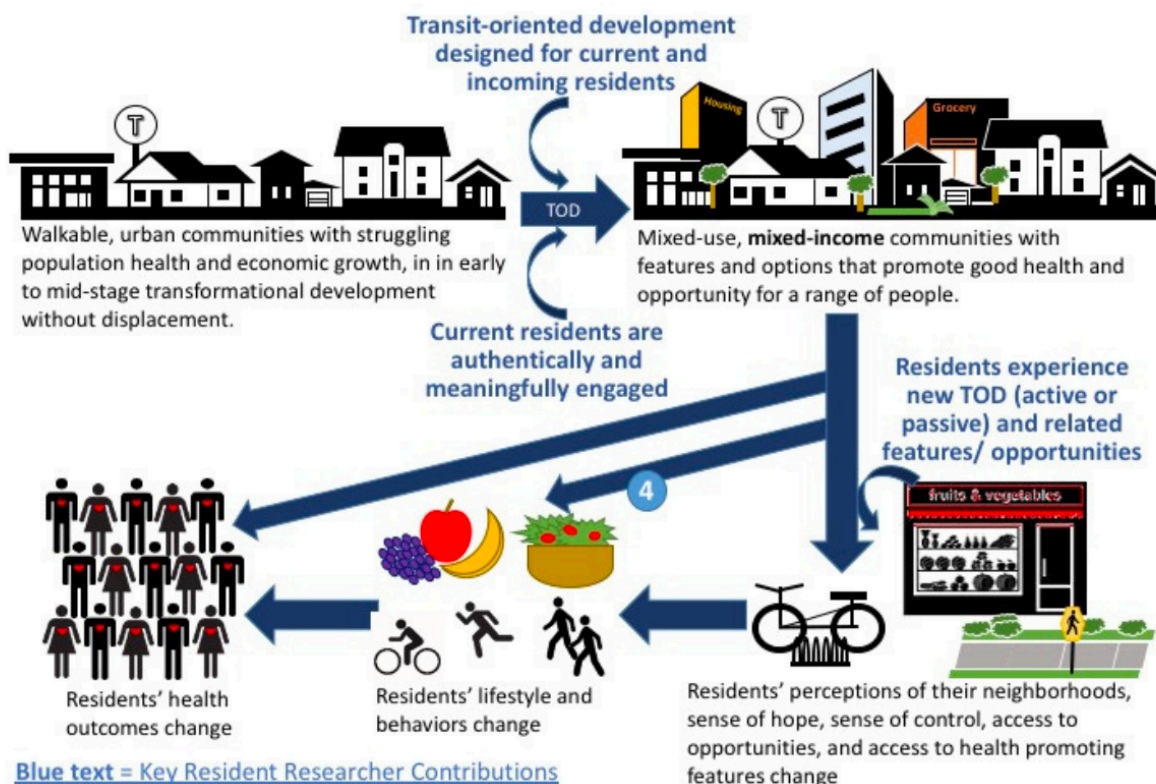
- (1) What changes in experiences, opportunities, health and quality of life are residents experiencing as their neighborhoods change?
- (2) How does what is built, how it's built, and for whom it's built impact health?
- (3) What roles do residential mobility and displacement play in changes in population health?

Each year, we develop new research questions that contribute to our answers to these overarching research questions as part of the process of directing our research agenda forward.

While care and social reproduction are not an explicit focus of the HNS, the themes pervade the study. The impacts of gentrification on people *qua* parents, children, families and kin are recurring themes in conversations and workshops with Resident Researchers, many of whom are themselves caregivers whose experience of gentrification has been shaped by this role. Many Resident Researchers are also leaders of or participants in mutual aid networks and other informal community groups that provided care for ill, elderly, homeless, or otherwise vulnerable neighbors and coworkers during the height of the COVID-19 pandemic. Indeed, Resident Researchers' involvement in the HNS may be seen as a form of care for the wellbeing of their neighborhood and community; many discuss their role in terms of meeting important community needs and helping to heal collective wounds. In collaborative research design and data analysis workshops, our team's discussions of changes to the built environment in domains like housing and green space are often explicitly focused on how these changes impact care work, as are our conversations about factors that might mediate the relationship between gentrification and health, such as financial security, social support, and one's ability to meet their priorities in life. It is my hope that this dissertation ties together many of the threads related to the themes of care and social reproduction that are woven through our work, and provides a venue for our team to build on these themes in future research.

Moreover, I believe that studying and planning for care is aligned with the HNS theory of change (*Figure 1.3, Box 1.1*). The HNS uses a theory of change to describe and connect the conditions and processes we see in the study communities, and the outcomes we expect to see as a result of actions we and others take. Our theory of change allows us to articulate and test multiple hypotheses at the same time in an effort to identify the conditions and actions that are necessary to bring about our broader goals for healthy and equitable neighborhood development. The HNS theory of change was developed by combining existing scientific evidence about how neighborhood development can support health with the experiential knowledge of Resident Researchers and community partners about how and where such interventions can fall short, and how such shortcomings should be overcome.

Figure 1.3: The HNS Theory of Change



Box 1.1: HNS Theory of Change Narration

“Many walkable, urban communities have gone decades without investment, have poor health, struggling economies, and are experiencing new development around transit hubs. If transit-oriented development is designed for current and incoming residents and engages residents in an authentic and meaningful way, the development will produce mixed-income, mixed-use communities with health-promoting options that residents can actually use and benefit from. As they experience changes in their communities that were designed for them, residents’ sense of power, control and hope and real opportunities for better health also improve. As a result, people in the community are able to do things from day to day that are important to them for good health and, ultimately, the health of all residents in the community, including those that were already there, improves.”

(The Healthy Neighborhoods Study, 2020, p. 23)

As a member of the HNS academic team, it is my goal and intention for this dissertation to contribute to the Consortium’s efforts to answer our three overarching research questions, and to contribute to Consortium members’ efforts to test our theory of change through action at the local and regional scale.

1.5.4 Primary data gathering: Surveys and semi-structured interviews

The HNS collects both quantitative and qualitative primary data from respondents living in the study communities. We collect quantitative data through a community survey tool that was developed and piloted in 2016 and which has since been fielded three more times on an annual basis with more than 3,000 respondents. We collect qualitative data via semi-structured interviews with members of a nested longitudinal cohort which we initiated in 2018. Below, I describe how each tool was developed and how we gathered our data using these tools.

1.5.4.1 Community survey

The HNS community survey was initially developed between March – September 2016 by HNS Resident Researchers and community partners via a series of six “collaborative research design” workshops, held in each of the nine study communities,

which I co-facilitated along with colleagues (Binet et al., 2019). These workshops had three goals: to familiarize Resident Researchers with PAR principles and methods; to facilitate the development of a common survey tool to be used across all communities; and to begin to generate ideas for future qualitative data collection (see below).

The workshops began by discussing how Resident Researchers understood the relationship between urban development and health in their own communities, and developing a theory of change. Based on the most salient themes that emerged through these discussions, academic members of the HNS team identified a variety of pre-existing validated measures for Resident Researchers to consider using to gather relevant data. For themes where pre-existing measures were non-existent, Resident Researchers developed their own measures with the assistance of the academic team. Where pre-existing measures did exist, Resident Researchers chose the measure that they felt best captured what they were trying to understand, and when necessary, made modifications to the language of the measure to ensure suitability to their community context (Arcaya et al., 2018).

The survey covers ten domains: demographics and household composition; housing and neighborhood belonging; health; prioritization; financial security; social support; transportation; local businesses; discrimination; and ownership of change. Prior to each subsequent round of data collection, Resident Researchers and community partner organizations go through a condensed collaborative research design process to revise the survey tool by adjusting existing measures across each domain based on their efficacy in the field, and/or by adding and removing measures according to changing data-gathering priorities as the study progressed and initial findings emerged. The survey is fielded by Resident Researchers in either English or Spanish and takes approximately 20 minutes to complete.

1.5.4.2 Semi-structured interview tool

During the first round of collaborative research design workshops in 2016, Resident Researchers expressed interest in gathering qualitative data from respondents in addition to the quantitative data collected via the survey. Their interest was driven by the need for

deeper understanding of respondents' survey responses and the knowledge based on work in the field that there was always "more to the story" than was being captured by the survey, as well as an interest in capturing cross-cutting themes that stretched across multiple survey domains. As a consortium, we agreed to prioritize survey development during the first year of the study, and then develop an interview tool during the second year of the study based on our experience fielding the survey and initial findings.

The "Round 1" interview tool was developed during collaborative research design workshops held in Fall 2017. During these workshops, Resident Researchers discussed how qualitative and quantitative data differ, and how qualitative data could complement the quantitative data they gathered via the survey. They identified six survey domains where qualitative inquiry would advance their understanding of the study's central themes: neighborhood and belonging, housing, health, prioritization, social support, and ownership of change. In addition, they identified a number of cross-cutting themes to explore: work and employment, sense of stability in life, and sense of control and direction in life. Academic facilitators drafted interview questions based on input from Resident Researchers about which aspects of these domains we should focus on learning about from interview respondents. Resident Researchers gave feedback on the draft interview protocol, and some Resident Researchers also agreed to be test interviewees in order to assess how well the questions worked. Final revisions were made according to their feedback, and the protocol was submitted to the IRB in preparation for interviewing to begin in Winter 2018 (*Appendix 1*).

In Winter 2019, as we prepared to re-contact interview respondents, we began developing a "Round 2" interview tool (*Appendix 2*). For this tool, we had three goals: to understand the major changes in respondents' lives since their first interview, to delve deeper into some of the themes explored in the first interview, and to explore new themes prioritized by Resident Researchers and community partners. We followed a very similar process to the Round 1 interview guide, the primary difference being that we did not have Resident Researchers test the questions through practice interviews this time. The Round 2 interview guide covers the following themes: major life changes since first interview, "pace of life," immigration, "living in the economy," financial security, access to

resources, social support and caregiving, health, stress, housing, and neighborhood interaction.

1.5.4.3 Data collection

The HNS collects primary data through two methods: quantitative data through a neighborhood survey, and qualitative data through a semi-structured interview, as described above.

Beginning with the baseline year of survey data collection in 2016, there have been a total of four cycles of survey data collection, approximately on an annual basis. Surveys are administered by Resident Researchers following a convenience sampling strategy designed by Resident Researchers in partnership with academic partners to yield responses across geographic, demographic, housing, and socio-economic strata of community residents (Arcaya et al., 2018). To develop this sampling strategy, Resident Researchers in each community select four indicators across which they would prioritize representativeness in the sample, thus ensuring that the sample represents the neighborhood across characteristics that residents deem most salient. These characteristics may change between data collection cycles as Resident Researchers' understanding of the dynamics in their community evolves. As surveys are received, Resident Researchers check-in with study personnel to adjust their sampling strategy to ensure representativeness across the indicators that they have prioritized.

In addition to annual cycles of field-based survey data collection, in 2018 the HNS began operating a nested longitudinal cohort of 150 people. Cohort members were enrolled in the study in one of two ways. First, cohort members could be enrolled by Resident Researchers during the course of regular surveying: Resident Researchers would offer every third person intercepted the option of joining the longitudinal cohort and receiving an interview and survey at a later date, or completing the anonymous community survey. Or, secondly, cohort members could be enrolled on "rapid enrollment" days where study personnel would station themselves at a community hub identified by Resident Researchers and community partners in that neighborhood (e.g. a library or YMCA) and try to recruit as many cohort members as possible. If individuals

agreed to be enrolled in the cohort, their contact information was collected (and, in some cases, the survey was administered), and a member of the study personnel would reach out to them in the coming weeks to schedule an appointment for an interview and survey (if not already administered) at a convenient time and place of their choosing, usually either their home or a nearby café or library.

Our original intention was to administer the survey and semi-structured interview to each cohort member on an annual basis, so long as we were able to contact them. This plan was ultimately not realized. Not all of the community Resident Researcher teams were able to successfully meet their cohort enrollment targets, and thus HNS staff conducted “rapid enrollment” efforts as described above. Not all of the people who were surveyed and enrolled in the cohort as part of these efforts were successfully re-contacted to schedule a Round 1 interview, and just a small handful of those who were not successfully contacted for a Round 1 interview were successfully contacted for a Round 2 interview. Though we will attempt to re-contact these respondents again for a Round 3 interview in the summer of 2021, Round 3 interviews are not included in this dissertation.

1.5.4.4 Consent

Immediately prior to completing the community survey, respondents are read a consent script describing the study and their rights as a participant in the study, including the right to decline to answer any questions or to stop the survey at any time. Survey respondents are instructed that their survey is anonymous and that all information will be kept private and stored securely. Finally, the consent form describes the compensation associated with completing the survey (\$20 Visa gift card).

Cohort members receiving an interview and survey undergo a different, combined consent procedure. This consent script similarly informs participants about the purpose and background of the study, and explains their rights as members of the longitudinal cohort. Participants are given the option of choosing whether or not they consent to their interview being recorded, whether or not they consent to being re-contacted in subsequent years of the study, whether or not they consent to direct quotes from their interviews being published in study findings, and whether or not they would like direct

quotes to be attributed to them or remain anonymous. The latter option was included at the direction of Resident Researchers and community partner organizations, who believed that some respondents might value being able to share their stories publicly if possible.

1.5.4.5 Transcription and storage

If interviewees consent to be recorded, interviewers record the conversation using either an application on their mobile phone or via standalone recording device. Audio files of interviews are professionally transcribed verbatim using a service called TranscribeMe. If interviewees do not consent to having their interview recorded, interviewers take handwritten or typed notes during the conversation, quoting directly only if the respondent provided consent.

All interview data is stored in an encrypted Dropbox folder provided by MIT IS&T. Only study personnel approved by the IRB are granted access to this folder. When interview respondents consent to be recorded, audio recordings are uploaded directly to the study Dropbox folder as soon as possible following the interview. Periodically, new audio files are uploaded from the Dropbox to TranscribeMe via password-protected SFTP. Audio files are stored on the SFTP while being transcribed and removed once the transcription has been completed. Transcription documents are downloaded from TranscribeMe's SFTP to the study's Dropbox folder, and also deleted from the SFTP. When interview respondents do not consent to be recorded and written notes are taken instead, these written notes are uploaded directly to the study Dropbox folder by the interviewer as soon as possible following the interview.

1.5.5 Research Ethics

The HNS is registered with the Biomedical Research Alliance of New York's Institutional Review Board (protocol number 18-006-520). The survey and interview protocols, along with consent procedures and data management procedures have all been approved by BRANY. All members of the HNS who collect interview and/or survey data,

including Resident Researchers, have undergone approved human subjects training and are registered with BRANY as study personnel (E. E. Anderson, 2011).

1.5.6 Analytical Subsample

To answer my research questions, I identified an analytical sub-sample of members of the HNS nested longitudinal cohort who play caregiving roles in their everyday lives. Given my experience with the HNS qualitative data to date, it was clear to me that the most common caregiving responsibility cohort members had was for children, and set this as my main sampling criteria. While my interest in care extends well beyond care for children, I knew that care for children was an extremely common and recognizable form of care in cities, and that the wellbeing of children and families was a key research priority for HNS Consortium members. However, I also knew from my experience interviewing cohort members that many of those who cared for children also cared for other adults, such as seniors or relatives with disabilities, and thus that my sampling strategy would still allow me to capture multiple forms of caregiving responsibility.

The sample was identified through a two-stage process. First, I used the only indication of caregiving responsibility on the HNS survey – whether a respondent has children – to identify all cohort members who reported that they had children (n=94). Then, I identified all of the cohort members who reported having children on the survey who also completed “Round 1” and/or “Round 2” interviews for which we had transcripts or written notes (n=68).

This sampling process had two notable shortcomings. First, it included some seniors whose children were adults and had not lived with them for some time. However, many of them were still involved in their children and grandchildren’s lives, and all shared experiences of being caregivers from earlier periods of their lives. Second, it included a group of three people whose children were under 18 but lived elsewhere and were not in the respondents’ care, the circumstances of which were not always clear. One of these respondents explained that they were working towards rebuilding caregiving relationships with their dependents, and two others did not state this to be the case. This group

nevertheless had past experiences of being caregivers in HNS study communities, even though they did not discuss them much, and moreover it is possible that the conditions of the urban environment contributed to the loss of their caregiving relationships. Even though I could not be certain of this, I was concerned that excluding them would be a form of selection bias, and so I kept them in the sample.

Brockton, Everett, Mattapan and Lynn are notably under-represented in the sample for two reasons. First and primarily, due to the challenges with cohort enrollment described in *Section 6.2.1*, these were communities where we conducted “rapid enrollment” days but had difficulty re-contacting enrollees to schedule an interview. Second, in Lynn and Brockton in particular, a disproportionately high number of cohort members did not have children. However, this latter group overlapped considerably with the group who were unable to be contacted for an interview, and so most of them would not have been included in the sample anyways.

Despite these shortcomings, the sample includes caregivers with a broad range of life experiences across the HNS study area. Descriptive statistics about the analytical subsample are presented in *Table 1.2* below. Three quarters of the respondents are women. Nearly 80% of the respondents are people of color, and 50% are Black. Most respondents report that their health is “good” or better, but one in five say their health is only “fair” or “poor.” More than half of respondents have an income of less than \$30,000 per year. The sample is thus reflective of who bears the greatest burden of care work in the United States: mostly women, mostly people of color, and mostly poor and working-class people.

Table 1.2: Analytic Subsample Descriptive Statistics

Variable	Count	Percentage
<i>Gender</i>		
Male	16	24%
Female	51	75%
NA	1	1%
<i>Race</i>		
Black	34	50%
Latinx/Hispanic	8	12%
Multiracial	8	12%
Other	4	6%
White	14	21%
NA	1	1%
<i>Age</i>		
18-24	1	1%
25-34	16	24%
35-44	17	25%
45-54	10	15%
55-64	15	22%
65+	7	10%
NA	2	3%
<i>Self-Rated Health</i>		
Poor	1	1%
Fair	13	19%
Good	31	46%
Very Good	16	24%
Excellent	6	9%
NA	2	3%
<i>Annual Income</i>		
Less than \$15,000	19	28%
\$15,00 - \$29,999	17	25%
\$30,00 - \$59,999	16	24%
\$60,00 - \$89,999	6	9%

\$90,000 - \$119,999	2	3%
\$120,000 or more	0	0%
Don't Know	3	4%
NA	5	7%
<i>Neighborhood</i>		
Brockton	5	7%
Chelsea	8	12%
Dorchester	13	19%
Everett	3	4%
Fall River	7	10%
Lynn	1	1%
Mattapan	4	6%
New Bedford	11	16%
Roxbury	16	24%

1.5.7 Abductive analysis of qualitative data

This dissertation is based on analysis of semi-structured interviews with caregivers in the analytical subsample described above. Interview data is appropriate for answering my research questions because interviews help illuminate how social and material structures and resources enable or constrain human actions (Lamont and Swidler, 2014). Interviews conducted across multiple sites, like those in the HNS, afford the additional advantage of being able to understand the effects of contexts and situations on actions through a comparative perspective (Lamont and Swidler, 2014). Thus, while what people say in interviews cannot perfectly predict how they will act, interviews provide windows into how people make sense of the world and therefore reveal “the contours of the landscape upon which action takes place” (Tavory, 2020, p. 457). In this case, the analysis seeks to understand how caregivers’ experiences of the characteristics of and changes in the contours of the urban landscape *through* which care takes place influence the work of care itself.

In each analytical chapter (Chapters 3, 4 and 5) I describe the specific analysis undertaken to produce the results presented therein. However, each specific analysis is united by a common “abductive” approach to reasoning and theory development. This approach is relatively recent compared to the more common inductive or deductive approaches to qualitative data analysis, and seeks to respond to some of their respective shortcomings. Below, I briefly explain what defines an abductive approach to qualitative data analysis.

An “abductive” approach to qualitative data analysis moves back and forth between theory and data, rather than unidirectionally from data upwards to theory following a strictly inductive approach, or from theory downwards to data following a strictly deductive approach (Tavory & Timmermans, 2014). Deductive approaches to qualitative analysis prioritize beginning with a pre-existing theory and proceeding to test, and ideally refine, the theory using the data. The “extended case method” is perhaps the best known example of an explicitly deductive approach to qualitative analysis in the social sciences (Burawoy, 1998). Inductive approaches to qualitative analysis, exemplified by “grounded theory” (Charmaz, 2006), emphasize constructing meaning from data with no *a priori* theory directing the analytical process. Inductive approaches have been criticized for being overly descriptive and thwarting theory construction by failing to help analysts direct their focus or link different observations in systematic ways. Deterding and Waters (2018) suggest that the grounded theory framework is a poor fit for contemporary studies with large samples, different types of data, and mixed methods approaches to analysis. Finally, it is commonly acknowledged that despite the pretense that grounded theory is constructed without prior engagement with existing theories, most researchers come to analysis with many theoretical ideas that will inevitably be applied to their data even if they do not intend to follow an explicitly deductive approach (Deterding & Waters, 2018; Tavory & Timmermans, 2014).

Abduction may be defined as “a creative inferential process aimed at producing new hypotheses and theories based on surprising research evidence” (Tavory & Timmermans, 2014, p. 5). In practice, this approach encourages moving back and forth between the data and theory, as researchers encounter observations in their empirical data that do not

seem to fit their knowledge of existing theories, and respond by speculating what these data could be a case of. In moving back and forth between specific data and general theory, constantly asking “what is this a case of,” researchers engage in the construction of meaning. Because of its emphasis on moving across different theoretical perspectives, and given the wide range of theoretical and disciplinary approaches to care that can be brought to bear on planning questions, an abductive analytical approach is well-suited to the proposed dissertation.

1.6 Context and site selection: Understanding experiences of gentrification across the Boston area

The HNS seeks to understand the relationship between gentrification and community health because gentrification is rapidly transforming the Boston region’s urban landscape, and while community organizations and local residents have long decried the harms of gentrification, systematic accounts of the individual and collective experience of gentrification and how it becomes embodied over time are necessary to advance more equitable forms of neighborhood development. In this section, I briefly review the context-specific factors driving gentrification in the Boston metro area. Then, based on this overview, I explain how the HNS study communities were selected, and describe their key characteristics. Finally, I report highlights from collaborative data analysis workshops where Resident Researchers have been working to build a framework for understanding the experience of gentrification based on HNS data and analyses, in an effort to complement academic and institutional ways of knowing about gentrification with grassroots perspectives.

1.6.1 Gentrification and inequality in the metro Boston area

Beginning with the South End neighborhood in the 1980’s, gentrification has transformed the urban landscape of the Boston metropolitan region over the past few decades, exacerbating longstanding racial economic inequalities and making the city increasingly inhospitable to ever-growing numbers of cost-burdened renters. Since the

1980s, Boston has experienced rapid economic and job growth in high-wage sectors like finance and the life sciences (Metropolitan Area Planning Council, 2014b, 2019; Modestino et al., 2019). This economic growth has been accompanied by an influx of socio-economically advantaged residents to the city's inner core, where many neighborhoods have historically been communities of color (Metropolitan Area Planning Council, 2014b). As the region's socio-economic profile shifts, it has witnessed rapid and widespread real estate development driven by high housing demand and economic growth, and shaped by emerging land use considerations such as climate change adaptation pressures. These changes are classic hallmarks of gentrification, with development in the region largely catering to the needs of socio-economically advantaged residents.

Accordingly, the rewards of the city's economic growth are not being equally shared across the population: economic mobility is declining while income inequality and wealth disparities are on the rise (Schuster & Ciurczak, 2018). A regional housing affordability crisis driven by a shortage of housing is at the heart of these challenges. The Boston area is one of the country's most expensive housing markets. Rents in Boston rose 55% between 2009-2018, with home prices climbing at a similar rate, and similar increases across the region (Chakrabarti & Bologna, 2018). Nearly half of renters in Boston are housing cost-burdened, paying over 30% of their income on housing (Modestino et al., 2019). Low- and middle-income households face tightly constrained housing options and the shortage of affordable housing options for families with children is particularly acute (Reardon et al., 2020). A key factor underlying the regional housing affordability crisis is that Boston has not been constructing enough housing to meet its needs since population growth took off during the 1980s (Modestino et al., 2019). Today, housing demand continues to outpace population growth due to declining household sizes, and the rate of multi-family housing development needs to increase considerably to accommodate demand (Metropolitan Area Planning Council, 2014b, 2014a). However, there is widespread opposition to new housing construction in the region, and restrictive zoning rules that make constructing apartments illegal in many areas (Bunten, 2020). These factors combine to make living in Boston increasingly prohibitive for poor and working-class people.

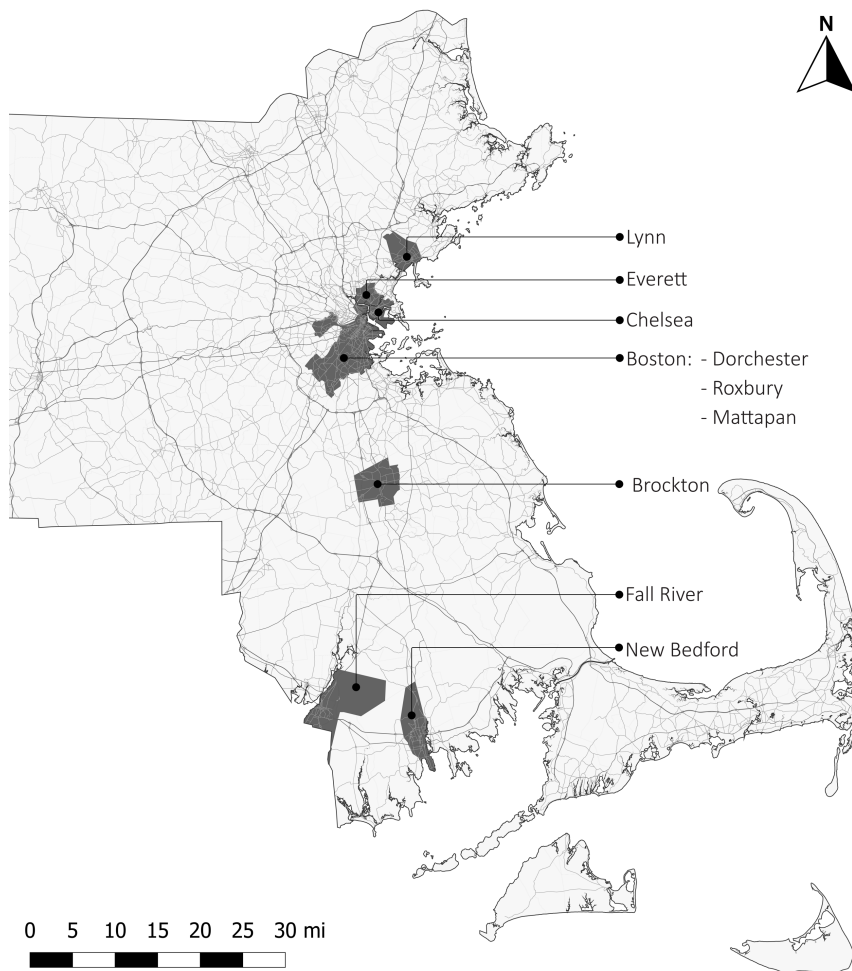
Unsurprisingly, these housing and economic pressures are most severe for the city's residents of color. The racial wealth gap in the Boston area is among the most polarized in the nation: a recent study found that the median net worth of Black households was \$8 compared to \$257,500 for white households (Muñoz et al., 2015). Decades of discriminatory housing and lending policies and practices at the federal, state and local levels that have inhibited people of color, and Black people in particular, from owning homes and accumulating intergenerational wealth, and leaving Boston as one of the most racially segregated cities in the country (Muñoz et al., 2015). During the 2008 housing market crash, foreclosures in Boston were heavily concentrated in inner core areas with high shares of Black and Latinx residents like Roxbury, Dorchester and Mattapan (Hwang, 2019b). Since then, Black and Latino borrowers have received far lower shares of mortgage loans than their shares of total households in the Greater Boston area (Campen, 2018). Recent eviction filings have also been disproportionately concentrated in Boston's communities of color (Robinson & Steil, 2020).

Thus, decades of dispossession and disinvestment have led to low-income neighborhoods of color in becoming hotspots of gentrification. While the overall region is increasing in racial and ethnic diversity, historically Black and immigrant neighborhoods in the city's core have become higher income and whiter since 1990 (Edozie et al., 2019). Community-based organizations have tried to sound the alarm about development trends that they believe are contributing to gentrification in their communities, and have advocated for policies that would prevent displacement and preserve affordable housing. Examples of these efforts involve lobbying for city-wide policy changes like the Jim Brooks Community Stabilization Act in Boston, protesting unaffordable developments in Lynn, and New Bedford's Cape Verdean community organizing to preserve the cultural identity of their neighborhood in the face of gentrification (Chakrabarti & Bologna, 2018; Rios, 2019; SouthCoastToday, 2020). However, many of the efforts to shift policy - including the Jim Brooks Act and a state-level push to allow rent control - have been thwarted to date.

1.6.2 HNS study sites

To investigate how residents of gentrifying neighborhoods in the Boston region experience the changes underway and how these changes are shaping community health, the HNS operates in nine neighborhoods across the Boston metropolitan area: Roxbury, Dorchester, Mattapan, Chelsea, Everett, Lynn, Brockton, Fall River, and New Bedford (Figure 1.4). Below, I explain how the neighborhoods were selected for inclusion in the HNS, and describe basic demographic characteristics and demographic trends across the neighborhoods.

Figure 1.4: Map of HNS Study Sites



Credit: Yael Nidam and Madeleine Daepf

Table 1.3: Population and Built Environment Characteristics of HNS Sites, 2009-2018

	Fall River	New Bedford	Brockton	Roxbury	Dorchester	Mattapan	Chelsea	Everett	Lynn
Population and Demographics									
Population (2018)	13,468	16,660	20,256	20,061	31,911	22,712	31,891	23,087	28,083
Population Change (2013-2018)	5%	1%	11%	14%	5%	15%	9%	13%	7%
Non-Latinx White (2010)	79%	53%	22%	13%	17%	19%	15%	52%	38%
Non-Latinx Black (2010)	4%	11%	36%	52%	45%	66%	6%	13%	15%
Non-Latinx Asian (2010)	4%	1%	2%	3%	17%	1%	2%	6%	5%
Latinx (2010)	9%	17%	16%	28%	14%	10%	74%	21%	39%
Other (2010)	4%	18%	24%	4%	7%	4%	3%	8%	3%
People of Color (2010)	21%	47%	78%	87%	84%	82%	85%	48%	62%
Socio-economic Indicators									
Poverty Rate (2018)	21.6%	21.7%	28.0%	32.3%	18.5%	22.4%	18.6%	14.6%	26.5%
Poverty Rate Change (2013-2018)	-32%	-36%	-16%	-17%	-10%	7%	-23%	17%	-16%
Unemployment Rate (2015)	20%	11%	30%	16%	16%	15%	13%	9%	12%
HOLC Zoning Grade (1935-40)									
Zoned Green	N/A	N/A	20%	0%	5%	5%	0%	0%	N/A
Zoned Yellow	N/A	N/A	72%	10%	75%	95%	55%	59%	N/A
Zoned Red	N/A	N/A	8%	90%	20%	0%	45%	41%	N/A
Housing Stock and Cost									
Median Gross Rent (2018)	\$737	\$745	\$1,013	\$940	\$1,467	\$1,509	\$1,367	\$1,404	\$990
Median Gross Rent Change (2013-2018)	7.99%	8.51%	1.34%	14.91%	20.00%	21.91%	20.49%	15.71%	23.40%
Median Home Value (2018)	\$213,650	\$203,729	\$246,980	\$375,800	\$400,217	\$349,940	\$316,867	\$408,133	\$250,386
Median Home Value Change (2013-2018)	-2.40%	-3.34%	6.79%	26.03%	23.35%	22.14%	28.42%	33.65%	9.90%
Vacancy Rate (2018)	9.80%	11.50%	8.00%	7.80%	7.80%	5.80%	4.80%	6.10%	4.80%
Vacancy Rate Change (2013-2018)	-28%	-17%	-49%	-31%	-34%	-59%	-50%	-10%	-30%
Change in Total Housing Units (2013-2018)	2.03%	-0.43%	-3.87%	6.25%	1.43%	2.42%	11.34%	4.32%	-3.16%
Subsidized Housing Stock (2020)	11.28%	11.83%	12.61%	18.54%	18.54%	18.54%	17.09%	7.87%	12.49%

Data Sources: American Community Survey; U.S. Census; Metropolitan Area Planning Council

1.6.3 Site selection process

The nine HNS research sites are neighborhoods where large investments in transit-oriented development were expected to occur between 2015-2020, and which were characterized by economic disadvantage and poor population health. Sites were selected for potential inclusion via a screening process of municipalities and neighborhoods across Massachusetts focused on built form, development context, and health outcomes (Arcaya

et al., 2014). The specific criteria for site selection were: 1) a walkable urban center near a public transit hub; 2) significant need for economic growth; 3) early- to mid-stage transformational urban development; and 4) poor population health outcomes. Of the Massachusetts neighborhoods that met these criteria, we focused on areas with the highest rates of a specific set of health challenges - including cardiovascular disease, chronic obstructive pulmonary disease, diabetes, hypertension, stroke, substance use, and asthma – that were ranked as important by two Consortium partners, the MAPC and the MDPH (Arcaya et al., 2018).

Honing in on the least healthy quartile of sites that met the four selection criteria, Consortium members from MIT, CLF, MAPC and MDPH selected three communities that were expected to receive investments from the Healthy Neighborhoods Equity Fund: Roxbury, Chelsea, and Brockton. The HNEF is a \$50 million private equity fund created by CLF and the Massachusetts Housing Investment Corporation to support healthy neighborhood development by investing in mixed-income, mixed-use transit-oriented development in neighborhoods with poor health outcomes in the early stages of economic growth (Conservation Law Foundation & Massachusetts Housing Investment Corporation, 2020). These three communities were each matched to two similar communities that lacked planned investments at the time based on the multidimensional community typology used in the initial screening process and geographic proximity (Arcaya et al., 2014, 2018). Roxbury was matched with Dorchester and Mattapan, Chelsea with Everett and Lynn, and Brockton with Fall River and New Bedford.

Table 1.3 provides demographic, socio-economic and housing data about each of the nine neighborhoods, collected from the U.S. Census and MAPC (Conservation Law Foundation, 2016). Six of the nine neighborhoods are majority persons of color. All but one of the neighborhoods in the study have higher poverty rates than the state average. In six of the nine neighborhoods, more than one in five people live below the poverty line; in three neighborhoods, at least one in four do. All nine neighborhoods have less college educated residents than the state average, and all nine have unemployment rates higher than the state average. At the same time, poverty rates in all but two of the neighborhoods

have fallen considerably in recent years, which begs the question of whether the poorest have been pushed out and been replaced by wealthier newcomers.

Of the six neighborhoods for which we have information about historical redlining, at least 80% of each neighborhood was zoned “red,” meaning “hazardous,” or “yellow,” meaning “declining,” by the Home Owners Loan Corporation, based on their racial makeup, decisions that resulted in white flight, racial segregation, and decades of disinvestment. Today, renters outnumber owners in all HNS neighborhoods, up to a ratio of 4:1. These renters are not benefitting from rapidly-rising home values – an increase of upwards of 20% from 2013-2018 in five of the study neighborhoods – and instead increasingly burdened with high rents that continue to rise at similarly high rates. In no community does the stock of subsidized housing surpass 20%, leaving renters increasingly vulnerable to untenable housing cost burdens and being unable to afford to stay in their communities.

1.6.4 Resident Researchers’ conceptualization of the experience of gentrification

Members of the HNS team, myself included, believe that the lived experiences of residents of gentrifying neighborhoods are missing from most academic and institutional accounts of how communities are changing, and that gentrification is not just something that happens around you, but something that you feel and embody. During collaborative data analysis in Spring 2020, I facilitated a workshop with Resident Researchers in which we sought to hone in on what the lessons learned to-date through the HNS told us about the meaning of gentrification from the perspective of residents’ lived experience. Below, I share some of the main themes about the experience of gentrification that emerged from these workshops. I do this to help bridge between academic debates and socio-economic trends on the one hand, and resident’s experiences on the other, for readers who may be unfamiliar with the dynamics of gentrification in the U.S. This workshop was very influential for advancing my own understanding of gentrification as I was preparing my proposal for this dissertation, and thus I see it as helpful background information for

readers seeking to understand how I have approached the research in the chapters that follow.

First and foremost, Resident Researchers highlighted stress as a key aspect of the experience of gentrification, and argued that stress runs through all negative experiences of gentrification. In gentrifying neighborhoods, they explained, everyone except the wealthiest face uncertainty and unanticipated consequences from neighborhood development: gentrification is perceived as being fueled by macro-level processes out of the scope of individual or even community control. There is uncertainty about whether or not development will benefit or harm you, which impacts peoples' ability to plan for their future wellbeing. Resident Researchers explained that this means that gentrification jeopardizes the comfort and clarity that come from being at home among people who hold the same values and ways of life as you do. As acts of displacement accumulate, people begin to feel the loss of a collective home and the safety that that home provides. Overall, they said, the more intense neighborhood changes are, the more stress and uncertainty they will produce.

The second major theme over the course of this workshop was social networks. Resident Researchers argued based on their assessment of our analyses that the gentrification is a process that 'disconnects you from who and what you need'. As your neighborhood gentrifies, they explained, the functions of peoples' social networks shift and often erode, detracting from their means and resources for living a life in accordance with their values. Over time, people increasingly become forced to rely on themselves to navigate life's challenges, leading to poorer health and lower levels of happiness. Accordingly, what they called "resourcefulness" becomes increasingly necessary to thrive – however, they argued that resourcefulness is a property of your relationships. When people lose the means to be resourceful, they lose the means to make affirmative moves, achieve cultural situatedness, maintain a sense of hope and worth, manage their stress, and navigate their logistical challenges, Resident Researchers said.

Moving and mobility was the third major theme that Resident Researchers highlighted. They argued based on the analyses under discussion that decisions that people vulnerable to gentrification make about moving depend on how much control they

feel over their circumstances and their ability to weather the changes in their neighborhood, and that being unable to move affirmatively (instead being stuck or displaced against one's will) led to worse health and wellbeing. Whether or not people are able to move affirmatively, they explained, is shaped by housing tenure and how people pay for their housing. When people do move, they are likely to lose significant parts of their social network, and their health depends on their ability to establish these parts anew. And when people are forced to move against their will, they explained, they become vulnerable to impacts on their sense of hope, worth and value, as well as their health.

Finally, Resident Researchers reflections highlighted the theme of people's efforts to build better lives. They concluded that people interpret gentrification-induced changes from the perspective of their own future as well as that of their descendants, because gentrification calls into question whether you and those you care about will be able to meet their needs where they are. They added that when gentrification-induced changes signal to people that this vision won't become a reality, people can "snowball" into hopelessness. When neighborhood changes do fit your outlook of where you want to be in life, people may experience a rising sense of hope and value, but when they don't, people are likely to experience rising levels of stress that is multidimensional, layered and compounds over time.

These perspectives represent the HNS' emerging framework for understanding the experience of gentrification, and we continue to build upon them in collaborative data analysis workshops as I write. Important gaps remain between academic debates about the extent of gentrification and its harms, and the experiences of those living in gentrifying neighborhoods and experiencing its consequences first-hand. More research is necessary to understand how the lived experience of gentrification impacts people's lives, and why these impacts are important. By exploring the impacts of gentrification-related neighborhood changes on the work of caregiving in Chapter 4, and experiences of stress among caregivers living in gentrifying neighborhoods in Chapter 5, I hope to contribute to this enterprise.

1.7 Dissertation Structure and Contribution

The structure of the remainder of this dissertation is as follows. In Chapter 2, I review the key bodies of academic literature from disciplines – including planning theory and history, feminist political economy, and public health – that inform my research questions, my interpretation of my data, and the arguments I make. In Chapter 3, I analyze how caregiving depends on and is shaped by the urban environment for caregivers in the HNS cohort, and provide an empirical framework for the urban infrastructure of care. In Chapter 4, I analyze how gentrification impacts the urban infrastructure of care and how this in turn shapes the work of caregiving, showing how gentrification produces “care insecurity” that jeopardizes caregiver health and contributes to the stratification of social reproduction in cities. In Chapter 5, I analyze how the changing relationship between the urban environment and the work of caregiving can influence caregiver health, focusing on stress as a pathway of embodiment, and explore caregivers’ visions for community interventions that would ease the burden of care. In Chapter 6, I summarize my findings, sketch a vision for what planning for care might look like, and reflect on the role of PAR as a research approach in shaping this dissertation.

Care is a necessary component of health and of the functioning of our economy. Care is ubiquitous, often morally- and emotionally-charged, and caregiving is one of the most important roles that many people play in their lives. And yet care is largely absent from how planners and urban theorists think about what cities are and do, who cities serve, and how cities ought to develop. This is a disconcerting lacuna that this dissertation helps to fill. In doing so, I endeavor to make three main contributions. The first is to research and practice at the intersection of planning and public health, to which I contribute a framework for understanding and investing in urban infrastructures of care in ways that enhance the possible forms care can take, ease the burdens of caregiving, improve the health and wellbeing of caregivers and their dependents alike, and chip away at health inequities rooted in socially and spatially uneven access to and control over the means of social reproduction. The second is to our understanding of the political economy of cities and urban change, to which I contribute new strategies for understanding the relationship

between social reproduction and the production of urban space, and for understanding the implications of this relationship for health and social justice. Third and finally, I seek to contribute to efforts to advance anti-racist and feminist planning agendas by opening up a new domain of understanding with respect to how the relationship between the urban environment and care is central to the reproduction of gender and racial inequities in cities, and how planning for care can advance or inhibit progress towards gender and racial justice.

2 Literature Review

2.1 Introduction

The purpose of this chapter is to lay the groundwork and establish the rationale for the empirical analyses to follow by reviewing the key bodies of literature that inform this dissertation and identifying the contributions that I intend to make to these different conversations. First, I review a range of literature on care and social reproduction from fields ranging from feminist ethics to political economy to establish these topics as key planning concerns, especially within the context of the “crises of care” that characterize capitalist societies. Second, I adopt care and social reproduction as a lens through which to view the history of the production of urban space in the United States from the industrial era to the neoliberal present, and argue that planners should view U.S. cities as landscapes of stratified reproduction. Third, I review developments in feminist urban and planning theory that seek to explain how cities contribute to – and how planning might alleviate – gender inequities, and consider how attending to gendered labor, specifically care and social reproduction, in addition to gender as a social category, may help advance a feminist planning agenda. Fourth, I evaluate recent arguments for incorporating care into planning and suggest that these efforts can be enhanced by adopting an infrastructural approach to planning *for*, and not just *with*, care, and consider how to do so in ways that do not perpetuate historical patterns of harm caused by attempts to govern care. Fifth, I consider the relationship between urban planning and public health and show how an infrastructural approach to planning for care might advance research and practice at this important intersection. Next, I suggest that a fruitful way to evaluate the progress of such an agenda is via a relational, structurally-sensitive version of the capabilities approach that measures wellbeing and urban livability in terms of the extent to which people have the freedom to give and receive care in ways that they value. Finally, I turn to the empirical focus of this dissertation – caregiving in the context of gentrification – and consider how assessing the impacts of gentrification on caregiving, particularly in terms of stress might advance our understanding of the relationship between gentrification and health and provide guidance on strategies to reduce the harms

of gentrification by investing in the urban infrastructure of care. Woven together, I argue that these diverse strands of scholarship make a compelling case for why urban planners need to plan for care and social reproduction, how to do so, and how to evaluate the contributions of such efforts to progress towards health equity and just, livable cities.

2.2 Care and Social Reproduction

Care and social reproduction are related but different terms with wide-ranging and entangled intellectual histories. There is not a clear consensus on the differences and alignments between these concepts. While the terms are occasionally used interchangeably, for the purposes of this dissertation, I treat social reproduction as a function or product of care in society, and care as the ‘active ingredient’ in social reproduction. Without care, social reproduction is not possible, but social reproduction is not only accomplished via care, and care may also serve other purposes. Despite the inter-relatedness and overlap between social reproduction and care, the bodies of literature on these topics are somewhat distinct from one another, although the basis for their distinction is typically disciplinary and/or scalar rather than conceptual. Social reproduction is typically employed by scholars engaging political economy and/or discussing macro-level patterns, while care is typically employed by those focused more on moral, ethical or emotional themes at more micro-level – but, of course, there are exceptions to this distinction (eg. Pratt, 2012).

2.2.1 Care

Care is “a species of activity that includes everything we do to maintain, continue and repair our world so that we can live in it as well as possible. That world includes our bodies, ourselves and our environment” (Tronto, 1993, p. 103). It is a vital activity engaged in the everyday maintenance of the web of life, enacted through specific relations of interdependence, and grounded in situated and emergent ethical commitments. The breadth of this definition of care is reflective of the fact that care is ubiquitous and a “defining element of what it means to be human” (Kleinman, 2015). Its ubiquity, however,

should not be taken to imply that care looks the same across space and time. Care is always particular and always context-specific, and anthropologists and geographers have documented an expansive range of care practices across a wide range of relational, institutional, technological, geographic, technological and temporal contexts (Atkinson et al., 2011; Garcia, 2010; Lawson, 2007; Livingston, 2012; Milligan & Wiles, 2010; Mol, 2008; Stevenson, 2014).

Defining 'good' care is not something that can precede the act of care itself, but is instead part of the process of caring. Mol (2008) argues that care is a process of complex negotiation between competing notions of the good that takes place through "tinkering" and experimentation in the service of "more bearable ways of living in - or with – reality." Rather than suggesting an answer to the question of what is good or passing judgement on the matter, care is actively involved in "handling" the question of the good. Specifically, care practices negotiate among different "goods" that reflect different values and ways of ordering reality but which must nevertheless be handled together, tinkering and experimenting to figure out how these different goods may coexist to ease suffering and enable one another to lead meaningful lives (Mol et al., 2010). As such, the work of caring is generally somewhat experimental in a pragmatic sense, interacting with the world to see what's possible and livable. In this same vein, good care isn't an ideal that can be defined in general terms or as a matter of principle; instead, it is something that is shaped, invented and adapted, over and over again, in everyday practices (Bellacasa, 2017; Mol, 2008; Mol et al., 2010).

If care is at once ubiquitous and particular, how might we know it when we see it? And how might we distinguish care from things like kindness, compassion or generosity? One strategy for empirically identifying specific actions and/or relations care comes from Tronto's (1993) assertion that activities of care have four elements. The first is *attentiveness*: a recognition and awareness of need is required in order for a response to emerge. Second is *responsibility*, by which we willingly take it upon ourselves to respond to the need we have recognized. Third is *competence*, or the skill of providing good care that appropriately meets the need for care. Finally, the *responsiveness* of the care receiver to the care must also be considered (Tronto, 1993, pp. 105–108, 127–137). Just as these

elements enable us to identify care in social and institutional action, so too do they enable us to identify elements of neglect by their absence: ignorance, abandonment, incompetence, and aversion.

2.2.2 Social Reproduction

The term “social reproduction” originates in the work of Friedrich Engels and Karl Marx, and was later expanded upon by feminist political economists to refer to “various kinds of work – mental, manual and emotional – aimed at providing the historically and socially, as well as biologically, defined care necessary to maintain existing life and reproduce the next generation” (Engels, 1884; Laslett & Brenner, 1989, pp. 382–383). Social reproduction has historically been under-valued, unwaged, and under-recognized, despite being necessary to the accumulation of wealth in capitalist systems (Bear, 2014; Fraser, 2014). Systematic devaluation of social reproduction has been crucial to the maintenance of durable structural inequalities along racial and class lines (Bhattacharya, 2017). Under neoliberalism, processes of social reproduction have been characterized by growing uncertainty and precarity – for example via the rising dependence on credit and debt to meet social reproductive needs (Bear, 2014; Han, 2012). Nevertheless, social reproduction has also been highly structured, with certain arrangements privileged and supported and others undermined, because historically-specific forms of capitalism depend on specific kinds of kinship and social reproduction; in the neoliberal era, the privileged form of social reproduction continues to be the white heteropatriarchal nuclear family (Cooper, 2017; Yanagisako, 2002).

Although the concept of social reproduction originated in Marx’s analysis of the relations of capitalist production, the concept remained underdeveloped in his work – a lacuna that feminist scholars have since sought to address in order to develop conceptions of capitalism that are “adequate to our time” (Fraser, 2014, p. 56). Social reproduction is useful for this task because it provides a framework for understanding interactions between paid and unpaid forms of labor in the reproduction of bodies, households,

communities, and environments, and how the organization of these activities supports or undermines human flourishing (Meehan & Strauss, 2015).

Social reproduction is a form of physical, cognitive and emotional labor (Daminger, 2019; Edin & Lein, 1997; Randles, 2020). However, the labor required to meet the same social reproductive or care needs is stratified across axes of race and class (Colen, 1995; Mullings, 2005; Randles, 2020). For lower-income people managing care work in contexts of deprivation and minimal support from the state, and for people of color caregiving in racist societies, this labor is typically increased. Additional work comes through efforts to promote upward mobility, help their dependents both avoid and cope with poverty and racism, and create a sense of security in conditions of precarity (Elliott et al., 2015; Elliott & Aseltine, 2013; Elliott & Bowen, 2018).

These dynamics of inequality are captured by the concept of “stratified reproduction,” which refers to “the power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered” (Ginsburg & Rapp, 1995, p. 3). Shellee Colen, who first proposed the concept of stratified reproduction in a study of West Indian care workers in New York City in the 1980s, specified that stratification occurs based on “hierarchies of class, race, ethnicity, gender, place in a global economy, and migration status” and that according to one’s location along these axes of inequality, social reproductive labor is “experienced, valued, and regarded” differently because of how these hierarchies shape access to material and social resources for social reproduction (Colen, 1995, p. 78). In the United States, Black women bear the brunt of these inequalities, to the detriment of their health and well-being (Mullings, 2005; Roberts, 1998; Stack, 1983). Crucially, Colen specifies that stratified reproduction, in combination with the increasing commodification of reproductive labor, reproduces broader social stratification by reinforcing and intensifying the inequalities on which it is based.

The implication of this is that addressing the inequalities upon which stratified reproduction is based requires systemic interventions that rectify unequal levels of power over reproduction. As I argue throughout this dissertation, planning ought to take up this charge by undertaking urban interventions that contribute to the decommodification of

social reproduction and in turn expanding – and making more equitable – access to the resources necessary for social reproduction. It is possible for planning to play such a role because, as I detail in the next section, social reproduction and care are inherently spatial activities.

2.2.3 The Crisis of Care

Today, our society is faced with a “crisis of care” (Fraser, 2016). The state is increasingly pushing responsibility for meeting care and social reproductive needs onto communities and families while simultaneously diminishing their capacity to perform it through systematic disinvestments in social welfare policies, programs and institutions (Fraser, 2016, p. 112). As a result, care is increasingly commodified for those who can afford it, and an individualized, privatized responsibility for those who cannot. These patterns are global, but in the U.S. they are accentuated by an aging population (Poo, 2016). Every form of capitalist society harbors social reproductive contradictions, Fraser argues, because social reproduction is the “condition of possibility” for capital accumulation, but capitalism’s orientation towards accumulation tends to destabilize the social reproductive processes on which it relies. Under neoliberalism, “endemic care deficits” have become normalized, and forms of care that do not serve the interests of extraction and profit are actively undermined as individuals are pushed to take more and more personal responsibility for their own wellbeing under austerity (Tarrant, 2018; The Care Collective, 2020, p. 9).

Over the course of the 20th century, care was relocated from the private sphere to the public, via the emergence of the Keynesian welfare state, and back again to the private sphere under neoliberalism (Sevenhuijsen, 2003). Neoliberal policy shifts in advanced capitalist countries, such as the shift from welfare to ‘workfare’ social policies, have changed the topography of care, redistributing responsibility for care away from the public sector and towards the private- and third-sector, as well as individuals themselves and their relatives, neighbors and friends (McDowell, 2004; Peck, 2001). Neoliberal discourse increasingly privileges the individual as the primary site for responsibility over well-being,

enacted through autonomy and choice. This is exemplified by governance patterns like public health policies that focus on individual behavior rather than structural conditions, and market trends like the commodification of self-care, for example (Hochschild, 2012; Kim & Schalk, 2021; Krieger, 2013; Mol, 2008; Rose & Miller, 2008). The result of discourses, policy patterns, and market shifts that individualize and privatize care for one another is an institutional and discursive separation of care and economy in ways that often constitute those in need of care as subordinate and less valuable, which is a fallacy considering care's ubiquity (Folbre, 2012, 2021; Folbre & Bittman, 2004). The continual re-creation of the boundaries between care and economy fixes care in place and serves to associate care with specific locations, organizations, and kinds of persons, while disassociating it from others (Tronto, 1993). This marginalization of care, via its exclusion from the public sphere, bolsters relations of economic and social inequality, and restricts individual and collective well-being (Lawson, 2007).

Transformations, upheavals, and ruptures that characterize capitalist systems create demand for care – which means that crises of care can compound each other over time. For example, Winant (2021, p. 19) shows how the growth of the care economy is intertwined with deindustrialization, which “manifested socially as a problem of populations of disposable and dependent people” and thereby created social and economic problems that became health problems, which in turn require care. In the wake of deindustrialization, care is the fastest-growing sector of the labor market, and also one of the largest, accounting for 1 in 7 jobs across the US and 1 in 5 in Suffolk County, MA, home to Boston. However, jobs in this sector are endemically underpaid, and certainly can't support a household like a factory wage once could. This is driving polarization in the labor market – including growth at the bottom of the labor market and racial/gender differences in job growth – and driving the overall increase in economic inequality (Dwyer, 2013; Winant, 2021). The proliferation of this type of employment has been accompanied by the deepening economic exclusion of those who perform it. As Mullings (2005) and Colen (1995) have both shown, these inequities in the labor market translate into further burdens on the social reproductive capacities of workers in their own lives, further compounding racial and gender inequities at the societal scale.

The crisis of care is also both reflected in and exacerbated by the built environment – after all, planning responds to capitalism’s crisis tendencies (Lefebvre, 1996, p. 100). We can see this in the growing care needs of an aging population many of whom are isolated from family and friends who might feasibly be able to care for them, and planning’s push to develop new means of “aging in place” (Forsyth et al., 2019). We can see it also in the fact that workers in the care sector, the fastest-growing part of the labor market, increasingly cannot afford to live in major cities or must work more than one job to be able to do so, which in turn puts the quality of care they give in jeopardy. Enclosures of public space and public goods are eroding capacities for community care (The Care Collective, 2020). From an urban planning perspective, alleviating the rising pressures of the coming “crisis of care” might thus involve coordinated policies that seek to increase the value of paid care work while simultaneously investing in infrastructures of social reproduction that shift the responsibility and burden for care and social reproduction away from individual households and back onto the shoulders of the collective in ways that reduce the time and resources people must devote to unpaid care work and the cognitive labor that undergirds this work (Damingier, 2019; Duffy et al., 2013; Randles, 2020).

2.3 Care, Social Reproduction and the Production of Urban Space

Geographers have long argued that care is spatialized and that spatial factors and processes shape the conditions and relations of care. Below, I briefly review this work, which centers on the concept of “landscapes of care.” I argue that for urban planners, it is helpful to combine this concept with that of stratified reproduction, introduced above, to conceive of urban spaces as landscapes of stratified reproduction (Buch, 2018). Then, I use the concept of landscapes of stratified reproduction as a lens through which to understand the relationship between social reproduction and the production of urban space in the United States from the industrial era to the present, showing how trends in the development of urban space empowered middle- and upper-class white people with respect to social reproduction while disempowering lower-income people and people of color, especially women and Black people. I argue that urban development has been a

force through which social reproduction has been stratified and through which this stratification has been maintained.

2.3.1 Spatializing care

Care is necessarily relational, in that it involves responsibility and commitment to an object of care. This relation is not typically purely dyadic, instead involving a complex network of actors, resources and actions, including elements of the environment where care takes place. As such, geographers have argued that care is spatialized (Lawson, 2007; Milligan & Wiles, 2010) and that care settings– including private spaces like the home, professional spaces like clinics, and well as public spaces like parks - form part of the social fabric of the places they are located (Conradson, 2003). It follows that practices of care are situated, and that care is a quality of spaces that is produced relationally (Bondi, 2003).

One of the most promising means of understanding how care exists in space is the metaphor of the landscape, through which different scales of care can be treated as mutually constitutive, and through which multiple sites of care can be connected (Atkinson et al., 2011; Milligan & Wiles, 2010). Landscapes of care can encompass institutional, domestic, familial, community, public and private spaces; they are “spatial manifestations of the interplay between the sociostructural processes and structures that shape experiences and practices of care” (Milligan & Wiles, 2010, p. 739). Multilayered and inclusive of different scales of caring relationships, landscapes of care both emerge from and reproduce relations of care. The concept of landscapes of care reflects the fact that care is organized at and across multiple scales from the dyadic or familial to the international (Folbre & Bittman, 2004; Razavi, 2007). For example, care is organized through the modern welfare state, as well as through institutions and sites outside of the state such as hospitals, social service organizations, or family homes (Conradson, 2003; Engster, 2015; Esping-Andersen, 1990; Fraser, 2016; Poo, 2016; Tronto, 1993). Further research is needed into how landscapes of care shape the relationship between health and place (Schwanen et al., 2012).

I propose coupling the concept of landscapes of care with Colen's (1995) concept of "stratified social reproduction" to conceptualize urban spaces as constantly evolving *landscapes of stratified social reproduction*. As I hope to show, doing so affords a way to understand how processes of urban change, as the manifestation of both structural and social forces, shape experiences and practices of care, and in turn reproduce racial and gender inequities in both the means of social reproduction as well as in related domains like health and the economy. While the concept of landscapes of care is useful for understanding how various scales and forms of urban space interact to produce the conditions for caregiving and shape caregiving relations, it does not provide a framework for understanding what changes in the landscape of care do and why they matter. Planning, as a normative field, needs such a framework in order to guide analysis and strategy, interventions and practice, and evaluations thereof. I suggest that stratified reproduction is an appropriate framework because it sheds light on both why landscapes of care matter and what to strive for by intervening in them – that is, an equitable distribution of power over the means of social reproduction. While this is certainly not attainable through planning interventions alone, this dissertation shows how processes of urban change contribute to stratified reproduction and how planners might intervene to pursue more equitable relations of social reproduction. In the next section, I survey the history of the relationship between social reproduction and the production of urban space to show how the development of cities has contributed to stratification of social reproduction and contemporary crises of care.

2.3.2 Social reproduction and the production of urban space from industrialization to neoliberalism

Given the significance of social reproduction to our economy and to our collective wellbeing, it is understandable to ask: How does social reproduction shape cities? And how does the evolution of cities shape social reproduction? Regrettably, these questions have received relatively little consideration compared to questions about the relationship between the mode of production and the production of urban space. This is, perhaps, for some of the same reasons that social reproduction has been under-considered in other

domains like economics or public policy-making: in capitalist economies, social reproductive work is de-valued and invisibilized, as are those who perform it (Bhattacharya, 2017; Folbre, 2012; Fraser, 2014, 2016). Nevertheless, it is possible to assemble a picture of the relationship between social reproduction and the production of urban space under the reigning political economic regime by pulling together threads of scholarship from across the social sciences. Below, I sketch out the contours of this picture in the context of the United States, beginning in the industrial era and culminating in contemporary processes of urban redevelopment and gentrification under neoliberalism. Overall, the relationship is reciprocal: urban interventions have explicitly sought to shape the conditions of social reproduction, and changes in patterns and structures of social reproduction have shaped the development of cities and urban life. These processes have contributed to the embeddedness of racial and gender inequality in urban environments, and this history helps form the basis for my argument in this dissertation that planners must seek to understand and rectify the ways that cities reproduce inequities in social reproduction by investing in urban infrastructures of care.

Historians and geographers have revealed how the organization of social reproduction has influenced the built environment in North America in such a way that the costs of reproduction are borne away from where the benefits of the production of space accrue, making the relationship between social reproduction and the production of space a key driver of racial and gendered economic inequality in cities. It is important to note that much of the extant scholarship focuses on the relationship between social reproduction and the production of urban space overlooks both the experiences of Black communities and communities of color, and the role of these changes in reproducing white supremacy, racial injustice, and racialized social and economic inequalities (Morrow & Parker, 2020). While many scholars have explored how large-scale changes in the relations of social reproduction have impacted Black communities and communities of color, and studied how these communities have built their own systems of care and social reproduction in the midst of political and economic neglect and oppression, connections between this work and the history of urbanization itself remain under-explored by planning scholars (Glenn, 2012; Hill Collins, 1990; Roberts, 1998; Stack, 1983).

In the nineteenth century, industrialization prompted rapid, large-scale urbanization in the United States. Living conditions for urban workers were generally substandard, and often squalid; health issues were rampant; racial segregation was firm under Jim Crow laws; and political unrest was frequent (Corburn, 2009; Roediger, 2007; Rosenberg, 1987; Taylor, 2009). Under these conditions, the working class' capacity to replenish itself was "stretched to the breaking point" (Fraser, 2016, p. 105). The white owning class managed the contradiction between the need for accumulation and the need for social reproduction through the ideal of "separate spheres," an idea made manifest in the transformation of the urban built environment during the industrial era (Fraser, 2014, 2016). The domestic sphere became institutionalized as the proper domain for women, and femininity became associated with domesticity, caregiving and dependence. Industrialists began to pay white men a "family wage" which formalized the gendered division of labor within urban white working-class households, with the factory seen as a male space and the home as the woman's sphere and site of social reproductive work. These new patterns of urban and domestic space made the labor of social reproduction invisible and control over it unequal. It isolated those who performed it from one another, from the rest of their families, and from rural social networks of kin and neighbors, which were disrupted by migration to urban centers (Hayden, 1983; Stack, 1983). The preference for a strong separation between public and private space and the functions performed therein has always been a patriarchal one (Saegert, 1980). The private home served as the spatial boundary of the "woman's sphere," and the unpaid domestic labor within that space was the economic boundary (Mohandesi & Teitelman, 2017). Smith (2002) has argued that this social division between production and social reproduction played a pivotal role in the determination of the urban scale from the nineteenth century through to the late twentieth.

However, if women's place was perceived to be in the home, for Black women and other racialized women, that home was usually someone else's (Hill Collins, 1990; Sandercock & Forsyth, 1992). As Glenn (2012) shows, in the late 19th century middle- and upper-class white women sought to educate poor women, Black women, and immigrant women in their ideals and practices of domesticity, efforts of social control that sought to

establish under-valued social reproductive work as a “status duty.” These patterns of coercion and subjugation in the domestic labor market, where Black women were cornered, were a manifestation of stratified social reproduction. The stratification of social reproduction was a key strategy in ensuring the persistent oppression of Black people both during and after slavery, along with other means of socio-spatial control like Jim Crow laws and racial residential segregation (Hill Collins, 1990).

In the early decades of the 20th century, suburbanization emerged as the primary spatial strategy for the state and capital to manage social reproduction and maintaining social reproductive inequities between white and non-white households, solidifying the patriarchal organization of social reproduction in the city. Corporations, seeking to quell labor unrest growing since the late 19th century by moving workers away from tenements. They began to support suburban home ownership for skilled white male workers, who would receive “family wages” and become responsible for mortgage payments while women would become “managers” of the home. These new single-family homes were intended to embody the nineteenth century bourgeois ideal of a haven from the industrial city, and became “the commodity par excellence, a spur for male paid labor and a container for female unpaid labor” (Hayden, 1980, p. S172). Meanwhile, widespread urbanization also coincided with the great migration of formerly enslaved Black people from the rural U.S. south to large cities, where domestic work was often the only form of work available to Black women and Black men faced exclusion from the labor market (Hill Collins, 1990). Redlining, the discriminatory practice by which geographic areas – typically home to predominantly people of color – were demarcated as ineligible for financial services like mortgage loans and federal mortgage insurance, was formally established during this era (Rothstein, 2017). By compounding racial segregation and uneven levels of access to resources and opportunity, redlining became a key instrument in ensuring the stratification of social reproduction and therefore broader patterns of racial inequality in cities and in the economy more broadly.

The Great Depression in the 1930s exposed acute contradictions between production and social reproduction, and central to the state’s strategy of defusing this situation was expanding single-family home ownership and assuming a degree of

responsibility for social welfare (Fraser, 2016). Following the Great Depression and through the 1940s-50s, single-family home ownership was endorsed at the national policy level as a long-term program for economic recovery, and expanded through mortgage innovations and policies like the GI Bill that favored white people, while redlining and restrictive covenants continued to exclude Black people and other people of color from the benefits of homeownership and building intergenerational wealth (Katznelson, 2006). These new single-family homes were overwhelmingly built in new suburbs, and suburbanization went hand in hand with commodification of the means of social reproduction such as dishwashers and laundry machines, and housework evolved to include more and more time involving the use of manufactured products (Hayden, 1983; Jackson, 1987). However, these technological advancements did little for women: time spent doing housework never went down (Folbre, 2012). Markusen (1980) has thus argued that the dominance of the single-family detached dwelling, its decentralized location within urban areas, and its separation from the workplace is an equal product of the patriarchal organization of household production and the capitalist organization of wage work.

Other urban policies during this era also transformed the landscape of social reproduction. Between 1949-73, urban renewal led to the displacement of over one million people via the bulldozing of 2,500 neighborhoods – 1,600 of which were predominantly Black neighborhoods. This destroyed kin-based webs of relationships which many residents of these communities relied on for survival in the context of historical patterns of racialized oppression (Fullilove, 2005; Stack, 1983). This disruption of household- and community-level systems of social reproduction produced “root shock,” defined as “the traumatic stress reaction to the destruction of all or part of one’s emotional ecosystem” (Fullilove, 2005, p. 11). It was thus in a state of “overwhelming injury” that Black people faced subsequent crises in decades to come including the loss of unskilled jobs, the influx of addictive drugs, and AIDS (Fullilove, 2005, p. 224). This process of “serial displacement” continues to this day, with gentrification as its most modern form, argue Fullilove and Wallace (2011).

In the 1970s, the U.S. experienced a period of economic decline amidst the rise of global competition, oil crises, high interest rates, and the collapse of post-war norms of labor-capital agreements (Harvey, 2011). During this time, a new way of thinking about the economy and its relationship to society – neoliberalism – gained prominence, championed by free-market economists and social conservatives. Neoliberalism is a political rationality – and corresponding policies and ideological norms – that posits the free market as the ideal model for how societies should function (W. Brown, 2017). Though many have argued that neoliberalism is characterized by an ethos of personal responsibility, Cooper (2017, p. 22) has shown that neoliberalism has in fact sought to reestablish the private family as the primary source of economic security and as an alternative to the welfare state, in what she calls a revival of the poor law traditions “in the idiom of household debt.”

The economic tumult of the early 1970s led to the collapse of the post-war system of organizing social reproduction, and a new neoliberal regime of managing the social reproductive contradictions of capitalism began to emerge. (Fraser, 2016). This regime promoted state and corporate disinvestment from social welfare while recruiting women into the paid workforce, the effect being to push responsibility for care work on to families while simultaneously diminishing their capacity to perform it (Fraser, 2016). This shift of women into the workforce coincided with increasing immigration to the U.S. for the purposes of working in the care sector following the Immigration and Nationality Act of 1965, and the beginning of decades of rapid growth in the care sector overall (Boris & Klein, 2012; Hondagneu-Sotelo, 2001; Parreñas, 2015). Immigration, including related to the care sector, has added further layers of stratification to urban landscapes of stratified reproduction. Indeed, Colen (1995) developed the concept of stratified reproduction through studying the experiences of immigrants from the Caribbean working in the care sector.

As women moved back into the workforce, and increasingly turned to fulfilling social reproductive needs through markets for goods and services, the enduring organization of urban space ensured that the work of social reproduction remained individualized, resulting in women working “a second shift” of unremunerated social

reproductive work (Hochschild, 1989; Markusen, 1980). During this era, wages fell below the costs of reproduction, and precarious low-wage service-sector work became increasingly predominant. The reduction in wages increased the number of hours of paid work per household necessary to support a family. Thus, the two-earner household emerged as the predominant form of organizing social reproduction, and due to wage stagnation, families have taken on increasing amounts of debt in order to meet their social reproductive needs, including housing (Fraser, 2016).

In parallel with economic shifts in how people could fulfill their social reproductive needs, key policy shifts in the 1980s-1990s also fulfilled the neoliberal impetus to transfer responsibility for social reproduction away from the state and on to the family by undermining social welfare provisions. In the U.S., the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) is the emblematic policy of this neoliberal shift. Rooted in racist and sexist stigma against welfare recipients and “unwillingness to include Blacks as full citizens,” PRWORA ended the New Deal guarantee of cash assistance for families with children living in poverty, and marked a shift in welfare away from charity and towards behavior modification (Roberts, 1998, p. 243). The act pushed welfare recipients into regular employment outside the home, rendering government assistance time-limited and conditional upon efforts to find employment, and bringing about a shift from a welfare system to a “workfare” system (Peck, 2001; Roberts, 1998). Fennell (2015) has argued that the HOPE VI program was the spatial extension of these welfare reforms, demanding that poor people living in public housing take increased responsibility for their family’s own wellbeing, and counting on chance interactions as the means to manage economic security rather than support from state institutions.

The move of women back into the workforce that began in the 1970s has more recently become a major but underacknowledged force in driving gentrification, Curran (2017) has argued. This because it occasioned (for those who could afford it) a search for urban neighborhoods that could accommodate dual roles at work and at home, as well as provide necessary services. Two-income households became a requirement to afford the increased cost of urban housing. Thus, gentrification has polarized inequities in the organization of social reproduction because the urban spatial structure did not respond to

the changes in the structure of work brought about by deindustrialization in the same way that it did respond to changes in the structure of work through industrialization. Those who cannot afford to live centrally must grapple with an organization of space that remains based on a patriarchal model of the city in which women are confined to the home, characterized by distance from services concentrated in downtowns, inaccessibility of public transportation, and a lack of adequate options for childcare (Curran, 2017). Gentrification, the essence of which is “intensifying competition for the unequal benefits of urbanization” as urban space is produced for ever more affluent users, has both contributed to the contemporary crisis of care as a vector of the financialization of capital and economic polarization, and thrived on the destruction of the forms of collective consumption that formed the core of the 20th century welfare state (Wyly, 2019).

Presently under neoliberalism, the relationship between social reproduction and the production of urban space favors the demands of capitalist production rather than those of social reproduction, as expressed by an increasingly generalized state of gentrification (N. Smith, 2002). Neoliberal urbanism has been characterized by policies that cast people as responsible for their own social reproduction (Simone, 2021). The dominant mode of urban policy making under neoliberalism is market-oriented, and market-oriented urban policies reproduce class, race and gender inequalities in the burden of social reproductive labor (B. Parker, 2017). Meanwhile the demands of social reproduction become harder and harder to fulfill in the context of increasing gentrification and economic inequality in cities. And, through the COVID-19 pandemic, socio-spatial relations of social reproduction are being reworked, yet again to the detriment of women and people of color, yet again demonstrating the “painful divergence between that which is socially necessary and that which is economically viable” in cities that are increasingly incapable of meeting the everyday needs of all but their wealthiest residents (Madden, 2020, p. 677; Morrow & Parker, 2020).

This history of the political, economic and spatial devaluation of social reproduction has not been without resistance from feminist and anti-racist social movements. These include the efforts of the material feminists that Hayden (1983) chronicles, and social reformers like Jane Addams and her colleagues at Hull House

(Hamington, 2001). Forms of resistance to the stratification of social reproduction also includes Black women's efforts to materially sustain their communities through cooperative economic models, and cooperative forms of housing, childcare and food provision (Gordon Nembhard, 2014; Leavitt & Saegert, 1990; Stack, 1983). Similarly, community-based groups like the Black Panthers and the Young Lords responded to the spatial stratification of reproduction with efforts to freely provide the means for social reproduction – like free health care and free meals for children – in oppressed and disinvested communities of color in cities across the U.S. (Heynen, 2009; A. Nelson, 2011; J. Nelson, 2001). This tradition of resistance continues into the present, exemplified by Moms4Housing resisting displacement and dispossession in Oakland, CA, and the mutual aid networks that have flourished in the absence of state support for social reproduction during the COVID-19 pandemic (Ramírez, 2020; Springer, 2020). Inspiring as these forms of resistance are, it is crucial not to forget that they themselves represent those communities most disadvantaged by the relations of social reproduction shouldering additional burdens thereof to ensure that their basic needs are met.

Overall, then, spatial arrangements of social reproduction as shaped by urban development have isolated women from one another and made domestic work invisible, thus reinforcing its devaluation (Morrow & Parker, 2020). How will this pattern change or persist in the context of new drivers of urban change in the 21st century such as climate change, natural disasters, and associated changes in land use and migration, the rise of precarious platform labor markets, or further welfare state retrenchment and austerity? Planners must attend to this question with a view to intervening to ensure the equitable distribution of the burden of social reproduction. In the next section, I consider how feminist planning theorists have considered the role of the city in reproducing gender inequities, and consider how a greater focus on social reproduction has the potential to advance these efforts.

2.4 Gender and feminism in planning theory

In capitalist societies including the U.S., the work of care and social reproduction has overwhelmingly been performed by women, and as I show above, the shifting distribution of the burden of this work has been intertwined with patterns of urban development since the industrial era (Folbre, 2012). The significance of care and social reproduction for understanding gender equity in cities raises the question of how these topics fit in to conversations in feminist planning theory. Since the 1970s, feminist planning theorists have sought to understand and explain gendered spatial inequities in cities with a focus on gender as a socially constructed category. Recently, some scholars have begun to reflect on how this work has been limited by a reliance on binaristic notions of gender, and called for ways to advance feminist planning theory beyond the gender binary (Beebeejaun, 2017; Doan, 2011). In this section, I review key developments in feminist planning theory, and consider the possibility of expanding the scope of feminist planning theory to foster greater attention to how cities reproduce inequities in gendered *labor*. I argue that expanding the scope of how we understand the production of gender inequity in cities from *who* to *what* – seeing gender as produced *through* spatial processes like care rather than as an *a priori* characteristic according to which individual and group experiences of space differ – is one strategy for moving towards non-binaristic feminist planning theory while still working towards the core feminist planning goal of gender equity.

With respect to care and social reproduction, this means seeing the unequal distribution and burden of these types of work across genders as an outcome of the production of space, rather than as an *a priori* property of inherent and binaristic gender differences which cities simply accommodate to some degree. The latter would only serve to reify inequities in the distribution of “life’s work” that are central to binaristic notions of gender difference and hierarchy and thus to gender inequality under capitalism (Federici, 2004, 2012). But as the historical patterns discussed in *Section 2.3* showed, what we understand gender as a social category to be – including binarism - has been shaped by the ways that care and social reproduction have been organized by the production of

urban space. It follows that attending to how gender is produced through the socio-spatial organization of care in cities is not only useful but necessary for advancing efforts to attain gender equity in cities in ways that do not rely on binaristic notions of gender through which these very inequities are reproduced.

Feminist planning scholars have long recognized that planning issues “spatialize and concretize many of feminism’s concerns” and that planning offers feminism with a venue for pragmatic and transformative application of its principles and ideals (Roy, 2001, p. 110). In the late 1970s and early 1980s, amidst the rise of second-wave feminism and alongside the civil rights, anti-imperialism, anti-war and environmental movements, feminist planning scholars began to examine the history of the relationship between the production of urban space and the reproduction of gender inequality (Peake, 2017; Sandercock & Forsyth, 1992). For example, Susan Saegert (1980) critiqued the binary associations of cities with masculinity and suburbs with femininity; Ann Markusen (1980) called attention to widespread ignorance of the value and importance of social reproduction in urban economic development policy; and Dolores Hayden (1980) began to envision what a “non-sexist city” would be like. Their efforts were accompanied by a flourishing of feminist scholarship in allied fields including urban sociology, where scholars like Lofland (1975) and Stack (1983) called attention to the invisible work women performed to maintain neighborhoods and the omission thereof from mainstream urban sociology, as well as in geography, where scholars explored how urban public spaces were the sites of contestation over the regulation of social reproduction (Bondi & Rose, 2003).

While these scholars demonstrated that gender could not be ignored in our efforts to understand cities and planning, male-dominated conversations in planning theory continued to be silent on the subject for some time (Sandercock & Forsyth, 1992). As Daphne Spain later asked, calling attention to the absence of attention to insights from feminist scholarship in historical and contemporary schools of urban theory, “what happened to gender relations on the way from Chicago to Los Angeles?” (Spain, 2002). Responding to this pattern of omission, Sandercock and Forsyth (1992) sought to identify aspects of feminist theorizing about gender from the era’s postmodern turn that could best

inform planning theory across domains including socio-spatial relationships, communication, ethics and epistemology, and offered a research agenda focused on feminist theorizing of planning practice and culture. In this dissertation, I seek to do something similar to Sandercock and Forsyth (1992) in terms of specifying how contributions from feminist theory can be applied in planning scholarship and practice, albeit with a focus on more materially-oriented feminist theories of political economy – in which care and social reproduction occupy a central position – rather than theories of gender itself.

Nearly 40 years after the initial burst of feminist planning scholarship, research contending with the patriarchal nature of the modern city has blossomed, but gendered forms of exclusion from urban life are still pressing in cities around the world, and still under-attended to in planning theory (Beebeejaun, 2017; Peake, 2017). Urban and planning theory are still often “disembodied,” and the notion of women’s lives in the city still has “an almost stable fixity” grounded in the dichotomies of public/private, household/economy, etc. (Peake, 2016). As a result, our understanding of how gendered processes of production and social reproduction are being transformed is “underdeveloped” theoretically and empirically, argues Peake (2017, p. 90).

Some scholars have critically attributed the lack of progress towards gender equity through planning practice to the process of “gender mainstreaming” under neoliberalism, whereby gender is incorporated into mainstream institutions in the form of guidelines and criteria for practice, but simultaneously depoliticized (Beebeejaun, 2017; Bertram, 2021; Fraser, 2009). Recent research on planning practice in the United States by Turesky and Warner (2020) validates these concerns, showing that while planning workplaces have diversified considerably with respect to gender, gendered inequalities nevertheless persist, particularly in terms of communication, roles, and opportunities for advancement. Similarly, in Germany, Huning (2020) finds that gender mainstreaming has not substantially advanced planners’ abilities to address the spatial manifestations of gendered power relations. She shows that while awareness of gender inequalities has expanded, political attention and planning interventions remain on individual-level solutions

characteristic of the broader neoliberal project rather than the underlying set of socio-spatial relations upholding gendered inequality.

Thus, efforts to advance feminist causes in planning have faced considerable barriers, and urban theory and policy discussions still pay too little attention to the gendered dimensions of urbanization. Some planning theorists and urban geographers have suggested that the persistence of binaristic notions of gender itself is a central obstacle our ability to understand and intervene in gender inequities in cities (Beebeejaun, 2017; Doan, 2011; B. Parker, 2017; Peake, 2016). Doan calls the hegemonic gendered divisions of space according to a male-female binary “the tyranny of gender,” and shows that this ideology’s manifestation in physical space as well as planning thought perpetuates gendered harm, especially for those outside the gender binary. Binary categorizations of men and women impede the integration of feminist planning scholarship into practice, Beebeejaun argues, because gender is socially produced rather than biologically innate. Along with others in geography, and drawing on decades of scholarship in gender and trans studies, she encourages a move towards understanding gender as a continuum and a process rather than a category (Beebeejaun, 2017; Peake, 2017).

A parallel strategy for overcoming the obstacles of binaristic approaches to gender in planning research and practice is to turn our attention to gendered labor. After all, social reproduction is a socio-spatial process through which gender relations are reproduced. To date, the scholarship reviewed above has examined the gendered dimensions of heteropatriarchal urban plans, policies and processes has typically focused on their impacts on women, and sometimes LGBTQ people, *qua* people. Less common has been a focus on how forms of gendered labor, like care work – overwhelmingly but not exclusively performed by women for political and economic reasons rather than reasons innate to their sex or gender – have been and could be shaped by urban plans and policies. Where is care in our conversations about the opportunities cities should afford inhabitants, and how cities should grow? Is care absent from these conversations because planners still treat it as a private concern, a matter for private space?

I argue that planners seeking to advance feminist causes should begin to attend to “life’s work”, that work which structures the gendered rhythms of everyday life and through which gender itself is socially produced (K. Mitchell et al., 2004). Indeed, doing so would involve uncoupling the dichotomous association between social reproduction and the private sphere, on the one hand, and production and the public sphere on the other, and instead treating care as both a public concern and a public good. Working through and past the binaries through which we understand the relationship between gender and space may also help work through and past binaristic notions of gender itself in planning. I would argue that care renders the supposed binary between public and private space moot. Private space is necessary for care, but it is not the exclusive domain of care, by any means, and nor should it be. Moreover, the ways that private space is necessary for care are shaped by what is afforded – or not – by public spaces. And what should planned public space be for, if not to ensure our mutual wellbeing and thriving, if not for meeting one another’s needs?

A focus on gendered labor has much to contribute to the overall agenda of feminist planning scholarship. For example, Beebeejaun (2017) calls for reinvigorated efforts to understand how women are able to access the affordances of the city and make claims to urban space, with an emphasis on everyday life. Studying these topics from the perspective of social reproduction could shed light on the effort involved in accessing the affordances of the city, motivations for doing so and whether they are fulfilled by the city, and what claims to urban space might afford in terms of livability. “Everyday life can become understood as the mediator of rights underpinning the usage of urban space to its fullest extent,” Beebeejaun (2017, p. 327) argues, and what is care and social reproduction if not the stuff of everyday life? A shift from a focus on individuals to a focus on activity offers an opportunity to explore how gender inequities and patterns of gendered exclusion – for example, from economic opportunity or housing security – are perpetuated in cities without relying on categorization of people according to their gender or the gender binary and instead focusing on the activities that make up their lives. Moreover, given the inextricability of race from the relations of social reproduction, understanding how urban landscapes of stratified reproduction are reproduced has the

potential to provide planners with valuable insight into mechanisms of racial injustice in cities. Accordingly, I also suggest that planning interventions that address inequities in the distribution and burden of social reproductive labor are a potentially transformative strategy through which to pursue not only gender equity but also racial and economic equity, since all three are intertwined in the relations of social reproduction in our society.

So, what would planning research and practice that attends to care and social reproduction look like? In the next section, I review how have planners considered the subject of care to date, as well as important considerations about some of the harms that can come from state interventions and policies undertaken in the name of care. Based on these considerations, I suggest that planners may benefit from adopting an infrastructural approach to understanding and intervening in relations of care and social reproduction.

2.5 Planning for Care: An Infrastructural Approach

In the urban planning literature, scholars have recently begun to engage with the concept of care from the perspective of planning ethics, calling attention to planning's capacity to be caring and the importance of care-full practice (Jon, 2020; Lyles et al., 2018; Martino et al., 2020). This emerging vein of scholarship about planning practice draws on a longer history of scholarship on the role of emotions and love in planning and the potential for "therapeutic" or "restorative" planning practices (Erfan, 2017; Porter et al., 2012; Sandercock, 2004; Sandercock & Attili, 2014; Schweitzer, 2016). Like these prior contributions, recent planning scholarship concerning care has largely focused on the moral and ethical dimensions of care, rather than more material dimensions of everyday caregiving in cities. Similarly, they focus on communicative practices, the relationships between planners and their constituents, and modes of engagement and participation, rather than actual interventions into the urban environment.

For example, work from the feminist care ethics tradition has recently been employed to advocate for the cultivation "compassionate planning" practices focused on increasing care and reducing suffering (Lyles et al., 2018). And, in a related vein, Forester has considered the role of kindness – which he defines as practical responses to

vulnerability aimed at another's wellbeing – in planning practices “to shape practices of justice that are neither empty nor blind” (2021, p. 64). From the perspective of participation and engagement, one recent reflection on Arnstein's ladder of participation proposed modes of planning centered on care and compassion for resolving the emotional paradoxes that planners often face in community engagement processes (Lyles & White, 2019). All of these contributions are valuable, but they focus exclusively on the *practice* of planning rather than the *object* of planning, and in order to leverage planning to address the crisis of care and social reproduction, it is necessary to do both. Put differently, we need to plan *with and for* care.

A similar pattern, wherein the focus is on cultivating caring forms of practice, has played out in scholarship related to urban design specifically. For example, Imrie and Kullman (2016) have drawn on the work of Kevin Lynch to argue that the attachments between bodies, materials and spaces that comprise the built environment are shaped and supported by caring labor, and have accordingly advocated for urban design practices that express caring skills and sensibilities by attending to and supporting this labor of attachment. They specify that this involves paying attention to the “fits and misfits” between people and their environment and how these may enhance or limit caring potential. Similarly, other urban design scholars have argued that “care is designed into being” and that planners and designers can seek to do so more intentionally “through the configuration of well-designed environments that are crafted from behavior that follows pathways of responsiveness or reciprocity,” echoing scholars in geography, anthropology and STS who show that care is not a purely human phenomenon but instead is mediated by material environments (Bates et al., 2016, p. 96).

Two exceptions from this pattern are noteworthy, and are more aligned with the contribution I intend to make in that they focus on how to attend to and make visible already-existing forms of everyday care within cities, and to value care practices and center them in our efforts to plan for more just and livable cities. The first is from Miraftab (2019) who in a recent talk advanced a vision of “humane” urbanism as opposed to the inhumane “bully urbanism” that she sees as characterizing much of contemporary planning and policy. She argues that inhumane urbanism, and the capitalist, sexist and

racist structures from which it stems, are sustained through the erasure of social reproduction and care from our collective consciousness despite their centrality to urban life. To challenge inhumane urbanism, she argues, we need to make care visible and “construct societies that allow deep sharing, feeling and collective empowerment across scales.”

The second comes from Morrow and Parker (2020), who bridge across geography, urban studies and planning to revisit Hayden’s (1983) early work on “domestic revolutions.” They offer valuable updates to Hayden’s arguments, addressing the absence of Black women and other women of color from her history of the relationship between social reproduction and public and private urban spaces, and these contributions are reflected in the historical narrative presented above. They also clarify that recent feminist design interventions that harken back to the vision of the “materialist feminist” activists whose efforts Hayden chronicles – such as community kitchens – have not resulted in changes in the distribution of reproductive work, the labor within them remaining feminized, racialized and poorly paid. In a similar vein, they show how shared spaces for social reproduction are becoming common lifestyle amenities in pricy condominiums and tech workplaces, thus primarily benefitting those who are already wealthy enough to be able to purchase social reproductive services as market commodities. These findings are reminiscent of those reporting that technological improvements to domestic work, like dishwashers and laundry machines, did not reduce the overall burden of that work (Duffy et al., 2013; Folbre, 2012). Morrow and Parker argue, and I agree, that “without challenging the broader social and economic relations around social reproduction, changes to the built environment [offer] at best design fixes for racism and patriarchy” (2020, p. 9).

Like Miraftab, Morrow and Parker argue that the central problem for planners vis-à-vis social reproduction is not one of design, but one of how social reproductive labor is valued. This suggests that planning interventions that seek to address racial and gender inequity by alleviating and redistributing the burden of social reproductive labor must seek to increase its value, beginning by recognizing it and centering it in planning decisions that are not only about design but also about policy and resource allocation. Morrow and

Parker speak to the appeal of “an anti-racist feminist materialist approach that would encourage investment in the many vital infrastructures that help us to common social reproduction and care in the city” (2020, p. 11). In the next section, I consider how such an infrastructural approach to care may be possible for planners.

2.5.1 Planning for Infrastructures of Care

In order to establish care and social reproduction as objects of planning attention and intervention, and not just characteristics of planning practices, we need a framework for understanding how caring activities are organized across urban space, and correspondingly how this socio-spatial organization may be improved in service of health, wellbeing, and urban livability. One option for doing so is the “landscapes of care” concept developed by geographers to express how different sites of care are connected and how different scales of care are mutually constitutive (Lawson, 2007; Milligan & Wiles, 2010). However, while this framework has *analytical* value for planners, it has less *practical* value for the task of intervening in the socio-spatial organization of care. Another option is to consider the socio-spatial organization of care in cities through the lens of infrastructure. In this section, I review recent developments in the understanding of infrastructure across various fields and make an argument for why the concept of infrastructure is useful for understanding and intervening in the socio-spatial organization of care in cities.

Infrastructure is defined in the Oxford English Dictionary as “a collective term for the subordinate parts of an undertaking, substructure, foundation” (“Infrastructure, n.,” n.d.). As a concept, infrastructure concept has its roots in Enlightenment-era visions of modernity characterized by free markets and progress. Thus it is perhaps unsurprising that, over the past two decades, critical interest in infrastructure, both its physical forms and its conceptual utility, has blossomed across a variety of disciplines, particularly in the fields of anthropology, science and technology studies, and geography (Amin, 2014). Reviewing this scholarship, Larkin offers a definition of infrastructures as “built networks that facilitate the flow of goods, people or ideas and allow for their exchange over space” (Larkin, 2013,

p. 327). The utility of such a definition with respect to care – which is itself a good, the accomplishment of which involves assemblages of other goods, people and ideas – has been borne out in recent efforts to call attention to the need for investment in the U.S.’ care infrastructure (Kalipeni & Kashen, 2020).

While Larkin’s definition focuses on the physicality of infrastructures, other scholars have also emphasized infrastructure’s social dimensions, arguing that people form part of infrastructures; that the physicality of infrastructures is inextricable from their sociality; that infrastructures blend the social and the technical; and that infrastructures shape the ways people interact and the types of relationships they can build with one another (Graham & Marvin, 2001; Klinenberg, 2018; Simone, 2004, 2021). In terms of health and wellbeing more explicitly, Solomon (2021) has shown how peoples’ interactions with urban infrastructures produce embodied effects and vulnerabilities which are distributed unequally within communities and societies. Thus, the infrastructural turn in the social sciences gives planners conceptual tools to understand how different elements and actors in the urban environment interact in systematic ways to produce social functions and outcomes.

The work of Susan Leigh Star was one of the early catalysts of this infrastructural turn. Star (1999) defines infrastructure as the background condition for other kinds of work. Based on her own empirical research into computer network infrastructures, she suggests that infrastructures have a range of properties, including embeddedness within other structures and technologies, and it’s reach and scope (*Table 2.1*). These properties convey the relational nature of infrastructure – that infrastructure becomes real in relation to socially-organized practices, like transportation and mobility, or internet use, or human sanitation.

TABLE 2.1: PROPERTIES OF INFRASTRUCTURE ACCORDING TO STAR (1999)

Property	Definition
Embeddedness	“sunk into and inside of other structures, social arrangements and technologies”

Transparency	“transparent to use, in the sense that it does not have to be reinvented each time or assembled for each task, but invisibly supports those tasks”
Reach or scope	“reach beyond a single event or one-site practice”
Learned as part of membership in a community of practice	Infrastructure is encountered as something to be learned about, and familiarity becomes naturalized over time, solidifying membership in a community of practice
Links with conventions of practice	“infrastructure both shapes and is shaped by the conventions of a community of practice”
Embodiment of standards	Infrastructure plugs in to other infrastructures, tools or systems with their own standards and conventions, some of which conflict, and is modified accordingly
Built on an installed base	“Infrastructure does not grow <i>de novo</i> ; it wrestles with the inertia of the installed base and inherits strengths and limitations from that base.”
Visible upon breakdown	Infrastructure’s qualities are normally invisible; when it breaks down, its importance and relational nature become starkly visible.
Fixed in modular increments	“Because infrastructure is big, layered and complex, and because it means different things locally, it is never changed from above. Changes take time and negotiation, and adjustments with other aspects of the systems are involved.”

**All quotations in this table are from Star (1999, pp. 381–382)*

Care is “a universal need and a public good that requires collective, public policy-supported solutions,” insist Kalipeni and Kashen (2020). Planners are certainly not new to the subject or idea of infrastructure, and the history of planning is characterized by infrastructural approaches and interventions to urban problems like sanitation, transportation, and housing (Melosi, 2000). Indeed, the problems that planners have sought to solve with infrastructure are problems about basic provisions for needs that we value as universal and/or functions that we deem necessary to our survival or thriving. Care clearly meets these criteria, but as the work of feminist political economists and

urban planners reviewed previously in this chapter indicates, we don't treat it as such. But, if we heed Miraftab's (2019) call to make the care that takes place in cities visible, and the call of feminist political economists to value it, it becomes an infrastructural problem.

Care is complex, challenging, and resource- and time-intensive, and therefore merits infrastructural provision and investment (The Care Collective, 2020, p. 28). The properties of infrastructure that Star defines provide a sense of how taking an infrastructural perspective on care has the potential to be valuable for planning research and practice. An infrastructural perspective would allow us to see and make sense of how caregiving is facilitated by underlying urban conditions and aspects of the built environment like homes, public spaces, and other infrastructures like transportation systems and utilities. It would allow us to figure out how local urban environments invisibly support (or hinder) care work and thus how to strengthen such supports, and to explore how urban environments shape what the work of care and social reproduction entail and why this is so. Finally, it affords a perspective on what types of interventions might be appropriate for alleviating inequitable burdens of care work.

While planners can be involved in *building* infrastructures of care in various ways, infrastructures also depend on considerable maintenance and repair – such labor is often invisible and, indeed, has many similarities to care (Graham & Thrift, 2007; Mattern, 2018; Star & Strauss, 1999). The infrastructure of care is consistently in need of maintenance and repair; indeed, it must be reproduced in order for people to survive. At the interpersonal scale, much of that work is ongoing – and often not undertaken in expectation of payment or profit – but it is typically unseen and un(der)-valued. At greater geographical and social scales, however, the maintenance, repair and extension of infrastructures of care is increasingly neglected – the contemporary unraveling of the U.S. welfare state is an example (Campbell, 2014). Maintaining and repairing the urban infrastructures of care are important domains for planning to engage in, and key sites where visions for care-full planning practices like those discussed in the previous section may be applied.

Recently, the concept of 'infrastructures of care' has begun to appear in a variety of academic contexts as well as within policy and advocacy work. Power and Mee (2020)

have defined infrastructures of care as “the infrastructural forms that pattern the organization of care within society” and argued that housing is an infrastructure of care because it organizes and “patterns” care across three domains: physically at the household scale, via markets, and via governance. In a similar vein, Kapsali (2020) has explored how refugee squatting encampments in Greece form infrastructures of care because of how care is collectivized within them. Relatedly, in urban geography, Alam and Houston (2020, p. 2) suggest that “everyday care practices generate particular infrastructural conditions and outcomes through the interplay and involvement of communities, materials and practices.” And, as mentioned in the previous section, Morrow and Parker (Morrow & Parker, 2020) call for investment in the “vital infrastructures” that support care in the city. The emerging interest in linking infrastructure and care is exciting. From the planning perspective, however, there has not yet been a systematic empirical assessment what the urban infrastructure of care is, nor how planners could intervene and invest in it.

Meanwhile, from the perspective of policy advocacy, Kalipeni and Kashen (2020) have operationalized the term in their proposals for investment in the care sector as a strategy for economic recovery in the aftermath of the COVID-19 pandemic. They conceptualize “care infrastructure” in terms of sources of care like childcare providers, home-based services, and community supports, as well as policies that determine care decisions like paid family leave. They argue that the lack of a more robust care infrastructure contributed to both the health and economic hardships of the COVID-19 crisis. They advocate for investments in care infrastructure as an economic recovery and equity strategy, claiming that investments in care infrastructure can generate twice as many jobs per dollar as construction of physical infrastructure, and arguing that “without investing in care infrastructure, women, and especially women of color, will not be able to fully participate in the rebuilding of our economy, prolonging the recession, undermining gender and racial economic and workplace equity” (Kalipeni & Kashen, 2020, p. 5). These proposals have gotten traction from the current Biden administration and are reflected in the Biden Administration’s *American Jobs Plan* as well as in other legislative efforts, including Boston-area Congresswoman Ayanna Pressley’s move to establish a federal job guarantee (Federal Job Guarantee Resolution, 2021; Tankersley,

2021). Given this increasing move towards investment in care infrastructure in service of economic development and racial and gender equity, the question of planning's role in supporting and advancing such an agenda is pressing.

Labeling something as an infrastructure is an epistemological and political “categorizing moment” (Larkin, 2013, p. 330). After all, infrastructures reflect a society's (typically contested) vision of interdependency and welfare. In this vein, Schwenkel (2013) shows how infrastructures can engineer and sustain specific forms of subjectivity vis-à-vis the state, and argues that the state's provision of infrastructure is itself a form of paternal care. Considering the relationship between infrastructure and structures of power in society, Berlant (2016, p. 393) suggests that the concepts of structure and infrastructure are intertwined: structure “organizes transformation,” she says, while infrastructure “binds us to the world in movement” and establish “world-sustaining relation[s].” And thus, assuming of course that social structures are not static, key questions emerge with respect to infrastructures of care. What forms of subjectivity, citizenship, empowerment, subordination, inclusion or exclusion do they engender? What structures-in-process do infrastructures of care bind us to? Moreover, given the normative orientation of planning as a field this question extends to whether these are the structures we *should* be bound to, and if not, what structures might we build infrastructures of care towards and how?

Under neoliberalism, as under previous eras of capitalism, the heteropatriarchal nuclear family is posited to be the ideal infrastructure of care – which is an insufficient, unreliable and unjust way to fulfill the imperatives of social reproduction (Cooper, 2017; Dalla Costa & James, 1975; Federici, 2012). As discussed in the previous section shows, this has been reflected in patterns of urban development and urban policy. A recent manifesto calls for a politics of “universal” and “promiscuous” care as part of a vision for “a world that takes the idea of care as its organizing principle seriously” (The Care Collective, 2020, p. 19). Such a vision draws inspiration from the radical politics of LGBTQ social movements that sought to expand relations of intimacy and care beyond the forms permitted under heteropatriarchy, as well as groups like the Young Lords and Black Panthers who sought to establish community-based forms of social provision to ensure that the needs of communities of color were met in the face of racist state policies

and systemic neglect. The Care Collective call for an ethics of promiscuous care – “all forms of care should be valued, recognized and resourced equally” (2020, p. 40) – and urge us to think more capaciously about the sources of care beyond the market and the family and proliferate the types of care that are available, with the goal being to make people feel secure enough to care for strangers as kin. Planners can play a role in such an effort by undoing the patterns producing landscapes of stratified social reproduction in the city and by investing in and supporting more robust urban infrastructures of care that equitably distribute the means of social reproduction across urban space.

2.5.2 *Care, governance and harm*

Within anthropology, care has become an increasingly important site for understanding forms of governance, and there is increasing consensus that the notion that care is inherently good may obscure practices of power and control operating in the name of care, which in turn may cause harm or perpetuate suffering (Buch, 2015). If planning is to take care as its object, and/or if planning practice seeks to become more caring, it will be necessary to be mindful of the ways that when planning is used as a tool of the state, it has the potential to replicate these patterns and harmful outcomes.

The foundation for much of the scholarship on care and governance is Foucault’s (1988, 1990, 2008) concept of biopolitics. Through a series of investigations into the history of asylums, prisons, and clinics, Foucault (1965, 1973, 1990, 1995) traces the evolving sensibilities of the state about its duties of assistance to those populations rendered unmoored and without resources in the transition to capitalism. He reveals how these institutions evolved in the eighteenth and nineteenth centuries via emerging practices of observing, reforming, converting, and categorizing people – he called these practices *governmentality*. In the transition to industrial capitalism, he argues, *population* came to be seen as an element of present and future wealth, and thus the population required maintenance as manpower for the growth of the nation. *Governmentality* became the means of disciplinary power through which governments could control citizens qua *population*. He argues that a specific form of governmentality emerged that was driven by

the goal of consolidating *power over life* via the control over the health and welfare of populations.

Foucault called this form of governmentality that deals with control over life *biopower*. As a form of power “bent on generating forces, making them grow, and ordering them,” (Foucault, 1990, p. 136) biopower is a form of regulation in the name of care. He argued that biopower had two core functions: the regulation of biologic processes at the level of the population, and technologies of discipline at the level of the individual (Hanna & Kleinman, 2013, p. 28). This was governance based on care, but crucially, the object of this care was the *population* as a statistical concept rather than actual individuals.

Anthropologists have demonstrated that biopolitical regimes of care directed at populations demonstrate two intertwined tendencies: they are universalizing, and they are anonymizing. For example, Ticktin (2011) has shown how a belief in the universality of suffering – and, correspondingly, that suffering can be identified, measured and understood at the level of the biological body - ingrained in humanitarian exceptions to French immigration rules, through which undocumented immigrants who are ill or who have/will experience gender-based violence may pursue legal residency in France. To remain legitimate sufferers in the eyes of the state, immigrants are forced to abandon other identities and the task of building a new life, with the result being the reproduction of a group of second-class citizens who must maintain lives defined by suffering and debility. Likewise, Biehl (2009) has shown how Brazil’s efforts to universalize access to anti-retroviral drugs to treat AIDS resulted in the pharmaceuticalization of public health whereby public health came to be centered on pharmaceutical distribution rather than individual care, and medicines came to be equated with healthcare. Under this regime of care, segments of the population who were unable to properly maintain adherence to pharmaceutical regimes were stigmatized as noncompliant and their subsequent deaths rendered inconsequential. Finally, Stevenson (2014) has characterized the Canadian government’s attempts to care for Inuit suffering from tuberculosis as “anonymous care” because the state’s care tended to life itself, measured in terms of population statistics, over actual Inuit lives and ways of life.

In an effort to imagine forms of care beyond biopolitics, Stevenson has offered the notion of *song* to describe “forms of recognition that do not depend on...fixing the identity of another person” and which instead figure forms of attention that “make space for the existence of another” and “recognize their potential as company, [and] recognize them as lovable kinds of beings, capable of showing up regardless of any subject positions they may have been asked to occupy” (Stevenson, 2014, pp. 157, 163). Following in Stevenson’s footsteps, Zigon has suggested that taking care of life must become a form of “attunement to the singularity of whoever arrives” (Zigon, 2019, p. 134) rather than a process of normalization or anonymization.

Mol has argued that “good” care isn’t something that can be defined in general terms or as a matter of principle – as biopolitical regimes of care may seek to do. Instead, she argues that defining good care is part of the process of caring, which she describes as one of “tinkering” and experimentation with “more bearable ways of living in – or with – reality” (Mol, 2008, p. 53). This is because care coheres in forms local to particular worlds with their own modes of organizing action and interaction, understanding bodies and lives, and distinguishing between good and bad. Thus, she argues, “good” care inherently varies according to the context and subject of care. For planners, this means we cannot reach a predetermined conclusion about how best to care for vulnerable populations; this would risk reproducing the universalizing and anonymizing tendencies of biopolitical forms of care.

I would contend that two of the merits of an infrastructural approach to planning for care are that it (a) does not explicitly seek to provide care itself, but rather full and equitable access to the means for care, and (b) does not require determining whether care is “good”. While it does rest on state resources and intervention, in my opinion it is possible for such an approach to avoid some of the pitfalls of anonymizing and universalizing forms of care on behalf of the state. However, there is still risk of harm associated with the necessity of identifying what counts as care to begin with in order to identify what activities merit what forms of infrastructural support.

2.5.3 *Planning for care, planning for health*

So far, I have sought to establish care and social reproduction as key urban planning concerns. I have shown that they are key aspects of everyday life for most people along the life course, but also key sites of gender and racial inequity because of the ways that, as work, care and social reproduction are made invisible and de-valued. I have shown further that urban development since the industrial revolution has contributed to the invisibility and devaluation of social reproductive work, and that we can understand the relationship between social reproduction and the production of urban space using the concept of landscapes of stratified reproduction. Based on this analysis, I have argued that one strategy for building on feminist planners' efforts to achieve gender equity in cities is to use planning tools to alleviate the inequitable stratification of reproduction by planning *for care*. I have advocated for doing so using an infrastructural approach that seeks to ensure equitable access to the affordances of the city that caregiving depends on. Investing in the infrastructure of care, I have argued, stands to help planners advance gender and racial equity in cities. Another perhaps obvious potential of investing in the urban infrastructure of care is the opportunity to improve public health and advance health equity. Care, after all, is inextricable from health across the life course, not only during periods of intense illness or disability, but on an everyday basis. Thus, in the next section, I argue that planners can expand the scope of their efforts to achieve healthy cities by planning for care in addition to the preventative and health promotion approaches that currently encompass most planning for health.

2.6 Planning and Health

Health is the ability to adapt to one's environment. It differs for each individual according to their circumstances and should be understood in reference to their "preferential behavior" as opposed to an abstract or quantitative standard (Canguilhem, 1989; Lancet, 2009). The health of the individual is inextricably connected to the health of their society and to planetary health, and accordingly, patterns of health and health inequities are largely explained by the social, material and ecological contexts in which

people grow, live and work (Krieger, 2013). The term “embodiment” is used to describe the process through which our environment – social, economic, political, ecological – gets under the skin, and thus how features of our society come to shape population-level patterns of health, disease and well-being (Krieger, 2005). A growing body of research demonstrates that the ways we embody urban environments – and thus, planning processes and outcomes – profoundly shape individual and population health patterns and outcomes.

Planners, public health professionals, and other social reformers have long understood that the conditions in which we live shape our health and our life chances. Indeed, the planning field has strong roots in the public health response to the ills of industrial society in the 19th century, when epidemics of infectious diseases like cholera forced municipalities to pay more attention to the relationship between the environment and health (Corburn, 2009; Taylor, 2009). Many of these early interventions in areas like sanitation and housing coincided with the work of, and were in some cases championed by, reformers in the municipal housekeeping and material feminist movements mentioned above. Over time, however, public health and urban planning became increasingly disconnected, due in part to the expansion of bureaucratic and technocratic public management and professional specialization, as well as the ascendance of the biomedical model of public health by the mid-20th century as the health gains achieved by sanitary engineering began to reach their limit (Corburn, 2009; Krieger, 2013; Sze, 2007).

During the post-war years, urban planning and public health institutions remained largely separate. Unfortunately, planners ignored the public health impacts of dispossession wrought by the destruction of poor neighborhoods via policies such as urban renewal (Fullilove, 2005). The result was deepening health inequities for the urban poor and poor people of color. Beginning in the 1960s, it was citizen activists rather than public health and planning institutions who successfully linked public health and urban planning concerns. These efforts included the creation of free clinics by the Black Panther Party and the Young Lords, and the birth of the environmental justice movement (P. Brown, 2007; Loyd, 2014; A. Nelson, 2011; J. Nelson, 2001). The environmental justice movement offered a framework for social change that integrated planning and public

health to analyze the unequal distribution of toxic sites, and built a decentralized networked movement of community groups to respond to and prevent local environmental health hazards (Brulle & Pellow, 2006). These grassroots efforts coincided with the emergence of the advocacy and communicative planning approaches within the urban planning field (Hall, 2014).

Academics and activists began to reconnect urban planning and public health in the 1980s, for example via the World Health Organization's Healthy Cities Project (Rydin et al., 2012). This has coincided with increasing debate among epidemiologists about the social and economic determinants of health inequities, the emergence of social epidemiology as a distinct field (Berkman & Kawachi, 2014), and the emergence of theories of disease distribution such as ecosocial theory that challenge the hegemony of the biomedical model and direct the attention of public health practitioners to the social, economic, and environmental determinants of health inequities (Krieger, 2013). Today, planning is increasingly seen as a form of "preventative medicine" intervening in the built environment and living conditions that make people sick – and that produce health inequities – in the first place (Corburn, 2015).

Research in recent decades has explored a wide variety of ways through which planning interventions, as well as characteristics of and changes to the built environment more broadly, shape a vast range of health outcomes and population health patterns. The bulk of this research has focused on how physical changes in the built environment impact discrete physical health outcomes – like asthma (Corburn et al., 2006; Eisenman et al., 2019), cardiovascular disease (Nieuwenhuijsen, 2018), or obesity (Durand et al., 2011; Rundle et al., 2007). Some research has focused on how the built environment shapes health across different aspects of the life course, such as childhood development (C. Brown et al., 2019; Goldfeld et al., 2019) or aging (Dragan et al., 2019; Plouffe & Kalache, 2010; Steels, 2015). While some research has explored how place-based changes impact mental health (eg. Fullilove, 2005; Galea et al., 2005; Negami et al., 2018) mental health outcomes remain relatively understudied compared to physical health outcomes. More broadly, a vast body of research demonstrates important associations between the built environment of cities and social characteristics of

communities such as social capital, collective efficacy, and social support, as well as economic outcomes and patterns such as inequality and poverty, that have well-established connections to health (Duncan & Kawachi, 2018).

Less attention has been devoted to how cities shape the lived experience of health – understood as the constant process of adaptation to one’s environment – and how people navigate and manage health challenges. In the more traditional public health vein, most prominent example of research in this vein concerns “health behaviors” such as walking and cycling (Frank et al., 2019). Separately, health geographers have explored how places may be therapeutic, restorative, or “enabling” of health, for example by studying the role of place in recovery from mental health problems or the management of substance use disorders, or “disruptive” in the case of green gentrification (Andrews, 2017; Duff, 2011, 2016; Triguero-Mas et al., 2021). However, to date research in this vein has been largely absent from discourse at the intersection of public health and planning, likely in part due to difficulties translating findings into practice. Overall, however, research has focused on health as outcome rather than process.

Of the emerging work on how urbanization and the built environment shape caregiving practices and relations across various scales, to the best of my knowledge none examines care as a key ingredient of health and potential mediator between changes in the built environment and health outcomes. However, there is a considerable amount of research on the ways that neighborhoods may impact caregiving relationships or the work of care by shaping different aspects of reproduction and dependency across the life course. For example, one recent study found that eviction was associated with low birthweight and premature birth, adding to evidence that unstable housing during pregnancy is associated with adverse health outcomes for both parents and children (Schwartz et al., 2021). Such health challenges would likely be financially and mentally taxing for caregivers, potentially increasing the strain and toll of caregiving. A growing body of work points to neighborhood conditions, like racial/ethnic and economic segregation, as an important causal factor for preterm births, with intergenerational consequences (Shrimali et al., 2020). Caregiving is the means by which such health consequences are navigated and negotiated over the life course. Similar considerations are

also relevant to the health of seniors with the rise of aging-in-place, a phenomenon that is now being studied in relation to gentrification (Forsyth et al., 2019; R. J. Smith et al., 2018; Versey, 2018).

Not only does investing in the urban infrastructure of care promises to improve health outcomes across the life course, it also represents one strategy to shift from planning for health to planning for health equity. Health equity is the commitment to reducing disparities in health and its determinants, and is central to the broader project of social justice (Braveman, 2006; Sen, 2002). Health inequalities and their determinants are rooted in the broader social, political and economic structures that produce racial, gender, and class inequities (Birn et al., 2017). This includes the devaluation of social reproduction and the contradictions in capitalist systems that produce crises of care, as well as their consequences for the unequal distribution of the burden of social reproductive labor. Health equity challenges are among the greatest equity challenges facing planners today, and planners have been encouraged to understand their cumulative impacts via a toxic stress framework (Corburn et al., 2015). By exploring how care depends on the urban environment, this dissertation stands to advance our understanding of how to invest in urban infrastructures of care in ways that reduce racial and gendered inequities associated with social reproduction and thereby advance health equity.

2.7 Wellbeing, Capabilities and Livability

How can we evaluate the impact of investments in the urban infrastructure of care on progress towards greater health equity, social justice, and wellbeing in cities? On one level, as indicated above, we can measure changes in health disparities. However, a broader normative framework through which to evaluate efforts to plan for care would also be advantageous, since goals like justice and wellbeing are not always easily measurable. In this section, I review recent progress in attempts to conceptualize and measure wellbeing, and focus in on one strategy for doing so called the capabilities approach. I argue that planners seeking to evaluate efforts to plan for care would benefit from adopting a modified version of the capabilities approach, according to which we can

measure progress towards health equity, social justice, wellbeing and urban livability in terms of the freedoms people have to care for one another.

“Wellbeing seems to be on everybody’s lips” across the social sciences and in public and policy discourses as well as in popular culture, write Andrews and Duff (2020). Concern with human wellbeing is at the historical root of modern social science, and today, wellbeing is a burgeoning area of research across the social and medical sciences. A significant body of work explicitly considers well-being, while an even broader range of work implicitly considers the concept – it is “a value in which the studies of many other concepts bottom out” (Alexandrova, 2017, p. 2). In the past and in the present, the story of the science of wellbeing is one concerning the role of scientific knowledge in efforts to improve the human condition. In this respect, the science of wellbeing is inherently tied up in judgements about what makes a good life (Alexandrova, 2017).

Contemporary social scientific interest in the concept of wellbeing originates in the mid-20th century. During this era, definitions of wellbeing centered on positive mental and physical health and the ability to fulfill basic personal needs, with correspondingly liberal notions of justice characterized by the fair distribution of basic goods (Fleuret & Atkinson, 2007; Maslow, 1954; Rawls, 1971). Beginning in the 1980s, needs-based definitions of wellbeing came under critique for not adequately taking into account different types of variation between people, and more relativistic approaches to wellbeing emerged like the “capabilities approach” (discussed in greater detail below) and other components-based approaches to wellbeing (Andrews & Duff, 2020; Fleuret & Atkinson, 2007; Sen, 2000). Components-based approaches have also since been critiqued for treating wellbeing as a definable and desirable endpoint, and scholars have subsequently turned to more fluid questions of affect and assemblage to understand wellbeing more openly and as an emergent and relational process (Andrews & Duff, 2020; Atkinson, 2013; Duff, 2014; A. Power et al., 2018). However, while process-based approaches to wellbeing are valuable for scholarly purposes, they are not as readily applicable in a practice-oriented field like planning at this stage, nor are they as operationalizable as components-based approaches, which inhibits near-term collaboration with fields like public health on spatial approaches to wellbeing. Additionally, at their core, both the capabilities approach and subsequent

process-based approaches conceptualize wellbeing fundamentally in terms of freedom. Thus, next I will turn to consider the capabilities approach in more detail, both its components and its critiques.

2.7.1 The capabilities approach: definition and key terms

The capabilities approach was introduced by economist Amartya Sen (1979) in response to shortcomings he perceived in utilitarian and Rawlsian theories of justice, both of which have informed contemporary notions of justice in planning (Reece, 2018; Steil & Connolly, 2017). First, Sen argues that the utilitarian emphasis on equality of marginal utility as the basis of justice was insufficient because it ignored differences in levels of disadvantage and intensities of need. Then, he argues that Rawls' framework of justice (Rawls, 1971) makes the mistake of being "concerned with good things rather than what these good things do to human beings" (Sen, 1979, p. 219). He insists that Rawlsian justice also renders disadvantage irrelevant, assumes that peoples' needs are fundamentally similar when in reality they are fundamentally diverse, and ignores the importance of happiness and desire-fulfillment. Ultimately, Sen concludes that both the utilitarian and Rawlsian frameworks of justice inadequately account for life's complexity and the fundamental diversity of human beings (Sen, 2000).

Sen contends that a notion of basic capabilities, or some reflection of a person's ability to do basic things that they value, is what is fundamentally missing from the utilitarian and Rawlsian theories of justice (Sen, 1979). He suggests that focusing on capabilities shifts the locus of justice from goods themselves to what goods enable for human beings, which he argues is necessary because the conversion of goods to capabilities varies substantially from person to person (Sen, 1995a). In his subsequent work (Sen, 1995b, 2000, 2004a, 2004b, 2005) Sen has developed the framework that has come to be known as the "capabilities approach." Sen's work has been complemented and developed by that of philosopher and legal scholar Martha Nussbaum, who has made efforts to refine the capabilities approach for application to the challenges of human development at a global scale (Nussbaum, 2001, 2002, 2003, 2006, 2013).

The capabilities approach has two central concepts: functionings and capabilities (Sen, 1979). Functionings are the various things a person may value doing or being, which may range from basic needs like food and shelter to complex experiences like a sense of belonging or leadership. Capabilities are a person's real freedoms or opportunities to achieve those functionings that they have reason to value (Hick, 2012; Sen, 1979, 2000). For example, if learning to play the piano is a functioning that someone values, the capabilities required to do so may include access to a piano, time and space to practice, and/or the availability of instruction. As a framework for evaluation and comparison, the capabilities approach thus offers both a metric of achieved well-being, in the form of functionings, and a metric of the freedom to pursue well-being, in the form of capabilities (Robeyns, 2016). Sen (1979) argues that on an individual level, equity in terms of wellbeing freedom matters more, but Robeyns (2020) points out that on a collective level, inequities in achieved wellbeing indicate inequities in wellbeing freedom.

The capabilities associated with specific functionings can be complex and may vary across individuals and settings. Nevertheless, proponents of the capabilities approach have also debated whether to specify a universal set of 'central capabilities' that would apply to any measurement of wellbeing, no matter the context, and capture the core moral entitlements of all human beings. Nussbaum (2001, 2003) has been the strongest proponent of 'central capabilities' and has attempted to articulate the "basic social minimum" of capabilities that reflect "what respect for human dignity requires" (Nussbaum, 2006, p. 70). Nussbaum's list of central capabilities includes: life; bodily health; bodily integrity; senses, imagination and thought; emotions; practical reason; affiliation; other species; play; and control over one's environment (Nussbaum, 2003, pp. 41–42). She argues that within each of these central capabilities there is a threshold level beneath which human functioning is not truly available, and thus these capabilities should also form the basis of political goals to get each person above the threshold. Sen (2004a), on the other hand, has declined to specify central capabilities, insisting instead on the importance of leaving the question of central capabilities open as a matter of public deliberation within specific communities. I am partial to Sen's view on this matter and agree with other scholars who have suggested that the approach should be broad and

tailored via application in a context-specific manner (McCallum & Papadopoulos, 2020; Robeyns, 2017).

2.7.2 Planning and the Capabilities Approach

For use in planning research and practices, the capabilities approach has a number of advantages as a way to conceptualize wellbeing. It generally corresponds with peoples' lived experiences in terms of how wellbeing is conceptualized (Robeyns, 2020). Empirical studies in fields like health economics and human development have shown that people formulate their wellbeing in terms similar to the capabilities approach (Coast, Flynn, et al., 2008; Coast, Smith, et al., 2008; Conradie, 2013). Additionally, HNS Resident Researchers developed a survey instrument to measure respondents' ability to fulfill their most important priorities, which we have argued also seeks to measure wellbeing in capabilitarian terms (Binet et al., n.d.). The capabilities approach is multi-dimensional and pluralistic, which affords context specificity within a larger overall framework that enables comparison, but it also operates at a relatively low level of abstraction, which makes it amenable to activities like planning and policy-making (Robeyns, 2020). The capabilities approach is agency-oriented, and sees people as agents of change rather than just "passive recipients of dispensed benefits" (Sen, 1999, xiii). The capabilities approach can be used to understand the relationship between place and wellbeing through the lens of the functionings and capabilities afforded and affected by the places where people live (Robeyns, 2020; Shinn, 2015).

From the perspective of the capabilities approach, the role of government, policy or planning is focused on strengthening capabilities – freedoms to be and do things of value – rather than just delivering services. The capabilities approach shows that we can shift our conceptualization of spatial justice from how spatial goods are distributed to whether the distribution of spatial goods makes people more capable of realizing functionings that they value, and functionings which respond to their demands for justice (Basta, 2016). In this way, the capabilities approach also affords planners the ability to sustain plural conceptions of justice rather than taking a one-size-fits-all approach to evaluating whether

processes and outcomes are just, which is advantageous in diverse contexts. The key insight from the capabilities approach for planners is that it is not spatial goods themselves that guarantee wellbeing and equality of opportunity, but “the relational condition between individuals’ capabilities and the good enhancing them” (Basta, 2016, p. 213). This means that planners must ask what spatial goods *do* for those they are provided to, and understand the reach of their interventions not just in terms of the provision of spatial goods, but also how spatial goods enhance the capabilities of their intended recipients.

In developing her concept of the “just city”, Fainstein (2010) argues that the basic elements of justice are democracy, equity, and diversity, but demonstrates that there are tensions within and between these values that planners must navigate. The capabilities approach, she suggests, is well-suited to figuring out how to apply these norms within particular contexts to realize the just city, as well as evaluating plans, policies and programs from the perspective of whether the outcomes enhance the capabilities of the relatively disadvantaged among a population. It is, she argues, “the most fruitful of the various philosophical strategies regarding justice applicable to urban governance” (Fainstein, 2010, p. 54). Similarly, Deneulin (2014) has suggested that the concept of the “right to the city” can be understood in terms of the capabilities approach, and argues that the capabilities approach can make important contributions to right to the city movements, including improved tools for wellbeing evaluation and a better understanding of how different dimensions of wellbeing positively or negatively affect each other.

Despite its advantages, application of the capabilities approach in the urban planning field has unfortunately been limited to date. Nevertheless, emerging contributions are promising. Scholars are beginning to apply the capabilities approach to evaluate progress on planning-related issues such as housing, social inclusion, and the role of arts in community development. For example, Frediani (2019) has applied the capabilities approach through participatory methods to examine the impact of squatter upgrading initiatives on residents “housing functionings” in Salvador da Bahia, Brazil. Frediani’s research employed the concept of the “capability space” which contains the individual, local and structural “conversion factors” that enable people to transform goods or resources, like a shelter or a bicycle, into achieved functionings like a sense of home or

mobility. Relatedly, Kimhur (2020) argues that the capabilities approach should be used to develop a housing policy framework to respond to challenges related to the financialization of housing, its disconnection from its social function, and the rise in evictions and displacement worldwide. Other applications of the capabilities approach relevant to planning include Zitcer et al. (2016) use of the capabilities approach to understand the contribution of arts and culture to community development, Fennell et al.'s (S. Fennell et al., 2018) use of the capabilities approach to explore strategies for human-centered housing development, and Hananel and Berechman's (2016) framework for incorporating the capabilities approach into transportation planning in order to reach more just outcomes. All of these scholars have suggested that the capabilities approach can help planning scholars and practitioners extend the reach of their investigations or interventions to ensuring that these goods can be used to expand the capabilities of residents in ways that allow them to achieve functionings of value.

While the planning field is still just beginning to take up the capabilities approach, allied fields have also made progress incorporating the capabilities approach as both theoretical and empirical tool. For example, environmental justice scholars have advocated for the use of the capabilities approach as a conceptual tool to expand the field's notion of justice beyond the distributional concerns in which the field has its origins, and posit wellbeing as the ultimate goal of environmental justice (Edwards et al., 2016; Schlosberg, 2007; Walker, 2009). Moreover, they have argued that the capabilities approach is useful in helping to know when and how different environmental outcomes should be understood as injustice, and how to accommodate pluralistic justice claims made in everyday practice across grassroots environmental justice movements. Sen (2002) has suggested that health equity should be understood in terms of capabilities, and scholars in public health and social epidemiology have used the capabilities approach to understand how powerlessness and lack of "control over destiny," including in relation to the built environment, underlie and perpetuate socio-economic inequities in health outcomes between different groups (Whitehead et al., 2016). Other applications in the field of public health include Hopper's (2007) argument that the capabilities approach enables researches to account for the contextual dynamics of health outcomes, and White

et al.'s (2016) observation that the capabilities approach can help health scholars consider how space and place can afford opportunities to enhance mental wellbeing. Similarly, Shinn (2015, pp. 247–248) has made a case for integrating the capabilities approach into the field of community psychology, and has demonstrated the potential of that field to develop theory about how social settings such as neighborhoods, schools, and social programs can foster capabilities by acting as “mediating structures” between individuals and society that create opportunity and empowerment.

2.7.3 Critiques of the Capabilities Approach

There are two major critiques of the capabilities approach. The first is that it is overly individualistic and ignores human interdependency and relationality. The second is related, and is that it elides structural considerations and the realities of capitalist systems. Both critiques are valid under certain applications of the capabilities approach, but as I show below, many scholars have shown that the capabilities approach is not *inherently* individualistic and that there are relational ways to apply it. On the other hand, the charge that the capabilities approach elides structural considerations has more standing, in my opinion, and I argue that for the purposes of urban planning it must be paired with a structural analysis and normative vision for structural change.

Dean (2009) has charged that in the capabilities approach, “the priority is individual liberty, not social solidarity” and that while in the approach the content of a good life is individually-determined, “human beings cannot be free from their dependency upon other beings.” While the capabilities approach’s origins are within a liberal-individualist framework broadly writ, many have responded to this critique by showing the ways in which the capabilities approach need not necessarily be individualistic in its application. “It is a foundation that must be built on, not just admired,” says sociologist Peter Evans (2002) in his illustration of how individual capabilities depend on collective capabilities and how enhancing the latter also benefits the former. Closer to home in the planning field, Susan Fainstein (2010) has argued that while the capabilities approach does emphasize the individual, it also understands individuals as existing within a network

of social and emotional relationships, not as atomized entities whose freedom and wellbeing is independent of that of others. She recommends employing the capabilities approach via a communal, rather than individualistic, ethic to ensure that urban residents do not have to sacrifice quality of life for the financial gain of a select few. Others have argued that the capabilities approach's focus on individuals should actually be understood as an emphasis on understanding justice and wellbeing in terms of agency, while still agreeing that individuals should be understood as embedded in networks of social relations through which structural forces are both experienced and reproduced (S. Fennell et al., 2018; Frediani, 2010). Environmental justice scholars have similarly suggested that the capabilities approach should be extended to include functionings at the collective level (Schlosberg, 2007; Walker, 2009). Thus, whether the capabilities approach is individualistic or not depends on how it is applied, and I follow the footsteps of other scholars who argue that it should be applied in a collectivist, communal, or relational manner rather than an individualistic one.

The second critique of the capabilities approach is that it neglects the nature of capitalism – such as the ways in which under capitalism individuals are not free from control over or exploitation of their actions, choices or values – and does not address “the systemic impediments to human freedom that are associated with the capitalist mode of production” (Dean, 2009, p. 9; Evans, 2002). I think this critique has more standing, and is substantiated by the extent to which liberal/neoliberal development institutions like the United Nations have incorporated the capabilities approach into their work (Fukuda-Parr, 2011). However, I don't think this critique means that the capabilities approach should be abandoned, and rather that it must be integrated with – or used in service of – a structural analysis and framework for change. Moreover, I would argue that “building on” the capabilities approach, as Evans suggests, using a communal or relational ethic following Fainstein, alleviates much of these concerns.

Notably, Dean (2009) himself cited the relational ontology of care ethics as an alternative approach to what he saw as the individualism of the capabilities approach. Perhaps this suggestion might also be extended to address his own critique of the neglect of structural factors associated with capitalism in the capabilities approach. If a care-

inspired relational ontology is adopted to understand how capabilities are attained, perhaps we could also draw on the theory of social reproduction to better understand the structural conditions that enable or inhibit capabilities and shape their uneven distribution across space. Doing so might help us plan for infrastructures of care that not only equitably distribute the means of social reproduction, but the conditions for freedom vis-à-vis care – that is to enhance the capability set underlying caregiving to ensure that caregivers can care and be cared for on terms that they value. With a focus on enhancing the freedoms of those who have been disempowered by urban planning and development, such an effort could help realize the promise of emancipatory and anti-subordination planning approaches (Anguelovski et al., 2020; Steil, 2018; Steil & Delgado, 2019).

2.7.4 Planning for livability and wellbeing

Care and social reproduction are central to our wellbeing over the life course, and are central aspects of urban life. Care and social reproduction are also central axes of structural racial and gender inequities and sites of their reproduction via how care and social reproduction are organized and valued within society. These inequities have been reproduced via the production of urban space since the industrial era: cities are landscapes of stratified reproduction. However, planning does not yet have ways to attend to the ways in which urban processes shape social reproduction, nor frameworks for intervening in cities to produce more equitable relations of social reproduction.

I have advocated for an infrastructural approach to planning for care, focused on how cities enable or impair the work of social reproduction, because it is useful for both analysis and intervention and draws on existing skillsets in planning. I also argue that taking up the urban infrastructure of care as an object for planning research and practice is a tremendous opportunity to both broaden and deepen ongoing efforts for using planning as a tool to advance public health. If health is defined as the ability to adapt to changes in one's environment, a robust infrastructure of care is necessary for health because by facilitating the equitable distribution and widespread availability of the urban ingredients

of social reproduction, it would afford the greatest degree of freedom with respect to giving and receiving care. Doing so also stands to advance the cause of health equity, and thereby social justice more broadly.

Over and above health itself, planning for care brings us to questions of wellbeing more broadly, and questions about what livability entails. Livability is a core ‘planning idea’ but is not well-, consistently-, or comprehensively-defined (Sanyal et al., 2012). As a normative field, planning should have a robust vision for the livable city that extends beyond the ability to achieve stability under capitalist conditions. Perhaps what makes a city livable is the extent to which it affords all of its residents to give and receive care freely, that is, on their own terms and in ways that they value, in accordance with individual and collective visions of wellbeing. To move in this direction, planners can turn their resources and skills towards investing in urban infrastructures of care with the goal of ensuring the greatest possible access to the widest possible range of caregiving possibilities – including self-care – in accordance with an ethic of promiscuous, universal care.

One way to evaluate progress towards this version of the livable city is via the capabilities approach. We can and should employ the CA in a relational rather than individualistic manner, understanding that one person’s freedoms depend on another’s, and in a manner that recognizes how the structures of a capitalist society impair freedom, including via how social reproduction is socio-spatially organized. In this dissertation, I seek to provide a model for doing so by evaluating how changes in the urban infrastructure of care impact caregiving from the perspective of the capabilities approach. Specifically, I seek to examine how gentrification impacts caregiving and, in turn, caregiver wellbeing and stress, and I turn to these topics next.

2.8 Gentrification, Health and Stress

This dissertation examines matters of care and social reproduction in relation to the process of gentrification, and with an interest in how the effects of gentrification on “life’s work” may influence health outcomes and health equity. In terms of health outcomes, I

am particularly interested in stress, given that this is an understudied but high-priority outcome of interest among researchers who study the relationship between gentrification and health, including HNS Resident Researchers (Anguelovski et al., 2019a; Binet et al., 2021; Schnake-Mahl et al., 2020b). Moreover, stress is a significant health consequence of caregiving responsibilities, and indeed a number of foundational contributions to contemporary stress research stem from the study of caregiver stress (Pearlin et al., 1990). In what follows, I review the state of research into gentrification and health; by and large, there are many questions and to date, few clear answers but considerable progress. Then, I review research on stress broadly, caregiver stress specifically, and finally gentrification and stress. I conclude by specifying what I intend to contribute to the study of stress and the study of the relationship between planning and health more broadly.

2.8.1 Gentrification and Health

In the effort to more fully understand the potential harms of gentrification, attention has also turned to the health and economic consequences of gentrification for lower-income residents. Since gentrification results in higher area-level socioeconomic status, some researchers have indicated that residents of gentrifying neighborhoods may experience health benefits via pathways including poverty deconcentration, better quality food options, improved access to amenities and city services, and new economic opportunities (Balzarini & Shlay, 2016; Freeman, 2006; Schnake-Mahl et al., 2020a; Sullivan, 2014; Zukin et al., 2009). On the other hand, researchers have also noted that gentrification could negatively impact health by exacerbating economic inequality, eroding social cohesion, and leading to residential, cultural and commercial displacement (eg. Anguelovski et al., 2019; Cole, 2020). Exposure to gentrification should be understood to interact with race/ethnicity, gender, class, and neighborhood tenure to produce different health impacts for different residents (Gibbons, 2019a; Gibbons & Barton, 2016; Hill et al., 2005b). Scholars have called for more qualitative research to advance our understanding of the lived experience of gentrification and illuminate causal pathways and sub-population effects that help us understand how this experience gets

under the skin and, in turn, shapes individual- and population-level health outcomes (Anguelovski et al., 2019a; Cole, 2020b; Ellen & Captanian, 2020; Schnake-Mahl et al., 2020b). Qualitative and participatory methods are also well-suited to understand the experience of caregiving and the subjective dimensions of stress (Buch, 2015; Kleinman, 1988).

2.8.2 Stress

Among researchers focused on the intersection of health and place, stress – and mental health more broadly – has received less attention than health behaviors and physical health outcomes like asthma or obesity. I don't intend to make an elaborate case for why mental health is equally important domain of the relationship between health and place – others have done (Curtis, 2016; Parr, 2008). Suffice to say that stress is both an important pathway through which we embody our environment, as well as an important health outcome in its own right that profoundly influences one's quality of life. As such, it should be of principal concern to urban planners interested in both health and livability more broadly. Moreover, since stress is produced through an individual's relationship with their environment, it is particularly amenable to planning and place-based interventions.

Stress is a continuous process of feedback between the inner lives of individuals and the environments and social structures that they are a part of (Lazarus & Folkman, 1984; Pearlin et al., 1981). Stress research has been conducted across three related traditions: environmental, focused on stressful life events; psychological, focused on the individual's perception and evaluation of potential harm; and biological, focused on the activation of physiological systems in response to physical and psychological demands (S. Cohen et al., 1997). Across all three traditions, there is a common understanding that stress is “a process in which environmental demands tax or exceed the adaptive capacity of the organism, resulting in psychological and biological changes that may place a person at risk for disease” (S. Cohen et al., 1997, p. 3). Below I will briefly elaborate on key aspects of each tradition that inform my analysis in subsequent chapters.

The psychological tradition focuses on an individual's subjective assessments of threats to their wellbeing. The classic stress model in the psychological tradition was developed by Lazarus and Folkman (1984), and has been used in recent research exploring the relationship between stress and changes in urban built environments (Binet et al., 2021; Gibbons, 2019b; Yang & Matthews, 2010). Lazarus and Folkman's model is based on two key concepts: appraisal and coping. Appraisal is a subjective process, shaped by both personal and environmental factors, by which an individual evaluates "transactions" between themselves in their environment. Lazarus and Folkman (1984) identify three specific patterns of appraisal, all of which are relevant to caregivers' experiences of change in the urban environment: harm, comprising damage or loss that has already happened; threat, defined as anticipation of imminent harm, and challenge, referring to demands that a person feels some degree of confidence about overcoming. Coping refers to "the constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). Coping is process-oriented, and coping actions can be problem-focused or emotion-focused. Stress occurs when a transaction with the environment is appraised by a person as taxing or exceeding their coping resources, and thereby endangering their wellbeing.

While psychologists have explored processes of appraisal and coping, sociologists working in the environmental tradition of stress research have focused on stressful life events and their social patterning. Important to note is the fact that this "environmental" focus was primarily social in nature, referring to objective events external to the individual's psychology such as divorce, death of a family member, or job loss, rather than environmental domains perhaps more familiar to planners like housing. Research in this domain often draws on Pearlin's "stress process model" to help explain how psychological stress is about the factors that over time connect the lives of individuals to the social systems and structural arrangements that they are embedded in (Pearlin, 1999, p. 396; Pearlin et al., 1981). Effectively, this perspective suggests that exposure to stress is not random, but patterned by social structure. Recently, this perspective has begun to consider place-based characteristics and events, with the neighborhood coming to be seen as a

particularly important context through which people witness “stressful social disorganization as a normative reality of life” as well as experience “ambient stressors” (Aneshensel, 2010; Aneshensel & Sucoff, 1996; Pearlin, 1999). Social, structural and spatial aspects of neighborhoods all shape the stress process, including how people are able to deal with stressors, for example via access to social support or other coping resources (Aneshensel, 2010). In a similar vein, Meyer et al. (2008) have suggested that forms of social disadvantage, including at the neighborhood level, can create two types of stress, both of which are relevant to the study of caregiving and gentrification: experiential stress, referring to perceptible events or conditions that tax the individual’s capacity to cope, and structural stress, referring to conditions that impact people even in the absence of specific identifiable events. At the neighborhood level, for example, the experience of displacement could be an experiential stressor, and the experience of the general condition of displaceability may be a structural stressor. The relationship between neighborhoods, gentrification and stress is discussed in more detail below.

The biological tradition has explored how physical and psychological demands of the stress process activate neuroendocrine systems, and the consequences of prolonged activation for increased risk of physical and mental health challenges (S. Cohen et al., 1997). Stress has been shown to predict increases in the severity and progression of a wide range of health outcomes including depression, asthma, HIV/AIDS and cardiovascular disease (Kubzansky et al., 2014). Some research in this tradition claims that stress’ most significant impact on health comes from influencing the body’s overall vulnerability to disease through chronic wear-and-tear on the body’s neuroendocrine systems. These regulatory systems protect the body in the short run and promote adaptation, but in the long run wear down the brain’s circuitry in maladaptive ways that can negatively impact health. This burden of stress on the brain is called “allostatic load” (McEwen, 1998, 2012). This research points to the significance of understanding the cumulative impacts of stress processes over the life course and intergenerationally. The accumulation of and repeated exposure to stressors has been identified as particularly damaging, and chronic events are generally expected to be associated with greater health risks than acute events (S. Cohen et al., 2019; Shonkoff et al., 2021; Slopen et al., 2018).

Together, these approaches provide a model for understanding the process whereby people evaluate the demands made on them by their environment and assess whether they have sufficient capacities and resources to cope with these demands. If they perceive themselves not to be able to adequately cope, they experience stress, which results in negative emotional states and behavioral and physiological responses over various time scales that influence a person's level of risk for physical or mental illness. Qualitative research methods such as interviewing have been identified as critical to understanding the relationship between environmental stressors and health because of the opportunities they afford to understand how changes are anticipated and come to be seen as threatening to different degrees of severity (S. Cohen et al., 1997).

Exposure to stress is unequally distributed across the population, and is an important contributor to health inequities (Thoits, 2010a). Indeed, experiences of unequal socio-economic structures and perceptions of one's position relative to others are major drivers of stress (Elstad, 1998). In many contexts including the United States, the racial inequities in exposure to and consequences of stress are significant, and important for planners to consider as part of efforts to address place-based health inequities. Many social stressors like racism and discrimination were under-accounted-for in early stress research, which centered on middle-class white males, leading to under-estimations of the contributions of stress to racial/ethnic and economic health inequities (Slopen et al., 2018; D. R. Williams, 2018). However, subsequent research has shown that contextual exposure to stressors plays an important role in shaping the mental health risks of racially stigmatized groups in racist societies (Shonkoff et al., 2021; D. R. Williams, 2018). Race-based inequalities in exposure to stressors and availability of coping resources have been expressed through concepts like John Henryism and Sojourner Syndrome, which both speak to the bodily toll that Black people pay via ongoing cognitive efforts to overcome the stressors of a racist society in the absence of substantial material coping resources (James, 1994; Mullings, 2005). Stress is a major contributor to the process of "weathering" – accumulation of allostatic load – by which racial inequalities in health persist via the embodiment of social conditions in racist societies and result in physical deterioration at an earlier age by non-

white groups in white supremacist societies (Geronimus, 2013; Geronimus et al., 2006, 2015).

2.8.3 Caregiver stress

It is worth briefly noting that the largest body of work on the health impacts of caregiving focuses on stress. Indeed, one of the central theoretical contributions to the sociological study of stress – the stress process model, mentioned above – emerged from the study of caregiver stress, and caregiving has been used as a model for studying the health effects of chronic stress (Pearlin et al., 1990; R. Schulz & Sherwood, 2008). Caregiving is treated as a chronic stressor because it creates physical and psychological strains over time, involves unpredictable and uncontrollable events and processes, requires high levels of vigilance, and has the potential to create secondary stress by impacting other life domains such as work and family relationships (R. Schulz & Sherwood, 2008).

Caregiver stress is understood to be dynamic, as the role and its demands change over time, and transitions in caregiving status and intensity have been found to lead to increased stress (Lyons et al., 2015). The uptake of new caregiving responsibilities at various stages of life is associated with increased stress (Nomaguchi & Milkie, 2003; Pavalko & Woodbury, 2000). Whether and how caregiving fosters stress is also context-specific and gendered (Reczek et al., 2014; Umberson et al., 2010). The extent to which stressors impact caregivers' health is largely determined by their subjective appraisal of the stressor rather than its objective characteristics (Son et al., 2007). In one study of caregiving stress among adults caring for partners with disabilities, the impacts of stress were shown to be worse for those in lower socioeconomic positions (Tough et al., 2019). Mental and emotional strain from caregiving have been shown to be independent risk factors for mortality in older adults (R. Schulz & Beach, 1999).

2.8.4 Neighborhoods, gentrification and stress

As mentioned above, neighborhoods have recently emerged as a key priority for understanding how exposure and vulnerability to stress are socially patterned (Aneshensel, 2010; Thoits, 2010a). Nevertheless, the study of the relationship between urban context and mental life has its roots in the formation of sociology as a discipline (Carpiano, 2014; Durkheim, 1984; Engels, 1845; Park & Burgess, 1925; Simmel, 1976). Current research in this vein bears special relevance to planners seeking to broaden our field's impact on health outcomes and inequalities by shedding light on the potential for planning interventions to alleviate appraised meso-level stressors and enhance the local availability of coping resources.

Research into the relationship between neighborhoods and stress has focused on exposure to “neighborhood disorder” and neighborhood-level characteristics of socio-economic disadvantage. With respect to the former, exposure to blight, decaying infrastructure, violence and crime have been shown to be stressful both in real-time and in a cumulative manner (Diez Roux & Mair, 2010; York Cornwell & Goldman, 2020). Neighborhood disorder is understood to signal breakdowns in social order and control in the neighborhood, and thus to introduce a sense of collective threat, which is distressing and increases levels of anxiety and depression (Ross, 2011). Similarly, with respect to socio-economic disadvantage, lack of resources and lack of economic opportunity have been shown to be predictors of higher stress (Hill et al., 2005a; Matheson et al., 2006; A. J. Schulz et al., 2008), while higher levels of residential stability and organizational resources like churches have been shown to help buffer against stress (Israel et al., 2006; Stockdale et al., 2007). There is evidence that subjective perceptions of neighborhood disorder and associated emotions mediate some of the observed associations between objective neighborhood conditions and health outcomes (Ross, 2011; Ross & Mirowsky, 2001; Scott et al., 2018). Relatedly, one study in Detroit found that stress disparities between neighborhoods explained the overall health differences across those neighborhoods (Boardman, 2004).

Surveying the relationship between neighborhoods and stress, Ross (Ross, 2011) argues that neighborhoods function as a source of “structural amplification,” a process whereby sense of control, which is needed to protect from the negative effects of the neighborhood environment on stress, is exactly what is eroded by the neighborhood. Supporting this argument, Gilster (2014, 2016) shows how exposure to neighborhood stressors is associated with a lower sense of mastery – the perception that people can influence their own life chances – which, in turn, is associated with poorer mental and physical health. Race and ethnicity have been shown to predict exposure to neighborhood stressors, with U.S.-based research showing the greatest magnitude of negative effects for Black people (Gilster, 2014, 2016; Sampson, 2003; D. R. Williams & Collins, 2001). The impacts of neighborhood-related stressors on health begin during youth and build cumulatively over the life-course (Brenner et al., 2013; Shonkoff et al., 2021; Slopen et al., 2018).

Some scholars have posited that stress may be a pathway between gentrification and a wide range of health outcomes (Anguelovski et al., 2019a; Gibbons, 2019b; Hyra et al., 2019). Recent findings indicate that stress is associated with living in a gentrifying neighborhood, and there are growing calls for qualitative and participatory research to deepen our understanding of stressors associated with gentrification (Anguelovski et al., 2019a; Binet et al., 2021; Gibbons, 2019b). One way that gentrification may cause stress is by raising the threat of residential displacement and corresponding social network fragmentation and loss of social cohesion (Versey et al., 2019). Cultural displacement may also lead to stress via feelings of exclusion and alienation, and the erosion of health-protective buffers like community connection and control, and social cohesion (Gibbons, 2019b; Gibbons et al., 2019; Versey et al., 2019). Gentrification may also lead to stress via financial insecurity related to housing unaffordability, rising costs of living, and increased feelings of economic inequality (Binet et al., 2021). To my knowledge, other researchers have not yet explored how neighborhood-level changes associated with gentrification contribute to stress by influencing how people fulfill social roles such as being a parent or caregiver. However, Curran’s (2017) work on the gendered effects of gentrification suggests that it has made the work of social reproduction more labor intensive and expensive for all but the wealthiest residents of gentrifying neighborhoods.

This is reason to believe that exploring whether these challenges result in stress might be a valuable contribution to deepening our understanding of the relationship between gentrification and health, as well as gentrification's role in exacerbating racial, economic, and gendered health inequities.

Examining stress associated with caregiving may also improve our understanding of other pathways between gentrification and health that researchers have identified. For example, studies have shown that low-income people who stay in gentrifying neighborhoods through the early stages of gentrification may see their health benefit from reduced segregation, poverty deconcentration, a greater sense of safety, and improved access to resources and opportunities (Ellen & Caplanian, 2020; Schnake-Mahl et al., 2020b). Perhaps some of these benefits could be explained by how these changes impact the experience of caregiving – for example, do they reduce parents' worries about violence and crime, open up opportunities for children and produce confidence in their future wellbeing, or make it easier to ensure that children are able to eat healthy foods and be active? Similarly, researchers have found that rising income inequality and deteriorating social cohesion driven by gentrification may have deleterious impacts on health (Chapple, 2017; Fullilove, 2005; Schnake-Mahl et al., 2020b). Could these negative effects be driven in part by the way they make caregiving more difficult or challenging, or raise fears about dependents' future wellbeing? This dissertation will explore these questions.

2.8.5 Contribution to research on stress, gentrification and health

Stress researchers have called for more research into the meso-/area-level and macro/structural factors linking social and economic characteristics to health, especially with respect to forms of neighborhood disadvantage (Aneshensel, 2010; Slopen et al., 2018; Thoits, 2010a). This dissertation heeds these calls by contributing insight on how the experience of meso-level processes like gentrification influence the stress process for caregivers, as well as socio-economic inequalities in exposure to environmental stressors and access to adequate coping resources.

To my knowledge, other researchers have not yet explored how neighborhood-level changes associated with gentrification contribute to stress by influencing how people fulfill social roles such as being a parent or caregiver. However, Curran's (2017) work on the gendered effects of gentrification suggests that gentrification has made the work of social reproduction more labor intensive and expensive for all but the wealthiest residents of gentrifying neighborhoods. This is reason to believe that exploring whether these challenges result in stress might be a valuable contribution to deepening our understanding of the relationship between gentrification and health, as well as gentrification's role in exacerbating racial, economic, and gendered health inequities.

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By way of exploring these questions, I also seek to identify built environment interventions that have the potential to reduce unequal exposures to stressors and increase access to coping resources. Indeed, the first researchers to propose the concept of allostasis suggested that interventions to buffer against stressors should “invest in social structures” that encourage more rest and play in proportion to work and striving and that increase the predictability of events and individuals' control over them (Sterling & Eyer,

1988, pp. 645–646). Thus, in the final chapter of the dissertation, I consider planning interventions that can reduce the burden of care work and thus afford more opportunities for “rest and play” for both caregivers and their dependents.

2.9 Conclusion

Care is what holds life together and is the means for ensuring that we are each able to live as well as possible, day in and day out as well as over the life course as our needs and abilities change. Unfortunately, until recently, care has mostly been overlooked as a planning concern, and broadly speaking it has been designed to “fade into the background” of cities (Mattern, 2018). However, it is not appropriate to treat care as a matter of the private sphere – care is most certainly a matter of public concern, and moreover, care shows how the divide between public and private spheres is at best blurry and at worst an instrument for the perpetuation of patriarchy. Care has been rendered invisible and de-valued, including via patterns of urban change since the industrial era, and this is a major factor in the gender and racial inequities that characterize cities today. If planning as a field seeks to advance the cause of social justice, it is imperative that we plan for care. Doing so also promises to positively transform efforts to plan for public health and health equity, which are inextricable from social justice.

The recent infrastructural turn in social sciences, combined with planning’s own history of adopting infrastructural solutions to urban challenges, suggest that there is merit to taking an infrastructural approach to planning for care by identifying and investing in urban infrastructures of care. These are the networked socio-material elements of the urban environment that perform the background conditions for care work. Adopting an infrastructural perspective provides a lens through which planners can see how the built networks of the lived environment facilitate (or not) the exchange of different forms of care across space and scale. It offers, I contend, a transformative way to see and understand how the material conditions of our existence are or are not conducive to health, wellbeing, livability, and thriving – that is, by the extent to which the infrastructure of care affords access to the social and material means to live in the world as well as possible.

Not only does it offer a valuable analytical lens, it offers a powerful approach to intervention, in two ways. First, it offers a way of understanding the impacts of planning interventions broadly writ: how will they impact already existing infrastructures of care and ongoing efforts to maintain and extend them? Second, it offers a way of thinking about what to do: planners can, and I think should, see the work of maintaining, repairing, sustaining and extending infrastructures of care as a central element of planning practice.

In the chapters that follow, I will demonstrate how planners can empirically identify local urban infrastructures of care and how to understand the role they play in shaping the work of care and social reproduction and patterns of inequality therein. I will then adopt this framework to analyze how changes in the urban environment, specifically those related to gentrification, impact care work and the real freedoms caregivers have to ensure their dependents' and their own wellbeing, using the capabilities approach. Finally, I will explore how the relationship between changes in the urban environment and caregiving becomes embodied over time, with a focus on stress, to shine light on how and why planning for care stands to be a transformative strategy for planning for health.

3 The Urban Infrastructure of Care

3.1 Introduction

Just as urban planners care about how the built environment of cities impacts individuals in their capacity as workers in the labor market, this paper begins from the premise that planners should care about how the built environment impacts people and communities in their capacity as caregivers. The purpose of this paper is to empirically establish the significance of care as a planning concern, and to develop a framework for understanding how characteristics of and changes in the urban environment shape the everyday work of caregiving. I seek to do so with the aim of providing planning researchers and practitioners a foundation for planning for care.

The paper proceeds as follows. First, I describe my analytical approach to understanding how respondents' caregiving efforts are shaped by the urban environment. Next, I present the results of my analysis. Caregiving is one of respondents' top priorities in life and a key lens through which they interpret the urban environment. Respondents have caregiving goals that are informed by how they interpret the urban environment, and that they adopt common sets of strategies to fulfill those goals that are shaped by the social and physical characteristics and affordances of the urban environment. My analysis indicates that respondents' caregiving strategies rely on combinations of eight key components of the urban environment that matter for caregiving. Finally, I show how the unavailability or unsuitability of these components can leave caregivers in "binds": when a caregiver's ability to carry out caregiving strategies and/or meet caregiving goals is inhibited by conditions of or changes in their social or environmental context.

I argue based on these findings that caregiving is shaped by the presence and suitability of what I call the "urban infrastructure of care" – the underlying social and material conditions of the urban environment that make care possible and shape the possible forms care can take. In the context of the HNS neighborhoods, the urban infrastructure of care is comprised of the key components of the urban environment upon which caregivers depend to fulfill their caregiving goals, and the nature of the relationships between these components. In the discussion, I argue that planners can

adopt an infrastructural approach to planning for care, just as we do with other basic human functions that cities help fulfill, like mobility. By doing so, planners can begin to undo the ways that care has been obfuscated and de-valued in how we make sense of cities, work towards alleviating and more equitably distributing the burden of care work and empowerment over the conditions of care across cities, and in doing so contribute to addressing the contemporary crisis of care through urban interventions that advance racial, gender, and health inequities produced by the stratification of social reproduction in cities.

3.2 Methods

The analysis conducted for this chapter is based on three rounds of qualitative coding. I received assistance with this coding from my colleague Rebecca Houston-Read at the Conservation Law Foundation. I created our analytic plan, and managed our progress through weekly check-ins. First, we used open coding on a subset of 10 transcripts to generate a preliminary understanding of key themes in the data and began to write analytical memos about these themes as they developed. Once we felt like we had a good grasp of the main themes that were emerging, we developed an analytical codebook based on a synthesis of the open codes we had generated so far. For the second phase of the analysis, we used this codebook to re-code the transcripts we open-coded, as well as to code the remainder of the transcripts in the subsample to the point of thematic saturation. During this round, we further developed our analytical memos and began to speculate about the relationships between different themes and the emerging theoretical structure of our results. In the third phase of the analysis, we conducted axial coding within specific significant themes in the analysis, to better explore their respective dimensions.

In the analysis, we sought to look at respondent's lives from the perspective of care. We analyzed each respondent's transcripts from the perspective of their role as a caregiver, inasmuch as we might analyze their transcript from the perspective of their residency in a particular neighborhood. We did so in order to attune ourselves to the ways

that caregiving shaped respondents' perceptions across the range of interview themes, from financial security to neighborhood belonging to priority fulfillment. Our guiding question in doing so was: when we look at urban life – how people interpret, make meaning of, and interact with the urban environment – from the perspective of care, what can we see? Our analysis sought to demonstrate what it would entail to see the urban environment through the lens of care: to see what caregivers pay attention to, understand where they are facing difficulties, and elicit the contextual contours of those difficulties.

While the large majority of respondents in the analytic subsample are caring for their own children, in reporting the results I have used the language of “caregiver” and “dependent” rather than, for example, “parent” and “child.” Not every caregiver in the sample is a parent – for example, some are grandparents – and not everyone is only caring for children – for example, some are caring for siblings or elders. Furthermore, the focus is on care as a type of work that stretches across different types of relationships of interdependence, rather than on parenting or children per se.

3.3 Results

During the initial cycle of open coding described above, two of the key themes that emerged early on were caregiving “goals” and caregiving “strategies.” The analytical codebook included a “goals” code to label data where respondents discussed what they sought or hoped to accomplish through caregiving or as caregivers, and a “strategies” code to label data where respondents discussed how they sought to fulfill. It also included a range of codes capturing different elements of neighborhood built and social environments. As we proceeded with analytical coding and moved in to the axial coding phase, it became clear that there were patterns in terms of both the types of strategies respondents undertook as part of caregiving, as well as in terms of the aspects of the urban environment that these caregivers employing these strategies relied upon. I also began to notice that when important elements of the urban environment were not in place or available – that is, when caregivers could not rely on or employ them - that the strategies they employed to meet their caregiving goals became both more demanding and less

likely to help fulfill those goals. Observing that crucial facets of respondents' caregiving were dependent on the characteristics of the urban environment in consistent ways, and that these characteristics were consistent across different caregiving strategies, led me to realize that this set of characteristics of the urban environment served as a sort of partial infrastructure of care – akin to how roads, sidewalks, buses and bicycles serve as part of the infrastructure of mobility. And I realized that these strategies were more labor-intensive and difficult when these components were absent or inadequate because caregivers had to try to make up for or work around their absence or insufficiency in order to continue pursuing their caregiving goals.

Overall, I find that caregiving is profoundly shaped by the characteristics of the urban environment because caregivers rely on the city as a form of infrastructure that enables and helps facilitate their efforts to meet their caregiving goals. My analysis identified eight key components of the urban environment that comprise this infrastructure, and I find that when they are available and adequate, they facilitate caregiving strategies, but when they are absent and/or inadequate, they hinder or undermine caregiving strategies, making them more burdensome and taxing. How easy or difficult caregiving strategies are to carry out in turn influences how readily caregivers are able to fulfill their caregiving goals, whether they need to make sacrifices and tradeoffs to do so, and what the consequences thereof may be. Thus, on the one hand, the urban infrastructure of care comprises the material and social background conditions of the urban environment that caregivers rely on to make care possible. However, given that this infrastructure is partial and fragmented, there is always a remainder of care work that is not supported by the urban infrastructure of care in a given context. This remainder represents the areas where caregivers own infrastructural labor must fill the gap – that is, where caregivers must work to secure, replace, or substitute what the urban environment did not provide, in order to care as well as possible. Thus, characteristics of the urban environment shape both the form and intensity of care work.

Below, I present the results of this analysis in five parts to introduce the framework of the “urban infrastructure of care.” First, I demonstrate the significance of caregiving in respondents' lives and as a primary lens through which they evaluate and relate to the

urban environment. Then, I describe the “goals” caregivers state they are working towards, and show how these goals are tied to their perceptions about and experiences in the urban environment. Third, I examine respondents’ caregiving strategies – what they do on a day-to-day basis to provide care, reproduce the conditions of care, and work towards their caregiving goals – and show how these strategies engage, respond to, and depend on the urban environment. Next, I show how these strategies depend on a common set of urban environmental components of care: material and social elements of the urban environment that matter for care. Finally, I illustrate how respondents can encounter “care binds” when environmental components of care are missing or inadequate, thus inhibiting or impeding caregiving strategies and leaving respondents with sub-optimal caregiving conditions.

3.3.1 The significance of caregiving for respondents

Most respondents in the sample described caring for and ensuring the wellbeing of their dependents as their top priority in life. Patrice, a caregiver in Dorchester explained: “I wrap my life around my kids.” It was common for respondents to explain that they felt such a significant sense of responsibility to their dependents because there was no other way for their dependent’s needs to be met. Patrice said that she also took care of her mother during the illness that took her life: “Nobody knew how to take care of her, and so I said I will.” For her and many others, their sense of responsibility also emerged from their own difficult experiences with being cared for or seeking care in the past. She explained that she grew up in foster care and was out of touch with her mother for much of her life. But, she says, “I did it because it’s like she did it for me. She was helpless. And when I was helpless...so even though I wasn’t with her my whole life... I believe that’s why God reunited us, because he knew she was going to need somebody.” Similarly, Jen, in Brockton, expressed the complicated sentiment that: “I don’t really care about anyone else but my kids. Because I feel like when I needed somebody to care, no one really did, so why should I? And honestly, the only people that need me to care for them is [my kids], so.”

Other significant priorities beyond care that caregivers had in their lives, such as finding a better job or different housing, were very often expressed as priorities because of how they would change the conditions of care for both respondents and their dependents – for example, by making it easier to afford healthy food or to access support for caregiving, or by making it safer for younger children to play outside the home. Fred, a caregiver in Roxbury, explained that “work will probably keep the roof over my daughter’s head. Work helps me to give her financial support. It helps to keep food in the house.” For most, the contours of their everyday life were drawn around their caregiving responsibilities in a multitude of ways. As Nina put it: “anywhere I go, my kids is right there.” Caregiving was also commonly an important lens through which respondents interpreted the meaning and significance of characteristics of and changes in their environment at different scales ranging from the immediate vicinity of their home to the city and region more broadly. Some indicated that the difference between their lives feeling stable or unstable was whether or not they were able to fulfill what they saw as their caregiving responsibilities. Others indicated that caregiving was the primary motivation for them to make changes in their lives, to “try our best to do better, not to fall back on the same.” Caregiving was thus an evaluative framework for respondents, and the value of the conditions of the urban environment were often interpreted based on how they impacted the conditions of care and the work involved in carrying out caregiving routines.

3.3.2 Caregiving Goals

Caregiving goals refer to what caregivers seek to work towards and accomplish as caregivers. Here I specifically focus on goals that are expressed in relation to the environment in which the caregiving takes place. This means that these goals, as articulated by respondents, concern the nature of the caregiver’s, dependent’s or community’s relationship to their environment. They are responsive to context. Sometimes these goals respond to perceived environmental characteristics or processes; sometimes they focus on the ability to navigate or continue living within the environment. Often,

goals reflected desires for forms of social and economic mobility that respondents' neighborhoods did not always guarantee, but that respondents believed would make caregiving and the conditions of care more secure. Three groups of goals are evident in the data: goals for the dependent, goals for the caregiver themselves, and goals for the caregiver's community.

3.3.2.1 Goals for the dependent

The most common type of goal expressed by caregivers were goals for their dependent. These goals typically focused on (a) ensuring the dependent's health and wellbeing as they develop, both by ensuring that their basic needs were met as well as by cultivating their awareness about their surroundings and community, as well as (b) ensuring the broadest possible range of opportunities in life rather than being confined – by environmental or structural factors – to any certain path. This sentiment was encapsulated by a respondent in Brockton who explained that she didn't want the area her kids grew up in to shape who they became.

Providing "exposure" to different settings and activities emerged as an important pattern in respondents' dependent-oriented goals, because respondents saw exposure as necessary to their dependent understanding the world around them as well as understanding how they want to live in it. Expressing a common perspective, Nina explained that "you don't know what you really like until you experience different environments or different views in life. So that's why I just want my kids to just experience different things, to see what they're really interested in." Closely related was the goal of ensuring that the dependent was "involved" and "active." Discussing her goal for her children to be involved in their community in Everett, Louisa said "I wish they had things for all ages to be involved with community service in the city, not paid, just to have that sense of helping each other and being generous and caring for others." Similarly, expressing a desire to create opportunities for her dependent to benefit from their environment, a respondent in Chelsea said "I don't want my son to miss out. I think we live in a really historic, cool area and I want to explore it more."

Education was commonly expressed as a goal, with one reason for this being that respondents saw education as a pathway to greater freedom and opportunity for their dependents with respect to how their environment shapes their life chances. Jen framed it this way: “They’re going to grow. They’re going to learn to do whatever they want to do and I’m not going to be there all the time to supervise... So, if they are a little grown and they start to do that, then they become a Brockton kid. And I honestly don’t want my kids to be a Brockton kid. I don’t. I really don’t. I want my kids to go to college and I feel like – far away, different place, and better environment – they’re going to want to go to college, be a better person, better than this.” As this example demonstrates, education often indexed a desire on behalf of caregivers for their dependents to have social and economic mobility in contexts where opportunities for such mobility can be limited.

The themes of exposure, involvement, and education all pointed to caregivers’ desires to ensure that their dependents were able to thrive independently, partly out of developmental and economic expectations and partly out of concerns about dependents wellbeing should their caregiver no longer be able to care for them, depending on the specific dependent. This was similar across those caring for children or other adults. For example, Maya helps look after her sister, who has a disability that leaves her with mobility issues. She explained that when she helps her sister with errands like going to the grocery store, she encourages her to take an active role in shopping and try to walk, in case there is a time that Maya will be unable to help her. Maya explained that she thinks pushing her sister to use her abilities to her fullest will make her quality of life better and help her ensure that she is able to meet her needs to the best of her abilities. As this example also demonstrates, the goal of independence was rarely in order to terminate the caregiving relationship, but to ensure that dependents could live as well as possible, including by being able to adapt to potential changes in the circumstances of their care.

While caregivers wanted to build exposure, opportunity, etc., as Jen indicated in her comment above, many also remained concerned about threats or negative influences from the environment, and thus ensuring dependents’ safety also emerged as a common goal. Marta, a caregiver from Chelsea, explained that: “I think everything that I wish that I could change...will be one goal: to make it safer for my kid.” The most commonly noted safety

concerns were violence and drugs, which respondents thought dependents may be exposed to via their peer groups in their neighborhood. Safety emerged as a goal both because of respondents' innate concern about perceived threats to their dependent, but also because perceived safety risks in their neighborhood limited the freedoms of their dependent. For example, Terri, who lives in Dorchester, explained that her dependents were scared of walking to their bus, and that she and other caregivers were often worried about their dependents walking around in the neighborhood because they didn't trust other people who might be out on the street. Safety concerns also taxed many respondents because they required them to be hyper-vigilant. Respondents often expressed the goal of moving to an area that they perceived as safer, or having moved in the past for reasons to do with safety.

Finally, related to but independent from the types of goals described above, caregivers also typically had goals related to the maintenance of their dependent's health. These included both ensuring the continued availability of resources to ensure their dependent's health – for example, healthy meals and a warm coat in the winter – as well as the means to care for their dependents when they were unwell and help them return to health. It was also common for caregivers to relate some of the themes discussed above – such as safety and education – back to their dependent's overall health and wellbeing.

3.3.2.2 Goals for the respondent as a caregiver

Respondents also expressed caregiving goals related to their own role as caregivers. Overall, these goals are related to stabilizing or improving the conditions of care and the respondent's own ability to fulfill their caregiving role. These goals focus on activities like resource management, securing more stable or better-quality housing, and looking after their own health and wellbeing. For example, Mike, a caregiver in Fall River explained how his biggest priority in life was “just to be better and learn from the mistakes I made before so that I don't have to pick up and have to have my family go through all that moving again... It's a lot of work...working on the budgeting, stretching things out, stocking things up.” However, he said that “I don't have anyone to help me so I do it myself...Sometimes I'll be like, “damn, I wish I had help.”” Similarly, Pearl, also in Fall

River, explained how her biggest challenge was “probably just figuring out where is the next best place to be and how to definitely be able to provide for my children because I do it totally by myself.”

Finding housing was perhaps the most commonly expressed goal that caregivers expressed for themselves, and they often identified housing as the priority they have had the most difficult time fulfilling. Many caregivers were seeking housing that they thought could better accommodate the needs of their dependent based on their life stage. For example, Daisy and her spouse were living in an apartment in Roxbury with their two children, who shared a bedroom. Their eldest was entering her teens, however, and they were looking for space that would allow her to have her own room. They didn’t want to have to leave the neighborhood, where they had family support nearby and convenient commutes to work, but she was concerned that they wouldn’t be able to stay in the neighborhood unless their financial situation improved. “I’ve been working now with a social worker...[and] now I say “Okay, we’re working, we paying this much rent, we pay this much bills, I don’t see what we’re saving.” So, we need to think, we need to have something that we can afford better so we can have savings so we can prepare more future for our kids,” she explained.

For other caregivers, finding housing was driven by health concerns. Alex explained that her child had elevated lead levels from exposure in prior housing, and said “finding safe housing” was her most important priority, but that she was facing difficulties. “I think a lot of people are struggling with affordable housing at this time,” she explained. “I mean, I’ve been on so many lists for such a long time. And then when we do find something that’s within our budget and where we want to live...they don’t have a lead certificate, or it seems like it’s always something.” Respondents also described how finding housing free from pests, or finding wheelchair-accessible housing, were important health-related housing goals.

Yvonne, a caregiver in Roxbury, shed light on why housing was such a common goal: stability. “I want to have my own home... That’s a top priority... Housing is number one, it’s huge. You have to have that stability with housing, and then I think everything else falls under that. You can fix everything else. Once you know...where you live is where

you're going to stay, then I think financially you're more stable." Some respondents often expressed the hope of owning their home in the future, but this goal typically felt out of reach given the high cost of housing in the Boston metro area and much of eastern Massachusetts.

Being able to provide for one's dependents and family was also a very common goal. Some respondents expressed a desire to provide "the best" for their dependents, but most were focused on meeting basic needs. For example, Paul said "I don't want to see my family going under. I don't want to see us losing anything. I want to keep food in the refrigerator, lights and gas on, and just a few extra amenities... And when you don't feel that you're able to carry that torch, man, that can be very discouraging," he said. Another caregiver shared that "As someone that came from a dirt-poor family, neighborhood, all of that combined, I don't want my kid to come from that. I didn't make it to this level in life, and I don't hope to continue getting better at it to not be responsible or stable for my kid. I don't ever want our lights to go out. I don't ever want my kid to get evicted with us or some craziness like that. It's not craziness, it happens every day, but no."

Finally, caregivers expressed goals related to their own health and wellbeing, which they typically described as frequently sacrificed for the wellbeing of their dependents but simultaneously essential for the wellbeing of their dependents. Mike explained that his biggest challenge was "to become the best I can be because it's not hard but it's kind of difficult because like I said, you're taking care of the family thing. And at the same time, you got to do for yourself, too. And if you can't do for yourself, you can't do for your family or anyone else. So, I try to keep things balanced...that's the hardest thing."

Often, goals for the respondent/caregiver were expressed as chains of events that needed to fall into place in relation to one another. Jen described how she wanted to move out of Brockton, but that first she needed to find a better job: "The only thing that's keeping me here is my job. Because if I did find something better somewhere else, I would move. And then him, he's a little young. So now, I kind of need that babysitting support. So, by next year, if he's in school and I can...work, then I get out of work, I pick him up, then it works. But right now, I work and I have to have somebody to watch him... usually my grandmother." Goals like this pointed to the contingency of care on combinations of

social and environmental factors, and the importance for caregivers of being able to combine these factors in specific ways that meet their own personal and economic needs as well as the various developmental and health needs of their dependents.

3.3.2.3 Goals for the caregiver's community

The final group of goals expressed by respondents were in relation to their community more broadly. These goals reflected a sentiment expressed by Roberta, a caregiver in Roxbury, who said that she wanted to make sure that her entire community was taken care of, not just her own dependents and family. Community-oriented caregiving goals can be broken down into two themes: meeting perceived collective needs and addressing perceived power imbalances. Typically, these goals emerge from the respondents' own experience of unmet needs or being negatively impacted by power imbalances, and the consequences thereof in their own lives.

The first set of community-oriented goals revolves around meeting needs that the respondent identifies in the community. Nina shared how she wanted to create more sources of support in her community for single parents. As a single parent herself, she found it difficult to find support. She described how she worked together with the pastor to develop a support group for single parents. "I give my voice because I'm a single mom also...they need that support... We try to give flyers to different churches and have open community meetings. Last Saturday was the first community meeting that we had... We had just three people, but... it's a start. I'm trying to push it too." She was simultaneously volunteering with another group focused on supporting people who have children at a young age, and described how she provided advice on how to navigate the challenges of single parenthood such as balancing work, education and childcare. Another respondent spoke of her efforts to develop a Cape Verdean cultural center in her community: "We want something more. We want something culturally. We have kids who born here, who don't even speak the language for they parents. When they go back, they don't understand. They don't know the food, they don't know the culture... This is what we want for the city. To have each diverse people to have they place, they culture center, they museum, they place to feel home and to be connect... You have to have a place

called home.” Goals related to meeting needs in the community were typically efforts to provide a resource or support that the caregivers had lacked in their own life and that they sought to provide for others so that they would not have to face similar challenges. These goals typically reflect caregivers’ own knowledge about their community’s needs with respect to care infrastructure. In Chapter 5, I expand on this theme with an analysis of caregivers’ visions for caregiving supports in their community.

The second, and smaller, theme in caregivers’ community-oriented goals is addressing power imbalances that the respondent identified or experienced in their community. A handful of caregivers referred to their own past experiences of unequal treatment – from men, from social workers, from policymakers – and expressed the desire to rectify the power imbalance that [fostered] their unequal treatment through community-level intervention. For example, one caregiver in Chelsea described how her experiences of sexual harassment in the workplace led her to embark on an effort to start a food service business that would employ other people who had experienced sexual harassment and that would also act as an information and support hub for people in the community who experienced sexual harassment. The goal of this initiative is to raise awareness about and prevent sexual harassment, while also providing alternative employment opportunities for people who experience sexual harassment on the job. In response to negative experiences as a child living in foster care, Patrice shared her goal of becoming a social worker in order to help young people from her neighborhood learn their rights and how to advocate for themselves when their family or housing situations become unstable.

In a similar vein, Elaine, a caregiver in Roxbury, shared how her experience raising a disabled child made her want to work with other disabled people in her community, as both an advocate and caregiver, in light of the lack of resources and support available to them: “I’ve been trying to look for a part time to make my own hours where I can work... I want to do more for the disabled because they done took so much funding and stuff back from when [we] first started – we used to get free baby wipes, we used to get clothing... they cut all of that.” She noted that her desire to become an advocate was also motivated by a sense that households like hers were being excluded from the changes in her neighborhood: “what hurts me the most, they’re building all these places, but look for the

handicapped, for more than two bedrooms...” she said, indicating that she didn’t see enough housing of that nature being provided.

The presence of community goals and goals for the caregiver themselves show how and why ensuring that caregivers are able to satisfactorily meet their dependents’ needs without exhausting their caring energies is important: because caregivers want to and can do more than that with their skills and knowledge of care itself. Moreover, the fact that caregiving goals included not only goals for the dependent but also the caregiver and the community more broadly demonstrate how caregivers perceive care as dependent on a multitude of contextual factors and relationships, and see accomplishing care as reliant on more than just what they do for their dependents. These goals represent caregivers investing in building the material and emotional support structures that they know they, and others like them, need. Already, then, these goals begin to push back against the prevailing notion that care is a matter of individual or private concern.

3.3.3 Caregiving Strategies

Caregiving strategies refer to the planned or coordinated actions respondents undertake in an effort to maintain the conditions of care, the efficacy of their care, and work towards or accomplish their caregiving goals. Strategies are how people try to accomplish what they deem necessary. The analysis focused on strategies that engage environmental features and qualities in caregiving decisions and practices, and/or which seek to change some dimension of the environmental context of the caregiving relationship, in service of meeting a respondent’s caregiving goals. The strategies respondents described fell into six domains: managing the dependent’s relationship to their environment; securing and maintaining the material conditions of care; building and maintaining relationships that support caregiving; preserving dependent and caregiver health; time management; and balancing work and caregiving (*Figure 3.1*). Together, these strategies show how the work of caregiving is shaped by material and social characteristics of the urban environment that determine the level of control that caregivers

have, the choices they can or must make, and the aspects of caregiving areas of life that require resources, time and attention.

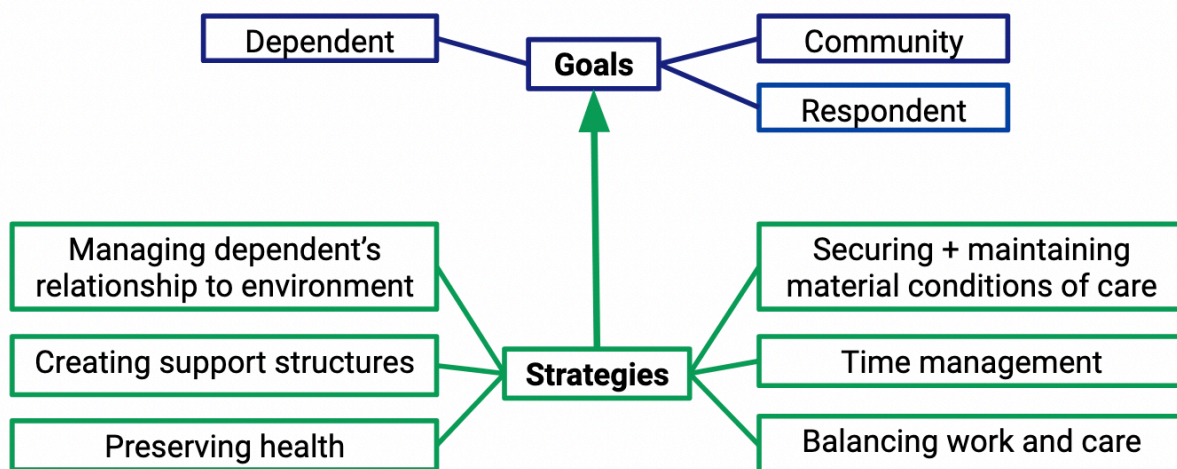
Not all caregiving strategies are freely chosen. They are shaped by numerous environmental – as well as social and economic – constraints and inequitably distributed opportunities that reflect structural racial and class inequities at the societal level, as well as the context-specific stratification of social reproduction. In the strategies they undertake, caregivers are more often than not trying to overcome the shortcomings of their context, doing so by balancing between what they deem to be most effective given their circumstances and their knowledge from past experience. Terrence, a father in Roxbury, explained it thus: “What's important for me and my family at the beginning of the day is always at the top of my list. How do I make that better? I minimize what I don't need... What I try to do at the most is get what's important done at that particular time. And I work towards getting that one thing done, and then work on the next thing.” As I explore in Chapter 5, tradeoffs and sacrifices of this nature can have considerable consequences for caregiver health and wellbeing.

Moreover, not all caregiving strategies are undertaken individually – as in, by the caregiver alone. Many rely on various forms of social and institutional support, however typically caregivers are nevertheless doing the cognitive labor of securing and marshaling these sources of support to carry out strategies in service of their goals. Access to these sources of support varies in numerous ways including tenure in one's community, access to information, language spoken, immigration status, racism and discrimination, and the caregiver's own energy and time to be able to maintain relationships with the sources of their support. Given that one of the strategies is creating support structures, this point also illustrates how strategies can be dependent on one another when we look at the big picture.

Overall, these strategies relate to the urban infrastructure of care – the components of which are the subject of the next section - in three fundamental ways. First, they depend and rely on it to the extent that it is there. Second, they involve the ‘infrastructural labor’ of coordinating across different elements of the urban infrastructure of care to establish connections and synergies between components that may not exist but which are

necessary for the caregiver to meet their caregiving goals. And third, they entail creating, replacing, or compensating for those aspects of the urban infrastructure of care that are not accessible or adequate. Thus, the amount of work that these strategies actually involve, and the difficulty of that work, is shaped by the underlying urban infrastructure of care. Next, I walk through each pattern of environmentally dependent caregiving strategies in turn.

Figure 3.1: Caregiving Strategies Dependent on the Urban Environment



3.3.3.1 Managing dependents' relationship to their environment

The most significant pattern of caregiving strategies in our data concerned caregivers' efforts to manage and modulate their dependent's relationship to their environment. Such strategies included efforts to cultivate specific types of exposure to the environment that the caregiver deemed beneficial to the dependent, or to protect the dependent from aspects of the environment deemed detrimental to the dependent's wellbeing. This group of strategies also consisted of efforts to build dependents' environmental awareness and understanding about how neighborhood, city and society work, with a view towards cultivating the dependent's ability to navigate these contexts with some degree of independence.

Depending on the caregivers' assessment of the environment, they may have sought to expose or protect the dependent from environmental factors, especially the neighborhood social environment. For example, Jen, in Brockton, is focused on protecting her dependents from perceived threats to their wellbeing stemming from their neighborhood social environment. She is concerned about "drama" around the neighborhood like violence and public drug use "that could potentially harm my kids somehow." She says her children like to play outside, but in her neighborhood, "there's nothing for kids to do...If there's a park or something, there's always some drama happening there. If they ever open something, they usually close it. So kids really have nothing to do. So I feel like Brockton should just have something...where we can bring our kids. That's how you make friends.... But there's nothing to do." She explained that as a result, her family mostly stays inside the home because "they're little and I want to keep them as far as I can from everything that's happening until we move out of here and find better." Unfortunately, protective dispositions towards the neighborhood environment often resulted in increased isolation and withdrawal for both caregivers and their dependents.

On the other hand, Nina explained that she takes a different approach to managing her dependents' relationship to her neighborhood in Dorchester: "I expose them to everything because they're already exposed anyway. So I expose them to everything." For Nina and others adopting similar strategies, exposure can take the form of involvement in various aspects of the community, whether in volunteering or activities – and can also take the form of interpreting the environment and educating the dependent about what they experience. Nina elaborated: "I get my kids involved in a lot of activities. They do...basketball, soccer, street hockey. Anything, I just get them involved...." She also described how she brings her kids along when she volunteers in the community, and lamented the lack of organized volunteering opportunities for children.

For some caregivers, involving dependents in the neighborhood can also play the role of protecting them from some aspects of the environment, typically helping to fulfill the goal of safety. Iris, a caregiver in Roxbury, explained that "Unfortunately, [my son] can't hang out in his community. That's the downfall of our community. My son can't go out and hang out on the block. I could in the projects. I could go hang out from sunup to

sundown in the projects because there was always a parent looking out for you. Unfortunately... today, not everybody knows who's everybody's children.... He's in something organized at all times because I don't want him diverting. And I know this is not a guarantee that he won't divert, but at least he knows he has options." Yvonne, also in Roxbury, described using certain neighborhood affordances to keep her dependent safe: "they're not able to just go outside and play freely, like if you had a house and a backyard with a fence. They're not able to do that so a lot of them stay inside. So you have to take them – we have a lot of amazing parks. Actually, yesterday, we took her to seven different parks." Often, however, protecting the dependent from environmental influences leads to staying home when possible, which typically led to social isolation for the dependent, caregiver, or both. "You want to get in, get out, and be careful where you're going," said Terri.

However they seek to balance exposure to and protection from environmental influences, caregivers use the environment to help their dependents build awareness of how their neighborhood works and how to live among others in the city. Patrice shared an anecdote from a walk with her dependent in their neighborhood: "We were walking to KFC, and a gentleman there, his shoes were so ran out, and my son says mommy, why's his shoes look like that? And I said, I don't know. I said don't ever knock a homeless person because you never know why they became like this. They could have probably had an executive job, working on Wall Street somewhere, and shit just happened. And I said everybody has a story. We just don't know his." Daisy shared a similar sentiment. "It helps because just how close everything is in the community and... I told him, 'I'm going to show you between the good and the bad.... In the neighborhood, you know not everybody is good, not everybody is bad'... It's your decision to take the good way, as it's your decision to take the bad way...I'm always giving him examples, 'This is happening in the neighborhood, it happens.' He's like 'It's real life.' And what happens in this neighborhood does not have to affect you, not have to affect me. You have to continue with your life." Awareness was a key priority for caregivers, as indicated in the discussion of dependent-oriented caregiving goals, and for those like the caregivers in this study who do not have the means to shield their dependents from the social and economic realities

of an enormously unequal society, spatial context and public life necessarily become the means through which this awareness is cultivated.

3.3.3.2 Securing and maintaining the material conditions for care

A second major group of caregiving strategies are efforts undertaken by respondents to ensure the availability and suitability of the basic material ingredients for caregiving, namely housing, food, and other essentials like diapers and clothing. This is often caregivers' most significant day-to-day challenge. This group of strategies is most focused on economic and resource aspects of the urban environment, and requires navigating both the affordances of the physical environment as well as structural limits on the availability of goods necessary for care. Often, caregivers' efforts to secure the material conditions of care combine market-based strategies with efforts to find free or subsidized goods through community resources and programs, which requires flexibility. As one caregiver explained, her strategy for securing basic goods "depends a lot on cost. We take free opportunities and change plans."

Many respondents were engaged in efforts to improve their housing situation. Most were navigating both the private market and long waiting lists for housing subsidies or public housing. Patrice described how her housing costs at her previous residence were supported by a grant, but the grant ended and she needed to make a plan. "I was going to stay where I was living and just pay the market rent, because it was a tax credit market rent. So I was willing to do that, because I didn't want to go back into a shelter. I didn't want to put my son through that. So if I have to struggle, I struggle. And then I got my letter stating that my subsidized Section 8 came through, and I had an empty unit. I don't even remember putting in for this place." Respondents expressed how housing assistance was often difficult to come by. One caregiver in Dorchester explained that she had waited for 10 years to get a Section 8 voucher: "I went through hell to get into it." In the near-term, respondents often felt stuck trying to carry out housing strategies. Pearl, in Fall River, explained: "I have gone to places where they're not for that purpose, but if I have a good camaraderie with someone, I ask them things, like my children's health center. But...there's only so much they can do." Multiple respondents reported benefitting from

programs that helped them find housing when they were living in a shelter, and programs that provided short-term rental assistance and basic furniture for parents expecting newborns.

Overall, housing was an area where caregivers often had very little choice or control over their circumstances, and had to build the rest of their lives around the housing options that were available. Mike's story exemplifies this pattern. Asked why he and his family live in Fall River, he said "It's pretty much I didn't have a choice. I was kind of forced out here." He explained that he and his family were living in a gateway city north of Boston, and that his girlfriend lost her job. "I couldn't afford the rent so we basically had to move... The only place we could find at the time, the rent was basically too high...but it was either that or go into a shelter...So we tried to deal with it, and we was there for about a year and just fell off with the rent, couldn't do it, and basically ended up in a shelter before we moved out here." Staff at the shelter helped them find their apartment in Fall River.

Providing food for dependents was another important strategy, often involving combining different types of neighborhood resources to make ends meet. Terri described how she combined different food procurement options to meet her family's needs – prioritizing sale items and using coupons at the grocery store, buying produce from a mobile produce market that stops near her home when she can afford it, and going to the pantry when money is tight. She also described how she has recently begun to involve her grandchildren in cooking to teach them how. Similarly, Elaine described her efforts to keep her and her family on a healthy diet. "You've got to have the right money to buy the right food to keep you healthy, and the stuff in the store is so expensive, [and] I haven't had food stamps in over 20 years. What I do, I try to catch the \$2 food bag truck...get me two or three bags, and sometimes I talk to the social workers in the hospital and they're giving me a gift card or something. But it's really hard because the stuff that's healthier for you is more expensive, and the stuff that's bad for you is more cheaper in the store."

Respondents also navigated community-based resources to get other basic goods for free. Mindy, a caregiver in New Bedford, exemplified this, saying "I know every single food pantry out here possible. I know everywhere to get deodorant, shampoo, toothpaste.

I know where to go to get everything...your basic body needs. I know where to go to get your little house essentials. I know where to go to get diapers, wipes... So I go all around, and I stock up on everything.... I think I went to like thirty events the whole month of December...where you can get free gifts for your child.”

In order to ensure that they and their dependents have access to what they need, respondents typically set priorities and calculated tradeoffs about how to use their limited resources. For example, Iris explained “I’m really, really good with budgeting, and I don’t live above my means. There might be some things I’d like to have, but realistically, okay, food, shelter, clothing. Clothing is at the bottom of the totem pole. Food, shelter, my son needing to hang out with his friends. That might take priority over food because he needs to have a social life... I can always tweak the shopping list. I can’t tweak the rent. I can’t tweak the car note, I can’t tweak the insurance. And I’m not willing to tweak his social life.” Similarly, Maya said her top priorities were paying rent and ensuring that she can keep food on the table for her dependents, and that everything else came after she could ensure that those priorities were fulfilled.

3.3.3.3 Creating support structures

Caregivers employed a range of strategies to build support structures to help them fulfill their caregiving goals and responsibilities. These strategies were dependent on the availability or absence of different potential sources of support in the respondent’s local context, since the support required was typically hands-on in nature, like child care, transportation or food preparation. Some caregivers also created and maintained emotional support structures with friends and family further afield, and while important, my empirical focus is local ready-at-hand support. Building local support structures is a crucial aspect of ensuring that care can actually be accomplished, and respondents described coordinating across relationships and timeframes to establish and maintain systems of support. These systems of support were described by respondents as being crucial both to the continuity and quality of their dependents’ care, and for the wellbeing of the caregiver themselves. Some respondents also connected these efforts to the task of building community-level social cohesion more broadly. Others remarked upon the ways

that the absence of social cohesion at the community level inhibited their ability to form trusting relationships of social support, particularly in cases where respondents were relatively new to their neighborhood or did not grow up there.

Respondents often sought to enlist family in their caregiving support structures, and often made housing decisions based on access to caregiving support from family members. For example, Elaine described how she trained her family members who live nearby in the skills necessary to look after her daughter, who was physically disabled: “that’s very helpful when they come and ask to keep my daughter while I can go do a day with my son one-on-one. That is all a blessing. And that’s a lot of support.” She also described how family members would bring over food and help with tasks like cooking and laundry, as well as provide services like hair-styling that the respondent would otherwise have to pay for. This is an example of how support structures can benefit both the dependent and the caregiver. Similarly, Daisy counts on her children’s grandparents, who live close by, for childcare support when her and her partner’s work schedules overlap. Indeed, a number of respondents reported strategizing about housing decisions based on family-oriented social support structures that they wanted to have in place. Jen described waiting to move until she and her son no longer needed to rely on his grandmother for day-to-day childcare support. And Alex continued to live in a community where she does not have many other friends or relatives and feels isolated because her partner’s mother was able to provide them with housing and assistance with childcare.

Respondents also reported trying to build supportive relationships with neighbors, like Terri, who explained that she checks in with her neighbors about their health and whether they need a favor like something from the corner store. Daisy described how she and some of her neighbors take turns organizing activities and outings for their dependents: “we manage things for them to be happy, for having friends because it’s really important when you’re in a neighborhood to have friends around.” Likewise, Louisa explained: “My neighbor, she has three kids and we watch each other’s kids when someone needs extra help. She just went to get her kid at school and I’m still with the baby downstairs for her. And the neighbor over here, next to us, my kids were...outside picking up all the leaves and they decided to do her front yard too, so we help each other. My neighbor on the

other side here, I always pick up her trash cans from the sidewalk. So we are looking after each other so that's good." These relationships may also come in handy in a crisis, as in the case of Iris who was able to organize neighbors in her building to sign a petition on her behalf when she and her son were at risk of losing their housing.

The caregivers mentioned above who have goals with respect to their community in addition to their dependent are also involved in creating support structures at the community scale. Examples include those mentioned above like Nina's efforts to set up a support group for single parents, and Amanda's efforts to provide employment and support for people who had experienced sexual harassment. Such efforts can also be more ad hoc in nature. For example, Pearl shared how at the time of the interview she was sheltering a homeless family while they got back on their feet. These examples demonstrate the myriad ways that some caregivers seek to build forms of mutual dependence that rise to meet one another's needs for support in the absence of coordinated support for caregivers from institutions and policies.

Unfortunately, many caregivers felt like they did not benefit equally from the support structures that they helped to create and maintain. Pearl explained: "I help a lot of people. But in turn, I don't feel like there's nobody there for me and that's probably the worst place to be in. Especially when you get older and you know that you're getting a little bit more tired and you just wish that you had a little bit more support in certain areas. And I just don't really feel like I have that... especially on a level where like-- the level of positive things that I really want to be around and surround myself around. And it's just not always there... It makes me sad." The experience of giving more than they were getting when it came to social support from family and friends was extremely common among respondents.

Finally, some caregivers also strategized to secure more formal sources of support for their dependents and themselves, like therapists, social workers, faith-based support groups, and parenting classes.

3.3.3.4 Preserving health

Unsurprisingly, respondents described a range of caregiving strategies related to preserving health – both their dependents’ and their own. Often, caregivers’ strategies to preserve their dependents’ health overlapped with strategies to preserve their own, as most caregivers saw their health and their dependent’s health as intertwined. At the same time, caregivers often sacrificed their own health to ensure that they were able to adequately ensure their dependents’ health. Health-oriented strategies related to the urban environment typically sought to protect against or ameliorate health threats that caregivers perceived to be stemming from their environment, as well as cultivate and maintain healthy behaviors by taking advantage of the environment. Some of these strategies, such as accessing healthy food, overlap with those concerned with securing the material conditions for care reported above.

Some respondents were focused on addressing health concerns in their housing. Terri shared that she was struggling with housing-related health challenges like mold and rodents, and was cleaning constantly to ensure that her grandchildren are safe when they play on the floor of her apartment. She said both of her grandchildren have asthma and allergies, and that she thinks these conditions are related to the condition of their apartment building. Two respondents reported that their dependents had elevated lead levels in their blood from previous housing. One, Alex, described how she was trying to save money to move to a new apartment, but at the time of the interview had not yet been able to secure new housing. Another, Pearl, described how, coming out of the shelter, her family was placed in an apartment with lead paint, plumbing issues, and mold, and she had to take her case up with the city to be transferred.

Respondents also worked hard to preserve their own health, efforts that were typically described as being for the benefit of their dependents as much as for the respondent themselves. Roberta captured this sentiment, explaining that because she was now raising her grandchildren, she was trying her best to take good care of her health by walking around the neighborhood, going to classes like yoga, and keeping on top of her medical care. Her comments demonstrating how much caregivers’ efforts to maintain their health depend on access to salutogenic neighborhood resources and amenities. Fred showed

how caregivers also rely on the urban environment to maintain their mental health. He described taking long walks through Boston to visit his favorite church downtown when he was feeling stressed or overwhelmed about his new caregiving responsibilities, having recently gotten custody of his adolescent daughter. "I think to make all the connections or connect all the dots, I'm a prayer person. I like to meditate. So I think that's a priority for me. If I plan on pulling this whole piece together, I think that spirituality has to be the foundation that gives me that guidance to go forward in this journey," he said.

Sometimes, caregivers' efforts to preserve their own health were oriented towards protecting dependents' from stress about their caregivers' wellbeing. For example, Iris shared that because of a health condition that impairs her mobility "I have limitations that I didn't have before.... So I have to gauge and monitor how much I can do because I have a [teenaged] son at home who lost [his] father. I'm his sole surviving parent, I don't want him to have the stress of concern of whether mom's okay." Stacey, a caregiver in New Bedford, shared a similar sentiment when describing her effort to hide the financial difficulties of affording healthy food from her son: "I think that what we know about child development especially is that if the child is worried about their basic needs or if they're seeing their parents or caregiver worry about their basic needs, they don't develop properly."

On the other hand, sometimes respondents had to make sacrifices in their own health for the benefit of their dependents. Pearl explained that her health "could be better. It could be better. I don't think that I necessarily eat trashy foods but I think that I don't eat three square meals a day type of thing. I'm one of those people where if I eat something now, that might be the one meal I eat for the day. And sometimes that's by choice and sometimes it's just not. Sometimes I just forego things to make sure my children have what they need." In a similar vein, Sara explained that the demands of caring for her household meant that "I'm probably the least active out of everybody, but I'm active in different ways because I'm always cleaning. I'm always doing things and working on the weekend...So it's like you got to keep yourself moving... I have to take more focus for me in order to do that, but I don't do that because I care too much for eeny, meeny, miny, moe and Joe and all the birds and the animals..."

3.3.3.5 Time management

Caregivers are often engaged in various forms of spatio-temporal choreography to ensure that there are not any gaps in the day-to-day continuity of care, which are of special concern for those who care for younger children and people with more serious health needs. Successfully figuring out the logistics of balancing different demands on caregivers' time was usually a relief. Nicole, a caregiver in Chelsea, spoke to the importance of coordinating different aspects of her responsibilities as a caregiver across time: "I feel much more confident now that I have this [new job], even though it's not the line of work that I expected to be in or really would like to be in. It works for me. The hours are the exact same as my son's so I don't pay for a babysitter, I don't have to worry about daycare or whatever, so. Yeah. It's helped."

Some time management is day-to-day. Respondents reported having schedules and routines to help manage childcare, activities, school, meals and other day-to-day aspects of caregiving over time. Respondents relied heavily on routine in order to fulfill caregiving responsibilities. Nicole continued: "We're very regimented, I guess, as far as that goes in order to keep us on track, emotionally healthy and physically." Other respondents like Elaine described establishing routines in order to ensure that there was enough time in a day to do things like read or watch movies together as a family, "to keep us bound together because they're growing up and...I'm not going to be here forever."

When routines were thrown off, some respondents turned to their support networks for assistance, and those who did not have access to support faced consequences like lost income as they prioritized caregiving over work. For example, Daisy described the choreography of carrying out childcare responsibilities with her husband, with one of them working an early morning shift and the other working in the afternoons and evenings to ensure that one of them is available for childcare as much as possible. Fortunately, when their routine breaks down, her mother-in-law lives nearby and can provide childcare support in a pinch. She is currently taking classes on the weekend to become an accountant so that she can have a job that allows her more control over her time for her kids.

Other time management strategies shared by respondents were longer-term. Often, these involved keeping things afloat while waiting, especially while waiting for housing circumstances to change. One caregiver in Mattapan explained “I’m just trying to find a good job and better housing. I’m hoping that somebody reaches out to me soon because I’m on a lot of [waitlists]...So I’m just praying that within 5 to 10 years, I have better housing...” Similarly, Elaine had been on a waitlist for about a decade for another apartment that could better accommodate her daughter’s disability. She said, “they said you’ve got to be on it for 10 years in order for something to actually come through for you, because there’s so many people. Because every time you get close and closer, you turn on the TV and someone’s been burnt out [in a fire], someone’s homeless, so they come first because of the simple fact that you already have a roof over your head... So it makes it very difficult for us to really jump up and be able to get something as soon as possible... I’ve been doing this ever since [my daughter’s] been little, and it’s very hard. And my son that’s 24, he signed up since he was 16, I started him signing up for apartments from him doing summer jobs.”

3.3.3.6 Balancing care with paid work

Many respondents were employed on a full- or part-time basis in addition to being a caregiver, and counted on their income to cover as much of their basic expenses as possible. Many also reported looking for or intending to look for new work that would improve caregiving conditions, such as by providing higher wages, more convenient hours, or less physical toll than their current job – however, for some it was difficult to find the time to engage in a full job search. Some shared the wish of moving in order to have access to better job opportunities, and one respondent shared that she had moved to her current neighborhood in order to be able to afford to support her dependents on a single person’s salary. “I had kids and it became harder with jobs and all that,” she explained, “so I ended up moving here, which is a little easier and it goes with my budget.”

Some respondents faced difficult calculations about whether or not to work a job in order to best provide for their dependents: since working would mean sacrificing access to

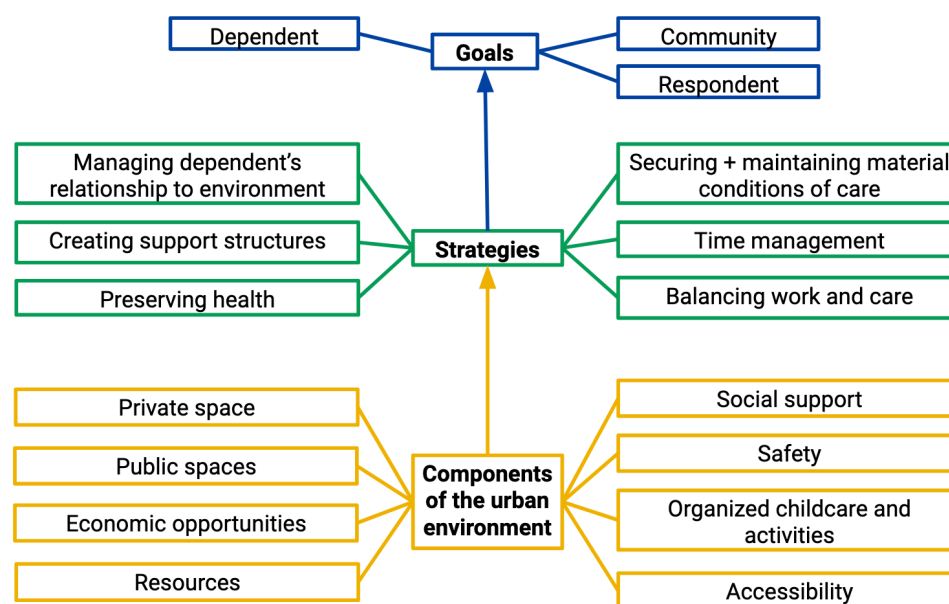
certain welfare options and needing to pay for childcare, it wasn't always the most sensible option. Iris broke down how she perceived the tradeoffs that she and others she knows have faced when it comes to combining work and caregiving. "You get an entry-level position. It's a minimum wage job. What is the minimum wage now? \$11.00? Let's think here. I'm coming from a Section 8 apartment. I'm getting MassHealth. I'm probably getting some food stamps. I may or may not be getting cash assistance. I get an entry-level job, all that's gone. All that's gone. Meanwhile back at the ranch, you might make \$370 a week, but you're only bringing home \$290. Realistically, can you afford to pay your rent? Because now, your Section 8's gone out the window, and you're at market value rent because there's no rent control anymore. Can you afford to feed your children? Can you afford healthcare for your family? If you don't have healthcare for your family, you're getting penalized at the end of the year. So it's a vicious cycle."

Some respondents were unable to work, however, whether because of the demands of caregiving or because of other issues that precluded them from doing so. Roberta was unable to work because of health issues, but volunteered in order to get a voucher for her grandkids to go to camp during the summer. Predictably, losing a job could be destabilizing, particularly for caregivers with high housing costs. Nina, who worked as a nanny, often had to change jobs when her clients' circumstances changed. She described a time when she was out of work: "I couldn't pay my rent, couldn't pay my bills. And I couldn't afford certain things for my kids...in six months, it will change again because I have to look for a new job because my job is ending. So I can't survive." Respondents' efforts to balance care with other forms of paid work depended on important components of the urban infrastructure of care like accessibility, economic opportunities, childcare and activities, and social support, as well as respondents' ability to coordinate across these different components day-in and day-out. Next, I elaborate on each of the empirically-derived components of the urban environment that make up the urban infrastructure of care upon which balancing work with care, and each of the other caregiving strategies discussed above, depend.

3.3.4 Components of the Urban Infrastructure of Care

Our analysis of caregiving goals and strategies indicated that caregiving strategies, and caregivers' ability to fulfill their caregiving goals, were dependent on eight components of the urban environment that we argue comprise the urban infrastructure of care within HNS communities. These include: private space; public space; economic opportunity; resources; social support; safety; childcare and activities; and accessibility (Figure 3.2). When these components are absent or inadequate, caregiving becomes more challenging for the individual caregiver. On the other hand, to the extent that these components are readily available or close at hand in the urban environment, caregiving becomes less demanding and caregivers are able to spend more time providing care as necessary and reduce the time and energy spent securing the basic conditions for care. Many overlap in some respects: private space can be a means for safety, childcare can be a means for support, etc. This overlap reflects the fact that, as the next section on "binds" shows, these components are not mutually exclusive but typically used in combination with one another to achieve caregiving ends.

Figure 3.2: Components of the Urban Environment that Caregivers Rely On



3.3.4.1 Private space

This component refers both to safe, stable and affordable housing, as well as adequate space within a home for caregivers and dependents to have privacy as needed. Most respondents expressed a degree of housing cost burden, and described making tradeoffs with other basic needs like food and health in order to be able to afford housing costs. Thus, the affordability of housing is one of the most important aspects of this component – especially in light of the fact that care is economically under-valued, that many caregivers work less and/or have lower incomes than people who are not supporting dependents, and that in the U.S. social welfare benefits are paltry. Respondents’ difficulties accessing housing subsidies or public housing also point to the importance of readily accessible housing assistance, as well as adequate sources of emergency relief for renters who fall behind on payments because of job loss or lost income due to caregiving demands. “I went through hell to get into it,” one caregiver said of the Section 8 voucher program. “That’s a journey that – I had my Section 8 for frigging 16 years now. But shit, I waited 10 years for [it]. It’s not easy... So whoever gets on one now, good luck. Good luck. That’s why you have so many people in shelters and all that stuff. Good luck. I’m praying to god that the government don’t just start taking them away because then we’re all going to be in trouble,” she said.

Many respondents expressed difficulty or anxiety in relation to securing housing that was adequately-sized as their caregiving responsibilities evolved, pointing to the importance of housing options with two or more bedrooms. A number of respondents shared stories about waiting months for things like plumbing and heating to be repaired in their homes, as well as dealing with concerns like lead, mold, and pests, pointing to the importance of housing quality and maintenance as part of this component. Finally, some respondents spoke to the impacts that the quality of the immediate environment around their housing, especially in multi-unit buildings, could have on their mental health and the quality of their dependents’ sleep and ability to spend time outside of their apartment – for example noisiness and disruptive behavior from other tenants and their guests.

3.3.4.2 Public spaces

Respondents – whether in dense center-city neighborhoods like Roxbury and Chelsea, or smaller cities like New Bedford or Fall River – relied considerably on public spaces in their neighborhood to ensure their dependent’s health, development, education, and socialization. Public spaces were identified as being important for caregiving because they provide people with outdoor space, activity space, and/or opportunities for building community cohesion. Types of public spaces respondents depended on for caregiving included parks, playgrounds, community gardens, sidewalks, and libraries. Each of these types of public space served as loci of certain activities that the space is geared towards – e.g. outdoor time at parks, learning at libraries – as well as open space that caregivers could repurpose towards their own needs, like holding a party at a park, spending one-on-one time with a dependent, or going to the library to relax when home felt hectic. Yvonne explained that parks were crucial to her caregiving routine: “They’re not able to go outside and play freely. Like if you had a house and a backyard with a fence. They’re not able to do that so a lot of them stay inside. So you have to take them – we have a lot of amazing parks. Actually, yesterday we took [my daughter] to seven different parks...From park to park... You have to take them out, but you have to watch them. It’s not like a city where the kid is able to roam on their own.” Respondents often avoided public spaces when they were deemed to be a risk to their dependent’s safety, for example because of the presence of used needles in the sandbox at a park, and when caregivers felt a lack of ownership and agency in the space, for example if they reported difficulty negotiating how to share the space with the others using it at the same time.

3.3.4.3 Economic opportunities

This component refers to the opportunities caregivers have to secure the economic means to support themselves and their dependents in terms of meeting material needs and living comfortably and safety. For respondents, this included opportunities to work, opportunities to receive financial support from the government, and opportunities to pursue further education. A handful of caregivers of color also reflected on racial inequities in their local landscape of economic opportunity, and felt that they and their

dependents were less likely than white residents of their neighborhood to benefit from new economic opportunities like small business ownership in ways that would increase their family's generational wealth.

Caregivers in our analysis often had difficulty finding work that could accommodate their caregiving responsibilities while also ensure economic means and stability. Pearl, a single caregiver, described the difficulty she faced finding work to support her family in Fall River: "I'd prefer the third shift at night because I want to be there for my children. And I can tell you that is definitely out of the question to try to find mother's hours in this city because I've searched them high and low and they're very hard to find... I would prefer to work third shift even though I know that's taxing on my body but at least it gives me the most time with my kids." Many caregivers reported delaying efforts to further their own education until their dependents were living independently because of the time and financial costs of caregiving, and living with lower wages and/or unstable jobs as a result. Finally, as described in the previous section, many caregivers faced sub-optimal tradeoffs between jobs that made caregiving more challenging or demanding (because of the hours or physical toll, for example) and applying for government benefits that only afforded a low standard of living.

3.3.4.4 Resources

Neighborhood resources are essential for helping caregivers make ends meet when money is tight and providing key services that caregivers depend on to ensure good conditions for care. Resources include institutions and organizations focused on helping a community, like food pantries or community health centers, as well as services provided by organizations like churches. Resources that provided no- or low-cost sources of basic necessities proved crucial because they allowed caregivers to reduce the risk of having to make tradeoffs between housing and other basic needs, thus providing a sense of security, and allowed respondents to enhance their quality of living without needing to make tradeoffs between paid work and caregiving. Neighborhood resources that respondents relied on for support in ensuring their dependents' wellbeing included: food pantries and sources of reduced-cost food (like \$2 bags of produce); organizations providing diapers

and other health and wellness-related products; organizations providing furniture; and organizations providing healthcare and supportive services like social work or counseling. Many respondents pointed to the importance – and often difficulty – of accessing information about resources. When such resources are not perceived by respondents to be present in a community, they are typically forced to go further afield or find alternatives rather than foregoing the resource, since most are essential: “we just have to figure it out however.”

3.3.4.5 Social support and cohesion

The prominence of “building support structures” as a strategy, along with the presence of community-oriented caregiving goals, indicates that social support is a key environmental component of care. Social support for caregiving is environmental in nature because it is dependent on physical proximity – for the most part, respondents received social support with care from friends or family who lived nearby. This is because the tasks for which they sought support – like food preparation, childcare, or transportation – required physical presence and, often, the ability to lend a hand at short notice. While in the previous section I demonstrated that building support structures was a common strategy among respondents, many respondents nevertheless found the support that they did have from family alone to be inadequate. For example, one respondent described how she could call on her elderly mother for childcare support in a pinch, but that her mother’s mobility issues made childcare difficult. Another respondent explained how family support wasn’t always as reliable as it needed to be: “[my grandmother’s] always there if I need anything or anyone to talk to...but she’s one of those that does things if she feels like it. So it’s not really 100% with her.” This points to the need for levels of community cohesion that would enable caregivers to have trusting relationships with neighbors who they could call on for caregiving support. Some caregivers pointed to what they perceived as an absence of social cohesion in their community as contributing to difficulties establishing new social support relationships after moving to a new place.

3.3.4.6 Safety

Safety was perhaps the most consistent concern across caregivers about the urban environment, pointing to the importance of safety in public space as an environmental component of care. Safety concerns were often articulated in relation to gaps in caregiving – for example, concerns about dependents being “on the street” in the after-school hours before caregivers were able to return from work. Respondents’ concerns about safety were overwhelmingly social in nature, concerning crime, violence, and substance use. The most often-cited physical safety concerns were physical disrepair and waste in parks. Safety concerns were often cited as reasons respondents and their dependents avoided spending time in public spaces in their neighborhood, such as parks, athletic areas, streets and sidewalks. For some, the intention was to avoid other members of their neighborhood, and for others, this was an unintended and unwelcome consequence of avoiding spending time in public.

Many respondents pointed to public drug use as a safety concern, pointing to the need for alternative spaces in communities for people who use drugs to safely do so, as well as for enhanced access to treatment and housing for drug users who may be homeless. For example, Crystal, a caregiver in Brockton, explained: “I’ll go look on my porch before I go outside to see who’s out there or what’s going on or if the cops are out there or if someone’s shooting up in my alley or if there’s needles. I can’t let my kids play outside.” A number of respondents contextualized their safety concerns related to drug use within the transformations underway in their neighborhood. For example, referring to rising rates of public drug use in her neighborhood, which were the source of safety concerns for her, Yvonne said “when you’re doing a transition like that, it’s hard...people are hurt and I don’t know how do you start the healing process because people are lost... I think that’s where addiction comes from, is when people realize that that dream that they were taught when they’re young is not really attainable anymore.”

Consequences of safety concerns included decreased social connection with neighbors, increased isolation, and increased desire to leave the neighborhood and find housing elsewhere. Decreased opportunities for dependents to spend time independently or with others meant increased demands on caregivers. Pearl described how safety

concerns led her to feel the need to withdraw from her community: “You can walk down a little one city neighborhood block and you can see so many things that you don't necessarily want to see and you definitely don't want your children to see, it turns you away from wanting to be a part of anything.” Others with similar experiences lamented that this left their dependents more physically and socially isolated than they would like, because it resulted in them spending more time inside the home than outdoors or in public spaces.

3.3.4.7 Organized childcare and activities

Childcare and activities are another crucial component of the urban environment for caregivers. They are grouped together because often, especially for children, they overlap. By childcare, I am referring to formal sources of childcare such as schools and daycares, as well as after-school programs, all of which respondents have identified as key sources of childcare that they rely on. Informal sources of childcare via social support from neighbors and families are covered separately under the “social support” component. Childcare is a crucial source of support for caregivers of children, especially those who do not have childcare support through their social support or family networks, and those who are working jobs in addition to caregiving. However, respondents commonly reported struggling to find affordable after-school childcare programs, and many forewent them as a result. For example, Stacey explained: “I think it’s not well advertised. So if you’re a struggling parent and you want your kid to just go to an after-school program and feel like they’re safe, you don’t know where they are. So you’re going knocking on daycare doors and it’s like \$200 a week and you’re like okay, never mind. Now my kid’s home alone.” Other respondents described spending considerable effort finding affordable childcare options, often at a cost in terms of accessibility. One respondent reported only being able to find affordable after-school care at an inaccessible distance without transportation options available.

By activities, I mean organized activities like sports clubs or summer camps, as well as those provided via institutions like museums. Informal activities, like going to a playground, are covered separately under the “public space” component. Activities can be

organized, such as after-school programs or events in the community, but can also refer to viable options for caregivers to do things with their dependent like go to a park, fish at a beach, or visit a museum. Caregivers mentioned valuing different types of activities including sports and games, arts and culture, community service, and internships and job/skills training for adolescents. Some caregivers noted that continuity of activities was important to them: this allowed them to build trust and rapport with organizers, and when activities doubled as childcare, feel confident that challenges their dependents encountered would be addressed appropriately. Respondents described activities as being crucial for socialization, exposure, physical and mental activity, health, and in some cases filling childcare gaps. Some caregivers also reported appreciating activities that allowed caregivers to build relationships among each other, noting that this contributed to social cohesion in their communities and more caregiver involvement in neighborhood issues.

Like childcare, cost is typically a concern with activities. Respondents noted that many activities can be unaffordable, especially for single parent caregivers, and described spending time searching for free or discounted options. Similarly, some respondents described facing difficulties finding activities they could access without a car, pointing to the importance of transport-accessible and walkable activities. Pearl said “we make a lot of memories through the summer because I find different events that don’t require money and they don’t require you to have a vehicle. And neither of which we really have much of. But I try to go to all the free events I can find.”

One respondent described the tradeoffs caregivers often face trying to ensure continuity of care throughout the day as they balance economic and time constraints, and argued that large-scale investment on the part of the city was necessary to alleviate many of the challenges caregivers face as a result. Yvonne reasoned that “With the city, what they’re going to have to develop with the children is daycare, it’s like care, because that’s what happened with me. You know job, 9:00 to 5:00. She goes to school from 7:00 to 2:00. There’s a problem... Everyone doesn’t have grandparents, everyone doesn’t have that extra...the Boys and Girls Club is \$75 a week... So the community needs to have an all-round support system for families...there should be a huge emphasis on youth childcare, huge. Playdates, childcare for kids for socialization. And I don’t even know

how much it costs them but I know to get childcare is very expensive.... When a person has to make a decision, is it more economical for me to go to work or stay home because daycare is \$250 a week?... you shouldn't have to make a choice like that."

3.3.4.8 Accessibility

The final component of the urban environment that our data shows is crucial for care is accessibility. By accessibility I am referring to the ability to physically access the locations of basic goods and services – including the above components – as well as key locations like work and family members' homes. For the respondents in the sample, accessibility means being able to travel in a car-free, safe, and comfortable manner such as walking or taking a bus, *with their dependent*. When the urban components of care are not accessible, respondents must either work to arrange alternate transportation, or they are just not used, and thus effectively unavailable to caregivers. Unsurprisingly, accessibility was a key factor in many respondents' housing decisions, and their assessments of whether their housing and neighborhood were adequately meeting their needs.

3.3.5 Uneven Urban Infrastructures of Care Produce 'Care Binds'

When the necessary components of the urban environment are not in place, caregivers may find themselves in what I call "binds." A bind is when a caregiver's ability to carry out caregiving strategies and/or meet caregiving goals is inhibited by conditions of or changes in their social or environmental context. Binds can arise when, as a result of the availability and quality of the urban environmental components of care (a) the work of care is individualized and/or (b) the demands of caregiving exceed the abilities of the individual caregiver. Binds can also arise when sets of "components" cannot be accessed simultaneously. Binds force sacrifice, compromise, tradeoff – they restrict the breadth of caregiving possibility, at least on a material basis. The result is that caregivers are stuck in sub-optimal caregiving circumstances, with their ability to improve or exit such

circumstances temporarily or permanently inhibited by environmental factors. Often, this leaves caregivers with a greater burden of care work.

Single parents and other solo caregivers – are particularly susceptible to binds. They face steep challenges carrying out care strategies and fulfilling caregiving goals in contexts where they have minimal support – both social support and from institutions – and housing is expensive, requiring them to work at the expense of devoting a satisfactory amount of time and energy to caregiving.

Housing was the most common factor leading to binds for respondents. In an expensive housing market like Boston, with a tight supply of market-rate, subsidized and public housing, respondents often found themselves struggling to keep up with rent payments, struggling to find housing that met their household's needs, and struggling to access subsidies and other housing-related resources. Yvonne described how trying to balance work and caregiving responsibilities as a single parent led to health issues, which in turn led to her being unable to keep her income and thus unable to afford housing, and she ultimately ended up homeless and living in a shelter before finding her way back to stable housing. She explained:

“So what happened with me was from having my daughter and trying to keep up, right? Eventually, my bottom fell out and I got depressed, and I got sick, and I couldn’t keep up with it. And so then if you miss one payment of rent, and then, God forbid, two. And you think you’re going to work overtime to catch up with it, you can end up on a gerbil wheel where in your mind you’re like “Okay. I can catch up. I can catch up. I can do this. I can do this.” And don’t let something happen, right? And then your bottom falls out.... I had a job, and then I worked two jobs. And then I was exhausted and then I lost both jobs. And then I was moving around and housing, it wasn’t good... You think you’re just going to pop back up. No, it’s taken years. When your bottom falls out, it takes years to rebuild, and it’s sad.”

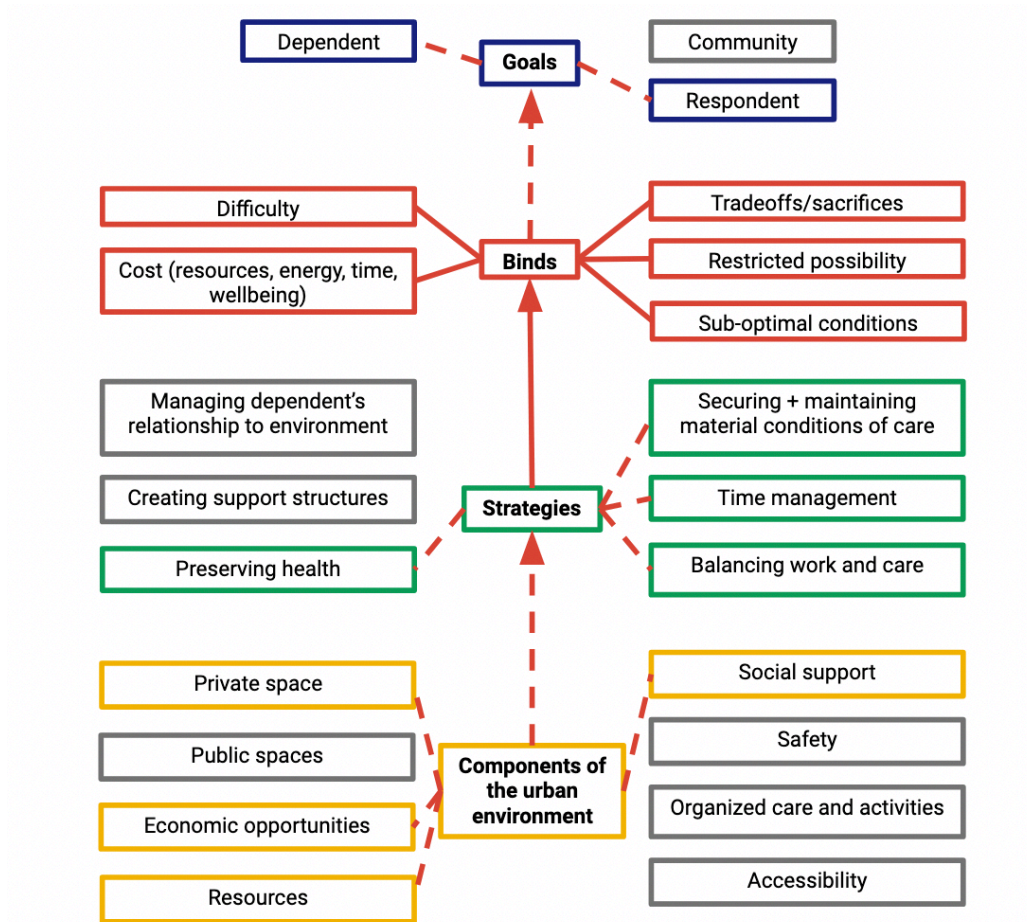
Though she was living in Mattapan when she became homeless, she was placed in a shelter hotel in a nearby suburb, where she lived for about a year. Living at the shelter

with her daughter, she was “getting \$300 a month on welfare” and was “severely depressed.” She was ultimately able to access housing through a lottery program she entered through the shelter. “Can you believe that? This [was] a lottery. Can you believe that? It’s really scary to think...” *Figure 3.3* illustrates the concept of care binds as they relate to the urban infrastructure of care and the caregiving strategies that depend on it, from the perspective of this example from Yvonne’s experience.

Limited or lacking support for caregiving can also lead to binds. Nina described that she had no support with childcare, so when her kids had health issues, she was forced to miss work and lose wages, leading to difficulty making rent payments in certain months. Jen explained that she wanted to move out of Brockton to find a better job and improve her and her dependent’s quality of life, but relies on childcare support from her grandmother in order to be able to work, which she would not have access to elsewhere, and is thus unable to move. Similarly, Crystal wanted to find a better-paying job to stabilize her household’s stressful financial situation, but felt that she didn’t have the time or support to do so while keeping up with her day-to-day caregiving responsibilities, and worried about finding a job with flexible hours.

Changes in neighborhood resources that respondents rely on for care support can also produce temporary binds. One caregiver described a recent summer where the library and community center in her neighborhood in Roxbury were both closed for repairs and renovations. She said that she and others in her neighborhood didn’t know what to do about childcare and activities: “Where do we send the kids?” The fees were higher at the other local options, and transportation plans had to change. “The kids got displaced,” she said. “It’s hard enough to get a job and keep a job before you have to worry about where your kids are going to go.” The buildings “needed to be fixed a long time ago,” she explained, “so why both now?” The change left her “trying to stay above water, making it day-by-day.”

Figure 3.3: Care binds illustrated through Yvonne's experience of homelessness



3.4 Discussion

3.4.1 Summary of findings

I find that caregiving is of paramount significance to respondents: to a large extent they build and “wrap” their lives around their caregiving responsibilities, and endeavor to change their lives as the demands of caregiving evolve. Our data shows that respondents have important caregiving goals for themselves, their dependents, and their communities that respond to perceived conditions and characteristics of the urban environment. These goals seek to ensure that dependents’ basic needs are met, that their dependents have the awareness necessary to nurture and maintain their health and wellbeing now and in the future, and that they have the greatest degree of freedom possible with respect to their

future trajectory. This means that the urban environment shapes caregivers' perceptions about what good care is and how to accomplish it – what they are working towards, and why.

The urban environment also shapes how caregivers carry out this work – what the work of care entails. In accordance with their caregiving goals, respondents adopt a wide range of strategies that take up or fend off various aspects of the urban environment in order to fulfill their caregiving responsibilities, from the day-to-day routine of putting food on the table to the sometimes years-long process of securing suitable and affordable housing. These strategies can be grouped into six domains: managing the dependent's relationship to their environment; securing and maintaining the material conditions for care; creating support structures; preserving health; time management; and balancing care with other forms of work. And, as I show in Chapters 4 and 5, these caregiving strategies not only reveal what the work of care entails but at what cost. Caregivers' experiences pursuing these strategies, doing the infrastructural labor of care, can be difficult, challenging, burdensome and taxing, primarily mentally but also physically. At the same time, these strategies illuminate caregivers' resourcefulness and adaptive capacity, and point to an important source of working knowledge about how cities function and how they might be improved.

Our analysis also reveals that these six types of caregiving strategies that rely on various combinations of eight components of the urban environment to fulfill their caregiving strategies. These include: private space; public space; economic opportunity; resources; social support; safety; childcare and activities; and accessibility. The availability and adequacy of these components influence the strategies that caregivers undertake in an effort to fulfill their caregiving goals, and the degree of choice and agency they have in doing so. These aspects of the urban environment that shape what caregivers are working towards, why, and how encompass well-trodden grounds of planning practice in areas including housing, community development, economic development, mobility, land use, design, and public health.

Finally, I find that the absence or inadequacy of these key environmental components of care can leave caregivers – and especially solo caregivers – in what I call “binds” where

their ability to carry out intended caregiving strategies is compromised, forcing sacrifices and tradeoffs that restrict the breadth of caregiving possibility and, often, make the work of care more burdensome.

3.4.2 The Urban Infrastructure of Care

I argue that from an urban planning perspective, we can view the eight components of the urban environment that caregivers depend on as part of their efforts to fulfill their caregiving goals as comprising the urban infrastructure of care in the HNS study context. Infrastructures are the background conditions that make other types of work possible (Star, 1999). In this case, my analysis hones in on the background conditions of the urban environment that make care work possible. Planners have often taken infrastructural approaches to address urban challenges, such as sanitation and mobility. I argue that just as we can analyze mobility from the perspective of infrastructure, and just as we can intervene to enhance mobility by developing infrastructure, planners can do the same for care in research and in practice. This is because the urban environment spatially organizes key resources and relationships that shape the possibilities for care.

As the experiences of the caregivers in this study show, the urban infrastructure of care is spatially uneven, incomplete in some cases, inadequate in others – just like the healthcare infrastructure, for example, or mobility infrastructure. The spatial unevenness of the urban infrastructure of care is a product of the ways that the history of urban development interacts with broader political economic shifts in the mode of production and state strategies for governing and supporting social reproduction. I find that the unevenness of the urban infrastructure of care in a caregiver's context shapes what the work of care entails – in terms of the strategies caregivers employ to fulfill their caregiving goals, the intensity and toll of the labor involved therein, and even their caregiving goals themselves. I also find that when the necessary components of the urban infrastructure of care are absent or inadequate, caregivers can encounter 'care binds' wherein the possibilities for caregiving are constrained in ways that introduce costs, difficulties, and tradeoffs for caregivers and often result in sub-optimal conditions for care.

Because the urban infrastructure of care is partial, caregivers can find themselves engaged in infrastructural labor, connecting and coordinating across different components of the urban environment to combine them into the conditions necessary for caregiving, to the best of their abilities. This is akin to what Star and Strauss (1999, p. 10), in their discussion of how different forms of work become visible or invisible call ‘articulation work’: “work that gets things back on track in the face of the unexpected, and modifies action to accommodate unanticipated contingencies.”

At the urban scale, population-level patterns of who has to perform infrastructural labor to accomplish care in the absence of the necessary infrastructural support from the urban environment, and of who ends up in care binds, contribute to racial, gender, and economic inequities in cities. In this way, the conditions of the urban infrastructure of care can contribute to the stratification of social reproduction. It follows, though, that by investing in the urban infrastructure of care – strengthening its components, building viable connections between them, and ensuring that it is equitably distributed across urban space – urban planners can work to both alleviate and more equitably distribute the burden of care work that relies on the urban environment.

3.4.3 Planning for Care

All individuals are cared for in some form over their life course, and most also serve as caregivers for others in some capacity. For the respondents in this sample, caregiving plays an important role in shaping how they interpret and make meaning of different aspects of the urban environment, for example: how they perceive qualities like safety, accessibility and affordability; how they make decisions about where to live and where to spend time; how they interpret whether or not changes in the urban environment are to their benefit; and how they endeavor to create healthy conditions for themselves and their dependent. For urban planners, this points to the importance of adopting care as an evaluative lens through which to understand the impacts of urban processes, plans, and policies on their constituents, since many constituents will perceive these impacts from the perspective of their own caregiving roles and responsibilities. While this is in accordance with Lyles and

White's (2019) charge to "reimagine planning as caring," evaluating urban plans and outcomes from the perspective of care means not just caring, but specifically caring *about care*.

Thus, I argue further that enhancing the socio-spatial conditions for caregiving at the urban scale should be a priority for planners, and a central aspect of planning for livability and healthy cities. Doing so would involve ensuring that all residents of a city had equitable access to the urban components of care, ensuring that caring strategies were as free as possible from sources of friction rooted in the urban environment, and that caregivers were able to fulfill their caregiving goals. Put simply, it means plans and policies that make care easier – whether by redistributing the burden of care work away from individuals and on to the collective, or by making the care work that individuals do as easy and as least taxing as possible. This entails integrating caregiving as a key consideration in planning processes, and assigning value to the impacts of plans and policies on caregiving, in the same way that planners would assign value to the economic, health, or environmental justice dimensions of interventions in the built environment.

The results demonstrate that planners ought to treat care as a central dimension of urban livability, inasmuch as characteristics of cities determine the nature of the work involved in making urban life viable on a day-to-day basis and over the life course, by affording or withholding important resources and enabling conditions for care. The urban environment structures respondents' access to and control over the means of social reproduction: the resources and relations necessary to make life day in and day out. Moreover, it shapes caregivers' sense of what is possible or good for their dependents and accordingly what should be done in terms of caregiving to ensure wellbeing and healthy development. Caregivers' strategies respond to enabling or inhibiting conditions in the urban environment in the service of meeting their caregiving goals, working with or against them like the grain of wood. How we measure and assess changes in urban livability, then, should account for how conducive cities are to caregiving. How easy or difficult it is to care in a city is very much a reflection of how livable that city actually is.

Planning with a focus on enhancing the conditions for care is likely to help planners simultaneously advance a number of key priorities, including racial, gender, and health

equity. This is because, on the one hand, the burden of care work is unevenly distributed across society, falling predominantly on women and people of color, with a broad range of economic, social and health impacts including lost earnings, lost time, and lost sleep. And on the other hand, care is central to health, whether in terms of preventative measures like eating well, spending time outdoors, and developing emotional skills, or in terms of coping with the consequences of health challenges, including those stemming directly from exposures in the urban environment.

An infrastructural approach to enhancing the conditions of caregiving in cities would entail treating the urban components of caregiving – the nature of which shape the caregiving strategies people adopt and the difficulty they encounter carrying them out – as important goods with uneven levels of availability and access across urban space. It would further entail seeking to understand the causes of and address unevenness in the availability of and access to the urban ingredients of caregiving (“means of social reproduction”) as part of efforts to design, execute, and evaluate interventions in the urban environment, with the goal of maximizing equitable provision of and access to the infrastructure of care. It is necessary to see the components of the urban environment that matter for care as a system because otherwise we will not be able to see the gaps between the components and how different elements do or don’t combine to produce what people need to fulfill their caregiving responsibilities and goals.

Many existing planning efforts already align with the goal of enhancing the urban infrastructure of care. Consider housing. Plans and policies to maintain and expand housing affordability stand to free up household resources for other priorities like food while also reducing the pressure on caregivers to work more than they have the time to in order to make ends meet. Housing stability initiatives stand to reduce disruptions to neighborhood social networks, thus ensuring that more nodes of caregivers’ neighborhood support networks can stay in place. Efforts to expand the availability of family-sized units would reduce pressure on caregivers to find new housing as their caregiving responsibilities evolve, and perhaps allow more geographic concentration of caregiving support by opening up more opportunities for intergenerational living. Healthy housing

initiatives can reduce the environmental stressors like lead, mold and pests that occupy caregivers' energy and resources and reduce the risk of dependent illness.

In other domains, an infrastructure of care approach might provoke new approaches. Economic development is one example: planners could ensure that the jobs created in a community can support a caregiver, both materially by paying a living wage that accounts for the fact that many wage-earners support dependents, as well as in terms of working hours and physical toll. Relatedly, planners could consider strategies to develop and elevate the status of the local care workforce – one of the largest and fastest-growing labor sectors in the country, albeit with low wages because of the historical value of care work. Finally, planners could begin to calculate the value of unpaid care work in their communities, following methods developed by Folbre (2006), Duffy et al. (2013) and other economists to assign monetary value to unpaid care, and integrate these calculations into assessments of economic costs and benefits of planning decisions.

With respect to addressing the broader 'crisis of care' under capitalism, planners might also gain traction by considering context-specific components of the urban infrastructure of care like the eight identified in our results as integral pieces of a broader infrastructure of care alongside more traditional components like hospitals, community health centers, or nursing homes. Researchers, advocates and policymakers have begun to argue for the merits of understanding care needs broadly in terms of the infrastructure that supports them (Kalipeni & Kashen, 2020; Tankersley, 2021). Planners have the potential to step into key roles helping to coordinate across and equitably distribute these infrastructural resources.

3.4.4 Directions for future research

There are numerous ways that planning scholars can advance our collective understanding of the ways that the urban environment shapes care, and further develop the framework of the urban infrastructure of care. The picture of the urban infrastructure of care arrived at in this analysis is specific to the context of the HNS: working-class communities with high proportions of people of color in a large U.S. metropolitan area.

The framework of the urban infrastructure of care derived from this context merits further development through comparison with the components of the urban environment that caregivers in other contexts – for example, suburban areas, affluent areas, rural towns, areas with different demographic characteristics, and areas outside of the U.S. – rely on to fulfill their caregiving goals, and the strategies involved in doing so. It would also be productive to analyze how the urban infrastructure of care is uneven across specific urban areas – where is it more or less robust, and why? And does what caregivers do to adapt to and compensate for this unevenness differ, and how?

Planning scholars might explore how interventions in urban environments – including those in familiar domains of planning like housing or economic development, as well as new interventions geared towards care itself – can contribute to more robust and equitable infrastructures of care. And similarly, we might explore – as I do in the following chapter – how different processes of urban change influence the urban infrastructure of care. We might also develop metrics for tracking how urban infrastructures of care evolve and perform, and for identifying how to upgrade and more equitably distribute it. By doing so, we stand to substantively advance our ideas of how well cities function, by better understanding how well urban environments support this most crucial of human functions.

3.5 Conclusion

Will cities exacerbate or alleviate the crisis of care under capitalism? This crisis is rooted in a failure of the market – in this case, to recognize and value care – which is historically cause for planning intervention. Moreover, most planners would agree that planning should remedy existing disadvantage (Fainstein & DeFilippis, 2016). Cities compound – via reinforcement – structural inequities in who bears the burden of social reproduction and how burdensome social reproduction is. I contend that not planning to alleviate the crisis of care amounts to exacerbating it. If planners are to plan *for* care – and not just plan *with* care – learning to attend to care as it already exists in the life of cities must be their first step. To do so, I recommend adopting the infrastructural approach

discussed above, which can help planners identify which components of the urban environment are most necessary for care, and assess the availability and suitability of those components – and inequalities therein – across the urban landscape. Planners can alleviate the crisis of care by investing in local infrastructures of care in ways that: (a) make care visible and valued; (b) ensure full and equal access to the environmental components of care; (c) ensure that caregiving is as free of material difficulty as possible; and (d) ensure that the burden of care work is equitably shared.

4 “You don’t win, okay?”: Gentrification and care insecurity

4.1 Introduction

This chapter explores how changes in the components of the urban infrastructure of care influence the work of caregiving. I focus specifically on changes in the urban infrastructure of care associated with gentrification, a term used to describe the process of “the production of urban space for progressively more affluent users” (Hackworth, 2002). Changes to urban environments associated with gentrification typically include new residential and commercial real estate development, upgrading public spaces like parks and sidewalks, the in-migration of wealthier and often whiter residents, and the displacement of individuals, communities and culture. My analysis focuses on how caregivers perceive these and other gentrification-related changes that they see in their neighborhoods, how they experience the condition of displaceability, and how these perceptions and experiences shape their experiences as caregivers and their overall wellbeing.

In the previous chapter, I established that caregiving is dependent on eight key components of the urban environment that can be understood as an urban infrastructure of care, enabling and shaping the conditions of everyday care work in the city. These include: private space, public space, economic opportunities, resources, social support, safety, organized childcare and activities, and accessibility. I also found that there were patterns of caregiving strategies that depend on the urban environment that caregivers employed to work towards goals for their dependents, their communities, and themselves. Six types of caregiving strategies stood out: managing the dependent’s relationship to the environment, creating support structures, preserving health, securing and maintaining the material conditions of care, time management, and balancing care with other types of work. Finally, I found that when elements of the urban infrastructure of care are missing or inadequate, “care binds” are produced. Binds occur when a caregiver’s ability to carry out

caregiving strategies and/or meet caregiving goals is inhibited by conditions of or changes in their neighborhood context. Binds force caregivers to make sacrifices, compromises, or tradeoffs that restrict the breadth of caregiving possibility. They also cause caregivers to perform additional “infrastructural labor” in order to compensate for the shortcomings of the urban infrastructure of care.

This chapter seeks to build on the results of the previous chapter by using the urban infrastructure of care framework as a lens through which to interpret the experience and impacts of gentrification and displaceability on informal caregiving and caregiver wellbeing. My analysis explores what the urban infrastructure of care framework and the typology of caregiving strategies that depend on the urban infrastructure of care reveal about the impacts of gentrification and what they mean for caregivers. Thus, I use the empirically derived components of the urban infrastructure of care to categorize the types of changes in the urban environment that respondents experience. Similarly, I use the typology of environmentally-dependent caregiving strategies to organize my understanding of how neighborhood changes shape the work of care and the abilities of caregivers to fulfill their goals. Because caregiving is such a significant priority and responsibility for the respondents in this study – as it is for most people for some portion of their lives – examining the impacts of gentrification on caregiving in such detail affords a deeper understanding of the meanings that people assign to their experiences of gentrification, as well as a new dimension through which to interpret the implications of gentrification for the wellbeing of poor and working-class people living in gentrifying neighborhoods.

To help operationalize the concept of gentrification in this analysis and identify neighborhood change processes that are associated with gentrification, I draw both on the large body of scholarly research on the subject, as well as findings about gentrification arrived at through HNS collaborative data analysis workshops, as described in *Chapter 1, Section 6.4*. Bridging academic and community perspectives on gentrification affords a broader lens on the phenomenon of gentrification that encompasses explanations of both the causes gentrification rooted in the political economy of urbanization, as well as of how these changes manifest in psychological, emotional, and material ways in the lives of

individual neighborhood residents. I drew on the HNS Resident Researchers conceptualization of the experience of gentrification to make meaning out of the data, and on the scholarly literature on gentrification to link this meaning to broader conversations about how cities are changing under neoliberalism.

This analysis is intended to contribute to three nested conversations about neighborhood change and community wellbeing. The first concerns the relationship between gentrification and health. Scholars working in this area have called for more qualitative research centered on residents' lived experiences of gentrification. This heeds these calls and contributes to my overall argument that we can gain a deeper understanding of the way that gentrification and conditions of displaceability become embodied by examining how they shape caregiving and caregiver wellbeing, because of care's centrality to health. Additionally, this analysis examines gentrification from the perspective of stage, pace and process rather than just whether or not a community is considered "gentrified" which affords a finer-grained perspective on how the machinations undergirding gentrification shape wellbeing.

The second intended contribution is to conversations about urban livability and planning for health and wellbeing. Gentrification has become a significant concern for urban planners and an important domain for different types of planning interventions, some of which seek to leverage or advance gentrification as a strategy for urban revitalization, and some of which seek to forestall it and allay its effects, particularly displacement. This chapter contributes insight into how some of the ways that gentrification is purported to benefit communities – for example by affording economic opportunities – fail to benefit low-income caregivers living in gentrifying communities. It shows how real improvements in some elements of the local infrastructure of care brought about by gentrification, such as improved parks and green spaces, may not actually translate into greater wellbeing for caregivers because of other forms of vulnerability brought about by gentrification, such as housing cost increases. Finally, the findings provide guidance for planners for ensuring that investments in the urban infrastructure of care benefit lower-income caregivers rather than harm (or potentially displace) them.

Third and finally, this chapter is intended to contribute to conversations about the contemporary “crisis of care” by showing how the capitalist production of space – of which gentrification is an exemplary process – exacerbates these crises. The chapter shows that the dynamic of uneven development of which gentrification is a part intensifies the crisis of social reproduction under financialized capitalism by further undermining and stratifying social reproduction. By showing how this crisis is produced in part by processes of spatial transformation, I hope to shine light on how planners can work towards alleviating the crisis of care by de-commodifying the urban infrastructure of care, thereby freeing up care itself and contributing to well-being by enhancing the spatial capabilities that afford people the opportunity to fulfill caregiving functionings.

4.2 Methods

4.2.1 *Identifying gentrification-stage clusters*

A hierarchical cluster analysis was conducted by my colleague Sebastian Olascoaga to evaluate similarities and differences in the pace of urban development between the nine HNS study sites. The analysis took into account a wide range of variables to measure changes in domains including: population demographics and socio-economic characteristics, housing cost and availability, environmental justice indicators, and zoning (see *Appendix 3* for full list of variables).

The results of this analysis revealed three clusters of HNS communities with different gentrification paces and trajectories (*Table 4.1*). Cluster 1 consists of communities where the pace of change stayed low between 2009-2018: Fall River and New Bedford. Cluster 2 consists of communities where the pace of change began low but became high over the course of 2009-2018: Everett, Brockton and Lynn. Finally, Cluster 3 consists of communities where the pace of change remained high over the course of the analysis: Roxbury, Dorchester, Chelsea, and Mattapan.

Table 4.1: Gentrification stage clusters

Cluster 1	Cluster 2	Cluster 3
<i>Low pace – low pace</i>	<i>Low pace – high pace</i>	<i>High pace – High pace</i>
Fall River	Everett	Roxbury
New Bedford	Brockton	Dorchester
	Lynn	Chelsea
		Mattapan
<i>Number of respondents per cluster</i>		
18	8	37

4.2.2 Sample

Grouping respondents' neighborhoods according to the hierarchical cluster analysis produces somewhat uneven groups for comparison (*Table 4.1*). There are 37 respondents in Cluster 3, which includes four communities. In Cluster 2, which includes three communities, there are only 8 respondents. Moreover, only one of these respondents was from Lynn, and while she has children, they were not in her care at the time of the interview and she indicated that this was not temporary and that they had lived elsewhere for some time. Cluster 1, which includes two communities, has 19 respondents.

4.2.3 Qualitative data analysis

The analysis conducted for this chapter builds on the three cycles of open, analytic, and axial coding undertaken for the previous chapter in two ways. First, I conducted additional axial coding on passages that were previously analytically coded as concerning perceptions and experiences of neighborhood-level change. I did so in order to analyze patterns of (a) what respondents saw changing in their neighborhoods, (b) what they thought was causing or driving these changes, (c) what they thought the consequences of these changes were or could be, and (d) what meaning they made out of the changes, causes, and consequences and how this made them feel. Via this additional axial coding, I sought to interpret this data about perceptions of neighborhood change through the framework of the urban infrastructure of care. Second, I applied attribute codes to each transcript according to the gentrification-stage cluster that the respondent's community fell under. Using these attribute codes, I explored differences in respondent experiences

across gentrification-stage clusters in: (a) components of the urban infrastructure of care and how they were changing, per the additional axial coding mentioned above; (b) respondents' experiences undertaking the different types of caregiving strategies identified in the prior chapter's analysis; and (c) the types of care binds respondents found themselves in.

Based on this additional coding, I sought to understand how respondents perceived the changes in their neighborhood to be influencing the components of the infrastructure of care, and the effects this influence on respondents' caregiving strategies, such as whether strategies became easier or more difficult to carry out as a result of neighborhood changes, or whether respondents felt more or less confidence or control over their abilities to carry out these strategies. Further, I sought to understand how these links differed across communities according to gentrification stage cluster. I used a table format to organize analytical memo-writing for this analysis, with the gentrification-stage clusters as columns and the various caregiving strategies and infrastructure of care components as rows. This allowed me to document patterns specific to each cluster while simultaneously build an understanding of differences across clusters.

Based on the patterns of respondent experience identified via the coding procedures and documented in the analytical memo tables described above, I identified 2-3 respondents from each cluster whose experiences most fully represent and convey the patterns of responses found in that cluster. I center my reporting of the results on these three cases, and highlight the ways that their experiences align with or differ from other respondents in their respective clusters. Exploring these cases in more detail, rather than just presenting snippets of data from a broader range of respondents, affords the opportunity to demonstrate in a more holistic manner how the full range of a caregiver's experiences of neighborhood changes interact with one another to shape the experience of caregiving, and to provide a more coherent picture of the meaning, emotional valence, and material consequences of these changes for these respondents. However, because of the level of detail, I have also changed some biographical details about respondents to help ensure that they cannot be identified based on their experiences.

This strategy is inspired by, though different from, the case-study logic approach to qualitative research put forward by Small (2009), who draws on the work of Yin (2014) and Mitchell (1983) to argue that treating interview respondents as cases is more conducive to generalizing findings via hypotheses and theory-building in a manner appropriate to qualitative data – that is, via logical inference about the internal conditions of the cases - than by treating a sample of interviewees as representative of a broader population and using the logic of statistical inference. An additional advantage of this strategy is that it helps work around the unevenness in the number of respondents in each cluster by focusing on understanding the logic of that specific set of cases and using that as a basis for comparison across clusters.

4.3 Results

First, I introduce the respondents serving as cases in each cluster and draw on their experiences to illustrate the types of changes that respondents see across the components of the urban infrastructure of care in their communities and how these changes interact with respondents' caregiving responsibilities, past experiences, and designs for the future (*Figure 4.2*). As discussed in the previous section, the respondents highlighted below were chosen as cases because their experiences most fully encompass, align with and represent the range of experiences and perspectives shared by caregivers in their respective gentrification-stage clusters. After reviewing the different experiences of caregivers according to gentrification pace and stage, I then explore in more detail how neighborhood-level changes associated with the gentrification process shape caregivers' experiences undertaking care "strategies" in the six domains identified in the previous chapter.

Figure 4.2: Comparing Caregivers' Perceptions of Changes in the Infrastructure of Care Across Gentrification-Stage Clusters

	Group 1: Low-Low (Fall River, New Bedford)	Group 2: Low-High (Brockton, Lynn, Everett)	Group 3: High-High (Chelsea, Roxbury, Dorchester, Mattapan)
Private space	Relative affordability and availability, but poor quality; Mostly small-scale development	Rising/unaffordable rents; major new residential developments, and associated feelings of exclusion; risk of homelessness/displacement	
Public spaces	More disorder (waste, safety concerns), few improvements unevenly distributed across community	Some disorder (e.g. waste, safety concerns) but optimism about increasing improvements (e.g. parks)	
Economic opportunities	Lacking (primarily low-paying, low-level jobs) with little hope for improvement	Expanding, but not always realizable or accessible; exclusion	
Resources	Limited/patchwork; some feel excluded	Expanding; mismatch between growth/change and resources	
Social support/cohesion	High social churn; Limited sense of cohesion, mistrust; limited social support networks	Strong sense of community and some social support but increased risk of social network fragmentation; lack of community control over changes	
Safety	Increased policing with fluctuating crime; concerns about violence and drug use	Increased policing and reduced crime; concerns about violence and drug use	
Organized care and activities	Low availability, not always affordable/accessible	High/increased availability, but not always affordable/accessible	
Accessibility	Low/moderate, very car-dependent	High (except when people must go further for more affordable options)	

4.3.1 Perceptions of Neighborhood Change: Cluster 1 (Fall River, New Bedford)

In Fall River and New Bedford, the pace of development remained low relative to other HNS communities over the decade between 2008-2018. The patterns of neighborhood change perceived by caregivers in these communities reflected the difficulties of local economic recovery in the wake of long-term post-industrial economic decline, the 2008 housing and financial crisis, and austerity governance. They also reflect the initial hints of gentrification via new urban development unevenly distributed across their communities and concentrated in downtown areas. Thus, respondents in Cluster 1 were for the most part grappling with the effects of economic disinvestment that often precedes accelerating gentrification, while also witnessing growing social and economic inequality in their neighborhoods that they say portends unequal patterns of future development. While a handful of caregivers in these communities had long-term roots there, the majority began their lives in other cities like Boston or Brockton and had ended up there within the previous 5-6 years because they could not find affordable housing in other areas and, in some cases, had been homeless for a period of time as a result. Thus, many in Cluster 1 were trying to regain economic stability after a prior setback but struggling to do so given the limited economic opportunities available to them on the one hand, and the costs and demands of caregiving on the other.

4.3.1.1 Pearl, Fall River

Pearl is a Black woman who, at the time of her first interview, lived in Fall River with her children. She grew up in Boston, she said, but lived elsewhere as an adult. A few years prior to our interview, she moved back to Massachusetts to be closer to family, and she explained that Fall River “was the only city that had an available bed for a woman and [children] at the time. And unfortunately I’ve been here for [a few] years too long now.” She said that from the shelter she was placed in an apartment “that should never have been inhabited,” citing reasons including lead paint, plumbing issues, and mold. As described further in the following section, she had to lobby the city government for a different apartment. While she doesn’t mind her current apartment, and likes that her

building has a back yard, she says “I don’t like this neighborhood at all.” She told a story about being catcalled and propositioned by a man driving by on her first day in the neighborhood after moving in. “A lot of things are happening, unfortunately, in broad daylight here, that my children have to see.”

Pearl finds the resources and amenities in her neighborhood lacking. “I feel like for my kids, there’s not enough – it just all feels impoverished. It feels so much like a struggle here. There’s not enough parks here... There’s not enough connection to public figures that I can go out and find out about positive things. It makes you not want to stand up for yourself in a city like this because it’s just got so many other problems and you feel so disconnected by them.” She told multiple stories about being let down and discriminated against by institutions ranging from churches to social service organizations to city agencies. “I think that the biggest challenge in this community right now is the lack of services that trickle down to people in need like myself,” Pearl explained. “In my worst moments, I wouldn’t know which way to go because of the level of distrust that I have for the authorities,” she said. “I just need a little help, and I’m scared to go left because of those reasons. And I’m scared to go right because of other reasons. It’s really what’s really draining me.”

She hasn’t had better luck building supportive relationships with her neighbors. Pearl volunteers in the community, and tries to involve herself in local churches, but says her neighborhood is characterized by “a lot of mistrust.” “I have nobody that I can talk to about what is bothering me” and “nobody” for small favors like a ride to the store, she said. The city has “been so crippled by different things that it leaves people feeling like they want nothing to do with nothing. I’ve just never seen a place where most people are just so unopen to being kind.”

Reflecting on the changes she saw underway in Fall River, Pearl observed that “There is a great divide in this city, unfortunately...It’s an ‘us vs. them’. I belong in the collectible group of... people that are the misfortunate that they just want to throw by the wayside.” She says that most of the changes she sees in her neighborhood “absolutely do not benefit me.” She gave the example of a rising number of vape shops she sees, and said “I think that they’re a smack in the face to things that need to be opening up around here with

real needs and real people with real needs.... I think it's another form of just using what stressors are already here in place against us."

Unfortunately, Pearl says she doesn't feel much agency when it comes to having the power to influence the changes in her community to be more beneficial to people like her. "When, say, I'm a Black woman, to talk to another African-American woman and we put our heads together and we'll complain about it. But when it comes time to say, "well, let's go do something about it" nobody here really wants to because we feel like our voices will never get heard anyway.... I've already been discriminated against in this city several times. So I don't really know at this point how I would feel if I wanted to reach out to someone and say, "look, perhaps this could change." I'm not sure that I would feel confident that my voice would be heard. So why bother?"

Pearl's experiences in Fall River point to significant gaps and inadequacies across multiple components of the urban infrastructure of care, including housing (and specifically housing quality), safety, public space, resources, and social support and cohesion. Her experience navigating these shortcomings as a caregiver has left her feeling a sense of powerlessness over the conditions in her community and alienation from fellow residents and institutions. With respect to the neighborhood-level changes underway in Fall River, she expresses concerns about rising inequality and social fragmentation, and a sense of neglect for the needs of people with few resources.

4.3.1.2 Stacey, New Bedford

Stacey is a white woman who is a solo caregiver for her teenage son. She was born in New Bedford, and though she left Massachusetts as a young adult in search of better work opportunities, she ultimately decided to settle in New Bedford. "I decided to [return] because I think the community needs betterment and it needs investment in urban ventures of all kinds, education, agriculture, those things. And so that is why I stayed," Stacey explained. "I said, my community really hasn't changed a whole lot [since] I've been gone... I need to do something.... So I went back to college for continuing education. I joined the Coalition Against Poverty, and then I became very active in that sort of thing. I did have to receive public assistance at that time... And I think that was

when I realized that I needed to invest in more here and I have since then." At the time of her interview, she was working two jobs.

Stacey says her neighborhood is a mix of long-standing homeowners and renters who turn over quickly. "Some of the people, particularly on the street I live on, are longtime homeowners. They've probably settled there two generations ago.... Others are in and out renters, stuff like that." She rents an apartment in a building that her landlord grew up in. "I think it's a fairly quiet street compared to some others not even, maybe, six blocks away from me where there are violence episodes over there. There's never been one on my street. So my son can go outside and play and I'm not worried about what's going on outside." As a lifelong gardener, her biggest gripe about her neighborhood is the lack of green space. She wishes there was a community garden nearby; she says there's one across town from where she lives, and one the next town over, but she doesn't drive and explains that without a car "you can barely get there."

Stacey's neighborhood is beginning to change after feeling stagnant for a while. These days, she says, "there's a lot of houses that have sort of gone by the wayside. And there are people buying them. But it's like the same people buying several properties and then they don't really maintain them... we see that here a lot." On the one hand, she says she's glad to see people living in the houses, which she says reduces the risks of vandalism and fires. But on the other hand, she knows these tenants are in a sub-optimal situation. She told a story of a landlord who had been buying up homes in her neighborhood and became subject to a number of lawsuits by tenants. "It's great that he's buying them but he doesn't treat people in them any better and he doesn't treat the homes any better. So that's sort of like good for you but... it's not so much quality, so it doesn't really help me."

Stacey is fairly involved in her community. "I do go participate in helping with the blacktop gardens...[the] garden produces fruits and vegetables and they donate them to the local food pantry." She also attends public meetings, especially about transportation-related changes and other issues that affect pedestrians, since she doesn't have a car. And she sees potential for her community's future. "We have a lot of history. We were the first

whaling port, it was the most successful in the whole world. And there's a lot here that can be offered...if we invest it properly."

In terms of urban development, she is frustrated by what she sees as the city government prioritizing the downtown area at the expense of other neighborhoods. She wishes community members could "[sit] down with the mayor and [get] him to understand that not everybody can afford to be in the downtown area, which he primarily invests in. The downtown area is beautiful. It's definitely tourist driven. But outside of that is a whole city and you have to help everybody.... I mean I personally would like... to tell the mayor, "Hey, there are some of us who live here that need these services. And you need to help us figure out...How can we help each other?" I work with children and I tell them there's a better way in life than what it is you're thinking or seeing and we can do this together and stuff like that."

Stacey explains that she sees an emerging divide in local politics "between people who support the mayor's downtown objective...and then the people who support bettering the entire city. And those people will tell you, "Hey, come to our meeting." And I let people know that I want more street lights, for instance, down my road because I walk as a pedestrian at night. I do feel like sometimes they take those kinds of things into consideration. But there are definitely things that I'm like, oh, there's a new building being built here and I have no idea what it's going to be." While she feels like her voice has been heard and reflected in recent changes around transportation, she's more concerned about whether the community will have a say in housing and economic development changes that she's noticed recently.

She emphasizes that greater community engagement and more grassroots organizing are going to be essential to steer New Bedford's new development in an equitable direction. "I have a different outlook than some people who are all like "New Bedford's horrible, I can't wait to leave it." And then I'll have a conversation, "Well, what do are you doing to change it? What are you doing to invest in it?" If you don't like something, make it better, become more aware of what you're putting in your body, become more aware of what your government is deciding to do for you on a local level." But based on some of her past experiences, she's unsure about the community's ability to

build enough power to sway the agenda in favor of more equitable development. “I think it comes in waves. I think we get a strong start. We get some momentum on some things. And we then lose support or it just becomes harder to do that while you’re doing everything in your own life... Keeping it going is community driven, it really is.” She’s committed to continuing her efforts. “I would like to see some success come out of hard work... I want to do more.”

Inequality is a common theme across Stacey’s reflections on the changes in New Bedford. With respect to housing, she sees real estate investors profiting while renters get stuck with poor-quality homes, and counts herself lucky to have a good relationship with her landlord. She also sees spatially uneven and inequitable development patterns, and worries about how these may translate into inequalities in resources and the quality of urban space outside the city center. While she has invested her own time and effort in improving social cohesion, support and resources in New Bedford, she doesn’t see these efforts matched by local decision-makers and institutions, and worries about the community’s ability to build power to ensure that future changes meet their needs. Her reflections illustrate a tension expressed by multiple Cluster 1 respondents: on the one hand, they can readily point to clear ways that their communities might benefit from development – for example, in terms of housing quality or green spaces – but on the other hand, they observe that the development that is underway does not seem to be meeting these needs and, moreover, seems to be contributing to a greater degree of inequality in resources, amenities, and overall environmental quality across different areas of their cities.

4.3.2 Perceptions of Neighborhood Change: Cluster 2 (Brockton, Everett, Lynn)

While the communities in Cluster 2 share the transition from low- to high-paced change, they are also quite different from each other in many respects. Everett is much closer to downtown Boston than Brockton or Lynn, and directly neighbors rapidly-gentrifying Chelsea. Recently it has been the site of a large casino development that was hotly contested by community stakeholders concerned about its impacts on housing prices

and quality of life in the city. Brockton, meanwhile, was one of the communities hardest hit by the housing crisis of the late 2000s with a high rate of foreclosures and subsequently lower housing costs than many neighboring areas closer to the city. About 20 miles from downtown Boston, it has attracted many people leaving the Boston area in search of more affordable housing. Recent development has to date been more moderate than that in Everett and has been focused on new residential and commercial real estate development in the downtown core geared towards attracting wealthy young newcomers. Lynn is a formerly industrial city about 10 miles north of Boston, where recent development has prioritized market-rate housing and been concentrated in the densifying downtown core, as well as on the city's waterfront as part of a waterfront revitalization effort. These developments have faced contentious opposition from local activists decrying their unaffordability and the fact that they privatize waterfront space (Rios, 2019). In both Brockton and Lynn, commuter rail stops connecting the cities to Boston have served as loci of development as officials in both cities seek high earners willing to leave Boston for more affordable housing. Plans for a commuter rail station in Everett are also in the works.

The small group of caregivers in the Cluster 2 communities of Everett, Brockton and Lynn had fairly divergent experiences that reflect differences between the communities in the stage and pace of investment and development. As demonstrated by Louisa's experience below, respondents in Everett were grappling with the ripple effects of the casino's impact on the local housing market, while in Brockton, recent movers from Boston-area neighborhoods like Crystal, in search of more affordable housing, may struggle to keep their economic footing because of a lack of opportunities, resources, and social connection. Seen side-by-side, these communities demonstrate the uneven, lurching quality of gentrification across the region rather than a rising tide lifting all boats. The unevenness of development and their location on the periphery of Boston mean that the urban infrastructure of care in these communities is disrupted both by the history and trajectory of local development and, as the evidence below shows, by the consequences of gentrification in Boston such as outward residential displacement.

4.3.2.1 Crystal, Brockton

Crystal is a solo caregiver for her children and also helps care for her elderly mother. She says she lives in Brockton because “it was cheaper than Boston.” Before coming to Brockton, she was living in Dorchester, and said “as crappy as Dorchester was, it was extremely expensive. And my best friend moved out here. She got a studio, and it was \$600. And so I kind of just followed her, and I went to the same building, and I stayed there about three years. And then I ended up getting kicked out. I couldn’t afford it. I lost my job, I had the kids. So really, I just couldn’t afford it. So I went to the [Department of Transitional Assistance], got in a shelter, finished the shelter, got Section 8, and here I am.” She was homeless for two years before finding her current apartment.

She says she doesn’t like living in Brockton: “No. It’s loud. You walk down the street and there’s needles everywhere. It’s just not for me, not for my kids. It’s not good.” She worries about the impact of the neighborhood on her kids. “I don’t like it for them... I don’t think kids should grow up here. The schools aren’t bad, but the kids are bad, a lot of them. And my kids have learning disabilities, so I don’t like Brockton for kids... But it’s still – they really have lived here all their lives, so this is what they know.” On weekends, she says, “we leave.”

Crystal doesn’t have any family in the area, and says that she doesn’t have strong relationships with any of her neighbors. “I don’t feel comfortable speaking like I’m talking to you. I feel like I have to put a whole different persona on just to cope with out here and get along with anyone ...I’ve adapted to more the Brockton life... I know who to stay away from. I know what to say around certain people. It’s dangerous, so.” She says it took her about four years to acclimatize, and that “it sucks because you can’t be yourself.” In her opinion, drug use and the economy surrounding it are both the biggest challenge facing her community and the “only connection” between people in her neighborhood. She lives across the street from a gas station that she says is “the absolute worst place. It’s where everyone sells drugs, everyone uses drugs, everyone picks up drugs...So I’m in the worst part of Brockton, the worst.”

Despite feeling alienated in her neighborhood, she’s made friends in other parts of town through volunteering with a group that provides resources to homeless people in

town. “I’m friends with people from out here that I never thought I would ever even speak to before. So I guess, even though I originally just did it to fit in so I wouldn’t get jumped out here when I’m walking with my kids, I understand more so of what people go through, and I’ve never been through a lot of it. So it made me, I’d say, a better person, because I understand more about other peoples’ lives than how I lived.”

Crystal sees a lot of change in her community. She sees increased police activity targeting drug users, which she says makes her feel a bit safer. And she says “they’re building everything everywhere, more apartments...condos...They’re fixing something every day.” But she doesn’t see this development making much of a difference to her community yet. “I guess in some ways, I feel it causes more BS. When they’re fixing up all these things, all the trucks and all this stuff is everywhere. People are breaking in and doing whatever they want. So sometimes I think it’s all right, and other times I think it’s worse.” She says that to her, the best-case scenario is that some of the new housing being built helps people in her shoes get out from the shelter and in to stable housing. But as to whether she thinks people like her have a voice in the changes, she says that aside from comments on news articles online, “I don’t see anyone actually speaking out... I don’t either. I just feel people know it’s not our place... I just don’t see what difference it will do, so.”

“I think Brockton used to be a better place,” she reflected. “It used to be the City of Champions. Never would they say that now about Brockton...Since I’ve been out here, it’s gotten really bad.” Crystal’s experiences reflect a number of common themes across interviews with caregivers in this cluster. These include the physical, social and economic disruptions of development – both in their own neighborhoods and the regional housing market as a whole. Caregivers experienced social fragmentation due to the combination of economic inequality and regional migration patterns, and connected these experiences to social challenges in their communities like public drug use and related police activity. Together these experiences combine to produce a sense of social disorder and, for some caregivers like Crystal, the feeling of being stuck in the middle of that disorder. Other respondents from Brockton in this sample also felt alienated from both their community

and neighborhood development, and expressed feelings of powerless with respect to both their own lives and the changes underway in their community.

4.3.2.2 Louisa, Everett

Louisa is a white woman who grew up in Latin America and lives in Everett with her husband and children. They chose to settle in Everett because of a local church that she was fond of. Now, she says, “our kids go to the church, and everything involves the church.” She loves living in Everett. “The location is awesome. Yeah, a sensibility of everything, the buzz, libraries, stores, everything, and the diversity. I love the diversity and seeing all different people, different languages... I told my husband, “I want to get old in Everett.””

While she has no family in the area, Louisa says he has lots of friends and is close with neighbors, who she says have watched her kids grow up. “My neighbor, she has three kids and we watch each other’s kids when someone needs extra help,” she said, adding that she also exchanges favors with other neighbors. “We are always looking after each other so that’s good.” Louisa and her children participate in activities at the library, a local community garden, and the community center. She says the city has recently invested a lot in public amenities like these that comprise important parts of the urban infrastructure of care. “The city spent a lot of money with the family stuff. I like that.” She thinks her children have gained a strong sense of community from living in Everett, but like other caregivers in the study, Louisa expressed a wish for more opportunities for young people to volunteer and participate in community service, “just to have that sense of helping each other and being generous and caring for others.” For example, she said, “we have so many seniors in our city, they should be treated a little better... I think it’s amazing how the older people are accepting the new people over here. Obviously, they have to somehow. But I think they’re very welcoming.”

She sees Everett changing rapidly. “I’ve noticed that many other lots have been filled with apartment buildings for the new, upcoming casino, wherever the city’s going.” This has affected housing costs, she says. “With the casino thing, they went all the way up... New places are much more expensive for very successful young people that are

going to be moving to our neighborhood; it's not a bad thing," she reasoned, "but it's going to make rent way higher too because it's going to compete with those places." While she says she doesn't agree with building more housing, she thinks that "all the other things that they have been doing, the playgrounds, the parks, and everything else to keep the good life that we have in the neighborhood... those are the kinds of things they should keep doing."

As a result of the boom in residential development, Louisa thinks Everett is facing a mis-match between the population growth it is experiencing and the resources that it has. "If you have more people move into the neighborhood, you need more schools, more parks, more everything, and if the city cannot provide all those things for the population that we have right now then why are you going to have more people coming?...Eventually, those people are going to have kids, or older people are going to get older and you need to provide for all those people, so." The schools are under-resourced, she says, and she thinks they don't have enough capacity to provide for the growing number of children in the neighborhood. "I really wish, instead of focusing on other things," she said referring to the casino, "they could have used that space for schools. That would have been needed the most over here."

Louisa says most people in Everett don't seem to have a voice in the changes underway in the community. "That has to do with the rich people. They're investing money and they just worry about themselves making money, money, money and that's it. They don't care what's around and how that's going to affect the neighborhood." She is pessimistic about the potential for the community to exercise more power over these changes because of the pressures of development. "I think in Everett, they're going to end up like any of those other neighborhoods around Boston. They're going to be very expensive to live in, and we're going to be moving further and further from the city to afford living in a nice home... I think it's going to change a lot because not everybody's going to be able to afford to live over here anymore."

Louisa's observations about the development underway in her community highlight how the threat of disruptive impacts from gentrification is perceived through the lens of multiple components of the urban infrastructure of care – like public space and social

support – and not just housing. In this respect, she also highlights a common concern about how development in one component of the urban infrastructure of care – housing – can be detrimental to other components of the infrastructure of care if urban development is not coordinated across them in line with evolving resident needs. Her concerns reflect a common pattern across respondents in this cluster of an increasing feeling of powerlessness over changes in their community and exclusion from decision-making. Finally, I note that Louisa’s perspectives demonstrate fear of losing positive aspects of one’s community via gentrification and development – a perspective more common to respondents in Cluster 3 than Cluster 1 – which stands out in comparison to Crystal’s perspective and those of others in Cluster 1 who are concerned about whether they will gain anything from gentrification.

4.3.3 Perceptions of Neighborhood Change: Cluster 3 (Roxbury, Dorchester, Mattapan, Chelsea)

Almost all caregivers in Cluster 3 communities said that they noticed significant and rapid processes of change underway across multiple components of the urban infrastructure of care in their neighborhoods, in line with the pace of change captured by the cluster analysis. As described by Marta, Derek and Yvonne, introduced below, residential and commercial development were seen by respondents in this cluster to be the main drivers of these changes, with rising rents and costs of living, feelings of social or economic exclusion, and fears of displacement as commonly perceived consequences. While most respondents saw development introducing housing and economic opportunities to their communities that they wished to benefit from, with the exception of Yvonne’s housing, these benefits have mostly remained hypothetical. The combination of a rising cost of living, social and economic exclusion, and elusive benefits of change left most respondents in this cluster uncertain at best and often fearful about the social integrity and economic wellbeing of their respective communities, as well as their own future in their neighborhood with the feeling that their foundation might be coming out from under them. More than others, caregivers in Cluster 3 expressed feeling like they had

a lot to lose in terms of valuable components of the urban infrastructure of care, and they felt like the risk of losing them was rising over time as development advanced.

4.3.3.1 Marta, Chelsea

Marta is a Latina woman who moved to Chelsea in the late 1990s from Central America. She lived with a relative for a few years, and was homeless for a period of time before meeting her husband. “I am here now, so, my home. This is my city. And because where I live is somehow more affordable than anywhere else.” She says she has a lot of friends in the neighborhood, many of whom she has met through her church, where she helps with cleaning and maintenance and volunteers with a program that provides produce to low-income households. Marta and her husband have a son who volunteers with her at church. “I do think he likes to be growing up over here, so I like that,” she says.

Marta sees her neighborhood changing fast. “I do think it’s a big change. The change that I’m seeing now, from now to 15 years ago, it is totally different.” Some aspects of the changes she’s experienced are positive, particularly with respect to community resources and sources of social cohesion: “People are more involved. Programs are being developed and the people are being notified about it. It’s more options. I was just talking to a friend about it. Because it seems like now you are well-informed of everything that is happening, good and bad. But before, you didn’t have any choices, any helps...so I think we are more connected.” She also remarked that crime seemed to her to have declined significantly over the past 15 years or so. “it’s not that it doesn’t exist, it does. But you hear it less than before. I think the police are more involved.”

However, Marta was very concerned about the rising cost of living in her community, which she sees as being driven by new residential development. “In Chelsea, something that we have noticed is that a lot of developments are new buildings. But it doesn’t benefit the people that are in here. It’s benefiting the people that are coming in...There’s people that have a long time living here, they are forced to be moving out of here because they can’t afford the rent. I mean, I’m talking about myself. I do think that a

couple years from now, I will not be living in Chelsea because of that problem. Yeah. So this is scary. It is very scary.” She says the rising cost of housing is the biggest challenge facing her community right now: “It’s the household situation...the living expenses...the rents are so expensive... So you don’t win, okay?... The housing problem is very difficult. I think it’s city-wide... I think now, it doesn’t matter where you are, the prices are so high.” On a personal basis, she says, “I think it adds to my stress, to my worries.”

Marta acknowledges that she thinks some of the newcomers are doing good things for Chelsea. She meets them when she is volunteering, and sees them becoming involved in the community. “And I like that. I like that... But because of that, then you get the pros and cons of things. Because the new people are coming in, the old people are going out... I know that they are bringing something good, but they are taking something away from us. They are making it worse for us to stay here. So we have to find a balance, but I don’t know where or how to find the balance or if anybody going to find it.” Marta was holding out hope for policy intervention from Chelsea city government. She said she wishes that city officials could “somehow regulate the rent so people like me can stay. We are Chelsea. We are the ones to make Chelsea what it is... We cannot be thrown out of our homes.... This is my home town. So to be forced to move out because I can’t afford to live in here is very sad.”

Marta’s reflections on the development underway in Chelsea and its impacts on the cost of housing, as well as the consequences of displacement on the community’s social fabric, are representative of almost all caregivers in Cluster 3 communities. However, Marta was much more explicit than most caregivers about her chance of being displaced due to rising rents in the near-term. Nevertheless her comments point to the rising sense vulnerability that most caregivers described experiencing in the face of gentrification, and her comment linking her experiences of vulnerability to stress also resonates with the experiences of many others.

4.3.3.2 Derek, Dorchester

Derek is a Black man who lives in Dorchester. He and his wife have a toddler, and rent an apartment in a relative’s house. Their previous apartment had no heat and they

had to scramble to find somewhere more suitable before their child was born. Derek works full-time, and volunteers at a youth program. He grew up in public housing that has since been demolished. "They're all townhouses now. And they kicked a lot of people out." He says he doesn't recognize his childhood neighborhood any more, and that "Dorchester is 100% next."

He says work has kept him from making many social connections in the neighborhood since moving there recently, but that he is friendly with his neighbors and feels safe among them. "As a Black man, seeing older Black men in the community, in my neighborhood, there's just a general camaraderie. "Don't let anything happen to me, I won't let anything happen to you," you know what I mean?" He says that having all of his neighbors know who he and his family members are makes them feel safe. "I think it's just a beautiful area. I think once we care about it a little bit more as a community, it'll be even more beautiful." He's still new to the area, but wants to be involved in building more community cohesion among members of his generation. "That's where infrastructure could help...I have a baby, my neighbor has a baby, these types of things we could all easily figure out but it's difficult," he says.

He says he feels "animosity towards gentrification at the current moment," and that rising rents are the biggest challenge his community faces. "It's like \$2,800 for a unit [and] there's nothing special about this unit...Four years ago, that unit would have been maybe \$1,900. That has nothing to do with the people in my neighborhood, and everything to do with the people that want to own my neighborhood." He continued: "A lot of companies...[will] go into a place like Dorchester and you see the coded language, which I can't stand, and is really annoying, but there'll be excellent credit and references required." This makes him wonder "Why are you here? You don't want nobody from this neighborhood to live there... And I'm not saying everyone from Dorchester has bad credit, but I'm telling you right now, as a Black man, it's difficult to keep it... the credit system is...not really built for you to succeed if you are not born with some backing."

Moreover, he says, "the construction crews that build the homes or build these buildings, they're all older Irish and Italian construction firms or construction companies. You know what I mean? It's a system, so why care about what we are saying and what

we're complaining about when it's not for us. There's some beautiful stuff in Dorchester that was built recently, and I still think it's wonderful and stuff like that, but there's no Black people in there."

He wishes the community had more control over the changes he sees. "They can gentrify our neighborhoods, but we could also just rebuild it for ourselves, you know what I mean?" He says he wants to see more opportunities for Black residents of Dorchester to improve their economic circumstances, particularly young people. "It'd be interesting to see what our youth would be interested in doing if they had more opportunities in the area." He gave the example of new bicycle shops popping up around the neighborhood, including one on his walk home from the T. "I have not seen one Black-owned one. I haven't seen one in my neighborhood that is encouraging, inviting to me... But I would love to see it. Because I know these kids can do it...I know that they can fix bikes. I know they can do all of this stuff but it's not there." He says he's working on starting a non-profit to help address these types of opportunity gaps in the neighborhood, and that he's motivated to do so by the economic changes that he sees underway.

Derek's voice exemplifies concerns among caregivers in Cluster 3 about individual and collective exclusion from the economic opportunities component of the urban infrastructure of care, including opportunities to benefit from, own and have agency over new elements of the neighborhood economy. His reflection on these issues through an intergenerational lens points to their importance as aspects of the urban infrastructure of care not only to ensure that caregivers have material security but to afford them a sense of security that their dependents will also be economically secure in the future. Derek also touches on the feeling, common among caregivers in Cluster 3 including Marta above, of being part of a strong social fabric and feeling a sense of potential for that fabric – exemplified in his comment about "infrastructure" to help parents – that he hopes to see fulfilled rather than undermined.

4.3.3.3 Yvonne, Roxbury

Yvonne is a Black woman who currently lives in Roxbury with her daughter. "I love it... I'm attached to it because I went to school here. And I love it because it's close to

downtown,” she says. The biggest downsides to her are that “it’s mad noisy. And because of so many people, trash is a big problem.” She lives close to Nubian Square, where the businesses are turning over quickly. “You see there’s a lot of shops that are old... they used to be there for years but they closed down.” She says it seems like “the plan is to have more coffee [and] to get people out in the evening,” but that right now everything is still “in transition.”

At the time of her interview, most of her family members had recently moved out of Boston because they had been living in a multi-family property owned by an elderly relative who passed away. “She died so that was the family base, that was in Dorchester up the road. So she had a three-family and she died. And my cousin sold it...” Some of her relatives moved out of the city to suburbs or to Brockton, and others left Massachusetts for the South. “So when you think about it, I’m the last one here,” she reflected.

Before moving to Roxbury, Yvonne and her child were homeless after Yvonne lost a job and went through a serious depression. As she described in the previous chapter, “my bottom fell out.” Yvonne and her child lived in a shelter in a nearby suburb for about a year. “The shelter was a hotel... A lot of hotels were getting into the shelter business because they could get a lot of money from the government... They sent me there. And then I find there’s like 200 other families there... And these people are working every day, every day... But they can’t find housing, the housing is too much, nightmare.” She said that “you have social workers that come and you’re just filling out anything and everything that looks like a housing paper. So somehow I filled out something that put me in a lottery and I got a phone call...” She said she was shocked, “in a good way,” but that “it’s really scary to think” about what would have happened if things worked out differently. She proudly showed me a picture of her with city officials and developers at the ribbon-cutting for the new building she lives in.

She wants to stay in Roxbury and wishes she could own a condo. “We see massive construction. I mean, massive... And I would love to get one of those units,” she says, but “I know I can’t afford it.” The people who can afford it, “money’s not their problem,” she says. “The rent is high and you can get a job but the jobs are paying \$11 an hour. And it just seems like you keep hitting a brick wall,” Yvonne explains. She says she thinks this is

why so many people in her neighborhood turn to alcohol and drugs. “There’s a lot of loss in the community... people realize that that dream that they were taught when they were young is not really attainable anymore. And that’s where depression and disappointment comes in and I think people escape it through substance abuse.” She says she worries about the same pattern with her daughter. “She goes to school and she comes home with a lot of dreams...but she will find out that it’s really not as easy...as you think it is.”

She says lack of access to technology is part of the challenge, and a reason why people are struggling to get jobs. She gave an example of trying to apply for a job at a department store that opened up in a renovated shopping center nearby; they would only take applications online, which meant going to the library and waiting to use a computer. She worries in particular about older people in the neighborhood. “A lot of people in our community are not up to the advances of technology and they’re getting lost in society. They’re sinking because they’re not connected. If you’re going to make it, you have to be connected.” She felt fortunate to have been connected to a local program that helps people over 45 who have lost jobs navigate the labor market. “There are ways to get help in the city but you’re only going to find it through talking to people.”

Yvonne’s comments point to a common feeling among Cluster 3 caregivers of the dust from development being far from settled, and persistent uncertainty despite a long course of development. In this vein, and similarly to Derek, she also points to the as-yet unrealized promises of social and economic opportunity that she thought might accompany development – as well as the mental and public health consequences of the opportunities people dream of being unattainable. In terms of housing, her reflections on her experience being homeless and trying to regain housing suggest a lasting sense of vulnerability and having only escaped a worse fate by chance. Like Derek and Marta, Yvonne also points to the necessity of social connection for staying afloat through the rapid course of changes in her community while also acknowledging that this is exactly what is being jeopardized through development. Together with her anecdote about her family members moving away from the city, her reflections highlight how the impacts of gentrification on certain components of the urban infrastructure of care, such as housing, reverberate through others, such as social support and cohesion.

4.3.4 Consequences of gentrification-related neighborhood changes on caregiving strategies

In this section, I compare how the neighborhood-level changes that caregivers are experiencing shape their ability to carry out caregiving strategies that depend on the urban environment. I use the typology of caregiving strategies dependent on the urban infrastructure of care derived from the analysis conducted in the previous chapter, and thus focus on six types of caregiving strategies: securing and maintaining the material conditions of care; managing the dependent's relationship to the environment; preserving health; building social support structures; time management; and balancing work and care. For the purposes of presenting these results, I group my discussion of the latter two strategies since the findings largely overlap. The purpose of this comparison is to develop an understanding of how neighborhood changes associated with gentrification change the physical and mental work involved in caregiving and its toll on caregivers. The results of this part of the analysis are summarized in *Figure 4.3*. I note that data from the sole respondent in Lynn is not presented in each subsection because some strategies – such as managing the dependents' relationship to the environment – did not come up in her interview due to the absence of her dependents from her life at the time of her interview and for an unknown time prior.

Figure 4.3: Comparing the Impacts of Gentrification on Caregiving Strategies

	Group 1: Low-Low (Fall River, New Bedford)	Group 2: Low-High (Brockton, Lynn, Everett)	Group 3: High-High (Chelsea, Roxbury, Dorchester, Mattapan)
Securing + maintaining material conditions of care	Stuck -> stress + lack of control	Instability -> stress + lack of control	
Creating support structures	Lower social support, difficulty building + accessing when necessary	Higher social support, under strain from economic and displacement pressures; harder to maintain	

Managing dependents relationship to the environment	Protection-oriented	Exposure-oriented
Preserving health	High stress, difficulty coping + lack of capacity for self-care	
Time management	Difficulty finding work that (a) fits with caregiving responsibilities/needs (b) pays enough to afford a basic satisfactory quality of life	
Balancing work and care		

4.3.4.1 Securing and maintaining the material conditions of care

This strategy refers to caregivers' efforts to ensure the continued availability and suitability of basic material ingredients for caregiving like housing, food, and other essentials like clothing. The caregiving work that falls under this type of strategy was the domain most impacted by gentrification-related neighborhood changes, as well as by the relationship between what gentrification *hasn't* changed to what it has. This domain was most impacted because of how gentrification impacts two components of the urban infrastructure of care in particular: private space and economic opportunity. Specifically, gentrification-related neighborhood changes introduced issues related to the cost and availability of housing, in Clusters 2 and 3 in particular, that were not accompanied by adequate or equitable development of economic opportunities for low-income residents of gentrifying neighborhoods. While the economic opportunities available to caregivers were limited across all clusters, gentrification caused respondents' housing costs to pull away from what low-income caregivers could afford given the economic opportunities available to them. Thus, instead of urban development materializing in improvements to the material conditions of care, it materialized as a binding force in this domain.

My analysis shows that gentrification can lead to both psychological and material pressures on strategies for securing and maintaining the material conditions for care. First, it caused the work involved therein to be difficult and taxing in new ways. Second, gentrification-related changes led to new forms of pressure, risk, uncertainty and insecurity via the specter of residential and cultural displacement as well as economic

marginalization and exclusion. It did so by removing or inhibiting affirmative options, choice and control, and constricting possibility. Meanwhile, the examples from Cluster 1 illustrate how disinvestment and uneven economic development impact strategies in this domain, in this case by pushing caregivers into sub-optimal housing situations. At the same time, the advance of gentrification in Clusters 2 and 3 means that these caregivers have access to fewer alternative or affirmative options for improving the material circumstances of care.

4.3.4.1.1 Cluster 1

Respondents living in Cluster 1, including Stacey and Pearl, did not typically face difficulty finding housing in these cities, relative to communities in other clusters. Stacey found her housing via word-of-mouth, and Pearl found her housing with support from a shelter. A number of other respondents in Cluster 1 communities were assisted by voucher programs operated by the state government, like HomeBASE. In fact, a number of respondents reported that they moved to Fall River or New Bedford because they could not afford housing elsewhere in the region, and/or because they became homeless elsewhere in the region and had been referred to local shelters.

However, while finding housing in Fall River or New Bedford was not in and of itself a challenge for these caregivers, accessing good-quality housing was a challenge, in terms of both interior conditions of the dwelling and the surrounding environment. Pearl's experience is an egregious example of such difficulties. "They condemned my last apartment because of the legal things that were there in the lead paint," she explained. At the time, she was working part-time to make ends meet. "I was paying market rate by myself...regardless of this being one of the cheaper rent cities, 750, 800 dollars for a woman with [kids] and a part-time job was damn near impossible." She said she had to "constantly...fight against the landlord, what he was doing to me and my family." She explained: "My back was against the wall and I went to City Hall and I got an attorney and...because of that, I was able to attain keys to this apartment."

Shawn, a white man who lived in the same neighborhood of Fall River as Pearl, described how his concerns about the quality of the immediate environment around his

home were motivating him to try to save up enough money to leave Fall River. He grew up in Brockton and was living there with his partner before coming to Fall River. He explained that when he and his partner got married, she lost her Section 8 voucher and they couldn't afford to stay. They became homeless and, along with their daughter, were referred to a shelter in Fall River. His wife was pregnant with their second child at the time. They stayed in the shelter for two months before receiving a voucher to move into an apartment. Shawn says his building can feel a bit chaotic, with lots of coming and going and lots of turnover among the tenants. "There's so many people doing different things," he says, and it's difficult to find things in common with others and build social relationships. He says the area around his building "used to be a bad area for drugs." Shortly before he moved in, he says, the building was renovated and reopened under new owners. "It was different, it was better. But progressively went downhill" over the course of a few years, he explained. Shawn says he's waiting for his eldest daughter to finish elementary school and then will try to move. "I don't see anything good about staying in this neighborhood," he says. "Losing that Section 8 and having to move out here away from my family who still live in Brockton...I want to get back there, it's important to me."

Pearl's experience also illustrates how the lack of economic supports for caregivers in Cluster 1 communities – including jobs but also non-commodified forms of care support that would reduce the individual burden on caregivers, as well as housing stability protections – can mean that even when low-income caregivers can find housing, it can nevertheless be difficult to maintain. She explained that after moving from the apartment with lead to her new apartment, she lost her part-time job because she was struggling to balance work with the demands of caregiving for her dependents alone, without any support. This, in turn, jeopardized her housing all over again. During her first interview in 2018, she explained: "I'm losing my apartment right now. When I lost my job last year, I fell behind on the rent. Now I paid almost half of what I owe and I don't know where I'm going to get the other half. And I turned away from going to some of the agencies because what the agencies do is, they call your housing authority and then when your housing authority learns that you haven't upheld your half of the lease, which is to pay in a timely manner, you're likely to lose your Section 8 and then really be on the street. So you can't

go to the authorities that are there to help you because that'll be how they get you and there's not enough church leaders here for me that I can go to without feeling some type of way. So I'm just in a pickle... My landlord has given me a week. What am I going to do? She wants \$200 by Friday. I was hoping that the \$60 from the study was in cash for that reason."

Cluster 1 caregivers, particularly those looking for part-time work that would allow them to balance work with caregiving, said they faced a number of barriers to economic security. Stacey said that New Bedford's biggest challenge was creating economic opportunities for all of its current residents. "I think job training, access to jobs that are not just minimum wage jobs, and access to education. People face barriers to education when they have kids already and they can't get to school," she explained. Mike, a caregiver living in Fall River at the time of his first interview, faced similar challenges. He suffers from chronic pain, and says it's been harder for him to find part-time work that would continue to help him fulfill his caregiving responsibilities while managing his pain than in other cities he has lived in previously. He says he thinks more jobs would make the community stronger, but says "I don't really see it changing right now, to be honest with you."

The lack of economic opportunities available to respondents in Cluster 1 affects caregivers' abilities to secure basic necessities for care, like food. Stacey, who works two jobs, says that "access to healthy food on a budget" is her biggest challenge. "I think that what we know about child development especially is that if the child is worried about their basic needs or if they're seeing their parents or caregiver worry about their basic needs, they don't develop properly. So when you only earn \$12.50 an hour, going to the grocery store and being able to feed your children on a budget is tough." She continued: "There are some weeks that I'm like, okay, I have \$72. That's all I have, this has to last an entire week. What are we going to do? And I definitely see that as something that comes up recurring."

Overall, caregivers in Cluster 1 were struggling to build and maintain the means to secure the material conditions for care. Though it was easier to secure housing than most other areas in the region, it was difficult to find affordable housing of a satisfactory quality.

Many of the respondents arrived in these communities after economic setbacks elsewhere, and a lack of economic opportunities that they could take advantage of while still fulfilling their caregiving responsibilities made it feel difficult to gain a steady footing. Caregivers in this situation often felt like their resources – mental and material – were consistently pushed to the brink, and it was often difficult for them to envision how their circumstances might stabilize and when.

4.3.4.1.2 Cluster 2

Respondents in Cluster 2 had somewhat divergent experiences with the impacts of gentrification-related neighborhood changes on their efforts to secure the basic material conditions for care, with those in Brockton more akin to respondents in Cluster 1, those in Everett sharing more in common with respondents in Cluster 3. Respondents in Everett reported that their housing costs were beginning to rise to levels of unaffordability in the long-term, and shared a sense that their alternative options were beginning to narrow. They expressed feeling a nascent sense of competition with newcomers and feeling of being overlooked by the city in favor of them. This didn't manifest as a full feeling of exclusion, but seemed like it could in time. The experiences of the lone respondent in Lynn fell in-between, homeless and struggling with quality issues in the shelter like mold, while also perceiving housing costs to be rising in line with accelerating development and expressing uncertainty about where she would stay in the future. Compared to Cluster 3 respondents who were worried about being forced out when they wanted to stay, Cluster 2 respondents were more worried about getting stuck in their current housing and not being able to move, either to a better-quality apartment or out of the community.

In Brockton, Crystal was hoping to move to better housing, but felt held back by the limited economic opportunities available to her. She says “my main goal, really, is to get out of here, to give my kids a better life. So it's come to the point where I think of my kids now, and my priority now is just save and get the hell out of here.... But as of now, I just don't even see myself in the next 10 years being able to afford anywhere.” She's working, she says, but doesn't feel like she has the bandwidth to find a new job that could pay better, and is uncertain that better jobs will even be available. “I'm working. It's just a

shitty job. So I'm just making it right now. So if that ever changes, then I'll be able to leave. But as of now, there's no near-term..." she said, trailing off. "Even though I manage, it's very difficult. It's a lot of stress.... It's not really in my control, except I guess I can get a better job, but how and when?"

Crystal said the jobs available to her in Brockton have mostly been warehouse jobs via temp agencies. "I don't see any jobs out here. I feel it's harder to find a job out here unless you go through a temp agency, and that's how I am working... But there's really nothing when it comes to jobs." With rents rising, Crystal says her paycheck is no longer lasting her household as long as it used to. To make ends meet, she takes advantage of resources offered by local churches and food pantries to help make ends meet. "I have kids. I get \$600 a week, and that's gone in three days. So I still have to go to the churches and still go to food pantries... Because I work, my rent's not cheap like other people on Section 8. So it's tough," she explained. In this respect, her experience was similar to the caregivers in Cluster 3 struggling to find their way towards a more stable economic footing

In Everett, Louisa's family was anxiously keeping track of rapidly-rising housing costs, hoping to be able to find a home to buy to escape the pressure of the rental market. They felt vulnerable to rising rents because her husband's income fluctuated seasonally. At the time of her interview, Louisa and her family had just moved to a new house. "The old house that we lived in...for 10 years...the location was very good, and we noticed that rent has been going up so crazy, and we were not sure where we'd be next...so we got comfortable. And then, unfortunately, our landlord passed away and her kids were kind of fighting over the house so we decided it's time for us to make a move.... We're planning to stay one more year and maybe buy a house...we're waiting for the prices to drop now. It has been because with the casino thing, it went all the way up...if things keep going high, the price, maybe we're going to go to the south where we can get a bigger house and a bigger back yard." In entertaining a move south of the city in search of affordable homeownership, Louisa and her family are following in the footsteps of residents from Cluster 1 communities like Dorchester and Roxbury, who in recent years have increasingly moved south to communities like Randolph and Brockton in order to be able to afford to buy homes.

For others in Everett and Brockton, uncertainty about their housing circumstances stemmed from the fact that they were in transitional stages of life – for example, moving away from the family home as young adults, or trying to re-build their lives following a period of homelessness. For example, Kate is a white woman who lives in Everett and works in construction with her fiancée. At the time of the interview, they were living in a house that they were working on, which their boss was rehabilitating after a fire. “We put our apartment together on the first floor, but we have three more floors to do...[We had] no toilets, nothing, no running water we had for a long time... I had to come to Dunkin’ Donuts half the time to brush my teeth. Family, friends to go take a shower. I slept in my car for the first two months...I had to go to the bathroom, I start the car, and I go to the store. We did what we had to do. Now there’s running water and now there’s electricity. The first floor done for us, and then now we’re working on the second and third floor.” Prior to this job, she had been homeless after experiencing difficulties with substance use, and her children were staying with family indefinitely as she tried to get back up on her feet. “I made a lot of sacrifices but they were minimal compared to what I could have lost,” she said.

In Everett, Lynn and Brockton, respondents noted that the absence of resources for people like Kate and Shawn who became homeless could make it very hard for families to get back up on their feet. Crystal, who became homeless in Brockton after being unable to keep up with rent after originally moving there from Dorchester, explained that her family’s transition from the shelter to stable housing has been difficult because of a lack of resources through which caregivers could access the basic material components of care at no cost. “This is a couple years now I’ve been here. I’m still working on trying to get every bit of furniture. The shelter didn’t help with any services. I paid first, last, security. They didn’t help with furniture, nothing. I left the shelter with my kids, and that was it.” She says she could have used help with furniture and with coming up with the move-in costs. “I feel especially anyone going from the street or from a shelter into a new place should always get help with furniture. I feel that should just be a given. You know they don’t have anything... And then I don’t feel people that are on the street really have it all together to

where they can come up with first, last, security...it took me a long time to come up with it. I was supposed to move to the apartment almost seven months before I did..."

The experiences of caregivers in Cluster 2 communities represented the destabilizing nature of accelerating gentrification. All were confronting increasing difficulties affording housing, and worried about their ability to do so in their neighborhoods moving forward. In Brockton, Crystal's concerns about the shortcomings of local economic opportunities echoed caregivers in Cluster 1. In Everett, Louisa's concerns about her husband's job no longer being able to support their family remaining in the neighborhood echoed those in Cluster 3 who were beginning to feel the ground come out from under them after periods of stability and satisfaction in their neighborhoods.

4.3.4.1.3 Cluster 3

Financial pressures brought on by rising rents and the experience of exclusive neighborhood development patterns led to Cluster 3 respondents reporting increased difficulty over time securing and maintaining the material conditions of care in communities where they had previously been more able to. Rising rents hit respondents' pocketbooks or savings accounts and forced current or near-term tradeoffs between paying for housing and paying for other basic needs like food, clothing and childcare. Respondents also reported difficulty securing a stronger economic foothold that would allow them to keep up with the rising cost of housing via either the labor market or state assistance. Overall, this led to respondents feeling insecure about their ability to secure and maintain the material conditions of care into the future, and to worry about the increasing demands of meeting their and their dependents' basic needs on their resources, relationships and wellbeing.

As Cluster 3 caregivers watched their rents – and those of friends and neighbors – continue to climb, and felt increasingly excluded from development in their neighborhood, many felt a looming choice of whether or not to try to stay in their neighborhood, and worried about the types of tradeoffs doing so would entail. Marta was among them. "I haven't made any decisions yet," she says, "but if the rent keeps going up, I will not be able to afford to live here. I will have to move... But that will take money

from other things that I need, food and clothes and things like that. So I have not made any decisions yet. I am thinking. I'm waiting to see what is going to happen." Wait-and-see was a very common attitude towards housing among caregivers in Cluster 3 communities, however most did not feel clarity about what in particular they were waiting for to indicate whether to stay or go. For some, this was out of control, like one caregiver who was forced to move to Chelsea from Revere after his former landlord sold the home his family was living in. Another caregiver, from Dorchester, reported that the process of trying to find an apartment after previously living with her parents-in-law for affordability reasons had led to stress and relationship strain in her family. Numerous other respondents reported applying for housing "everywhere" and joining many waiting lists that were years long, remaining unclear on how they would make ends meet in the near-term.

Marta described how some of her friends had been priced out of Chelsea, and their only option was to move further away from the city, where they faced accessibility issues. "It's not easy because to go out of Chelsea means that you are going to have to rely on a car," she explained. Though they were able to find housing they could afford, they faced new costs in terms of transportation, illustrating a common double-bind. "Over here, you don't have to worry about it, because like I say, it's the bus, it's the commuter rail...So it's a lot of options. But if you go out, more farther away, it's less options.... So that makes it difficult for people that cannot have a car, cannot afford the car. That is the solution, to move out, and that is a problem."

Some Cluster 3 respondents worried that if they could not keep their current housing, they would end up on the streets, as Yvonne had. Iris, a caregiver in Roxbury, explained that she was recently at risk of being pushed out of her housing after her husband died and their subsidy was in his name. She mobilized some friends to help her do research and build a legal case to stay – she was also on the lease and her rent payments were up-to-date. The management company was claiming that a prior criminal charge was evidence that she was a "danger to our community." So, she says, "I had every tenant in the unit that we were living in sign a petition. And I had my pastor, I had my employer, I had my old probation officer...send letters. And I presented it" in court, she explained. She and her son were ultimately able to stay in their unit.

A minority of respondents in Cluster 3 communities shared that they were trying to save enough money to buy a home, but regretted that this would probably mean having to leave the community. Yvonne was attending “mortgageability” classes but was concerned that, as she was getting older, banks would be less likely to offer her a long-term loan that would be more affordable. She expressed the wish of buying one of the new condominiums in her neighborhood, but was pessimistic about this being possible. Most Cluster 3 respondents also wanted to stay in their communities because of their roots and ties, and in this respect, they were different than most respondents in other clusters except for caregivers like Stacey in Cluster 1 and Louisa in Cluster 2, who also had longstanding ties to their communities.

While most Cluster 3 respondents expressed some degree of hope for the potential of neighborhood development to create economic opportunities that may benefit them, most did not actually feel as though they were experiencing upward economic mobility or financial security as a result of the changes they saw in their neighborhoods. Derek’s example of witnessing a growing number of bicycle shops but none owned by Black residents and with limited opportunities for young people exemplifies this. In Marta’s case, she described how for her part-time sales job – “not your dream job, but something I enjoy” – being close to downtown Boston gave her lots of opportunities to find clients. However, she had to take on a second job to make ends meet, and wasn’t sure how much potential there was for her to earn enough more to keep up with her rising cost of living. Other respondents in Cluster 3 communities also reported being unable to take steps towards stronger economic footings because of the near-term demands of caregiving and the desire to avoid additional forms of economic uncertainty such as job searches, tuition fees or the risks of starting a business.

4.3.4.2 Building social support structures

The caregiving strategy of building social support structures refers to caregivers’ efforts to establish and maintain relationships with family, friends or neighbors whom they can count on for support with the work or burden of caregiving. This can take the form of actual childcare support, but can also take the form of financial support or emotional

support for the caregiver, for example. In the case of this caregiving strategy, there was a clear divide between caregivers in Cluster 3 and Everett and those in Cluster 1 and Brockton and Lynn, so I just compare these groups. Caregivers in Cluster 3 communities and Everett were most likely to have social support structures that they could count on in or near their neighborhood, most often because one or more generation of family members had lived in the same area for many years. Many Cluster 3 caregivers also tended to express greater feelings of social cohesion and report being more familiar and friendly with – and trusting of – their neighbors than those in Cluster 1. On the other hand, respondents in Cluster 1 communities, Brockton and Lynn were more likely to report having little to no sources of social support – whether on a material basis, for emotional matters, or to assist with childcare. For many this was because they had moved to these communities more recently for reasons related to the cost of housing or the availability of services like shelters.

4.3.4.2.1 Cluster 1, Brockton and Lynn

Caregivers in Cluster 1, as well as those in Brockton and Lynn, reported few sources of social support and thus having difficulty accessing it when they needed it. Their lack of social support seemed to stem from some combination of four factors: (1) not having longstanding relationships or family in their neighborhoods; (2) having difficulty building sustainable new relationships with people in their neighborhoods; (3) perceiving other people as being unable to provide the support they need in the first place; (4) an absence of local organizations or resources for building effective relationships or networks of social support.

Crystal didn't have much of a local social support network in Brockton, where she had been living for six years. "Nobody, really." The friend that she followed there from Dorchester had since moved out of Massachusetts. Like most others, she wished she had more support. "Yeah. Because things are tough. Even if it was just support talking-wise so I can vent about things, that would be better than what it is now." She said she could also use more financial support when unexpected expenses come up, "but you'll never find that." She says she's tried to build more supportive relationships with others in her

community, but hasn't had much luck. "I try. No one is ever there unless you have money, and if you don't have extra money, people you would think are your friends are still like "Oh, no, sorry.""

In Fall River, a caregiver named Mindy made the point that it takes some time to build support structures, especially in areas with lots of residential churn - "in and out renters" as Stacey called them in New Bedford. "I think I make a lot of effort," Mindy said. "But when I first moved in, no one really was that neighborly. But...each year it gets better. My second-floor neighbor, I met her at a job. And she told me she got HomeBASE and she was looking for an apartment. And I told her my second floor was open... She was pregnant, so I helped her move upstairs. So that's cool to have somebody that I feel safe with and I know living right upstairs from me."

Shawn, also in Fall River, shared a similar experience. He says he has a few neighbors that he can count on for favors if he's in a pinch. But, he says, "a lot of people have moved in and out. I mean, there's 19 apartments in here." He says that he and his wife, along with three other households, have been there the longest, and they've only lived there for three years. "The other people are in and out six months, eight months. In and out, in and out. It's constantly changing." He thinks it's partly because the building often caters to others in the voucher program that allowed he and his family to move out of the shelter. But he says his few friends in Fall River look out for his children, "make sure they're okay...and if I need any help with them, they'd be there for me to help out."

Pearl has also had difficulty finding social support in Fall River. "I don't feel like there's nobody there for me and that's probably the worst place to be in. Especially when you get older and you know that you're getting a little bit more tired and you just wish that you had a little bit more support in certain areas. And I just don't really feel like I have that..." Not having support "makes me sad," she says. She indicated that she tries her best to help others in need – such as when she tried to organize the tenants in her previous apartment building, or her current efforts to help a homeless friend and her children. "When people come to me, I don't say no...I'm helping a whole family right now. They were homeless and she... was one of the first people I met here. I took her and her [children] in.... It's cold out here. I wouldn't want to be left out here."

Pearl thinks that the people she helps wouldn't have the capacity to help her if they wanted to. Instead, she says, there need to be more community-based resources where people can receive support. "In this neighborhood, for seniors, they have a senior center. They have a place where they can go during the day and drop in and do nothing more than conversate, do free yoga. They might have their lunch together, see some buddies they haven't seen in a while. They need more of that here. Everything out here is a private club for the men or you need to be a member here. But there's no real place that, say, a mother like me can go or let's just say an open-door place where you know you can go and talk to somebody, even if you and that somebody have nothing more to talk about than to complain together. At least it's freeing in that way because you have something to comment. You know what each other's struggles are from living in this neighborhood. But when you just don't feel invited or you don't feel warmth from anybody here, that's crippling..."

Thus, while caregivers like Shawn and Mindy had managed to build a few relationships of social support over the course of a few years in Fall River, others who had lived in their respective neighborhoods for just as long, like Pearl and Crystal, did not. Notably, Shawn and Mindy both lived with partners, while Crystal and Pearl were both single caregivers. The greater burden of work caregiving without any support from a partner may have been a factor in why they felt like it was difficult to develop supportive new relationships. At the same time, both Pearl and Crystal also pointed to other community-level factors, like a lack of social cohesion and a lack of community resources for caregivers, that also contributed to their feelings of isolation.

4.3.4.2.2 Cluster 3 and Everett

Compared to other caregivers, respondents in Cluster 3 were the most likely to have strong local networks of social support, and be actively engaged in maintaining and building these networks. This reflects the fact that many of these respondents, like Marta and Derek also had extended family living in these communities, and most had themselves lived in these communities for large portions of their lives. Their social support networks had to date provided them with the means to weather many of the financial and

emotional difficulties of neighborhood change, and they said that they counted on their social networks as key buffers against the pressures of gentrification and the associated risks and vulnerabilities they faced. Family- and neighbor-based social support networks played crucial roles in helping respondents meet childcare needs or care-related resource needs. Because of experiences of social exclusion, they tried to invest in social support networks as a strategy for building social and economic resilience. At the same time, caregivers in Cluster 1 communities were afraid of the risks of losing these social networks via their own displacement, like in Marta's case, or that of others in their networks, as Yvonne experienced as her family moved out of Boston for more affordable areas.

Marta described how she has a strong network of family in her neighborhood, and also receives lots of support from her church, and from a therapist. While she could rely on her husband for support, she noted that he was "also overwhelmed with the same problems that I am." She said she could turn to a neighbor in her building for material social support when times are tight. "I have a dear friend that lives across from me...she needs \$20 to go and buy something to eat today, I give her \$20. I need \$10 to go buy something to eat tomorrow, she gives the \$10 back. Things like that, that's the way we help."

Marta said that the support she received had motivated her to increase the amount of time she spends volunteering in her community. "My life has changed because the more you receive, the more you want to give back to somebody else that needs... And if I am being helped, of course, I am going to help more. And having all these people around me, just to know they are there, that I can ask for help... I don't know how to even describe that...You don't feel lonely. That's the main gift." Having such a rich support network helps her seek help when times are tough. "When you are not feeling good, the first thing is that you withdraw from everything and from everyone. And that happens to me, too. But then I remember that seven-year-old kid that I cannot say, 'I don't have food for you.' So I have to go out and try to get help." She told a story of being worried one year about having nothing to cook for Thanksgiving, and a friend helped connect her to a program where she could receive some ingredients. "Those are the kind of things that you are able to have here in Chelsea, so I'm glad for that." She says her pastor "is always trying

to help me out, to connect me here, to connect me there, to find a way to help me... she even sometimes appears at my door with a bag of beans, a bag of rice, a bag of something... I mean, I know that I will not starve. And like her is other people that you just need to tell them sincerely what is happening in your life and they run to help you. So those are the kind of people that I have in my life, so I'm blessed."

Similarly, in Everett, Louisa felt like she had built a strong network of social support with her neighbors; it's a big reason her family wanted to stay if they could continue to afford it. "We're like a little community. Everyone says good morning, everyone says hello, and I think that if I needed something...I'd be able to get it from my community. And I don't think you could do that in many places....[but] I think people do things to people that they see....[and] I think if people know you daily, it tends to build the trust...we have that sort of bond here." Her efforts to help maintain these bonds of trust helped allay some of her fears about safety in public, which she says she's become concerned about recently. "Because all of the crazy things that have been going around with violence and especially around kids, we have our kids everywhere...We really don't like them walking around by themselves." But, she says, "I notice that you always have other parents and your neighbors looking out for each other, so that makes me feel safe. I had a couple of occasions that I needed my kids to walk back home, and it was nice to have people say "Oh, I saw them walking, they're okay.""

In an effort to contribute to community-building in her neighborhood, Yvonne volunteers regularly in a community garden. She says a lack of social cohesion is a big barrier to well-being in her community, and explains that the biggest obstacle to social cohesion that she sees is people withdrawing and isolating because money is short. "Boston is amazing but I don't know, we need to organize," she says. She sees the garden as an opportunity to try to pull people together. "We have to plan another event for August...[and] I asked them if it could be like an open mic. That people can stand up and say how they feel. How are you feeling about the community? How's your family doing? Because it's a mass exodus to down south where it's cheaper... We're trying to get people to come out together and talk more but people are becoming pessimistic. They're becoming hopeless..." What's happening, she explains, "is that Boston is rapidly changing

so fast that if you're not up on it, you're going to be lost. You're doing to be lost and you could be lost here. You could be here and lost...if you're not up on it. And how you get up on it is from information, is from getting out, asking people and staying connected to the community."

Thus, while caregivers in Cluster 1 were struggling to build social support networks, caregivers in Cluster 3 were struggling to preserve them in the face of rapid neighborhood development and associated displacement pressures. Indeed, many Cluster 1 caregivers, like Mike, Crystal, and Shawn, were struggling to build social support networks precisely because they had been forced to move to Cluster 1 communities due to being unable to afford housing in other areas closer to Boston. This was the fate that Cluster 3 caregivers were hoping to avoid, because of how significant their social support networks were for their wellbeing and, in some cases, economic security.

4.3.4.3 Managing dependents' relationship to the environment

Again the data revealed a stark divide in caregivers' strategies of managing their dependents' relationship to the environment between Cluster 1 and Brockton, on the one hand, and Cluster 3 and Everett, on the other. In Cluster 1 and Brockton, almost all caregivers adopted protection-oriented strategies for managing their dependents' relationship to the environment. Meanwhile, in Cluster 3 and Everett, almost all adopted exposure-oriented strategies. In the first case, caregivers pointed to public safety concerns and a lack of adequate public spaces and activities appropriate for their dependents as reasons for their protection-oriented strategies. In the latter, case, two factors informed caregivers' exposure-oriented strategies: one, a desire to take advantage of improving neighborhood amenities, and two, the intention (often out of a sense of necessity) to cultivate their dependents' awareness or know-how about how to navigate their community. One notable factor that may help explain this difference is that most (but not all) caregivers in Cluster 1 and Brockton did not hope to stay in their neighborhoods long term, instead hoping like Jen to protect their dependents until they could move elsewhere to "find better," while most in Cluster 3 and Everett did want to remain and felt a greater sense of belonging.

4.3.4.3.1 Cluster 1 and Brockton

Respondents in Cluster 1 and Brockton for the most part – though not exclusively, such as in Stacey’s case – adopted protection-oriented strategies to managing their dependents’ relationships to the environment. This was driven by safety concerns related to crime, violence, and drug use, as well as the perspective that there were not many positive opportunities for social or environmental exposure available.

In Brockton, Crystal said that because of the drug activity she observed in her neighborhood, “when my kids are with me, I choose not to go outside... If my son wanted candy at the store, I’m not going to walk with him to the store. So it sucks.... I don’t want my kids outside when I know outside is nothing but trouble. I don’t want my kids subject to anything extra that they don’t have to be.” She says that before she goes outside, she steps on to the porch “to see who’s out there or what’s going on or if the cops are out there or if someone’s shooting up in my alley or if there’s needles in my alley.”

Jen, a Black woman who lives in Brockton with her two children, seemed to share Crystal’s perspective. She said she wants to keep her dependents “as far as I can from everything that’s happening until we move out of here and find better,” she says. She says she wants to move because of her concerns about violence and negative peer influence. “If you allow your kids to be following what everybody else does, they end up being a Brockton kid. Because these kids are terrible. I’m not going to be there all the time to supervise and watch and know what they’re doing. So if they are a little grown and they start to do that, then they become a Brockton kid. And I honestly don’t want my kids to be a Brockton kid. I don’t. I really don’t.” She says it didn’t always feel this way. “When I first moved around here, I would actually see people, kids playing around. And then a while ago, something happened around here. We had choppers up there. We had all these entrances blocked and there’s cops everywhere. So people got a little scared, and I don’t really see them out anymore.”

In Fall River, Shawn says that in terms of parks and other public spaces, “I don’t see anything is changing,” he said, giving the example of a park down the street that he takes his children to. “It’s just big open fields, it’s nothing.” He reasons that “there’s plenty of

land, plenty of room. And it would be nice...they could turn them into a baseball field or a football field. But it's been the same thing the whole time that I've lived here...just a mound of dirt." Because there aren't many places to go, he says "we pretty much stay around here. We go outside in the afternoon when my wife and I get home from work. Take the kids outside and play with them or walk up the street to the park...we mind our own business." Otherwise, he says he and his family "pretty much just leave," often to visit family in the region.

Similar to public spaces, respondents in Cluster 1 were hoping to see the resources offered in their communities continue to expand as economic development progressed. Stacey explained that places like libraries and community centers were crucial nodes that could enable people to access information, resources, and opportunities and thereby benefit from the community's growth. "I think as soon as we have access to things like libraries, community centers, then you have more access to resources because those places are usually where resources are listed or where advocates for those resources are... I use three branches of the library in the city, and I think that's super rewarding... When my son was younger, we used to do the free movie night at the public library downtown...So I believe that those things are important. I think that knowing you have them is important." She says the community center near her house is broadening its offerings, and that she recently began attending yoga and craft classes at the one downtown. "I think those things are important. You need to have something to do that's not expensive." Another caregiver in New Bedford was engaged in an effort to build a cultural center to create more opportunities for young people to engage in the arts.

In Fall River, Pearl echoed Stacey's point about the importance of affordable opportunities for exposure, and also emphasized the need for more inclusion. "We make a lot of memories through the summer because I find different events that don't require money and they don't require you to have a vehicle." However, she noted that many of the events she sees are geared towards Fall River's large Portuguese-speaking community. While she often still tries to take part, she says "I think that it doesn't leave much room and much space for people of other ethnicities to be able to reach out and to connect to other people when there's not a broader range of things to do.... I have to really go a great

distance to seek and find. And that's kind of like...a little draining... There's not a lot [to do] and it's really a divide."

4.3.4.3.2 Cluster 3 and Everett

In Cluster 3, most respondents adopted exposure-oriented strategies for managing their dependents' relationships to the environment. While the protection-oriented strategies in Cluster 1 and Brockton were more reactive, exposure in this case was more pro-active. Caregivers in Cluster 3 and Everett adopted exposure-oriented strategies for managing their dependent's relationship to the environment for a handful of reasons. For some, there wasn't an alternative; these neighborhoods are dense, and like Marta many respondents lived in small apartments that made spending time away from home a necessity for well-being. Additionally, as Nina, from Dorchester, put it, "they're already exposed anyway." A number of respondents linked this to the need to cultivate a satisfactory degree of independence for their dependents, for example the ability to move through the city on foot or via public transportation safely and effectively.

The second reason was because they wanted to try to take advantage of the positive aspects of the changes in their neighborhood, such as updated amenities, as much as possible. Compared to other Clusters, Respondents in Cluster 3 were most likely to feel like there were positive changes in amenities and social exposures in their neighborhoods. Respondents mentioned taking advantage of options including: museums and other educational opportunities; renovated libraries and community centers; and public outdoor spaces like parks and walkable sidewalks. For example, Derek said that "as far as opportunity, there's way more opportunity that I see now for the kids that we didn't have. Me and my friends and people I know, we always say, "Oh, they didn't have that when we were growing up." And I think about it like, people say that about us. When we were growing up, the older generation said, "Take advantage of this, because they didn't have that when we were growing up." And I'm seeing the same thing." Nevertheless, respondents in these clusters still had to navigate a constant balance between "the good and the bad," as Daisy from Roxbury put it, when it came to environmental influences on their dependents.

Additionally, respondents in Cluster 3 and Everett seemed to feel the most like there were positive social exposures in their neighborhood, relative to most respondents in Cluster 1 and Brockton. While many were equally concerned about negative peer influences on their dependents, respondents in Cluster 3 neighborhoods were much more likely to report instances of their dependents having friends in the neighborhood, having mentor-type figures, and enjoying being involved in volunteering, community events, and institutions like churches.

While most Cluster 3 respondents shared many of the same safety concerns as their peers in Cluster 1 – for example, Marta’s concern that her kids may have a negative encounter with someone buying or selling drugs echoed Crystal and Pearl’s concerns – they were much more likely to trust that friends, neighbors, or other local figures like crossing guards would help to ensure their dependents safety in such an instance. For example, Yvonne explained that she and her neighbors in the building were “all close. We look after each other. And because we know about the crime and things, the children are very close as far as watching out for each other and making sure the building is safe.”

4.3.4.4 Preserving health

In terms of their own health, caregivers across all clusters shared common challenges – most commonly stress and depression – to which they attributed different causes. In Cluster 3, caregivers were most likely to attribute stress to fears about rising housing costs and potential displacement, whereas in Cluster 1, caregivers were more likely to attribute these issues to either the difficulty of getting back up on their feet from difficult circumstances and/or not having any support. For caregivers in Cluster 3, social support helps them cope with their health challenges, but for many their stressors are rooted in environmental and structural factors that they don’t feel control over and don’t see resolving in the near-term. Overall, this was a domain of strategies where the differences across clusters was minimal, with most caregivers struggling in various ways to preserve their own and their dependents’ health.

Marta exemplifies this pattern. She says stress about being able to afford to stay in Chelsea, and about the safety of her building, makes her health issues, including arthritis

and depression, worse. "Stress doesn't help anybody... My depression gets worse. And because my depression gets worse, my pains gets worse... And the stress is not going away. It's not something that we can fix right away. I mean, we are hoping that eventually my ideal world will come. But I mean, realistically, it will not happen soon." She explains that preserving her health has forced her to make caregiving sacrifices. "So it takes me longer to do things. With [my child it] is more painful, a bit more sad because I wish I have the energy. I wish...not to have the aches that I have usually to do more stuff with him.... I wish I can spend more time with my son. And although the Boys & Girls Club is really good for him, I do think that nothing's replace the time that he can spend with me and the things that I can teach him. But because of my pains and aches and my apartment being too small, it's better for him to be away from me. So yeah, that has prevented me for giving my son what he needs."

Marta says her top priority is to improve her health and "to feel better... to make it safer for my kid. Safer if I am healthy. Safer if I am not worried about if I can pay the rent this month or if I cannot pay it. Safer if I have food in my table for him. Safer if I don't have to worry about him going out of my door and have to worry about that somebody going to approach him with drugs. And safer that I know that he going to get in the bus, go to school, and come back safe and sound." Unfortunately, when she thinks about the changes she expects to see in the next five years, she imagines they will make her health worse. "Because of the changes that Chelsea is going through, I see people are being forced to move. Friends of us are being forced to move because they cannot afford to live here... So it makes it worse, I think. Doesn't make it any better."

In Brockton, Crystal shared similar health struggles as Marta, and also indicated that only large-scale environmental and structural changes would really address what distressed her. She said that her two biggest health concerns for her dependents were "safety...and the mental health, I don't want my kids out here being subject to the crap that goes on out here." These concerns stem from her experiences with her own mental health and how it has affected her overall wellbeing. "I think because if you're depressed and your mental health isn't good, you're always going to feel like crap in general, physically, mentally, everything. So me where I am, I hate it. So I'm always miserable.

And people in your hallway smoking crack and that's all you're inhaling, that's not healthy. So there's a lot." Asked what she would change about her neighborhood to improve her health, she laughed and said "I'd tear everything down and start over."

Pearl in Fall River also struggled with stress and depletion. "I'm sluggish, I'm fatigued, I'm all in all tired. I've been having some issues like high blood pressure... My asthma bothers me," she said, noting that her kids also have respiratory problems. "I remember a time when I was at healthier spirits physically and didn't feel so lack of energy, didn't necessarily rely on turning to the cigarettes that I smoke lately a little bit more than I used to." She also attributed her health struggles to her neighborhood. "My home and my neighborhood affects my health because when you know that you can walk down a little one city neighborhood block and you can see so many things that you don't necessarily want to see and you definitely don't want your children to see, it turns you away from wanting to be a part of anything. I would say that there are times where I know I want to be doing more but because of the way I feel about the neighborhood that I live in, I refuse to do the little bit more that I really want to do... I sometimes sacrifice taking my children to a lot of places in advance because if it requires me to do long-distance walking or if I know that it's in the evenings and I don't feel safe in my neighborhood, chances are we won't go." In summary, she said "When I feel like I'm trapped or I can't take part in some things because of what might be out there, it depresses me, and that's my health."

Another respondent from Fall River, Mike, described how caregiving could take a physical toll on him and contributes to his difficulties with chronic pain. "I stand up on my feet a lot because I do all the housework. So I do all the cooking and cleaning and picking up and walking to pick my daughter up from school, walking her to school, stuff like that. So there'd be some nights when the night's over, my feet be hurting so bad. I just can't wait to lay down and get off my feet, but I just deal with it. It got to be done. Deal with it.... I bust my ass every day to pick up. I'm not perfect but I can honestly say every day, I bust my ass." He says he lacks support and that this takes a toll on his mental health as well. "I don't have anyone to help me so I do it myself... Sometimes I'll be like, "Damn, I wish I had help"... I be having problems like other people. Sometimes I just

wish I had someone I could talk to, you know what I mean?" He says he's particularly stressed about his finances, having struggled to pay rent that month, and that this keeps him awake at night. He says his only source of social support are his kids. "Sorry to put the pressure on them but...If I have a problem or anything-- sometimes if I just have to talk to someone and I don't have somebody else I can call, like an adult or someone, I would put on my kids. But nothing too heavy, obviously."

Caregivers across all clusters also faced challenges finding and affording healthy food options for themselves and their dependents. For example, Stacey explained that her diet is important for her health, and when asked about how her health is influenced by where she lives, she said: "I think definitely the access to healthy food, which is an ongoing theme for me, is definitely related to where I live." She says that accessing affordable healthy food in New Bedford has proven to be a big economic challenge. "We have four like pay for your bag type grocery stores in the city and we don't have too many farmer's markets or access to healthy food. That shows you kind of the economic strain." Her budget limits the produce she can get, which she says is of a low quality at the grocery stores in her neighborhood that she can afford. Stacey said this was one of the reasons that she wished there were more community gardens in New Bedford. Pearl also reported difficulties accessing food, and said that there are days when she goes hungry in order to ensure that her children can eat.

Others in Cluster 3 communities like Chelsea and Dorchester had similar difficulties, but typically indicated that they were more readily able to address them by combining resources from food pantries, food distribution programs like the kind Marta volunteered for, and farmers markets during the summer months. Sara described how her neighborhood in Chelsea felt like it hindered her efforts to improve her dependents' nutrition. "We try to eat more healthier choices. And honestly, if there were more healthier choices available around here for us, we would do that. Even small stuff. Everything has candy, junk, candy, junk, candy, junk. And it's like, "What are we doing?" You go to other cities now, like more suburban cities and you can't even find a corner store for like a mile into the city. Here, in this one city, two by two miles, I'm going to say

there's at least 20 corner stores, and they all sell junk and candy, junk and candy to your kids."

Across all clusters, caregivers reported common challenges with respect to preserving their own health. These included stress and depression, which could be caused by neighborhood-level factors like Marta's fear of displacement and Crystal's neighborhood safety concerns. These also included physical health challenges stemming from the burden of care work, like Mike's difficulty managing his pain or Pearl's recurring asthma. Caregivers could also face challenges ensuring health with respect to access to healthy food.

4.3.4.5 Balancing work and care and time management

The main time management concerns respondents expressed in relation to changes in their urban environments concerned balancing work and care, and so I discuss these two strategies together. As above with strategies concerning preserving health, the similarities between respondents across clusters in terms of efforts to balance work and care were more significant than their differences. As indicated in *Section 3.3*, Cluster 3 respondents by and large had not personally experienced better job opportunities or upward economic mobility as a result of the changes in their neighborhood. Rather, they shared concerns with Cluster 2 and 1 respondents about being able to find work that was a suitable fit for their caring responsibilities and needs, as well as work that paid well enough to afford they and their dependents a satisfactory quality of life. Caregivers from across all clusters also spoke to the difficulty of maintaining paid work in the context of the demands and tolls of caregiving and the challenges of balancing paid work with care.

In Chapter 3, I shared Yvonne's story of how taking on an extra job to help afford rent and the costs of caring for her daughter caused her "bottom [to] fall out": she became severely depressed and, eventually, homeless. At the time of her interview, she was working part-time at a community garden for a stipend. Though she was trained as a nurse, she did not want to re-enter that field because of the burnout that she had previously experienced. Instead, she was considering retail jobs. She described facing difficulties navigating the job market without a computer at home, but recently

discovering a program that assisted older adults re-entering the labor market with job applications, which gave her some optimism.

Marta also reported losing a well-paying job after a period of depression. At the time of her interview, she was working part-time in sales to help make ends meet, and that she also received a small income from helping to clean her church each week. She explained that her husband's income also fluctuated. "When it's raining, he doesn't work, so he doesn't get paid. So it's only my little income... if I feel good to go to work, I do mine. But if I don't feel good, I cannot bring money. So some months we barely make it, some months we fall behind. That's how we live." Not being able to cover her expenses causes her additional stress, which makes her arthritis flare up. "It is tough. I mean, there's a lot of people that has it tougher than me. I'm very sure of that... For me, it's very sad because I have a little person that I have to take care of. Like, I can go without a meal for a day, two days. But when he come's and he's saying "I'm hungry" I cannot say "Oh, I have nothing to give you."

About a year before her interview, Marta's husband lost his job. He could only find work in another city outside of Massachusetts, and traveled there for four months. "My son and I, we were devastated. My son even thought that my husband has abandoned us." When he was back, she says her son followed him around to make sure he wasn't going to leave again. "But I think eventually he's going to have to go back again because it's not easy to find a job here," she explained. Uncertainty also loomed over Louisa in Everett, who was considering returning to work to help her family keep up with the rising cost of housing and making ends meet. "Sometimes things are a little tighter than other times, and then you need to change your priorities," she explained. She had previously worked as a nanny, but said that she stopped because the cost of paying for childcare for her kids just about surpassed her income. was not sure what type of job she would seek.

In Brockton, Crystal had finally found a job that works with her caregiving responsibilities, which she says is a relief. She works in a warehouse for a pharmaceutical manufacturing firm. "You're kind of just putting the covers on bottles, but you do that all day long... for now, it's all right. So I'm not switching. I like the consistency, so I have weekends off. That's kind of my goal for when my kids are in school...So for that reason

alone, I wouldn't change." She says her job is important to her being able to continue to care for her dependents. "If I didn't have my job, I probably wouldn't have my kids because I couldn't take care of them. So my kids are the most important, but without the job I wouldn't have them anyway, so." She's only had this job for a year; before, she was working in another warehouse, but "it was all different hours, nights, weekends. Before, my kids had to go to work. I had to figure out how to get them to school and – so it was – yeah..." The only downside of this job, as she explained above in *Section 3.4.1*, was that she was barely scraping by on what she was able to earn, and regularly relying on food pantries and other forms of assistance. This inhibited her from saving any money to move, which she strongly desired. Unfortunately, she said, she didn't have the means to look for another job, and wasn't optimistic that she'd find anything different than the types of jobs she had already worked.

Another respondent in Brockton, Jen, had similar concerns as Crystal. She worked at a grocery store, and shared that the only new jobs she saw being created as a result of development in Brockton were other low-wage service-industry jobs. "It is going to create more jobs, but a café don't pay well enough for somebody to survive in Brockton. Because rent is super high over here, and the bills, and working at a cafe is not really going to cut it. They should create something that pays better than a cafe."

In Fall River, Pearl was facing a similar issue to what Crystal experienced, struggling to find work locally that would also allow her to fulfill her caregiving responsibilities. Pearl said "I dropped out of school because I had to get a job. Then I lost the job and now I'm no longer in school. Those were the things that kept me happy because I knew that I could provide for [my children] and that I was trying to better myself." She says that her most difficult priority to fulfill has been trying to find a new job. Part of the difficulty, she explains, is "trusting somebody to keep my children so I can work overnight... I'd like to do the third shift because I know that they're sleep and things like that and I'll be there for them when they wake up.... And I can tell you that is definitely out of the question to try to find mother's hours in this city because I've searched them high and low and they're very hard to find."

Stacey has mostly worked part-time jobs because she couldn't afford the cost of additional childcare. She said that when her son was younger, "affordable childcare was a challenge because paying for an after-school program when he was in elementary school was not financially possible. There is a community center in my neighborhood that became affordable. They just don't provide transportation... [So] then it was asking a friend, "can you be the one to bring him? can you be the one to pick him up?" and having to pay them." She says she wouldn't have been able to afford the \$200-week cost another program near where she works. "That's like half of my paycheck. So we weren't doing that." The result, she said, was her son staying home alone, with her worrying about his wellbeing. Through one of her jobs, Stacey says she knows a lot of other caregivers in New Bedford, and she says many face similar challenges balancing work and care in their effort to make ends meet. "We have parents who don't have food at home. They don't have access to food. They're working three jobs and there's no one home with their kids. We have kids who can't get picked up on time because there's no one to pick them up because mom's at work and that's her second job of the day."

Stacey says balancing work and caregiving has led to her sacrificing looking after her own health. "I work too much. I don't take care of myself as much as others. That's part of...caring about everybody else is I'll burn myself out. I have a good work ethic almost to a fault where if I'm sick, I will still come to work." She says her brother and godmother tell her "you have to take care of you before you can take care of all those kids and your students and all of those things that you do."

Across all clusters, caregivers experienced difficulty finding economic opportunities that were conducive to a feasible balance between paid employment and caregiving. However, most caregivers nevertheless needed to work in order to make ends meet, and thus typically ended up working jobs that afforded them minimal economic security or mobility in order to fulfill caregiving responsibilities. These jobs could still leave caregivers feeling like their capacities and resources were stretched thin.

4.4 Discussion

In this chapter, my analysis focused on how gentrification produces changes in the urban infrastructure of care from the perspective of caregivers, and how these changes influenced what the work of caregiving entailed and how this work was experienced by caregivers. Overall, I find significant differences in caregivers' perceptions of changes in local urban infrastructures of care according to the trajectory and pace of gentrification in their communities, and the broader patterns of disinvestment and uneven development of which gentrification was a part. The differential effects of disinvestment and uneven development via gentrification on the urban infrastructures of care in HNS communities were linked with notable differences in what the work of caregiving entailed and how it was experienced between caregivers in low- vs. high-pace gentrification communities. Below, I summarize my findings and then argue that together they demonstrate that gentrification produces "care insecurity."

4.4.1 *Summary of Results*

Caregivers in Cluster 3 like Marta, Derek and Yvonne experienced significant and rapid changes in their neighborhood, which they saw as being driven by residential and commercial development and the moneyed interests therein. While they saw certain potential upsides to the changes in their neighborhoods, like improved amenities, other benefits they hoped to incur by way of neighborhood development, such as expanded economic opportunities, had not materialized for them. They were already experiencing negative material and psychological consequences from the changes in their neighborhood, including rising rents and cost of living, financial insecurity, feelings of social and/or economic exclusion, threats to existing social networks, and fears of displacement.

Caregivers' experiences of neighborhood change in Cluster 2 communities differed considerably from one another. In Everett, Louisa was grappling with the ripple-effect of the large new casino being built in her neighborhood; while she appreciated the improvements to neighborhood amenities that coincided with this development, she was

concerned for her family's financial wellbeing and worried about being priced out of the neighborhood despite wanting to stay. Meanwhile, in Brockton, Crystal bore witness to the results of the housing market crash and decades of disinvestment and strongly wished to leave her neighborhood to secure a better future for her children. While she saw development beginning to trickle into the community, she saw it as mostly geared towards outsiders with little potential benefit to people like her. The changes that Louisa, Crystal and others in these neighborhoods saw illustrate the lurching and uneven course of gentrification.

Caregivers in Cluster 1 communities like Stacey and Pearl were largely confronted with the results of disinvestment that precedes gentrification. They experienced the effects of long-standing social and economic inequalities that were just beginning to be replicated or compounded by changes in their neighborhoods. They worried about the potential for uneven investment in their neighborhoods that would only leave low-income residents behind.

The domain of caregiving strategies impacted most by the neighborhood changes that respondents were experiencing was, unsurprisingly, 'securing and maintaining the material conditions of care.' This domain was most impacted because of how gentrification impacts two components of the urban infrastructure of care in particular: private space and economic opportunity. While respondents in Cluster 1 did not have difficulty securing housing itself, they struggled to find housing that was safe, comfortable and which satisfied their needs. Because of what they saw as a lack of economic opportunities that would enable them to secure better housing, they felt stuck in sub-optimal circumstances. In Cluster 2, respondents reported that they were beginning to see their housing costs creep up beyond what they could comfortably afford, yet they did not feel as though new economic opportunities that would allow them to keep up with these costs were accompanying these changes. This led them to feel stuck in situations that they had thought would be transitional, and doubting their ability to make affirmative steps towards goals of securing longer-term residential and economic stability. In Cluster 3, respondents reported distress about high and rising rents, which were undermining their

ability to secure and maintain the material conditions of care in the present and their confidence in being able to do so into the future.

In terms of efforts to build social support structures, the experiences of caregivers in Cluster 3 and Everett differed from those in Cluster 1, Brockton and Lynn. In the case of the former, the majority of respondents had long-standing relationships in their neighborhoods that were being strained by development pressures and that they risked losing. In the case of the latter, most respondents reported high levels of social fragmentation and disorganization and an inability to form many sustainable supportive relationships. In Cluster 3 and Everett, respondents saw neighborhood changes jeopardizing their social support structures, and in Cluster 2 and Brockton, they saw them as inhibiting them from building social support structures.

When it came to managing their dependents' relationship to the environment, caregivers in Cluster 3 and Everett adopted exposure-oriented strategies while those in Cluster 1 and Brockton adopted protection-oriented strategies. The latter were driven by safety concerns related to social disorganization, while the former were driven partly by necessity and partly by a desire to take advantage of positive aspects of the changes in their neighborhoods. Protection-oriented strategies largely resulted in social isolation for both caregivers and their dependents, while exposure-oriented strategies offered positive opportunities for dependents' socialization while also requiring considerable effort and expenditure on the part of caregivers to orchestrate exposures.

Caregivers efforts to preserve their and their dependents' health were not a domain of significant variation across clusters. Instead, the main axis of difference was the causes to which caregivers attributed common patterns of difficulty with stress and depression. In Cluster 3, caregivers were most likely to attribute stress to fears about rising housing costs and potential displacement, whereas in Cluster 1, caregivers were more likely to attribute these issues to either the difficulty of getting back up on their feet from difficult circumstances and/or not having any support. For caregivers in Cluster 3, social support helps them cope with their health challenges, but for many their stressors are rooted in environmental and structural factors that they don't feel control over and don't see resolving in the near-term.

Finally, in terms of balancing work and care, again the similarities between respondents across clusters in terms of efforts to balance work and care were more significant than their differences. Cluster 3 respondents by and large had not personally experienced better job opportunities or upward economic mobility as a result of the changes in their neighborhood. Rather, they shared with Cluster 2 and 3 respondents concerns about being able to find work that was a suitable fit for their caring responsibilities and needs, as well as work that paid well enough to afford they and their dependents a satisfactory quality of life. While there were differences across clusters in the types and range of jobs that caregivers perceived to be available, that did not change the underlying similarities across clusters. Thus, for the most part, caregivers struggled to navigate a mismatch between their caregiving responsibilities and the economic opportunities available to them where they lived, and this typically had negative impacts for both their material circumstances and their mental health.

Overall, these results show that gentrification primarily affects caregivers' efforts to (a) secure and maintain the material conditions for care, and (b) build social support structures. In doing so, it had secondary but significant effects on their ability to preserve their own health and to satisfactorily balance work and caregiving. In terms of the urban infrastructure of care, the affordances of gentrification in terms of improved neighborhood amenities were considerably outweighed by the rising economic and social pressures they and their communities faced. While Cluster 1 respondents and those in Brockton clearly would have benefitted from further neighborhood development – of the kind that Louisa described went in to Everett's parks, for example – the trajectory of development towards what we see in Cluster 3 would seem to hold little potential for providing them with a solid foundation for caregiving or broader possibilities for caregiving.

A picture thus emerges of neighborhood development trajectories in HNS neighborhoods producing a double-bind for caregivers, leaving them trapped between a rock and a hard place. On the one hand, caregivers in Cluster 1 and some Cluster 2 communities feeling stuck trying but struggling to gain a stable footing, and on the other hand, caregivers in Cluster 3 communities feeling stuck while the ground is feeling like it is crumbling under them. Those in Cluster 3 were trying to become increasingly

resourceful in an effort to protect their access to who and what they need, while those in Cluster 1 were struggling to get what they need in the first place, and had difficulty being resourceful without strong social networks. These results show how the process of the capitalist production of space characterized by cycles of disinvestment, uneven development and gentrification destabilizes the urban infrastructure of care and in doing so undermines the reproductive labor of the respondents in this sample. In doing so it produces feelings of uncertainty, exclusion, and loss of control. Thus, while disturbances in the urban infrastructure of care increase the burden of care work for respondents, the conditions of this work also become more precarious, and this precarity can come to characterize the feeling of caregiving in the context of gentrification.

4.4.2 Care Insecurity

Based on the results of this analysis as summarized above, I argue that gentrification produces care insecurity. This concept was developed through discussion with members of my Community Advisory Committee during a meeting discussing the interpretation of these results. As far as I am aware, this is not a concept that is already defined in the academic literature. I suggest that care insecurity can be defined as a caregiver's feeling of: lacking adequate access to the necessary components of care; anxiety or fear in relation to one's caregiving circumstances and a related lack of confidence in one's ability to provide satisfactory care in the future based; and/or a diminished capacity to prepare for and respond or adapt to adverse events that impact the dependent or the caregiving relationship. In the context of this study, I emphasize that the care insecurity I am referring to concerns the caregiver's perceptions and feelings about the components of the urban infrastructure of care.

Most caregivers in this study, regardless of their community of residence, experience care insecurity in one form or another, and to different degrees. This reflects the broader crisis of care as explained in Chapter 2. What this analysis shows is that gentrification is productive of care insecurity because it destabilizes the urban infrastructure of care, affecting key components as well as the relationships between them and the "articulation

work” involved in maintaining the connections between the components that are necessary to continue to pursue key caregiving strategies. Gentrification not only makes it more difficult for caregivers to secure and maintain the material conditions of care and create social support structures, but undermines existing strategies for doing so. For many caregivers, the consequence of these patterns are sacrifices in self-care and efforts to preserve their own health. The result can be feeling like you’re stuck on a hamster wheel, as the rising demands of caregiving coupled with care insecurity can leave caregivers feeling like they have less care to extend to their community more broadly, and less capacity to fight what is undermining their survival.

Care insecurity is a relational and multi-scalar concept. This means that it can be understood at the level of individuals, as well as at the neighborhood level or other geographic scales. While the results presented here focus on individual-level experiences of care insecurity, they also show how caregivers may experience care insecurity as a meso-level phenomenon, that is, a collective experience shared by a group of people within a specific spatial context. We can see this in how caregivers speak about the experiences they have in common with other caregivers in their community, how their perceptions of other people’s experiences shape their own caregiving strategies, and when they suggest that changes in community social dynamics, such as diminishing social cohesion, impact their own caregiving strategies.

Recognizing that patterns of production and social reproduction are mutually constitutive and in tension under capitalism, it is worth considering how the production of care insecurity for low-income caregivers and caregivers of color is part and parcel of the process of producing urban space for increasingly affluent people (Katz, 2001). Insecurity has long been recognized as a key aspect of capitalist production, which is destabilizing by design (Marx & Engels, 1848). The generation of care insecurity is one way through which the production of urban space renders people displaceable and facilitates the redistribution of populations across urban space, thereby accelerating the processes of extraction, dispossession and profit that characterize the “productive” side of gentrification. This coincides with the hollowing out of the U.S. welfare state, the purpose of which was to mitigate insecurity under capitalism, and the dismantling of which in the

favor of market-based access to care has served the interests of further capital accumulation (Esping-Andersen, 1990). As Curran's (2017) research with middle-class caregivers in gentrifying neighborhoods shows, even those who stand to benefit from gentrification and the commodification of care have experienced gentrification as rendering social reproduction more labor intensive and expensive.

The results of the analysis conducted in this chapter suggest that the consequences of care insecurity can include: an inhibited sense of priority fulfillment; undermined sense of control; disempowerment; diminished "vital reserves" for social reproduction; and stress (Mohandesi & Teitelman, 2017). These are important consequences of gentrification and reveal that care insecurity is perhaps a significant aspect of the condition of displaceability, as well as one way that displaceability is gendered and racialized (Yiftachel, 2020). These consequences suggest that by producing new forms of care insecurity, gentrification increases the cognitive labor associated with care, making the work more burdensome (Damingier, 2019). In the following chapter, I explore how the impacts of neighborhood changes like these on the work of care may be embodied by caregivers with a focus on stress as a pathway of embodiment.

4.4.3 Limitations

The relatively small number of interviews with caregivers in Cluster 2 communities, including the absence of any in Lynn, impedes a deeper understanding of how caregivers experience the transition from low- to high-paced development. The differences between respondents' experiences in Everett and Brockton suggest that this stage is turbulent and uneven. Fortunately, the large number of interviews from Cluster 3 and 3 communities helps to mitigate this limitation by providing a sense of the overall progression of this transition and therefore the contours of what we can expect for caregivers in Cluster 2 communities.

The absence of data on Lynn points to how selection bias – and specifically selection on care as an outcome – is a limitation of this analysis. There was one respondent in Lynn who was initially included in the sample for this analysis because she

reported having children on the HNS Survey. However, in her interview, she explains that she does not have custody of her children and that they live in a different state. She does not indicate if or whether they will be returning to her custody. Because she did not have any dependents present in her life, and did not substantively discuss her own experiences caregiving during her interview, I excluded her from my analysis. However, her situation begs the question of the extent to which the place-based conditions in Lynn contributed to her no longer caring for her dependents – that is, the extent to which the hostility of the environment is responsible for the absence of a caretaking relationship. This is cause for reflection on the extent to which researchers may not be able to observe people engaged in care when the relationship has been broken or ended. The theme of selection bias is also discussed more broadly in Chapter 6.

4.4.4 Significance and contribution

This chapter shows how gentrification is a mechanism for the stratification of social reproduction in cities via the production of care insecurity. Stratified social reproduction, discussed in detail in Chapter 2, refers to “the power relations by which some people are empowered to nurture and reproduce, while others are disempowered” (Colen, 1995; Ginsburg & Rapp, 1995). The production of care insecurity – both on its own terms, and in terms of its consequences for the cognitive burden of care, caregiver health, and wellbeing interpreted via the capabilities approach – is a means through which caregivers are disempowered by changes in the urban environment. Care insecurity and stratified reproduction, through their simultaneously demanding and disempowering effects on caregivers, exacerbate the racialized and gendered conditions of displaceability that characterize gentrification. In doing so, the production of care insecurity and the resulting stratification of social reproduction likely serve to accelerate gentrification by undermining residents’ capacities and resources that would enable them to stay in their homes and organize and fight for more equitable neighborhood development. Mezzadri (2021) reminds us that we must see social reproduction as value-producing, and attend to the externalization of social reproductive costs from urban centers as one mechanism of value

production. Thus, I argue that gentrification contributes to the contemporary crisis of care by producing profit and power for some through the generation of care insecurity for others, and the stratification of social reproduction which coincides with other forms of social and economic inequalities that characterize gentrifying contexts.

In terms of understanding the impacts of gentrification at the level of resident experience, these results show how respondents' lives and wellbeing are undermined by the changes in their neighborhood long before they may be displaced. While displacement has been called the central harm of gentrification, these findings show that the state of displaceability brought on by gentrification-related changes may be harmful to health and wellbeing of caregivers and, perhaps consequently, their dependents, independently of whether someone is ultimately displaced. Care provides a valuable lens into the experience of urban processes that affords an important way to understand the significance and meaning of changes in the lives of residents as they exist in relations of interdependence.

From the perspective of research into gentrification and health, these findings show that care insecurity produced by gentrification detracts from and is detrimental to health and wellbeing. In terms of health, my findings show that caregivers cope with care insecurity generated by gentrification by making sacrifices when it comes to self-care and preserving their own health. From a theoretical perspective, if we follow Canguilhem's definition of health in terms of the ability to adapt to changes in one's environment, we can also see how new forms of care insecurity undermine health during a time when caregivers may need their health the most – that is, when their environment is changing increasingly quickly. And, relatedly, interpreting these findings through the lens of the capabilities approach shows how the impacts of gentrification on the infrastructure of care, and the resulting production of care insecurity, undermine wellbeing. Given the demographic composition of this sample, the HNS communities more broadly, and most urban gentrifying neighborhoods – that is, predominantly people of color – these findings highlight care insecurity as one pathway through which gentrification contributes to racial health inequities. Finally, returning to Colen's concept of stratified social reproduction and drawing on Mullings' research into 'Sojourner syndrome', I note that the day-to-day

disempowerment of caregivers of color can lead to chronic strain and stress, with effects that exacerbate racial and gender health inequities (Colen, 1995; Mullings, 2005). I explore the subject of stress further in the following chapter.

This analysis has shown how care insecurity and stratified reproduction can be driven by spatial changes and how they are experienced by caregivers. Spatial drivers require spatial interventions. Planners, designers, policymakers and others have a crucial and necessary role to play in alleviating the crisis of care by taking steps to enhance housing stability and affordability, as well as community cohesion and networks of social support, in order to stave off gentrification and combat the prevailing wind of displaceability in U.S. cities. Such efforts must center caregivers and the work of caregiving, and be part of a broader anti-capitalist planning agenda in order to make meaningful gains towards cities that equitably empower all caregivers to give and receive care freely.

5 Caregiver stress, neighborhood change, and visions of the caring city

5.1 Introduction

“I’m different now because of being here,” said Pearl, a caregiver in Fall River who was introduced in the previous chapter, when we spoke with her again about a year after her first interview. “Some of the hardest things that I’ve had to deal with and some of the biggest challenges that I’ve had to deal with have been here. Some of the things that, I mean, I’ve held on to that are most important to me I’ve let go of here. These weren’t good feelings.” Pearl’s reflection points to a constant theme throughout this dissertation: that one’s context shapes what is difficult and challenging about caregiving. But she also raises two new dimensions that I have yet to consider: how the relationship between context and care makes caregivers feel, and how their lives become different as a result. This chapter explores these questions from the perspective of a particular type of feeling: stress.

Stress has been identified by both other academics, as well as HNS Resident Researchers, as a priority area of inquiry for advancing our understanding of the experience of gentrification and how it becomes embodied over time (Anguelovski et al., 2019a; Cole, 2020b; Schnake-Mahl et al., 2020b). In this chapter, I heed these calls with a focus on caregiver stress, a significant and well-documented phenomenon that sits at the root of much contemporary stress research. Caregiving is “fertile ground” for stress, and can produce a variety of stressors, which can be defined as “the conditions, experiences, and activities that are problematic for [caregivers]: that is, that threaten them, thwart their efforts, fatigue them, and defeat their dreams” (Pearlin et al., 1990, pp. 584, 586). While caregiver stress can emerge from stressors intrinsic to the caregiving relationship, it can also coexist with and be influenced by stressors from other forms of work, as well as the effort to balance between various responsibilities, particularly for caregivers whose circumstances are characterized by low levels of control and social support (Eick et al., 2020; Hochschild, 1989; Kelly & Moen, 2020). Stress has significant consequences for

health, particularly cumulatively, and neighborhoods have been identified as key contextual influences on the stress process (Aneshensel, 2010; Thoits, 2010b).

In this chapter, I conduct a longitudinal qualitative analysis of transcripts from a subset of caregivers who were interviewed twice, exploring how and when characteristics of and changes in the urban infrastructure of care can produce stress for caregivers. I do so in order to consider the embodied and emotional costs of ‘infrastructuring’ care: that is, of constantly engaging in the “articulation work” of combining components of the urban environment to make care possible, in addition to or as part of performing the labor of care itself (Star & Strauss, 1999; Strauss, 1988). In order to help make the case for centering care in planning for health equity, it is necessary to understand the toll of caregiving undertaken in urban contexts that have been planned and designed to individualize and commodify social reproduction and to perpetuate racist hierarchies of human value through deep spatial inequities in resources.

I conceptualize stress as both a psychological experience and a social process of continuous feedback between individuals and the environments and social systems that they are a part of (Lazarus & Folkman, 1984; Pearlin, 1999). Along with other researchers who have explored the relationship between stress and changes in urban environments, I use Lazarus and Folkman’s (1984) model to conceptualize stress (Gibbons, 2019b; Yang & Matthews, 2010). This model is based on two key components: appraisal and coping. Appraisal refers to the process by which individuals evaluate their evolving relationship with their environment, and Lazarus and Folkman identify three types of appraisal that can lead to stress: harm, referring to damage or loss already incurred; threat, referring to anticipation of imminent harm, and challenge, referring to demands that a person feels like they may be able to overcome. Coping refers to how people attempt to manage that which they appraise as stressful. Combining these two components, Lazarus and Folkman (1984, p. 19) define stress as a relationship between a person and their environment that is appraised by the person as taxing or exceeding their coping resources, and/or endangering their wellbeing.

Following Tuck’s (2009) charge for researchers to shift from damage-centered to desire-based research, I complement my analysis of the tolls of caregiving with an analysis

of what caregivers desire for their communities – and for themselves – in terms of community-based care supports. Specifically, I analyze caregivers’ responses to interview questions about their visions for a new community center in their neighborhood, which were intended to serve as a canvas upon which caregivers could sketch their vision of what more robust community-level supports for care could and should look like. Tuck argues that damage-centered research “operates, even benevolently, from a theory of change that establishes harm or injury in order to achieve reparation” (Tuck, 2009, p. 413). She suggests that an alternative to damage-centered research are desire-based research frameworks, arguing that desire is integral to our humanness and ought to be understood as not just “mere wanting but our informed seeking...It is closely tied to, or may even be, our wisdom” (Tuck, 2009, p. 418). Much like care, I would add.

Planning is an applied field dedicated to intervening in urban conditions and processes so as to transform it in accordance with a particular vision of the future and assessment of the past. When we intervene to promote health, whose desires are these interventions in accordance with? And what does this say about how we value care and the degree to which we seek to empower those who do care work in planning processes? Taking seriously Tuck’s argument that desire may be wisdom, we can learn from caregivers’ desires for a future in which the work of care is better-supported provides in order to determine how to plan and intervene in the urban environment to reduce the individual burden of caregiving.

This chapter makes several contributions to the study of the relationship between care and processes of urban change, as well as to broader efforts to understand how to plan for health equity by planning for care. First, my findings highlight stress as a pathway through which the relationship between social reproduction and the production of space may become embodied, and demonstrate the utility of the infrastructure of care model for identifying urban stressors and buffer/coping resources relevant to the caregiver stress process. I specify key sources of caregiver stress rooted in the urban context, and identify certain components of the urban infrastructure of care as key coping resources for caregiver stress. My findings demonstrate that when these coping resources are not robust, caregiver stress produced in part through the caregivers’ perceptions of and interactions

with the urban environment can have a range of detrimental influences on caregiver health. More broadly, this chapter demonstrates how processes of urban change contribute to the crisis of care by undermining caregiver wellbeing and contributing to caregiver “depletion” (Mohandesi & Teitelman, 2017), and identifies focus areas for planning interventions to alleviate caregiver stress by investing in community-based care supports, as guided by caregivers’ desires.

5.2 Methods

Stress, caregiving, and urban environments are all processes – none are static, all change over time. The purpose of this paper is to explore how these three processes relate: how changes in the urban environment produce stress, how the production of stress shapes caregiving, and how the knowledge and experiences gained through the often-stressful labor of caregiving might inform how we as planners seek to intervene in and shape urban space. One method that is well-suited to attending to and understanding processes and changes over time, and the contexts and conditions that influence these changes, is longitudinal qualitative analysis (Calman et al., 2013; Hermanowicz, 2016; Saldaña, 2003).

Longitudinal qualitative analysis adopts the techniques of qualitative analysis to study the same people at more than one point in time to understand how they “successively make meaning about the trajectories of their lives, or specific conditions of their lives” (Hermanowicz, 2016, p. 491). There are two layers to this type of analysis: one of change within each case, and one of patterns of change comparatively across cases. Rather than conceptualizing change as occurring “from-to” discrete points in time, Saldaña (2003) suggests analysts consider change “from-through” time, focusing on the process of the passage through time rather than the product thereof. He encourages analysts to consider a set of key aspects of change through, for example: emergence, accumulation, surges, decreases, consistencies, idiosyncrasies, interrelations between changes, rhythms, and through-lines. Longitudinal qualitative analysis is thus useful for

exploring how three different processes – such as caregiving, stress, and urban change – interweave.

The analysis for this chapter built on the four rounds of qualitative coding conducted for the previous two papers, and proceeded as follows. For each respondent, I first re-read the transcript and case memo from their first interview. Then, I analyzed their second interview employing two types of qualitative coding simultaneously. On the one hand, I conducted analytic coding using codes for the components of the urban infrastructure of care and caregiving strategies identified during the previous analysis. On the other hand, I conducted open-coding to track different types of changes that respondents reported experiencing. While coding, I wrote analytical memos using a matrix that tracked respondents' experiences of changes in their lives along the different dimensions of change specified above by Saldaña (2003) as well as their observations of changes in their neighborhood context. The matrix allowed me to analyze change both within cases and across the sample as a whole.

Separately, I conducted one cycle of open coding on respondents' answers to a question in the Round 2 interview guide that asked: "If you were to design a new community center for your neighborhood, what would it be like?" This question was asked in order to solicit respondents' desires for more robust community-based care supports, and using them as a way to reflect on their past experiences with access to neighborhood resources. One cycle of open coding was sufficient to identify patterns across responses to this question to the point of thematic saturation. Results of this analysis are presented separately from the longitudinal analysis exploring stress, since this question was only asked in the second interview, and concerns hypothetical visions for the future rather than past experiences.

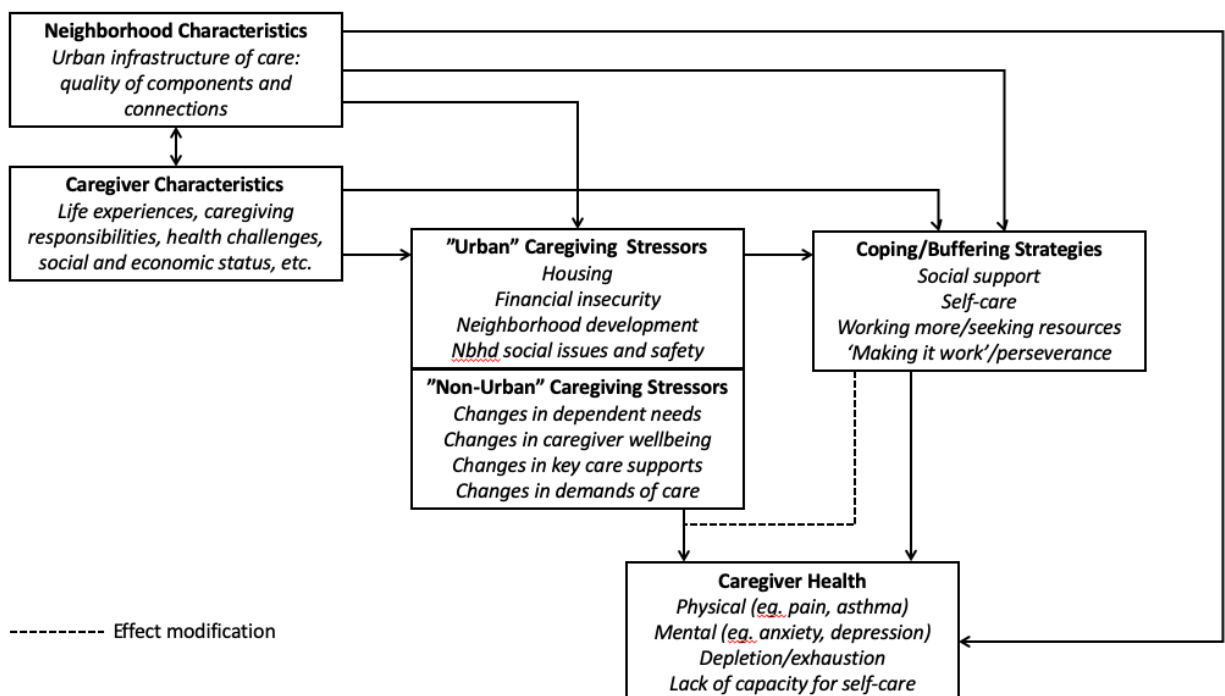
5.3 Results

The results of my analysis are reported in five parts. First, I describe the significance and consequentiality of caregiving for respondents as a high material and emotional

priority, and establish that part of why changes in the urban infrastructure of care can be stressful is that the stakes of caregiving are high. Second, I present patterns of caregivers' stress appraisal in two domains, one focused on urban context, and one focused on other individual characteristics and life events, and also show how they can interact to exacerbate one another. Next, I identify key coping resources and strategies that caregivers use when they appraise contextual stressors, and evaluate the extent to which they help buffer against that which is appraised as stressful. Then, I highlight key physical and mental health outcomes that caregivers reported in relation to increases and decreases in their levels of stress. Fifth and finally, I report patterns of respondents' desires for community care supports in their neighborhoods, which suggest ways that caregiver stress may be alleviated by reducing the psychic, physical and material tolls of caregiving.

Figure 5.1 provides an overview of my findings about the role of the urban environment in the production of caregiver stress and consequent health outcomes inspired by Aneshensel's (2010) stress process model of neighborhood effects on mental health.

Figure 5.1: Caregiver Stress Process Model



Adapted from Aneshensel (2010)

5.3.1 Caregiving responsibilities, experiences and burdens

“Who are you usually looking out for?” we asked Sara, a caregiver living in Chelsea. “The whole world,” she laughed. “My sons, my daughter, my mom, my dad, my brothers. I have friends who I work with who are young and they don’t have great homes and I offer them guidance. My son has a friend who he’s always over here, and he’s from Somalia and he left an abusive home.... Then I’m also supportive of my younger kids’ friends, their animals, their pets. It just comes along. A lot of people, the kids at the YMCA, the kids who need advice or they want to talk.... There’s even a few kids, they come here just to eat because they don’t have food in the home. And that’s just the reality. And it’s fine, I don’t mind. I don’t even mind the mess. I clean a lot too. So I’m constantly moving. Right now, it’s probably the longest I’ve sat down for a couple days now.”

For most caregivers in the sample, like Sara, caregiving is one of their most important priorities, and fulfilling their caregiving responsibilities shapes how they spend most of their time. Caregiving is a top priority for respondents for three reasons. First, they feel a significant sense of responsibility for their dependents. Second, caregiving is demanding and involves learning, adaptation and sacrifice. Third, some caregivers feel like there is nobody else who could ensure that their caregiving responsibilities were fulfilled if they were unable to. Caregivers thus, on a certain level, feel responsible for the survival of others – a heavy responsibility to bear, but also one that for many also brings a sense of growth and pride. Still, particularly for women like Sara, their sense of responsibility as well as the feeling that nobody else can support them also reflects the historical feminization of care and the gendered distribution of the burdens of emotional, cognitive and physical burdens of care work within families, communities, and our society at large.

Caregivers felt a significant sense of responsibility for their dependents’ wellbeing, often over and above their own wellbeing, which, as I will demonstrate later, can jeopardize their health. “It’s priority number one, even over myself sometimes,” said Damien, a father living in Dorchester. Jen, a caregiver in Brockton, explained of her kids that “If they’re not okay, I’m not okay.” Mike said of his kids that “You brought them in this earth, you know what I’m saying? They need you... They didn’t ask to come here. It’s

my job to take care of them, I made an oath. Like a gang oath, I made an oath to my kids. I will be there for them until the end of time and I am living up to that. I know it sounds cheesy but it's true." He continued: "Everything revolves around my kids. They're first. That's what keeps me grounded. I have food so they can eat."

For caregivers like Damien, Jen and Mike, being able to provide for their dependents helps them feel stable. But doing so can be difficult and demanding. Many caregivers reported that care was a high priority in part because of its constant demands and the stakes of the sacrifice involved. Nina, a caregiver for her children as well as her elderly mother, explained that caregiving is demanding because "you're trying your best to do everything right." Many caregivers feel similarly to Sara, who explained that the sacrifice is considerable but also brings rewards. "Sometimes you got to be the sacrifice, the lamb," Sara said. "But everything that I do sacrifice, it shows up in another aspect of my life, so I'm okay with that." For Louisa from Everett, who was introduced in the previous chapter and who had her third child between her first and second interviews, the demands of caregiving never dissipate, and the challenge is coming to terms with them and persisting. "You never have enough money. You never have enough space...but it's like my people say in Brazil, "just put a little more water in the beans, and everybody's going to be fine.""

For some respondents, care is a priority because they are solo caregivers. Some have support, but typically only on an ad-hoc or partial basis. Ana lives in Chelsea and cares for her father, who has Alzheimer's, as well as an elderly neighbor. She also raised two children who are now adults. She explained that caregiving is a high priority for her because her father and neighbor do not have other sources of support. "I feel like my purpose right now – I don't know about tomorrow – but right now, it's helping my dad and my neighbor because if I'm not there, there's nobody else," she explained. "I'm the only daughter, so it's all on me," she added, touching on the gendered distribution of the burdens of caregiving. Jackie, who lives in Roxbury and is the primary caregiver for her grandchildren, explained that friends often question why she took on responsibility for their care as a senior, and she explained that she thought that if she didn't take them, they would suffer. She says it's a lot of stress, but that she didn't see a choice in the matter and just tries to take it one day at a time.

Fred is a caregiver in Roxbury, and his experience illustrates the life-defining weight of responsibility that many caregivers feel, but also how, daunting it may be, caregiving nevertheless also feels like a source of growth and fulfillment. Shortly before our first interview in 2018, he gained custody of his teenage daughter after her mother unexpectedly passed away. He explained that he and his daughter's mother had a poor relationship, and as a result, he did not get to spend much time with his daughter as she grew up and he did not have a very strong relationship with her when she came into his custody. "There's a lot of things I never got right in my life, and I said to myself, I said, 'Self, you have a chance to get something so important in your life, and that's to be a good father. And to put her in the best position possible, right, that she can survive in this big, ole world...' Later, he continued: "Me and her relationship, that part, that intangible part, that part you can't put your hands on, that's that faith, that hope, that love, that joy, that peace. That's the part why I'm doing all this stuff. And learning to now have incorporated in my life since I have everything all there in front of me, my daughter and stuff. And that's what I want."

Over both of his interviews, Fred described his experience of coming to terms with this new responsibility for his daughter and all of the demands it entailed, as well as balancing this new caregiving responsibility with caring for his aging mother. "I got a responsibility to the household I take care of. My daughter's number one. Got to have food. Got to have heat. Got to have lights. I got to work. So I think just making sure that she's secure, the household's secure, my mother is secure...I think it's the most important. Health-wise, taking her to appointments, taking her to her medical exam, little small things. I didn't go to no medical exams. Now I'm responsible. I've got to take her. And I've got to take myself, too, because I want to be around to see her through."

Though Fred became a primary caregiver at a unique time in his life relative to most others in the sample, his experiences trying to provide satisfactory care to his mother and daughter trace a common thread through the data of caregivers struggling to balance their own health and wellbeing with the physical, mental and emotional demands of caregiving. For most caregivers, the pressure of the responsibility they had for the wellbeing of their dependents could sometimes boil over into stress.

5.3.2 Stress Appraisal

The high significance of caregiving for respondents means that caregiving can become a source of stress. Almost all caregivers in the sample reported feeling some form of stress in relation to caregiving, as well as the need to work through that stress in order to continue to fulfill the sense of responsibility described above. Caregivers spoke about paying considerable attention to stress due to concerns about its consequences for their own wellbeing – and thus their capacity as caregivers – as well as the health of their relationships. Iris, a caregiver in Roxbury, put it thus: “It matters, my mental stability. My physical stability, my mental stability has to be in one accord. You know what I’m saying? In order for my overall health to be good, I really feel like stress is a dangerous, dangerous thing. Stress has impacted my life, and I do see it in other people’s lives.”

In this section, I present results on caregivers’ appraisal of two types of stressors, which for the sake of simplicity I call “non-urban” and “urban.” I define non-urban stressors as those which the caregiver appraises as being independent from aspects or changes in the urban environment. Urban stressors are those that the caregiver appraises as being associated with or rooted in aspects or changes of the urban environment. For example, if the loss of an elder relative who provided caregiving support caused a caregiver stress, that would be a non-urban stressor. However, if instead of passing away that relative moved away because of the cost of remaining in the caregiver’s neighborhood, that would be labeled an urban stressor. The purpose of this distinction is to help identify the ways that changes in the components of the urban infrastructure of care may contribute to caregiver stress, given that caregiver stress can have many causes independent from the relationship between the caregiver and the urban environment. It is important to acknowledge that at a certain level, this distinction is artificial. Perhaps in the first scenario, the elder who provided caregiving support passed away due to health complications related to where they have lived; perhaps in the second scenario, the parent had always planned on returning to their home country to retire. However, the experiences of Iris, Fred and others also show how non-urban stressors come to be

experienced through the lens of the urban environment, and how urban stressors influence and interact with stressors that are non-urban in origin. In the next three subsections, I review patterns in caregivers' appraisals of non-urban and urban sources of caregiving stress, and show how for some caregivers, non-urban stressors can also be experienced through and compounded by their relationship with the urban environment.

5.3.2.1 Stressful non-urban factors

Caregivers appraised experiences or changes in four main non-urban domains as stressful: changes in dependents and dependent needs; changes in caregiver wellbeing; changes in key care supports; and changes in the demands of care itself.

Some respondents gained new dependents shortly prior to their first interview or between their first and second. For example, Paul shared in his second interview that he had become a grandfather for the ninth time, which heightened feelings of stress related to financial insecurity and his declining health. When Fred gained custody of his daughter, he said "It was all unexpected. 'Where am I going to get the furniture? Can I take on this responsibility?...Can I take on the mental health part of it, the counseling part?' So, of course, it was like, 'Wow, man.'" Other respondents saw their caregiving responsibilities increase as their dependents' needs changed. For example, Ana, who cares for her father and neighbor in Chelsea, experienced stress as the demands of caregiving rose as her father's Alzheimer's progressed. Similarly, Sheila, a woman living in Roxbury, took over the responsibility of looking after some of her siblings after her mother passed away shortly before our first interview. Gaining dependents, or increased dependent needs, was typically not permanently a source of stress, as caregivers adapted to shifts in the nature of caregiving. However, in some cases like Sheila and Fred, the stress from these changes persisted through the time of the second interview, and was often accompanied by temporary losses in caregivers' energy and ability to look after their own wellbeing.

A few respondents also experienced stress from the loss of dependents. Pearl, a caregiver in Fall River who was introduced during the previous chapter, shared in her second interview that her children were recently taken into foster care due to an incident that occurred while she was away receiving treatment for a substance use disorder.

“When I came out the program, I came out to no children at all...that’s been difficult...that’s heartbreaking for me.” She reported that her mental health was much better since she participated in the treatment program, but that she was very concerned about when she would be able to regain custody of her children and fulfilling the steps necessary to do so. Similarly, Mike, who lived in Fall River during our first interview, said that “Since the last time I seen y’all, like I said I lost everything.” He explained that he got evicted after struggling with a substance use disorder, and that his children were staying with a relative while he was living at a sober home in a neighboring town. He said he was working on getting his life back together in order to be able to provide a home for his children again. Though he expressed confidence in his ability and commitment to do so during our interview, he acknowledged that the process had been emotionally difficult and stressful for him over the previous months.

Independently of significant changes with respect to dependents, caregivers appraised the overall demands of caregiving as stressful. Nina said “Sometimes I’m stressed because I don’t have a social life. My life is just with my kids 24/7. I go to work, I come home, I volunteer. That’s it, and there’s nothing else.” One of her children has epilepsy and the other has asthma, and she explained that “with these types of issues, it’s like you don’t want to leave them because you don’t know when it’s going to occur.” Stacey, in New Bedford, expressed a similar sentiment: “I sometimes feel that it’s just very circular, with no goal towards something different... It’s really just work, work, work, repeat, work, work, work repeat. I’m not really looking at something for my own personal benefit right now, and I think I probably should...” Jen in Brockton also feels stressed by the responsibility of caregiving sometimes and the uncertainty she feels. “It’s just stressful. It stresses me out. Well, sometimes...Because when you think about how you’re going to do this, how your kid’s going to do this, it stresses you out because you’re responsible for two human beings.” She continued: “Some days it’s “I’m making it.” Some days it’s like “How am I going to make it?””

Changes in caregivers’ own wellbeing were also appraised by caregivers as stressful. Iris described how she has degenerative disc disease, which is worsening as she ages. “I have to gauge and monitor how much I can do because I have a 16-year-old son

at home who lost a father when he was 5. I'm his sole surviving parent. I don't want him to have the stress of whether mom's okay... that level of stress he should not have to carry," she said. Similarly, Stacey had major surgery between her two interviews, and expressed worry about minimizing her son's stress about her health while needing to rely on him for physical assistance. For Sara in Chelsea, the prospect of stress itself was stressful because of its potential consequences for her health. A lot of people will get in these certain situations in life and just become in the biggest rut and depression and let it eat them. And I'm afraid of that. So I'm like...you just got to keep it going because if you don't it'll eat you up. And then I'll be more overweight because I'll be eating off depression and stress. And it just creates a snowball effect."

Finally, changes in key sources of care support that were not related to aspects of the urban environment – such as a parent passing away or moving out of the country – were also appraised by caregivers as stressful. Daisy lives in Roxbury and receives childcare support from her mother. In our second interview, Daisy shared that her mother was about to leave Roxbury to return to the Dominican Republic, which would mean losing a crucial component of her social support system since Daisy and her husband both work full time. Sheila, also in Roxbury, lost her mother about a month before our first interview. Sheila has two adult siblings who she described as "special needs" who her mother had been caring for and who Sheila took responsibility for after her mother's passing. "I took over the house and took over the responsibility. It's a bit much...it's overwhelming at times....It's emotional, it's a rollercoaster. It's up, down, up, down."

5.3.2.2 Stressful urban factors

Caregivers reported appraisals of urban stressors in four primary domains: housing; financial insecurity; neighborhood development and change; and neighborhood social issues and safety. These appraised stressors overlap with key components of the urban infrastructure of care – including private and public space, economic opportunity, social support, and safety – which were also those identified in Chapter 4 as being most vulnerable to gentrification and most likely to be sources of care insecurity as gentrification proceeds.

Unsurprisingly in a housing market as tight and costly as the Boston metro area's, housing was the most significant urban source of stress appraisal for caregivers in this sample. Caregivers appraised the work of finding housing, managing housing quality issues, and affording housing costs as stressful. Often, these challenges combined, as in Daisy's experience trying to find a new apartment for her family while struggling to be able to afford their current place, or Mariah's struggle to find housing that was affordable and did not pose health risks to her son.

In her first interview, Daisy mentioned that she and her family were going to have to move soon in search of a bigger apartment, so that her kids could have separate rooms as they entered their teens. When we spoke to her a year later, she mentioned that she had been looking for almost six months for an apartment that they could afford in Roxbury, and had joined long waitlists for housing subsidies. Another caregiver, Mariah, was living in a relative's apartment in Chelsea with her partner and son during her first interview. They had moved there after finding elevated lead levels in their son's blood in their previous apartment, and were in the process of looking for lead-safe housing. By the time of her second interview, they had relocated to a small town outside of the city. She said she ended up spending about two years trying to find housing that she could afford that was certified as lead-safe. "I guess just in the Boston area there's a lot of places just don't have lead certificates. They're older houses. So that came up a lot. That they won't rent to people with kids under the age of six" she explained. "We would just [feel] like nothing's going to ever happen and kind of give up for a couple of weeks. And then start back on it again to have no luck. It was so close so many times and so many let-downs." Living at her relative's without enough space, and the long housing search, were very stressful. "I was getting used to living my life in chaos," she reflected.

Housing quality issues could also plague those who wanted to stay put and could afford to, like Colette, who takes care of her grandchildren and lives in Dorchester with a housing subsidy. She shared that she had experienced stress related to the impact of neighborhood development and the quality of her housing on her and her dependents' health. For one, she said, the area around her building has been teeming with mice. She indicated that, with construction on her block, "we're disturbing their grounds... We

couldn't go into the backyard. It was that bad. We couldn't even empty the trash. It was like, I'll say, hundreds of them, just like every day, crawling and crawling and I'm like videoing this to tell them about it." She said that rodents are a problem inside the building, along with mold. She suspects her grandchildren's asthma and allergies have "a lot to do with our building." She says she's stressed out because she feels like she constantly needs to clean the apartment to make sure that it's safe enough for her grandchildren to be in.

Caregivers frequently appraised the high cost of housing as stressful. "My rent's going up," Iris said, "And that's a scary place now, considering the amount of homelessness we have. And all of these...lovely buildings and apartments are coming up in our communities, but we're not eligible for them. So the answer to the level of stress that could create heart attacks, aneurysms, strokes, it's right there." In Chelsea, Ana also indicated that she had been stressed out about rising housing costs. "Chelsea becoming expensive is the main thing that worries me – it hasn't affected me yet, but I worry that's where it's heading.... It's frustrating because what's going to happen to us if – I mean, I don't know...I worry for my daughters...it looks good, but again, I don't see it's for our benefit, so." She continued: "I do worry about what's going to happen to us. Where we are now, will we get kicked out somehow? It's fine, if you have to leave, you have to leave. But I would hope we have the means to leave if we ever have to." Jen had a similar perspective on rent in Brockton: ""The cost of living [and] rent. Rent is really expensive, so it's the main reason why people are really stressed around here." She explained that "recently, it's gotten worse. There's no rent control here. So [landlords] make up their own rent, and it's always so expensive...They're just abusing."

The high cost of housing could impact caregivers' financial situations and for some – especially solo caregivers - lead to feelings of financial insecurity, which is the second main domain of urban stressors for respondents. Financial insecurity can be stressful because it means caregivers feel more vulnerable to future financial risks and threats. For example, Jackie, a caregiver from Roxbury, said she has no savings for the future anymore because of how high her rent is. Sara in Chelsea also said her rent has been going up, while at the same time, it's getting more expensive to feed her kids as they grow up. "The main thing that creates stress is not being able to always uphold the financial end of the

family and make sure everything is always there,” Sara said. Ana in Chelsea says she hasn’t been able to find a full-time job that she can balance with caring for her dad, which makes her nervous about being able to stay in her apartment in the future. “I feel a little stressed out sometimes...nervous, anxious...when I think of bills and rent and stuff,” she explained.

The lack of a protective buffer against even small financial shocks or pressures can be a source of stress for caregivers who are responsible for ensuring their dependents’ wellbeing. In her second interview, Daisy explained that her high rent in Roxbury combined with trying to save enough in order to move to a better-sized apartment can mean that her family is navigating tight margins. “It can be okay sometimes, can be not okay at others... Sometimes things are coming up that we were not really expecting...like one of our kids is sick, and we have to take some time off of work...But when it comes in the house, we have to be making sure that those things are taken care [of]... I told my husband, I was like, “well, I can always go to food pantries,” but food pantries happen when I’m working, and I cannot just stop working to go to food pantries.” After gaining custody of his daughter, Fred said, his experience felt similar, especially after learning that he couldn’t qualify for food stamps. “It’s just a check away from a shelter, a check away from “I’m done,”” he explained. He has had to ask his landlord for extra time to make rent, which was granted on a one-time basis, he explained. “So that’s what made me get the part-time job. But then if any of that collapsed, a week or two weeks, man, I’m done. Real talk, I’m done.” These experiences also point to how high housing costs can combine with elements of the political economy of work – such as low wages and lack of family leave – to produce feelings of financial precarity for caregivers trying to meet the most basic need of shelter.

The processes of neighborhood change that many see as driving increases in housing costs, like the new construction of market-rate housing unaffordable to low-income residents of gentrifying neighborhoods, are also a source of stress for caregivers. Iris said she and her neighbors are increasingly concerned about the risk of displacement: “It feels kind of scary...because at any minute, we could be uprooted from our homes...We talk about it a lot within the complex.” Shannon, a caregiver in Dorchester,

said that “the lack of knowledge” about development in the neighborhood, and the unpredictability of its impacts, creates stress in her life because it makes her feel powerless. “We don’t really know nothing,” she explained. “We don’t know nothing about the meetings coming up. We don’t know anything about the change in our development. We don’t know nothing. If we had more knowledge – you know better, you do better.”

Finally, caregivers note that health and safety concerns in their neighborhood driven by social exclusion and disposability of some populations are a source of stress. A number of caregivers indicated that concerns for their dependents’ safety in their neighborhood related to crime, violence, the drug trade, and homelessness caused them stress. These issues felt stressful in part because they felt intractable and out of caregivers’ control, especially in communities where development had advanced rapidly for some time, like Roxbury, Dorchester and Chelsea. Moreover, Jackie in Roxbury said, it presents challenges with respect to how caregivers manage their dependents’ relationship to the environment. She describes feeling like she wants to shelter her children from some of the social dynamics she sees in her neighborhood, but that she can’t because the isolation would be bad for them and they won’t know how to navigate the neighborhood as a result, potentially risking ending up in a dangerous situation without realizing it. One of Jackie’s fellow Roxbury residents says she’s afraid for her teenaged kids’ safety when they go out in the summer.

Fred explained that rising levels of homelessness along with a lack of support for the health of people who use drugs, which many caregivers cited as reasons they worry about their dependents’ safety, were hitting close to home for him and causing stress in his family relationships. He said he has siblings with substance use disorders who are unhoused and “come to the house all kinds of nights, wanting to get in.” While previously he would have been more open to providing them with shelter and assistance, he says now, “I have to tell them no because of my daughter” and that he worries about his siblings’ wellbeing. Often, Fred said, his siblings will go to their mother for money; this frustrates Fred because he sees it taking a toll on his mother, whose care he is responsible for. “Even though we’re older, we’re always mama’s babies so mama don’t look at it like

that. And sometimes, it creates a lot of pressure on her...I'm looking for her to take care of herself but eventually, she ends up taking care of them dudes sometimes. But that's mama and that's her baby."

Overall, these experiences demonstrate how physical, social and economic changes and challenges at the neighborhood scale can be appraised by caregivers as stressful – and specifically, appraised as threatening or challenging key conditions of care like housing, the ability to put food on the table, or the ability to maintain supportive relationships.

5.3.2.3 Non-urban stressors experienced through the lens of the urban environment

Iris' experience grappling with stress and depression shows how distressing changes in caregiving circumstances can be experienced through and interact with distressing changes in the urban environment. In Iris' first interview, she mentioned that her adult daughter had recently passed away. Iris said she had to "exhaust" her own 401k to pay for her burial, and she was in the process of finding a new job to help her regain some financial security. In our second interview, Iris seemed much more downhearted than in her first interview, where her mood was quite upbeat. She mentioned that she had recently been diagnosed with major depressive disorder, which she speculated was brought on by the anniversary of her daughter's passing. She also shared that she had taken a new job as a caseworker in a housing assistance program run out of a local social service organization that seeks to provide homeless families in the shelter system with short-term housing and financial assistance to help them regain and maintain stable housing.

Iris' experience working at the program illustrates how urban and non-urban stressors can intertwine and have cumulative and compounding effects on caregivers' wellbeing, and can thereby undermine caregivers' intentions to support others in their communities. "I took this new job based off of what I thought I would be doing, helping [homeless women] with housing," Iris said. "And I found out that I'm not really helping them... it's pretty much the opposite, we're literally setting these women up for failure... It's very discouraging given the fact that my daughter was homeless when she passed

away. These women are not as old as my daughter. It's personally very hard for me to think that I'm putting people in a really bad situation, and it just doesn't feel like it matters to anybody but me... It's defeating. It just really feels heavy."

"It's getting harder for people to live in Boston," Iris continued. "The high-rises that are coming up, the rents? It's ridiculous.... At my job, trying to find housing for these young people, they're in shelter in Boston, and they're established in Boston, so either they're going to school in Boston or they work in Boston or their kids are in daycare in Boston. And then we're saying to them, "well, everything that you have is established here in Boston but we're going to move you out to Barnstable because it's cheaper." And then so it's really challenging... It's really stressful trying to find people housing that are not qualified for these housings, and we're putting them in these positions that they can't afford after these stipends run out. And the expectation is just that they'll be prepared in a year when they're not prepared now. But it's going to be completely different... Everything you know is here. All your supports is here and then we're asking you to move out to the boondocks where you have no supports. Some of these women don't even drive. They would rely on public transportation, and they're getting entry-level jobs...It's not going to pay anything, because in a year, they're going to cut your benefits off. You're not going to get food stamps anymore. You're going to be forced to pay into health insurance if your job even offers it... You lose everything but gain nothing... Yeah. So. It's probably not the healthiest field for me."

Iris' experience losing her daughter and then becoming increasingly stressed at and depressed by her job shows how caregivers' experiences and perceptions of the urban environment shape the stress process even for caregiver stress that has a non-urban direct cause, in this case, her daughter's passing away and an emotional trigger at her workplace. However, this is also an instance where it is possible that the urban environment played a role in the "non-urban" stressor of Iris' daughter passing away, since Iris mentions that her daughter was homeless when she died. Moreover, it is also notable that Iris took the job at the housing assistance program because she wanted to help other caregivers find and maintain stable housing – that is, she wanted to enhance the conditions of care for others, which corresponds with the pattern of community-oriented

caregiving goals identified in Chapter 3. “If the job let you really prepare the clients and they wasn’t just pushing numbers,” Iris said, “it would feel so much different.”

5.3.3 Buffers and Coping

Fortunately, not everything that caregivers appraise as stressful ends up manifesting as long-term stress. Caregivers reported four different types of buffers against stress and coping mechanisms against stress: social support and cohesion; work and other strategies to bolster financial security; self-care; and ‘making it work’ by struggling through. Each of these buffers is influenced by the urban environment broadly, as well as specific components of the urban infrastructure of care, particularly social support and cohesion, economic opportunity, public space, and accessibility. It is important to note that not all buffers and coping resources fully alleviate stress or substantively address the source of stress, and that some buffers may take their own toll: for example, caregivers explained that they can only draw so much on social support before risking straining relationships; similarly, working more or ‘making it work’ may take a toll on the caregivers’ health. Some of these issues are addressed in the next section on stress outcomes. However, in this section I focus solely on the buffering and coping resources and strategies themselves.

5.3.3.1 Social support and cohesion

Social support and cohesion are a crucial buffering and coping resource against caregiver stress, and one that is directly related to the conditions of and changes in the urban environment. As my findings in the previous chapter show, caregivers in early-stage gentrification study sites often have difficulty building social support and cohesion, while caregivers in advanced-stage gentrification often feel like their social support networks are at-risk and, in some cases, fragmenting due to displacement. The ability to remain in place, if desired, is crucial to avoid the dissolution of social support networks and the difficulty of rebuilding them.

The most important sources of social support for caregivers in the sample who had social support – and not all did – were other caregivers, like respondents’ mothers,

siblings, or sponsors and mentors. Nina shared how, between our first and second interview, she had gotten a divorce from her children's father, who had been living in the Caribbean. While her mother, who she lives with and cares for, had previously been more withholding of caregiving support out of the belief that Nina's husband should be playing a more active role, Nina says that after the divorce, her mother became much more supportive. "It eases a lot of my stress," she says, "I'm not as stressed as before." Nina's mom helps with childcare sometimes, though has health issues of her own and is not always able. Sara in Chelsea also described how social support helps reduce her stress and ease the burden of caregiving. "Talking to my friends" is a big way that she relieves stress, she says. "I have a friend who actually just picked [my son] up because my schedule got rearranged. And she's a good friend of mine from childhood, and I will talk to her or...my son, if I'm stressed, he's going to be 22, I'll talk to him. I can sit and talk to him for like two hours. So that helps. And then at least you breathe, and you walk away from it. And then you just regroup. Pick yourself back up, truck it on to the next problem, "what else y'all got for me?" she joked.

Caregivers received both emotional and material social support from people they could lean on, with a number of caregivers in the sample relying on financial support from friends or family members to ease their stress. In her second interview, Daisy in Roxbury said that with the exception of housing, "Right now, I don't have any stress because I have a partner who I can go to, my husband, and we support each other. And he knows if he needs to make up the money...I was like, "honey, I don't think we're going to have enough for these bills for this month," and he goes, "I can work some extra time, that's fine." And it's like, okay...I talk to my mom, I talk to my sister." Similarly, Iris said that "If push comes to shove, there are people in my life that I can say, "can you pay my bill this month?" and they know that I'm good for it." Colette, who as described above has had issues with rodents and mold in her apartment, shared an example of a different type of material support. Colette says her sister supports her negotiating with her landlord about maintenance and repairs in her unit and building. She described an instance of how her sister helped her document damage and negotiate with her landlord's contractors when they damaged her belongings when making repairs to her floor. She said her sisters also

help out with small favors like rides to the grocery store or the doctor's office when needed.

Some caregivers also reported that investing in social cohesion and building new relationships of social support in their community was a way that they sought to buffer against and cope with stress. Nina, in Dorchester, said that to cope with stress, "I go and volunteer. I just like doing it...it's fun. You meet people. Some people going through a lot of stress. Even though I do too, just going, I think it helps me deal with my stress." She says it gives her perspective. "Because you're out with other people, you're talking. Everybody gives different opinions of their life and their struggles...Yeah. Kind of bring down the stress level." Pearl also reported volunteering to cope with stress by feeling more connected to her community. In her second year, Shannon said she had started a non-profit to help her cope with the stress she felt about the changes in her neighborhood, and that "giving back to the community, trying to make a change in the things that I wish I could see happening" helps her relieve some of her stress. Reflecting on her second interview, Sara demonstrated why being able to build new relationships in the community helps her relieve stress: "This helped with stress because I just talked to you for an hour...about things that were important to me, important to my community, important to the neighborhood, and that's just beneficial however you look at it." However, not all caregivers felt like they could benefit from this strategy. Jen, in Brockton, mentioned wanting to build stronger relationships with neighbors to engage more in neighborhood changes, but feeling pessimistic about her prospects. "Getting together and talking about what bothers everybody and how we can fix it...That would be nice, but no one here likes to get together."

5.3.3.2 Working and building financial security

Unsurprisingly, caregivers reported that feeling financially stable and able to provide for their dependents reduces the threat of stressors and helps them cope. Unfortunately, caregivers did not have many substantive strategies for financial security at their disposal that did not come with their own risks or costs. Moreover, all of the strategies reported were individual even though respondents understood the causes of the

financial insecurity were more systemic or structural, like economic exclusion or gentrification. Nevertheless, faced with the near-term demands of caregiving, respondents did what they could, and sometimes succeeded in alleviating stress in the short-term.

One strategy respondents used to try to cope with stress was to work more, though this strategy could also undermine caregivers' wellbeing in other ways and detract from their capacity to care for dependents. This strategy was typically only used by those who were not solo caregivers – that is, had another primary caregiver sharing care responsibilities. Daisy shared the example of her husband taking on more shifts at work, above, and said that sometimes she also takes on extra work to avoid stress over finances. Damien, in Dorchester, is another example. Between his first and second interview, he suffered a shoulder injury that left him out of work for nearly six months because he works as a landscaper. Once he was healthy enough to work again, he took on a second job as a delivery driver for Uber Eats to have a bit more of a financial buffer. A couple months later, he explained, his kids' mom's house, where they stay sometimes, flooded. He said he was able to use the extra money he made from his second job "to make sure their day-to-day didn't take a drastic change...so that they wouldn't really have to take the brunt of what was going on, even though they did, but not the full pressure of it...if something happens, to be able to have the backup or to have the money to take care of it, it showed me that what I was doing, it paid off. It paid off to pick up the extra job, to put money away, because look what happens... If I didn't have that second job when that happened, it would've been "Okay, I'm broke"... But being financially okay, it was just a matter of prioritizing, and it wasn't really a stress factor."

Working extra can take its toll in other ways, though, and some caregivers who worked extra reported feeling depleted and un-rested. Like Damien, Fred also took on a second job, after assessing that his income from one job wasn't enough to care for his daughter and learning that he wouldn't be eligible to receive food stamps. However, he says that even with working part-time on weekends, he feels "a check away from "I'm done."" Moreover, he feels spread thin and worries about the impact of working so much on his wellbeing. "The only day I have off is Sunday...That's my revamp day, regroup day,

necessary day. So there's really not much more I can do...nothing more I see that I can really do but take care of me, have faith, keep hope and stay healthy," he said.

Respondents also reported employing other strategies to make ends meet. Some tried to access social welfare programs food stamps and housing vouchers, and others leaned more heavily on community resources like food pantries. Others took on financial risks like starting a business or trying to invest in the stock market.

5.3.3.3 Self-care

The majority of caregivers in this sample reported in their second interview that they had either tried to or been forced to – by circumstances like changes in health – make more time to care for their own wellbeing in better balance with that of their dependents in order to try to reduce their stress. For example, Iris, whose struggles with stress and depression after her daughter passed away were discussed above, said, "I think that's the thing that I learned this year is that I had to take care of me." Respondents sought to take care of themselves through rest, food, activity, meditation and spirituality, and seeking out space to be with themselves and reflect.

"I love to cook, I just found that out," said Pearl in her second interview, reflecting on how her life had changed after temporarily losing custody of her children. "I'm getting good with the herbs now. I'm starting to really, really see what garlic can do... I'm getting on this healthy kick with my veggies and I love it. Those little things like that make me feel good." She said she was also walking more, listening to music, and doing crafts. She didn't have time for any of these activities when she was caring for her children full-time before entering substance use treatment. Other caregivers were also drawn to music, food and gardening as ways to look after their mental health. Sheila said that when things get overwhelming at home, she will "go on strike... I take a day and just say "I ain't doing nothing."... I'll keep myself busy, go to the garden or something. I have to get out of my own head sometimes... I give them space, that's my space for me not to deal with you."

Opportunities for reflection, spirituality and meditation were prized by a number of caregivers, and doubled as ways to reflect and have time and space to oneself. Mike shared that prayer and faith had gotten him through substance use treatment and helped

him persevere in his effort to get ready to care for his dependents again. Jackie shared how she tries to make time to go to free meditation sessions a few times a week run by a women's shelter in her neighborhood. And Ana in Chelsea explained that reflection was central to her feeling capable as her father's caregiver: "I have to just have a talk with myself. If I don't take care of myself...if I'm not trying myself, it's not going to work. So it was like reflecting, a lot of reflecting."

In his first interview, Fred shared how he had a mental map of places around the city he could go to find peace: "'I call them pockets in the city,'" he explained. "You can be going through something in this area, and you have a safe haven you can go to and relax and just be connected. And it kind of helps to lift the challenges. Even though it's still there, the pressure's not there." In our second interview with Fred, he shared a few examples and explained how he had relied on these "pockets in the city" to keep calm as he dealt with the challenges of caring for his daughter: "Across the street, there's a church called Old South Church. It's an open church where you can go in there and pray informally...And that always brought a lot of comfort to me. ...It's kind of like, me gravitating to that helped to take some of the stress out....If I'm at Downtown Crossing, I can go to St. Anthony's Shrine. If I'm in Mattapan, I can go to Jubilee. Dorchester, Morning Star Baptist. And these places help when I feel like the whole world's against me. I don't know to turn right or left or left or right. I can go into these little pockets and they help to give me clarity. They help to give me that oomph to get back up and continue to move forward."

Others found opportunities for solitude and reflection through physical activity, especially walking. Pearl said that she takes lots of walks, as does Stacey. "I like to walk and I like to read. So taking time to do both of those things is definitely something I'm learning to make time to do," Stacey said, reflecting on her process of recovery from surgery. Sheila said that walks help her keep her cool when her siblings cause her stress: "I have to go for a walk sometimes to calm my mind, get the edge off, so I don't blow up on nobody." Aside from walking, a couple of respondents mentioned trying to make it to the gym, but having difficulty keeping up with the routine. And in Brockton, Jen took up boxing: "At one point, it was getting very stressful for me. So I picked up a little boxing,

and I go and then I feel better then I go there... it helps me get rid of the build-up that's inside."

Finally, I note that a few respondents mentioned being able to access mental health care like counseling or therapy if needed, or having accessed it in the past, but nobody reported regularly attending therapy or counseling. "I once had a therapist who helped me a lot in terms of stress. So that was good. It's just that I don't look for it, but it's there," said Jen. She says sometimes she doesn't feel like she has time to go to therapy again, and sometimes pride feels like a barrier. Similarly, Mike said that substance use treatment had provided him with "techniques" that make him feel a lot more confident managing his stressors.

5.3.3.4 'Making it work' and struggling through

"Nothing can stress you unless you allow it to... If it gets to that point where it starts to overwhelm you, you shut it off. Don't let it get to that point," insisted Paul. His stance represents the extreme end of responses to stress – most other respondents acknowledged feeling stress and trying to work through it in some way or another. But Paul's stance is nevertheless representative of an attitude that most respondents held, which is that it was necessary to struggle through stress and "make it work" regardless of the strain the caregiver is under. Sara, in Chelsea, exemplified the attitude of many caregivers when she said: "I feel like it will get better because I'm going to make it get better. So I have to just keep pushing and keep doing what I've been doing."

In this way, caregivers' persistence through stress comes full circle to the depth of their sense of responsibility for their dependents as caregivers discussed at the beginning of the results section. Moreover, as some respondents indicated, they wanted to be able to demonstrate to their dependents that they too could persevere to meet priorities that are important to them, be they parenting or education or other pursuits. Indeed, as Jackie from Roxbury indicated, this was a lesson that many caregivers learned from those who cared for them. "You know what my mother told me day before she passed away after she had a child?" Jackie asked. "She said, "Life still goes on. No matter what, life still goes on." Didn't know this was going to happen to her, didn't know. It was horrible. But she told

me, "No matter what happens, life still goes on." You got to stay optimistic. You got to stay positive. You got to do the best that you can and can't let nothing tear you down. You got to keep going no matter what."

5.3.4 "You think you're not taking it on but your body knows you're taking it on": Stress Outcomes

In this section, I report on the health-related outcomes of the stress that caregivers experienced. These results are presented with two important considerations. First, caregivers didn't always explicitly attribute these outcomes to caregiver stress itself, but when they attributed their stress to the work involved in fulfilling their responsibility as caregivers, and attributed these outcomes to the stress they experienced, I assume that caregiver stress has played some role in producing these outcomes. Second, I note that stress doesn't always have acute, discrete consequences, and may take a longer-term toll on the body, for example via accelerated ageing or chronic low-level depression. These cumulative effects of stress and wear-and-tear on the body aren't necessarily perceptible on a day-to-day basis, and so while respondents are less likely to be able to speak to them, we can still assume they exist, like the part of the iceberg that floats underwater.

Caregivers reported physical and mental health consequences of their stress, as well as knock-on complications from these health consequences in other domains of caregiving. Some caregivers also reported improvements in health when caregiver stress or burden is reduced, pointing to the prospect for urban interventions that alleviate caregiver stress to contribute to increased health and wellbeing. Overall, caregivers' reflections about the impacts of stress on their health also reveal a desire for more balance between, on the one hand, being as healthy as possible in order to be a responsible and reliable caregiver for one's dependents, and, on the other hand, achieving health through making fewer health sacrifices for the sake of caregiving.

Caregivers experienced a range of mental health consequences of stress including depression, anxiety, and panic attacks. As already indicated above, Iris said that her stress had caused her to be diagnosed with major depressive disorder. She reported having memory issues, sleep difficulties, and difficulties articulating as a result of the drugs she

was being treated with. As a result, she says, her motivation and energy level have been low, and she has been cooking less and getting less physical activity. Multiple other caregivers in the sample reported being depressed as a result of stress. Sara said that in addition to depression, stress from caregiving could exacerbate symptoms of PTSD from domestic violence she experienced before moving to Chelsea. Pearl said that the pain of feeling no support from her family or from her community in Fall River had been very damaging to her mental health.

Caregivers also indicated a range of physical health complications from stress. Pain was common. "I had a pain under my abdomen and my back was really, really bad," Nina said. "I didn't know what was going on. I went to the doctor... She says it could be stress, could be you think you're not taking it on but your body knows you're taking it on." Others mentioned that stress exacerbated pain from other conditions like arthritis. Two grandparent caregivers mentioned that their stress can lead to pain which makes it harder to do activities like take their dependents to the park or walk to the bus. Two caregivers also indicated that their stress leads to their asthma flaring up. Many caregivers mentioned sleeping poorly and regularly feeling exhausted. Caregivers also expressed concerns about the potential future impacts on their health from being unable to take health precautions like dieting and physical activity due to the demands of caregiving and making ends meet in the present. For example, Amelia, a caregiver in Roxbury, said she was concerned about her health because: "Number one, I'm overweight. Number two, I'm on the borderline for diabetes. And number three, I don't know what number three is next. But...I have to get it together because I've got to live for my kids." She explained that her health isn't a priority because she is always looking after others first.

I also note that caregivers reported some consequences of stress that could lead to physical or mental health difficulties. For example, some reported being more isolated as a result of stress. A handful of caregivers said that they had developed substance use patterns that they deemed problematic or unhealthy as a result of trying to cope with the stress of caregiving. And, finally, some reported financial consequences from health difficulties like missed work or low income from disability benefits.

In her first interview, Jen, a solo caregiver in Brockton, shared a story of a time when she had been hospitalized for stress during a time when she was struggling to balance work and childcare, and was unable to earn enough money which left her “choosing rent or food, food or rent.” This caused her considerable stress, she explained. “At one point, I got really stressed out, and I couldn’t eat and I was just a mess. And then I got really sick. Ended up in the hospital for stress, and I was seeing things and stuff like that. It messed me up.” In her second interview, she said that she’s not feeling as stressed as she used to. She picked up boxing, which she said “helps get rid of the build-up that’s inside” and changed her diet and is sleeping more. “It’s been working for me.” She says that having enough time has been the biggest obstacle to maintaining her new state of health.

Jen is among a group of caregivers whose health and wellbeing are improving by virtue of spending more time taking care of themselves. Some, like Fred and Ana, are spending more time taking care of themselves because of a strengthened sense of responsibility and commitment to caregiving. Fred says that he’s learned that he’s “not Superman anymore” and that becoming his daughter’s caregiver has led him to get a primary care provider and regularly attend medical appointments. He also indicated that he had been trying to arrange to go to counseling after being inspired by his daughter who does so. Ana said that although her father’s and neighbors’ health were continuing to worsen, she was learning how to find more balance emotionally and in her daily routines, and that this left her feeling calmer. “I’ve learned in the past two years to just handle things. And everything seems very stable now.”

Others in this group, like Mike and Pearl, have had more time to take care of themselves because of temporary decreases in their day-to-day caregiving responsibilities, and both reported feeling a greater sense of wellbeing and like their overall health was much better than in their initial interviews.

Mike said that after he and his family were evicted from their apartment in Fall River, his kids went to stay with a relative. He took himself to the emergency room one day because he was worried about staying on the streets, and he says he “ended up in detox around people, getting more skills, them pointing me in other directions.” During his second interview, he was living in a sober housing program in a neighboring town and

feeling optimistic. "I think I had to lose everything to make it because if I didn't lose everything, I'd still be fucking up... [God] took everything away from me to get to this point and I know for a fact I'm getting it back. They say you get it back tenfold. I'm going to get it back tenfold, I just know that." He said he felt a profound difference in his health from the year before, when he was depressed, overwhelmed, and felt like he didn't have any support. "A year ago you couldn't get a genuine laugh out of me. It's like a forced smile. I'm genuinely happy now... To the point where people think I'm crazy because they be like, "why the fuck you so happy?" You know what I'm saying? I'm just happy, it's different. I'm happy, I'm hoping to get my life back." Reflecting on the difference between his two interviews at the end of the second, he said "it's like I was in two different places... now, I'm in such a much better place. Even though I'm in a halfway house and you would think like, "How would you be?" But I got peace now."

Pearl also found herself with considerably more time to care for herself in her second interview, after her dependents were temporarily taken into foster care. "I've been able to just find ways to better myself from it and just not let myself be disillusioned or overwhelmed by the so many things that I have to do. And these steps and orders to get back at what I would consider a good place. But I've just accepted that it's going to be a process and maybe a slow process," she reflected. She said that she has quit smoking with the help of a support group and coach, and found more time to walk and reflect, to cook and to listen to music, and to do crafts. Her latest hobby was making wreaths with things from the dollar store. "I wish I had one to show you but I gave them away," she apologized. "I start with just the plain metal part and then I get the sackcloth, the ribbon cloth, and I just – little flowers and a little glue and before you know, you've made something. And it's something that you feel proud of."

The lifting of Pearl's caregiving responsibilities – though under painful circumstances – provided her with the opportunity to reflect on the extent of the burden she had been bearing and the toll it was taking on her health and wellbeing. Looking back on the time around her first interview, she said "I was helping a lot of people back then... I think I've become a little bit sheltered now. I think this is time for me to just really work on me and I'm ready to take those steps. It's nice to know my heart is good. I have helped quite a few

people. Yes, I have," she affirmed. "The scary part is now knowing that I have to work on me and it's kind of the last thing I've ever wanted to do but the most important thing to do." She went on: "I'm missing the people that I adore and love and care about the most. So that's hard. That's just hard. And so I have to start doing what's necessary for myself. And it's not so much selfish. It's more selfless because I know in the end it's going to bring about a better change for me and my family."

"I really haven't had a moment to just let my hair down and just kind of go out and just kind of just freestyle it. Like I would like to walk to the [park] on the nicer days and just hang out just to have a moment to reflect on my life... When I'm in the house I'm concerned with things that are right now: bills, food, this, that. A lot of times when I'm outdoors it does a lot for my anxiety. I feel less stressed. I feel like I'm able to think, I'm able to reflect, I'm able to just find time that's good for my soul." The time to look after her physical, mental and emotional health has also given Pearl an opportunity to come to terms with getting older. "My health is changing and I just needed to take the time and really begin to understand what's happening," she said, explaining that she was slowly beginning to try to treat herself better. "I don't try to jump off that last step. I hold the banister tightly. There's a lot of things you do as you get older differently. You ain't cutting through that rocky path. You just going to go the long way around. The safer ground... I want to live longer. I'm interested in the gym. Just interested," she laughed. "I might do a squat on the way to the bathroom. Just little things. Little things. Little things."

While most caregivers spoke in one way or another to the toll of caregiving, Pearl and Mike's cases, while extreme, help demonstrate how much can be lost when caregivers have no choice but to sacrifice their own wellbeing for that of their dependents in the absence of adequate supports to help them bear the burden of caregiving. Sadly, the circumstances through which Pearl and Mike's burdens of care work were reduced were not of their choosing (indeed, they had both tried hard to avoid these outcomes) and it remains to be seen what the long-term effects of these changes are on them as well as on their dependents. The question their experiences prompt is how we might plan and develop communities such that caregivers like Pearl, Mike, and everyone else introduced so far are able to maintain their caregiving relationships, fulfill their responsibilities to their

dependents to their satisfaction, and also preserve their own health and find opportunities for personal growth. As the results in the next section show, the answer lies in finding ways to shift as much of the burden of care as possible off of the shoulders of individuals and on to the community and its environmental affordances.

5.3.5 Infrastructural Visions: Ideas for meeting community care needs

In the second round of interviews, respondents were asked to imagine they were charged with designing a community center for their neighborhood, and that money would be no object. They were then asked what their community center would offer or feature, and who these offerings would be for. The purpose of this question was to offer respondents a canvas upon which to sketch out their visions for community resources and supports, and reflect on their experiences using community resources in the past. Below, I report common themes in the visions and desires that the caregivers in this analytical subsample shared; these are summarized in *Figure 5.2*. Though the question itself was not geared specifically towards the needs of caregivers, the visions and desires these respondents shared call for the acknowledgement of the demands of care labor, the shortcomings of individualized care, and the necessity of robust infrastructural supports for care. As visionary as they are, they are also highly practical, demonstrating both the acuity of caregivers' insights into opportunities for community development and the ways in which better supporting caregivers through community-based resources might be readily feasible. These visions respond to real needs and people's own experiences seeking out support, resources and connection to help meet these needs with varying degrees of success.

Figure 5.2: Caregiver desires for meeting community care needs

Childcare and eldercare	Physical activity spaces
Resource navigation and coordination	Play spaces
Mental health services	Arts and culture opportunities
Health care services and navigation	Educational support
Peer/social support groups	Economic security resources
<i>No financial barriers to access</i>	
<i>Integration within shared physical space</i>	
<i>Collaborative, community-led planning and design</i>	

First and foremost, caregivers envisioned that their community center would provide care itself. Some, like Sheila in Roxbury, mentioned free childcare: “Like a little daycare or something like that so that maybe it could help them out. So people could go to work or something like that. So they could benefits to that, not having to worry about struggling to pay a bill for a babysitter, stuff like that.” Others, like Colette and Iris, mentioned eldercare. Colette spoke to the importance of neighborhood supports for younger adults caring for elder relatives aging-in-place, and Iris emphasized the importance of creating more opportunities for seniors to have social interaction: “give them someplace to interact. They can be mentors...A lot of times, we have a lot of elders that are home alone,” she explained.

In addition to childcare and eldercare, respondents spoke to spaces where people could encounter a caring disposition more broadly. That is, spaces that would meet people where they’re at to help ensure their needs are met, and that acknowledge in practice the complexity of care and the demands and toll of caregiving, particularly given how individualized and market-oriented social reproduction can be. Stacey’s vision exemplified this perspective. She said, “I think a community center needs to have a place for people to go who don't know what they need, sort of. To give them an umbrella of let me help you with that. If you don't know what you need yet, let's talk about it. Just come in here and be like, "Look, this is what's going on. What do I need? Because I'm so in it, I don't know what I need." And I think it would need child care services for people who

just need a minute because it's very hard to get child care services in the city. And there are people who make bad mental health choices because they're dealing with their kids, all day every day. And they don't get a break because they can't afford a break."

Caregivers envisioned robust professional and social supports for individual and community mental health. For example, Sheila said that her community center would offer people "someone to talk to if they was having problems: a social worker or an advocate." Iris also envisioned accessible counseling services, as well as "a rubber room...[so] when people get angry, they have some place to go to take their frustrations out." Colette also indicated that it would be beneficial to have mental health care for caregivers whose dependents have mental health challenges. Moving outwards from individuals and families, Fred pointed out that mental health support at the community scale was necessary for community health: "Why are these people acting wild and crazy in the community – they're dealing with trauma that's unresolved. So having a place where people can talk freely about that and not feel stigmatized.... In your whole community, if you see a bunch of violence...that's trauma on the whole neighborhood. So how do you un-traumatize a whole neighborhood or community." Fred's vision of the potential for addressing community-level trauma was echoed by other caregivers who were concerned about how collective trauma was impacting their dependents' wellbeing and growth.

Many caregivers also sought basic healthcare supports, mentioning walk-in clinics, dentists, eye doctors, and substance use treatment, for example. Caregivers envisioned healthcare being integrated with childcare, so that caregivers could access healthcare while knowing that their dependents are nearby and safe. Caregivers also envisioned healthcare being integrated with other services like therapy and transportation. Pearl gave an example from her own life: "There's a woman I have. She's a care coordinator. She sort of the go-between person where people fall between cracks. So let's say you had a trip to the ER or you're in substance abuse treatment and you get out and you know that you need to have a therapist or you need to go and to be physically seen or you have other things going on that need to be addressed that are important. She's this person that will help you get a PT-1 signed if you need transportation. She'll give me a bus pass once

a month. There are things like that.... So I would apply that same concept to the community...let people in on the know-how."

Iris' vision perhaps best encapsulated the desire expressed by caregivers for more integration across different forms of care and support, and the hopes for greater community wellbeing and stability undergirding these visions. She said her vision for her community center was informed by "My experience in life, period. I mean, I think that you have to treat the whole holistic person. You got to treat the whole person. You can't just treat the housing because if somebody has never had housing before, then it's fair to say learning to budget their finances is going to be a barrier. And then you have everyday life stresses, where do you go? I think if their whole spiritual, mental, physical was being addressed, then you would probably have less drug addiction, less alcoholism, less domestic violence. You would have less eviction, no need for housing court because you have to treat the whole person... The smallest thing turns into the biggest thing, a snowball effect. It just gets bigger and bigger and bigger. Well, if they knew how to prevent the small problem, then they wouldn't run into the big problem."

Above and beyond care itself, caregivers also envisioned community centers that gave dependents opportunities to express and extend themselves, be energetic and active, and build healthy relationships. Caregivers suggested swimming pools, musical programs, sports and games, gyms, quiet areas, opportunities for dance, and "some outdoorsy kind of things like kayaking." Some respondents spoke of these resources as being geared towards children in particular, while others suggested them more broadly. For those who did speak of these resources being geared towards children, there was often a safety component intertwined with their vision. Specifically, they sought safety through engagement and spatial affordances. For example, Ana in Chelsea suggested "a place for younger kids and teens to go instead of being out on the street getting in to trouble." No respondent mentioned the police in describing their community center.

In addition to fulfilling a vision for more safe opportunities for activity, many respondents envisioned a community space that would offer space for play, pointing to less available or less usable public spaces for doing so in their neighborhoods. Sara in Chelsea envisioned "some type of recreation type of thing. Remember good times when

you were a kid? This is just like nothing...what is here is apartments and apartment buildings and more apartments and more apartments." In Brockton, Jen envisioned rectifying what she saw as a history of disinvestment in programming for young people: "It would be something that they will help kids find a place to be instead of being on the streets because...there's nothing kids could do, no activities... Childcare, it's expensive here. And I would like something like that for the kids... We all do. There's literally nothing. We used to have after-school programs. Now, you have to pay for it. They cut it. We used to have like basketball, soccer fields, and stuff like that. Now, it's all shut down. There's nothing for kids to do... It's either far, or they can't really afford it... [They're] either home watching TV or around in the streets." Pearl pointed out that opportunities for recreation could be just as valuable for adults: "There's things for the kids to do and I find them... I just wish there was somewhere for me to go. I need somewhere to go. Is there a grown-up Boys & Girls club?" she said, laughing.

Providing a foundation for dependents' to be economically secure as they progress over the life course also emerged as a theme. Caregivers suggested educational supports like tutoring for both school-aged children and parents "so you can help your children." They also envisioned apprenticeship programs, assistance with job applications and career navigation, language classes, and opportunities to learn skills like budgeting and financial planning. One caregiver also suggested providing young people with guidance on how to apply early for housing assistance like Section 8 given how long the waiting list in Boston is. Caregivers also envisioned other types of economic supports like a food pantry, furniture, housing assistance, transit vouchers, and shelter beds for unhoused people in the neighborhood.

The final major theme of caregivers' visions for community centers in their neighborhoods was social support and cohesion. First, caregivers sought opportunities to provide each other with peer support. Daisy said: "I know how difficult it can be. And before I even got married, I was a single mom. And it was a struggle just to be me and my son... I feel like I know that we sometimes feel like we don't really want to come out and talk about it, but to have support for somebody, they know exactly how we navigate and live in that. And I think that's the best way." Others, like Stacey and Nina, echoed the

desire for peer support for solo caregivers in particular, speaking to the negative mental health consequences of feeling isolated through such a demanding experience.

Caregivers also pointed to the potential for the community centers they envisioned to contribute to broader social cohesion in the community. Colette explained: "Say if you have 10 people with experience in the same thing, and those 10 people see an issue that arrive, you can get more help. So you can add to that. You can add to that and say, "Well, how do you feel about housing and are you treated fair?"' Sara applied the concept to food justice in particular, which is an area of concern for her. "A lot of people don't know. They don't know. We've lived generations like that. We're living and eating crap in poor communities, and there's nobody who's like, "Okay, let's have a forum where there's 100 people." And you know how you go to those churches and there's a pastor and he's on the microphone, and you have everybody listening to it, and everybody's following it? If there was somebody there to talk about the food and the health, I think that people would listen," she hoped.

Finally, and perhaps fittingly, a number of caregivers suggested that the community center they envisioned could be planned and designed in collaboration with those who it would serve. Paul, in Roxbury, said "At some point you're going to have to bring the community involved. How do you do it?...Now, if it takes a party for that to happen, my God, do it. If it takes a lot of time to do it, do it. But do it with the sense of urgency. That urgency is I want to impact the community." Cindy, a caregiver in Fall River, envisioned a community center focused on teenagers, and explained that to design it, "I would have to sit them down and say, "What are your interests?" That would inspire me." Similarly, Colette explained that she "would want to hear what the people want because I could put together a list and say, "Okay. I want to do this, this, this, X, Y, and Z," but I got to listen and hear what the other people want. What do you think that best serves our community to make it work? What do you think we need in this [inaudible] to make it work?"

5.4 Discussion

5.4.1 Summary of findings

In this chapter, I sought to understand how the relationship between the urban environment and caregiving might influence caregiver health, with a focus on stress as a key pathway through which this relationship might come to be embodied. I drew on the theoretical contributions of stress researchers in the fields of psychology and sociology to analyze what caregivers in this study appraise as stressful from the perspective of their roles as caregiver, and what resources and practices they use to cope with or buffer against these stressors and with what degree of success. I assessed the health consequences caregivers reported experiencing when they were unable to fully cope with or buffer against stressors (and, in some cases, as a result of their coping efforts), as well as what happened to caregivers' health when their stressors were alleviated through the reduction of their caregiving burden. Finally, I sought to learn more about how caregivers might intervene at the neighborhood level to enhance the availability of community-based buffers against caregiver stress and resources for caregiver and dependent wellbeing.

I find that the relationship between the urban environment and caregiving can be a source of stress for caregivers, with harmful consequences for health and wellbeing. For most respondents in the sample, caregiving is one of their highest priorities in life, and accordingly, they have a significant sense of responsibility with respect to the role and the wellbeing of their dependents. Because caregiving is so important to respondents, threats, harms or challenges to the dependent, the caregiving relationship, and/or the conditions of care are readily appraised as stressful. Caregivers appraised both "urban" and "non-urban" sources of care-related stress. The primary urban sources of care-related stress include: housing; financial insecurity; neighborhood development and change; and neighborhood social issues and safety. These aspects of respondents' urban context, which overlap with the components of the urban infrastructure of care identified in Chapter 3, were appraised as stressful because they reflect access to and quality of key resources for care, without which caregiving is more difficult and taxing. My analysis also revealed that non-urban

sources of caregiver stress can be experienced through the lens of urban sources of caregiver stress, as Iris' experience grieving the loss of her daughter while trying to support others in similar circumstances shows.

When caregivers appraise aspects of their urban context to be stressful, they employ coping and buffering strategies that draw on key components of the urban infrastructure of care. These coping strategies include: relying on social support and cohesion; practicing self-care; working and seeking financial security; and perseverance and trying to 'make it work'. These strategies overlap with key caregiving strategies identified in Chapter 3, like creating support structures, and making work/care tradeoffs. For the most part, while these buffering and coping resources can help caregivers alleviate feeling stress in the moment, they are not sufficient to address the appraised stressors themselves, largely because they are individual-level responses to community-level and/or structural challenges. When stressors exceeded the coping resources available to respondents, they experienced a range of detrimental physical and mental health consequences including pain, asthma, poor sleep, depression, and harmful substance use. Caregivers also expressed concern that a lack of time and resources to be physically active and maintain a healthy diet would harm their health in the future. I also found that respondents whose stressful caregiving burdens were alleviated between the two interviews experienced improvements to their health and overall wellbeing.

Finally, I found that respondents expressed desires for community-based care supports that would integrate and support the components of the urban infrastructure of care, while enhancing the wellbeing of both dependents and caregivers themselves. These desires sketch a powerful and transformative vision for care-centered community development that align with the infrastructure of care framework.

5.4.2 Limitations

I note two potential limitations of my analysis. First is the potential for desirability bias in interviewees' responses, particularly working with follow-up interviews in the longitudinal analysis, since some interviewees may have sought to demonstrate

improvement on past conditions or experiences and progress towards a desired future. I note that this may also reflect (gendered and racialized) pressures that caregivers may feel to portray themselves as competent and confident. The second potential limitation is the fact that my longitudinal analysis only included two touch-points for each respondent, 1-1.5 years apart. This raises the question of what can be observed over such a time-frame. While I was able to see big changes in some caregivers' lives, like Iris' depression, or Pearl and Mike losing custody of their dependents, such shifts don't happen all the time for everyone. And indeed, for some, much was the same in their second interview as in their first. However I note that big changes are not the only sources of stress in caregivers' lives, and that constant pressures and worries can be just as detrimental to their wellbeing. Nevertheless, the time-frame of a single year is still a limited vantage point on the cumulative build-up and toll of chronic stressors, which are just as crucial to understand as major event stressors.

While desirability bias is less something to be overcome than accounted for, further longitudinal data-gathering and analysis may help address this second limitation. However, I would also argue that, practically speaking, and given the urgency and importance of the matter, planners need to be prepared to alleviate caregiver stress without needing to (a) wait to see the cumulative toll emerge over time, or (b) only focus on acute stressors. This requires a values shift that accepts at the outset (a) the difficulty and toll of caregiving under capitalist political economy and specifically neoliberalism; (b) research showing the cumulative burden of care to date and its unequal distribution along racial, gender, and class lines. This, in turn, requires valuing care equally to or even more than other forms of work to begin with.

5.4.3 Implications of results

The results of this study emphasize the importance of attending to caregiver health and wellbeing as part of planning research and practice. This is particularly so in contexts where care is under-valued and individualized, as is the case in the United States, and in communities where caregivers are more likely to be disempowered vis-à-vis the

environmental conditions of caregiving, as is the case in many low-income communities that are predominantly of color like those in the HNS. Caregiving, day-in and day-out, is psychologically, socially, and physically difficult. The conditions of the urban environment shape the nature and distribution of these difficulties, as well as the threats, harms and challenges caregivers perceive to their and their dependents' wellbeing. The difficulty of caregiving, combined with the stress caregivers experience when they are unable to sufficiently cope with or buffer against appraised stressors in the urban environment, can take a toll on caregivers' bodies and minds. Even when caregiver stress has origins away from the urban environment, it is still the context for the stress process, influencing the coping resources available and the magnitude of the stress that caregivers can experience. The fact that most can still accomplish care to some degree despite these challenges and stressors does not justify the costs to caregiver health, nor the potential costs of diminished caregiver health to their dependents' health and wellbeing.

My findings call attention to the fact that a major part of planning for care must be planning for caregivers themselves. The experiences and visions of the caregivers in this chapter show that it is both necessary and possible to enhance the possibilities for caregivers to care for their own well-being, to practice self-care – not so much in the commodified form popularized today, but on a more basic level of meeting material, emotional, and psychological needs in the wake of over-extension (Kim & Schalk, 2021). Self-care is a crucial buffer against urban stressors in the absence of collective power over the conditions in which these stressors originate, and it is a central priority for caregivers who are seeking a healthier balance between caring for others and maintaining their own health.

At the same time, as my results show, while self-care on an individual basis is an extremely valuable coping resource, it does not address the structural conditions and systemic patterns that produce “urban” caregiving stressors in the first place. This is why for Lorde, who argued that self-care was not only “self-preservation” but “an act of political warfare,” it was imperative to understand the self as “never about the individual, bounded body but about how the self exists in relation to and in support of other bodies” (Kim & Schalk, 2021, p. 339; Lorde, 2017, p. 130). Following Lorde, I argue that

caregivers should be empowered to care for their own wellbeing as much as they are for that of their dependents, and that this requires *infrastructural* solutions that foster caregivers' *collective* empowerment in order to appropriately address the "urban" sources of caregiver stress.

Otherwise, planning for self-care and caregiver well-being risks falling into the "resiliency" trap: purporting to strengthen people's ability to take the next punch without addressing the punch itself. Simone (2021, p. 5) observes that formations of people as infrastructure that respond to urban vulnerability, and especially the individualization of social reproduction, "always pursue repair." This tendency towards repair is evident in the experiences of caregivers and in their visions for stronger caregiving supports. It is inspiring, necessary, and worthy of support and empowerment. However, Simone also asks whether this reparability is becoming "a calling card for the capacities of resilience" that are purported to be "an essential capacity...to roll with the punches and still remain operative."

For planners, answers to the question of how to plan for caregiver's collective empowerment, and self-care "in relation to and in support of other bodies," might be found in the knowledge and vision wrapped up in caregivers' own desires (Lorde, 2017, p. 130; Tuck, 2009). This means centering not only care, but caregivers, in planning for community health. The caregivers in this study shared their visions for specific types of interventions – in the form of models for community centers – to integrate and invest in the urban infrastructure of care in ways that stand to reduce the burden and toll of care on individual caregivers. These visions were characterized by desires for specific opportunities for more formal infrastructural linkages between different components of the urban environment, and spatial affordances that would help redistribute the burden of caregiving from the shoulders of individuals to the community. While some of the caregivers' visions may fall more into the domain of social work and social services, these nevertheless need to be spatially planned, and integrated into community and economic development, in ways that empower caregivers, and this remains a role that planners can play.

Caregivers' visions for enhanced community support for caregiving also give us guidance on the broader task of planning the urban infrastructure of care itself. They point to the importance of coordination across forms and dimensions of care; of fostering social cohesion for the purpose of collective empowerment over the conditions of care; of doing so in ways that seek to repair collective wounds and support healing from trauma; and of doing so in order to enhance the freedom of both caregivers and their dependents while also affording all people the means to maintain viable and beneficial caring relationships.

6 Conclusion

This dissertation was written over the course of the COVID-19 pandemic in the U.S., conceptualized just as rampant infections in a Seattle nursing home made the news in January 2020, and revised in June 2021 as vaccination rates began to plateau and public health orders lifted, with governments and many people rushing to wash their hands of the matter even though we are still far from in the clear. As hundreds of thousands of people in the U.S., and millions more around the world, died from the virus, most people were forced to rapidly reorganize their lives in an effort to protect their loved ones and attempt secure their livelihoods in the face of government neglect and economic devastation. A quarter of households experienced job loss, economic and food insecurity spiked, and millions of households fell behind on rent (Dubowitz et al., 2021; K. Parker et al., 2020). As daycares and schools closed, and workplaces closed their doors or moved online, millions of caregivers were left scrambling to manage their most important responsibilities alone after having their often-threadbare institutional, social and economic supports pulled out from under them. These increased caregiving burdens have been associated with increased stress, anxiety, and frustration with dependents, with implications for both caregiver and dependent wellbeing that were exacerbated for those whose childcare arrangements were disrupted or who experienced intensified work pressures during the pandemic (Calarco et al., 2020).

Unconscionable, unjust, and yet entirely predictable racial, gender, and class inequities characterized the distribution of harm and hardship during the pandemic. People of color experienced excess COVID-19 deaths compared to white people, and young people of color had a much higher risk of death than young white people (Bassett et al., 2020). People living in the poorest, most crowded, and most racially and economically unequal counties experienced the highest rates of illness and death (Chen & Krieger, 2021). These inequities were rooted in underlying factors like housing unaffordability, poverty and economic insecurity, a threadbare social safety net and structural racism. At the same time, it was poor and working class communities,

immigrant communities and communities of color who nevertheless continued to bear the burden of ensuring the minimal functioning of society all the while (Rho et al., 2020). They formed the majority of the “essential” workers – nurses, bus drivers, grocery store clerks, warehouse workers, etc. – who remained on the job during the pandemic despite being overworked and underpaid, and faced increased COVID-19 risk and exacerbated caregiving strains as a result. In the summer of 2020, protests erupted across American cities in fury at the myriad ways – racist policing but one – that the state continued to produce and exploit “group-differentiated vulnerability to premature death” during this period of crisis (Gilmore, 2007, p. 28).

Within our era’s crisis of care, the pandemic has revealed how changes in the conditions and practices of care reshape urban life, how we use and inhabit the built environment, and the meaning and experience of living in cities. We have seen the built environment re-purposed into new infrastructures of care, such as rapid-built quarantine sites, homes becoming workplaces and schools simultaneously, parks turning into temporary hospitals, parking lots turned into morgues, hotels repurposed to shelter the homeless, and schools serving as meal distribution venues. The pandemic has called on people to extend relations of care through their communities – to loved ones and elders, through mutual aid networks, and by practicing social distancing and mask-wearing as a small but signal form of care for the collective. Many have had to largely withdraw from urban life in the interests of public health (and many have abandoned it entirely) while others – largely “essential workers” in jobs necessary for care and social reproduction – have been forced to carry on their roles sustaining life within an urban landscape posing increased risk to their health and with drastically less support for meeting their own intensified caregiving needs. The burden on “essential workers” reflects the historically unequal distribution of social reproductive labor: 1 in 3 jobs held by women are deemed essential, and non-white women are more likely to be doing essential jobs than anyone else (Robertson & Gebeloff, 2020).

All of this has been destabilizing. The pandemic has revealed the extent to which the infrastructures of care in our communities are brittle and under-resourced, almost certainly inadequate to withstand inevitable future public health crises, whether the next viral

pandemic, or ever fiercer natural disasters brought on by climate change. These physical and social infrastructures of care do not only for the prevention of harm in moments of crisis, though. They are just as crucial for the work of healing, rebuilding, and living with trauma in the aftermath, and creating the capacity for long-term resilience in the face of future destabilizing events. Similarly, the shortcomings in our infrastructures of care do not only matter in relation to crises and extreme events. They matter just as much for the everyday work of ensuring that people are able to live as well as possible: that their needs are met, that they have support when they need it, that they have the power to change their circumstances to make a better life when they want to. The crisis of care is structural and ongoing; the pandemic has just forced us to pay closer attention.

The data I analyze in this dissertation was collected between 2018 and early 2020. Given that the pandemic undoubtedly changed the world, and that in many ways it feels impossible to draw lines of continuity from 2018 to the present, one might rightly wonder what this study offers in the wake of the pandemic. COVID-19 threw the question of how we organize – and have failed to organize – care into stark and painful relief. It revealed and exacerbated underlying structural problems and contradictions in how we organize care: the instability of the institutions, systems and ways of life we rely on to sustain our health and well-being, and the inability of capitalist markets to meet our needs for survival. This dissertation helps us understand why the pandemic was as devastating as it was, and for who. It does so by helping us understand the role of cities in shaping the work of everyday caregiving, in affording or withholding resources necessary for caregiving, and in expanding or constricting the possible forms care can take. Moreover, it does so by focusing on those who were among the most vulnerable to the harms of the pandemic – poor and working-class people, women, and people of color. People like Nina, caring for particularly vulnerable people like her mother and her asthmatic son, fighting to afford to stay in a city insistent on pushing people like her to the brink of their capacities and resources. Their vulnerability to the pandemic was shaped to an important degree by the urban conditions and processes explored in this study that shape what the work of survival entails. Though my analysis is based on data collected over the two years prior to the pandemic, it illuminates like an x-ray the ways that the form and function of

cities shaped the distribution of harm and hardship during the pandemic, and attends to the very social practices and urban affordances that planners must cultivate to try to prevent a similar fate in the inevitable public health crises to come.

In the following sections, I summarize my findings and main arguments about the role of cities and gentrification in the contemporary crisis of care, and the importance of attending to care in planning research and practice in order to repair the harms of stratified reproduction. I also discuss several important limitations to my analysis, and reflect on the contributions of the HNS PAR process and my roles therein to this research and my development as a scholar more broadly. I conclude with a vision of what an infrastructural approach to planning for care can look like, and the challenges and opportunities such an approach offers for accomplishing pressing planning challenges of our time: health equity, climate adaptation and resilience, and abolition and reparations.

6.1 Summary of findings

This dissertation has three purposes. First, to explore how everyday caregiving or social reproduction is dependent on and therefore shaped by characteristics of and changes in the urban environment. Second, to examine how the relationship between the urban environment and caregiving may become embodied and shape community health. Third, to understand the planning ingredients of urban environments that better support caregiving. The first two purposes of the dissertation have been fulfilled through the three analytical chapters, summarized below. The third forms the basis of my discussion of the implications of these findings for “planning for care” in *Section 6.3*. Altogether, I argue that this research demonstrates the importance and value of caregiving as a priority area for attention and specific types intervention for planners seeking to advance health equity and racial, gender and economic justice in cities. Below, I summarize the findings of my three papers in turn.

6.1.1 The urban infrastructure of care

In Chapter 3, I sought to empirically establish the significance of care as a planning concern by analyzing how the work of caregiving is shaped by the urban environment. The analysis yielded five key findings. First, caregiving is one of respondents' top priorities in life and a central lens through which they interpret their relationship with the urban environment and the changes therein. Second, respondents have three different types of caregiving goals – for their dependents, for themselves as caregivers, and for their communities – that are responsive to and sometimes seek to change the urban environmental context where care takes place. Typically, these goals reflected desires to cultivate and secure material, psychological, bodily, and social conditions conducive to wellbeing of caregivers and those they cared for – to ensure that they could live as well as possible both within and beyond their urban environmental context. Third, I found that in order to work towards these goals, respondents employed six types of caregiving strategies that relied on affordances of the urban environment for their success. These strategies included: managing the dependent's relationship to the environment; creating support structures; preserving health; securing and maintaining the material conditions of care; time management; and balancing care with other types of work.

Not only did respondents' caregiving strategies depend on the urban environment for their success, the urban environment also shaped what the work of carrying out these strategies – and thus trying to fulfill caregiving goals – actually entailed, and how demanding it could be. The fourth finding of this chapter was that caregiving strategies relied on, and were shaped by, the availability and adequacy of eight specific components of the urban environment: private space; public space; economic opportunity; resources; social support and cohesion; safety; organized care and activities; and accessibility. Fifth and finally, I found that when these components are unavailable, inadequate, either individually or in combination with one another, caregivers can encounter “care binds” in their efforts to carry out environmentally-dependent caregiving strategies. These are called “binds” because they are circumstances in which the possibilities for caregiving are constrained and the freedoms of caregivers, and sometimes their dependents, are thus

restricted. When conditions of or changes in the urban environment introduce “care binds,” caregivers may encounter increased difficulty, costs, tradeoffs or sacrifices, and sub-optimal conditions for caregiving. Care binds can mean that the work of fulfilling caregiving strategies becomes more challenging and taxing, and/or that caregivers must adjust their goals and strategies. Although this analysis did not explore variation in caregiving experiences and strategies with respect to the urban environment by race, gender, or other axes of social inequality, I note that access to the components of the urban infrastructure of care differs unequally along these lines due to historical patterns of segregation, housing discrimination, neighborhood disinvestment, and the stratification of landscapes of social reproduction in cities described in Chapter 2. Thus, I would expect that access to robust infrastructures of care differs along racial and economic lines and that care binds are more common and detrimental for poor and working-class people and people of color.

I argue that together, these findings suggest that caregivers rely on an “urban infrastructure of care.” By this I mean that the underlying social and material conditions of the urban environment where care takes place both make care possible and shape the possible forms that care can take. In the context of the HNS neighborhoods, the urban infrastructure of care is comprised of the key components of the urban environment upon which caregivers depend to fulfill their caregiving goals, and the nature of the relationships between these components. Just as mobility is accomplished via infrastructures embedded in the urban environment, care is too. However, a key difference between urban infrastructures of mobility and of care is that infrastructures of mobility are frequently planned, formalized, and invested in to a great degree, while infrastructures of care are not, at least from an urban planning perspective. In the absence of planning, coordination and investment, caregivers themselves must perform the “articulation work” or infrastructural labor of connecting and maintaining the components of the urban infrastructure of care in order to ensure satisfactory background conditions for caregiving itself (Star & Strauss, 1999). This infrastructural labor becomes part of the work of caregiving, at least for those who cannot buy their way out of it.

Thus, the urban environment in which caregiving takes place profoundly influences what type of work caregiving is, and how difficult and taxing caregiving is, and the distribution of the burden of this labor across the population through the affordances - or lack thereof - of the urban infrastructure of care. The urban environment also influences for whom the work of caregiving is more difficult or taxing than others, since the affordances of the urban infrastructure of care are spatially uneven, in ways that reflect both the embeddedness of structural inequities of race, class and gender in the urban environment, as well as processes of urban change through which these inequities, along with the urban environment itself, are reproduced. I explore the influences of one such process of change, gentrification, on the urban infrastructure of care in *Chapter 4*.

6.1.2 Gentrification and the production of care insecurity

In Chapter 4, I set out to understand how gentrification produces changes in the urban infrastructure of care from the perspective of caregivers, and how these changes influenced what the work of caregiving entailed and how this work was experienced by caregivers. Gentrification refers to the production of space for progressively more affluent users, and it is the central contemporary feature of a broader historical process, underway at multiple geographic scales, of the capitalist production of space characterized by disinvestment, uneven development, and the proliferation of the condition of displaceability, according to which the benefits and harms of changes in the urban environment are inequitably distributed along lines of race, class and gender (Hackworth & Smith, 2001; Hwang & Ding, 2020; B. Parker, 2017; N. Smith, 2005; Yiftachel, 2020). Reflecting the study's design, the HNS neighborhoods are at different stages of gentrification which, as Resident Researchers have highlighted, are inter-related at the regional scale and facilitate the dispossession of low-income communities of color. Based on conversations facilitated as part of the HNS collaborative data analysis process, Resident Researchers have found that the experience of gentrification for low-income residents of gentrifying communities is characterized by feelings of stress and uncertainty that can compound over time, the destabilization of social networks through which

people access who and what they need, reduced ability to make affirmative moves and the increased likelihood of being forced to move against one's will, and as a result, intergenerational concerns about the ability of those you care about to meet their needs in a community where they feel like they belong in the present and in the future.

To explore how gentrification influences the work of caregiving through its impacts on the urban infrastructure of care, I compared caregivers' experiences across three different groups of communities according to the speed and stage of gentrification. These gentrification-stage groups were identified via a hierarchical cluster analysis of similarities and differences in the pace of HNS neighborhoods' development trajectories, measured by variables including population demographics and socio-economic characteristics, housing cost and availability, environmental justice indicators, and zoning. The three groups comprised communities where: the pace of development remained low relative to other HNS communities over the period 2009-2018 (Group 1: Fall River, New Bedford), the pace of development accelerated from low to high over the same period (Group 2: Brockton, Everett, Lynn), and the pace of development remained high throughout (Group 3: Chelsea, Roxbury, Dorchester, Mattapan). Building on the infrastructure of care framework specified in Chapter 3, I compared two aspects of caregivers' experiences across these clusters: how they perceived the changes in their neighborhood impacting the eight components of the urban infrastructure of care, and how they perceived these changes to be influencing their efforts to carry out the six types of environmentally-dependent caregiving strategies.

I found significant differences in caregivers' perceptions of changes in local urban infrastructures of care according to the trajectory and pace of gentrification in their communities, and the broader patterns of disinvestment and uneven development of which gentrification was a part. For example, in Group 1 neighborhoods, caregivers perceived housing to be relatively affordable and easy to secure but of poor quality, while in Group 3 neighborhoods, caregivers perceived housing to be increasingly unaffordable and an increased risk of displacement or homelessness. In Group 1, caregivers experienced economic opportunities – especially those that would allow them to satisfactorily balance paid work with caregiving – as lacking and felt little hope that this

situation would improve, while in Group 3, caregivers perceived economic opportunities in their communities to be expanding but felt excluded from them. And in terms of social support and cohesion, caregivers in Cluster 1 communities mostly expressed a lack of social support and felt a low sense of social cohesion due to high levels of population churn and public disorder, while caregivers in Cluster 3 often felt a strong sense of community and adequate social support, but that these support networks and the broader fabric of their community was at risk of fragmentation. There were also important similarities across gentrification-stage clusters, including perceptions that policing was increasing in line with urban development, concerns about public safety related to rising levels of public drug use, and feeling a lack of ownership over the changes in their communities. The perspectives of caregivers in Group 2 were largely split between those in Everett being more aligned with Group 3 communities, and those in Brockton being more aligned with Group 1 communities; my ability to identify clearer patterns unique to this group was perhaps hampered by the small number of interviewees in this group due to the sampling challenges described in *Chapter 1, Section 5.5*.

The differential effects of disinvestment and uneven development via gentrification on the urban infrastructures of care in HNS communities were linked with notable differences in what the work of caregiving entailed and how it was experienced between caregivers in low- vs. high-pace gentrification communities. These differences were most pronounced in three caregiving strategies: securing and maintaining the material conditions of care; creating support structures; and managing dependents' relationship to the environment. When it came to securing and maintaining the material conditions of care, caregivers in Group 1 typically reported feeling stuck trying to gain a stable footing, for example by securing adequate housing, making affirmative moves after housing setbacks like displacement, evictions and/or homelessness, and gain economic security in the absence of local economic opportunities they could take advantage of. In Group 3, on the other hand, most caregivers felt stuck as their footing was crumbling under them, finding it increasingly difficult to afford basic ingredients for care like housing and food, and feeling increasing amounts of uncertainty about whether they would be able to remain in their community and if so at what cost. Due to lower levels of perceived social cohesion and

trust, and smaller social networks often as a result of past moves, caregivers in Group 1 had a harder time creating support structures for help with the burden of caregiving, and expressed feeling low levels of social support. Meanwhile, caregivers in Group 3 typically felt like they had been able to foster stronger support structures, but that these were becoming harder to maintain under the strain of economic and displacement pressures. Finally, caregivers in Cluster 1 overwhelmingly adopted protection-oriented approaches to managing their dependents' relationship to the environment in response to what they saw as inadequate public spaces and activity opportunities, and public safety concerns related to drug use and poverty. On the other hand, Cluster 3 caregivers typically adopted exposure-oriented strategies for managing their dependents' relationship to the environment, partly in an effort to take advantage of improving neighborhood amenities and partly in response to the imperative to cultivate dependents' know-how about how to navigate the community safely.

I also found commonalities across community clusters in terms of three caregiving strategies: preserving health, time management, and balancing work and care. With respect to preserving health, caregivers across all communities reported difficulty preserving their own health to a satisfactory degree. Some felt considerable stress and had difficulty successfully coping with this stress, and most reported feeling that they lacked the capacity for self-care due to the demands of caregiving. The impacts of neighborhood development trajectories on time management and balancing work and care were intertwined, I found, with caregivers across all communities reporting difficulty finding work that fit with the rhythms of their caregiving responsibilities, and that paid enough to afford a satisfactory quality of life for their households. These common challenges regardless of gentrification stage also reflect the political economy of care and social reproduction more broadly. However, as I established in Chapter 2, the production of urban space, including via gentrification, is part and parcel of this very same political economy.

I argued that taken together, my findings show that gentrification produces "care insecurity," which can be defined as a caregiver's feeling of: lacking adequate access to the necessary components of care; anxiety or fear in relation to one's caregiving

circumstances and a related lack of confidence in one's ability to provide satisfactory care in the future based; and/or a diminished capacity to prepare for and respond or adapt to adverse events that impact the dependent or the caregiving relationship. As my findings show, caregivers in Group 1 communities where the pace of development has to-date been low also experience care insecurity. However, the experiences of caregivers in Groups 2 and 3 show that gentrification (a) transforms the nature of care insecurity from an experience characterized by the absence of key components of care to one characterized by the vulnerability and jeopardy of present components of care, through (b) introducing care insecurity to aspects of caregiving like housing and social support that had previously felt more secure. Gentrification is productive of care insecurity because it destabilizes the urban infrastructure of care, affecting key components as well as the relationships between them and the "articulation work" involved in maintaining the connections between the components that are necessary to continue to pursue key caregiving strategies. Gentrification not only makes it more difficult for low-income caregivers to secure and maintain the material conditions of care and create social support structures, but undermines their existing strategies for doing so. Given that gentrification in the U.S. is concentrated in communities of color, and that people of color disproportionately bear the negative effects of gentrification, including but not limited to displacement, it is reasonable to expect that gentrification-induced care insecurity disproportionately affects caregivers of color and in doing so exacerbates the stratification of social reproduction in cities (Hwang & Ding, 2020; Rucks-Ahidiana, 2020).

The findings of this analysis uphold and complement HNS Resident Researchers' conceptualization of the experience of gentrification, and make two important contributions to the emerging body of research about the relationship between gentrification and health. First, they heed calls for research that centers resident experiences and perceptions of gentrification, and do so at a unique regional scale that affords a perspective on how the experience of gentrification is transformed as the process proceeds across time and space. Second, the findings contribute to the urgent matter of incorporating caregiving into how we conceive of the relationship between gentrification and health, both by demonstrating how to apply the infrastructure of care framework in

the study of the impacts of gentrification, and by identifying which specific caregiving strategies and components of the urban infrastructure of care are impacted and rendered insecure by gentrification. In Chapter 5, I make a third contribution to our understanding of the relationship between gentrification and health by advancing our understanding of how the experience of the evolving relationship between the urban environment and caregiving can become embodied via stress.

6.1.3 Caregiver stress and visions of the caring city

Stress has been identified by HNS Resident Researchers and other academics as a priority area of inquiry for improving our understanding of how processes of urban change like gentrification become embodied over time. In Chapter 5, I explored the hypothesis that changes over time in the urban infrastructure of care, and their impacts on the work of caregiving itself, could produce caregiver stress, and that stress might thus be a pathway through which the relationship between caregiving and the environment might come to be embodied by caregivers. Caregiver stress is a specific type of stress related to the conditions, experiences, and activities that challenge, threaten, and thwart caregivers and their caregiving relationships (Pearlin et al., 1990). Stress can have substantial, damaging effects on physical and mental health, but these impacts can be reduced when people have high levels of mastery, self-esteem and/or social support (Thoits, 2010b). The uneven distribution of stressors and coping resources, across space and over generations, is a key characteristic of contexts of stratified social reproduction, is one way that the effects of racism, sexism, and class hierarchy can have compounding and multiplicative effects on the health of women, poor and working-class people, and people of color, and stress is thus a key driver of racial, gender and class health inequities at the population level (Mullings, 2005; Thoits, 2010b). The neighborhood is a key context that shapes the distribution of stressors and access to coping resources, which in turn condition the overall mental health impacts of neighborhoods themselves (Aneshensel, 2010).

I conceptualized stress as a process of continuous feedback between individuals and their environment centered on two key components, appraisal and coping, with stress

occurring when aspects of the person's relationship with their environment are appraised as harmful, threatening, or challenging, and taxing or exceeding their coping resources, and thus endangering their wellbeing (Avison & Pearlin, 2010; Lazarus & Folkman, 1984). To assess how the work of caregiving changed over time in tandem with changes in the urban infrastructure of care, and with what consequences for caregiver stress, I conducted a longitudinal qualitative analysis of pairs of transcripts from those caregivers who were successfully re-contacted for a second interview in 2019-20. A longitudinal analysis suited my purpose because it affords a process-based perspective on how people make meaning about the conditions and trajectories of their lives (Hermanowicz, 2013; Saldaña, 2003). My analysis explored four aspects of respondents' experiences of change over time: the types of changes that respondents saw in their local urban infrastructures of care; the types of changes that respondents experienced in the work of caregiving; changes in their level and experience of caregiver stress; and changes in how they coped with their stressors and with what degree of success.

I found that the relationship between the urban environment and caregiving could be a source of stress for caregivers. Caregivers appraised threats, harms or challenges to caregiving emerging from their relationship to the urban environment in four specific domains: housing; financial insecurity; neighborhood development; and neighborhood social issues and safety. These domains overlap with components of the urban infrastructure of care, and were appraised as stressful because they concern caregivers' access to and the quality of key resources for care. I further found that, when faced with these stressors, caregivers employed some combination of four types of coping or buffering strategies: relying on social support; practicing self-care; working more and seeking financial security; and perseverance and trying to 'make it work'. While these strategies were able to help some caregivers alleviate stress on a momentary basis, they were not sufficient to address most urban sources of caregiver stress because they were individual-level responses to meso- or macro-level challenges. My findings showed that when caregiving stressors exceeded the coping resources available to respondents, respondents could experience a range of detrimental physical and mental health consequences, as well as increased fears for their health in the future. Finally, I found that

the small subset of respondents whose caregiving burdens decreased substantially experienced reductions in stress and improvements in their wellbeing.

Inspired by Tuck's call for a shift from damage-centered to desire-based research, I complemented my analysis of caregiver stress appraisal and coping with an analysis of caregivers' responses to interview questions about how they would design new community centers in their neighborhood. These questions were intended to serve as a canvas for caregivers to express their visions for enhanced community-based resources and reflect on their past experiences with resource access in their communities. I found numerous patterns of overlap in respondents' desires, the overwhelming majority of which were focused on better meeting community care needs through things like childcare and eldercare, peer support groups, mental health services, and economic security resources that were spatially integrated and free of financial barriers to access. Most caregivers explained that these desires were rooted in the hope of enhancing the health and wellbeing of people like their dependents as well as other caregivers like themselves. These desires sketch a powerful and transformative vision for care-centered community development that align with the infrastructure of care framework.

6.1.4 Interpreting the relationship between the urban infrastructure of care and caregiver wellbeing through the lens of the capabilities approach

One overarching objective of this dissertation was to understand how the relationship between caregiving and the urban environment influences not only health, but wellbeing more broadly. To do so, I will briefly interpret my findings through the lens of the capabilities approach, a philosophical framework for justice introduced in Chapter 2 wherein justice is based on wellbeing, and wellbeing is a function of one's freedoms to be and do things of value. The capabilities approach is centered on two concepts: functionings, those things which people value doing or being; and capabilities, a person's real freedoms or opportunities to achieve the functionings they value. In addition to its utility as a framework for understanding wellbeing, the capabilities approach has been touted as particularly well-suited for guiding and evaluating progress towards the just city (Fainstein, 2010).

The findings of my analyses in Chapters 3 and 5 of the significance of caregiving for respondents and the high degree of responsibility they feel for their dependents' wellbeing suggest that caregiving is a functioning of great importance for the respondents in my sample. In Chapter 3, my findings further established that the availability and adequacy of eight components of the urban environment are necessary to enable caregivers to carry out the work of care and fulfill their caregiving roles in ways that they value and with outcomes that they value. I argued that these components of the urban environment comprise the urban infrastructure of care which, though its unevenness, shapes what forms caregiving can or must take. Under the framework of the capabilities approach, I would argue that the urban infrastructure of care constitutes the spatial capability set according to which caregivers are or are not free to be caregivers or do care in ways that they value. Or, put differently, the infrastructure of care is part of the set of capabilities that shape the possibilities for caregiving in a specific context (Shinn, 2015). The concept of "care binds" captures the loss of freedom, in the form of constraints on caregiving and the circumstances thereof, and thus the loss of wellbeing that caregivers can incur when the infrastructure of care is inadequate and/or they are forced to perform more infrastructural labor to make up for these inadequacies than they can reasonably bear.

The results of my analysis in Chapter 4 show how the experience of gentrification and the condition of displaceability de-stabilizes and restricts the capability set underlying caregiving *qua* functioning. Instead of expanding caregivers' freedoms to care in a satisfactory manner and freedoms to fulfill their caregiving goals, and thus enhancing their wellbeing, as we might hope urban development would, my analysis showed how gentrification-related neighborhood changes rendered the infrastructure of care more precarious for low-income caregivers and produced feelings of care insecurity, thus detracting from their freedoms to care in ways that they value. Following the logic of the capabilities approach, gentrification is detrimental to the well-being of low-income caregivers because it restricts the capability set or set of freedoms at their disposal to attain a high-value functioning, and in so doing, constitutes an injustice unto them.

My analysis and findings in Chapter 5 help establish a bridge between the abstract framework of the capabilities approach and the embodied experiences of caregivers in

gentrifying neighborhoods by illustrating how perceived threats or challenges to the capabilities that enable them to give care in ways that they value can detract from their wellbeing by producing unhealthy stress. Moreover, the specific finding that the coping and buffering resources available to respondents to cope with urban caregiving stressors are inadequate because they are individual rather than collective in scale points to the importance of collective empowerment as a crucial capability for substantively enhancing caregiver wellbeing. Finally, I would also argue that the respondents' desires for community-based care supports illuminate how the spatial capability set according to which care takes shape can be enhanced in ways that expand caregivers' freedoms to give care in ways that they value, thereby enhancing caregiver wellbeing and furthering the cause of social and spatial justice in the city.

The urban environment plays a major role in shaping the extent to which caregivers are free to give and receive care in ways that they value, and the extent to which they are constrained from doing so. The degree of freedom or constraint that caregivers face in fulfilling this important functioning is an important indicator of individual and community-level wellbeing, and a measure of social justice in the city. Based on the capabilities approach, I argue that to maximize caregiver wellbeing and justice, planners must seek to bring about neighborhood changes that maximize caregivers' freedoms to give and receive care in ways that they value. Crucially, such approaches must account not only for freedom with respect to how people care, but for how much people care; they must afford people the freedom not to give care, and not to bear a disproportionate burden of care work. This is only attainable through the socialization of the means of social reproduction, such that responsibility for ensuring everybody's care needs are met falls on the proverbial village and is held collectively. This is the goal of the infrastructural approach to planning for care that I outline in *Section 6.4* which seeks to provide planners with a pathway for addressing the stratification of social reproduction in cities as a way to work towards resolving the contemporary crisis of care. In the next section, I summarize what my findings add to our understanding of these issues.

6.1.5 Infrastructural labor, the stratification of social reproduction, and the crisis of care

In Chapter 2, I argued that cities should be understood as landscapes of stratified reproduction, inspired by the scholarship of women of color like Colen (1995), Mullings (2005), Roberts (1998), Nakano Glenn (2012) and others who have traced the contours of racist and sexist inequities in who is empowered or disempowered to care for whom in the United States. I argued further that the history of the production of urban space in the United States since the rapid urbanization of the industrial area contributed to the stratification of social reproduction, and in so doing, should be seen as contributing to the contemporary crisis of care. The crisis of care under neoliberalism is one characterized by the normalization of endemic deficits in the broad infrastructure of care, including the welfare state, and the simultaneous externalization of care work on to communities and families who are pushed to shoulder ever-greater personal responsibility for fulfilling the imperatives of social reproduction while their very capacity to perform this care is actively being undermined (Fraser, 2016; The Care Collective, 2020).

The results of my analyses contribute to our understanding of how the uneven development of urban space broadly, and specifically gentrification, serve to stratify social reproduction and in turn contribute to the contemporary crisis of care. In the context of the HNS study sites in the Boston region, I have shown that the urban infrastructure of care is a necessary feature of caregivers' ability to give care in ways that allow they and their dependents to live as well as possible. However, because of the characteristics of capitalist urbanization and the priorities of and power relations between those – including planners – who can influence the production of space, the urban infrastructure of care is incomplete and fragmented. This means that in any given place, at any given time, crucial resources for the work of care are either missing, inadequate, and/or disconnected from one another.

Where cities fall short in ensuring adequate conditions for care, caregivers themselves must pick up the slack and try to make up the difference. They can do so in one of three ways. The first is with money, paying to ensure that the requirements of care are fulfilled by labor and goods bought and sold on the market. Most people are forced to do this to a

certain extent and seek to limit it; few can afford it; and even fewer are fully able to compensate for the shortcomings of the urban infrastructure of care by doing so. The second is by making sacrifices and tradeoffs with respect to what caregiving is and does, and what opportunities to live as well as possible caregivers can afford to their dependents. Most caregivers are forced to do this, too, but seek to avoid it because it threatens to detract both from their dependents' present and future wellbeing, and because it can be upsetting – to say the least – to do so. That leaves the third option: to 'make it work,' to take the burden of ensuring the conditions for good-enough care on their own shoulders, to take on mostly alone what ought to take the proverbial village.

Making it work makes work – the overall amount of work caregiving entails increases. But my findings show that what contributes to the increase in care work when the urban infrastructure of care is insufficient is actually a specific type of work that is both part of and prior to caregiving. This is what Star and Strauss (1999) called "articulation work": the usually invisible work that makes other forms of work possible, the work that enables other forms of work *to* work. The purpose of infrastructures is precisely to perform articulation work, ideally speaking. With respect to care work, articulation work is what makes caregiving possible in the first place, and what makes it possible for care to work. But the urban infrastructure of care was not planned, designed or invested in as an infrastructure – it is just used as such by caregivers because it is necessary for their care to work. It is not an ideal infrastructure at all: it is unequal, uneven, and more often than not inadequate for making good-enough care possible. And so it is the articulation work that the city fails to perform to make care possible that adds to the burden of the caregiver's work. The extent to which the urban infrastructure of care fails to enable care to work is the extent to which caregivers must themselves perform additional articulation work, or what I have called infrastructural labor. And the cruel twist of it all is that a person's capacity for work is finite: the time and energy that caregivers put into necessary infrastructural labor to ensure the conditions for their care's success in the absence of a robust infrastructure of care ultimately detracts from the time and energy they can put into care itself, for their dependents or for themselves.

And so I argue that it is through the uneven and unequal distribution of the articulation work or infrastructural labor *necessary to ensure that care can work at all* that the urban environment contributes to the stratification of social reproduction and compounds the contemporary crisis of care. The process of uneven urban development characterized by disinvestment and then gentrification, as represented by the range of developmental trajectories in each of the nine HNS neighborhoods, is a process through which this infrastructural labor is both produced and rendered precarious. This explains why, as I show in Chapter 4, gentrification produces care insecurity for low-income caregivers in gentrifying communities: because gentrification destabilizes and undermines the urban infrastructure of care, and without the reserves to make up for these disruptions on the market or the willingness to make sacrifices in their ability to care as well as possible, these caregivers must take on additional articulation work to make care work. *And*, as a result of gentrification, this articulation work can become more difficult, more financially and cognitively taxing, and less likely to feel like it will actually succeed. So gentrification contributes to the crisis of care in three ways: by creating more work for low-income caregivers in the form of infrastructural labor; by making the work of this infrastructural labor more challenging; and thereby through the toll of this additional work, detracting from caregivers' reserves and capacities available for care itself.

The burden and toll of this infrastructural labor is made clear in caregivers' experiences with stress as described in Chapter 5. Among the many possible sources of caregiver stress, I identified four in the data: securing, affording, and maintaining housing; financial insecurity and the struggle to gain financial security; concerns about how one's household and community will navigate the impacts of neighborhood development and displacement; and preserving dependents' wellbeing in the face of perceived threats to public safety. All of these stressors have to do with the articulation work that makes care possible in the absence of more robust and equitable urban infrastructures of care. These caregiving stressors do not apply to all caregivers who live in gentrifying neighborhoods; they apply to those who cannot secure the conditions of care through the market alone, who must rely on the affordances of the city itself to make care work. The very same group who are most vulnerable to the harmful impacts of gentrification itself, like

residential or cultural displacement. Moreover, most of the coping resources available to caregivers for buffering against these stressors involve more work. The stressors thus have a greater chance of compounding than alleviating unless caregivers pack up and leave to try again somewhere else, lose or sacrifice the responsibility of caregiving in the first place, or manage to build not only strong structures of social support but collective power over the changes underway in their communities so as to disarm what is threatening the conditions of caregiving in the first place.

Overall, my findings demonstrate the following: that the characteristics of the urban environment contribute to the stratification of social reproduction and the crisis of care by delegating crucial aspects of the articulation work necessary for care to work to caregivers themselves; that gentrification, a predominant form of urban transformation the world over, exacerbates the burden of this articulation work for the most vulnerable and renders its outcome less secure; and that the challenges and difficulties of performing this articulation work in order to give care can physically, mentally and emotionally deplete caregivers in ways that are detrimental to their health and wellbeing. This is how the production of urban space, and gentrification in particular, contribute to the stratification of social reproduction and thereby exacerbate the contemporary crisis of care. This state of affairs is not only unjust and untenable but unsustainable and poses a clear threat to the livability of cities and the health and wellbeing of those who call them home. So what can planners do to make cities more viable for care, and why might it be worth doing? I turn to these questions after discussing some of the limitations of this study and the advantages of the HNS PAR approach.

6.2 Limitations

This study confronts a handful of limitations, including with respect to: sample; length of data collection; interview protocol; respondent biases; and data type. Fortunately, many of these limitations can readily be overcome through future research, both via the Healthy Neighborhoods Study and by other researchers. Below, I will address each limitation in

turn, consider its impacts on the results of my analyses, and suggest how it might be addressed in future research.

6.2.1 Sampling

This study faced two important limitations with respect to the sample. The first limitation introduced by the sample selection was geographical bias, which was most evident in Chapter 4. A number of factors related to both project management and community capacity meant that recruitment into the HNS nested longitudinal cohort – from which the sample of caregivers analyzed in this study was derived – happened with varying degrees of success across the nine study communities. This produced a cohort sample with unequal numbers of interviewees across each of the nine communities, as well as uneven levels of success re-contacting respondents across each of the nine communities. This translated into the sub-sample of caregivers drawn for this analysis over-representing some communities (particularly Roxbury and Dorchester) and under-representing others (particularly Mattapan, Lynn and Brockton) relative to one another.

While HNS staff tried to support communities who fell behind with cohort recruitment, I suspect that this may have inadvertently contributed to the unevenness in success re-contacting respondents. The reason for this is that our strategy for catching up on cohort recruitment was to use “rapid enrollment days” where a number of Resident Researchers and HNS staff would go together to community spaces like libraries or community centers to do public intercept recruitment. My experiential observation was that in communities where we used this strategy, we recruited a higher proportion of people who were homeless, living in temporary or transitional housing, and/or otherwise difficult-to-recontact compared to communities where the cohort sample was recruited mostly via Resident Researchers’ neighborhood-based street intercepts. Especially because “rapid enrollment days” were held during the winter months, this could be because people who were homeless or in temporary/transitional housing sought shelter in places like libraries or community centers during the day, and/or used the computers and other resources that they may not otherwise have had access to.

The geographic unevenness in the efficacy of cohort recruitment measures reflects challenges inherent to multi-sited PAR that relies on partners with differing degrees of formal organization and Resident Researchers with different types of community relationships to conduct cohort recruitment. In this respect our experience offers lessons to future PAR practitioners about the importance of monitoring and supporting community-based sampling strategies like that used in the HNS. The findings of this study, particularly those in Chapter 4, also suggest that the greater difficulty recruiting participants may reflect the lower degree of social cohesion in rapidly-gentrifying communities that are also home to recently-displaced and/or precariously-housed people in an increasingly unaffordable regional housing market.

While I do not believe that the geographic unevenness of the sample seriously undermined this analysis, it did result in less detail than would have been desirable on caregivers' experiences in communities that accelerated from low- to high-paced gentrification, with the weight of the evidence instead laying in communities that remained at either low- or high-paces of development relative to one another between 2008-2018. In my assessment, there was sufficient detail from under-represented communities to understand the impacts of the overall trajectory from low- to high-paced neighborhood development. However, additional detail could have better helped pinpoint specific "pivot points" in community development trajectories where care insecurity may have been generated. This limitation may be overcome within the HNS through future data collection and the potential of recruiting new cohort members in communities where initial recruitment and retention was less successful. At the time of writing it is unclear whether this will take place.

The second type of bias introduced by the sampling strategy is selection bias, which was introduced by limiting the sample to respondents who reported on the survey that they had children. This decision was made because it was the clearest way to identify respondents for whom caregiving was likely to comprise a significant part of their lives in the present, in the absence of any other standard measure of identifying caregiving responsibility on the HNS survey. This was effective to the extent that it identified a large number of unpaid caregivers with widely-ranging caregiving experiences and

responsibilities – many respondents with children also cared for elders, neighbors, etc. However, this decision introduced bias because it excluded respondents who may have had significant caregiving responsibilities for other people who were not their children. The consequence of this was, perhaps, a loss of greater detail on how non-child-oriented caregiving is shaped by the urban environment. This is important because of the ways that urban environments, despite privileging production over social reproduction, were nevertheless also designed to favor certain configurations of social reproduction, specifically heteronormative nuclear family structures of households and livelihoods. Thus, the experiences of those caregivers whose caring relationships fall entirely outside of these traditional arrangements may have been excluded. It would be relatively straightforward and worthwhile to address this limitation to a deeper understanding of the urban infrastructure of care through further research focused on how non-child-oriented caregiving relationships – perhaps, for example, related to caring for seniors and disabled people, and/or caregiving relationships among LGBTQ+ people – are shaped by the characteristics of and changes in the urban environment.

6.2.2 Longitudinal timeline

A second limitation of this analysis is the number of follow-up interviews with cohort participants and the interval between them. When the longitudinal analysis for Chapter 5 was conducted, the HNS had only conducted two rounds of interviews with the longitudinal cohort, and these interviews ranged from 1-1.5 years following each respondent's first interview. As the analysis in Chapter 5 shows, plenty can change in so short of a time, and even such a short longitudinal perspective can illuminate significant shifts in both life events and respondent perspectives that change how caregiving and the urban environment relate in their lives. However, a 1-1.5-year interval is also not long enough to fully capture bigger picture phenomenon at the level of both the neighborhood and the within specific caregiving relationships. For example, major changes in neighborhood development may not be witnessed by everyday residents in so short a timeframe, and residents' cumulative perceptions of those changes and their impacts on

their lives may also not shift considerably in so short of a time frame. Similarly, 1-1.5 years may not capture significant shifts in dependents' developmental stages or needs. This limitation would best be addressed by continuing to conduct further rounds of follow-up interviews with HNS cohort members, which is planned for the duration of the current grant through 2023. The third round of interviews is beginning in Spring 2021, as I write, after being delayed by the COVID-19 pandemic.

6.2.3 Interview guides

Because the HNS semi-structured interview tools are co-designed by Resident Researchers and reflect community priorities for qualitative data on a wide range of topics, the interview guides for each round of interviews were not tailored specifically to the purposes of answering my research questions. This was both a limitation and an advantage.

Interviews were broad in scope, covering a wide range of themes, not all of which were relevant to caregiving. Caregiving was my research interest, but the HNS Consortium had a broader spectrum of interests that also needed to be catered to. The section most directly geared towards caregiving was that on "social support." Most other sections made no reference to caregiving aside from asking about the impacts of changes or experiences on one's family or social network. The interviews did not include questions focused on, for example, caregiving histories or experiences coping with caregiving burdens. When we asked about stress in the second round of interviews, there was no question specific to caregiver stress. This pattern also reverberated into how interviews were conducted by members of the HNS' academic team: when the purpose of the interviews were explained to respondents during cohort enrollment, or when the interviewer explained that it was time to transition to a new theme in the interview guide, caregiving was not typically a part of how the interview was framed to respondents. Additionally, interviewers' follow-up questions for respondents weren't focused on establishing connections or digging further into issues related to caregiving specifically, instead reflecting the broad range of themes under investigation. Thus, the structure of the interview guide was a limitation in the sense

that it precluded a more singular focus and consequently depth of data on caregiving in particular.

An additional limitation of the interview protocol for this study that is a reflection of constraints relative to the structure and process of the HNS was that it was static. Often, qualitative researchers are advised to adapt their interview protocol as they collect data to respond to and deepen their understanding of emerging themes and explore hypotheses that they may also develop. For example, in the case of this study, that could have looked like developing questions seeking to explore the theme of “care insecurity” in more detail based on preliminary analysis of early interviews before data collection was completed. Due to the size and complexity of the HNS, such iteration was not possible.

While an interview protocol and prompting strategies focused on caregiving would certainly have been advantageous, I was instead left to piece together a picture of care from a heterogeneous range of data covering many different themes. Fortunately, for respondents for whom caregiving was a significant part of their everyday life, the subject permeated their responses to questions ranging across themes. Indeed, the fact that this was the case in an interview designed to solicit experiences of neighborhood change is testament to the significance of caregiving as a perspective through which planners need to understand experiences and consequences of neighborhood changes. I also reflected that if the interview had been explicitly about care, it might have been harder to ask respondents to connect it to experiences and perceptions about their neighborhoods, than it was to ask about experiences and perceptions about neighborhoods and learn about care. Additionally, I saw this experience as somewhat fitting because it seemed to me to mirror the work that planning researchers and practitioners would need to do to learn to attend to caregiving as planning concern. That is, to learn to see caregiving where we’re not used to looking for it and where it may seem to have faded into the background because it has been so marginalized and under-valued in how we see the urban world, and to excavate it and engage with it on equal terms as more traditional planning concerns like housing, economic development or mobility.

6.2.4 Interview protocols

From a PAR perspective, a notable limitation of the HNS interviewing protocol is that Resident Researchers were unable to be involved in conducting the interviews themselves. HNS staff had initially envisioned conducting the interviews in pairs of one MIT/CLF team member and one Resident Researcher. However, our IRB determined that this would not be permissible due to privacy risks from the perspective of respondents, and the risks to Resident Researchers of encountering traumatic experiences during the interview process due to the nature of the subjects covered in the interview guide. As a result, it was determined that interviews could only be conducted by MIT/CLF personnel. I note this as a limitation for two reasons. First, it is one way in which the research was not fully participatory, and thus represents a limitation of the HNS PAR process itself. Second, although there is no way to know for sure, it is possible that this outcome diminished the quality of the data itself by removing the opportunity for Resident Researchers to ask questions and probe interviewee experiences from the perspective of their own experiences in the community.

6.2.5 Respondent biases

Researchers making inferences based on analysis of interview data have been cautioned to be careful with respect to three types of respondent biases: desirability bias, agency bias, and hindsight bias (Tavory, 2020). Agency bias refers to the fact that interviewees are likely to center themselves as protagonists in the stories they tell, and is typically motivated by the interview situation itself, wherein the individual respondent is positioned as the “locus of action” (Tavory, 2020, p. 452). Hindsight bias refers to the fact that people may not accurately recount the way that things happened. Because my goal was not to make causal inferences based on the interview data, but instead understand caregivers’ experiences and perceptions, neither of these biases should be of significant concern as limitations to my analysis. Desirability bias, on the other hand, is of considerable concern.

Desirability bias refers to the fact that interviewees may be less likely to tell interviewers things that they believe may reflect poorly on them, and instead favor representing themselves in a positive light. With respect to caregiving, desirability bias can certainly be expected, especially because of gendered cultural expectations of the moral imperative and value of caregiving as well as the sexist and racist history of denigration and punishment for those who are not perceived to be caring properly or appropriately. Thus, respondents may have been less likely to share experiences where they felt like they fell short as caregivers. Given the focus of this analysis on when care is experienced as difficult and/or burdensome labor, desirability bias is certainly a limitation of the data. While I do not doubt that desirability bias led to respondents withholding experiences and feelings about caregiving – particularly in light of the lack of probes on the subject in the interview as explained in the previous section – I also admit that I was struck by the degree to which respondents were forthcoming about times that they felt like they had struggled as caregivers or the ways in which they had felt short of their own goals or standards. Moreover, so much of the experience of caregiving is about effort rather than accomplishment and so even when respondents may have been withholding with respect to ways they feel like they may have felt short, they often nevertheless spoke to how hard they tried and thus still afforded a deep perspective on the *work* of care itself.

6.2.6 *Data type*

The final limitation of note is that only one type of data that was used for this analysis: transcripts of semi-structured interviews. As with most research, given more time and resources this study could certainly have benefitted from incorporating quantitative data and other types of qualitative data. With respect to quantitative data, it would have been particularly valuable to be able to test for associations between caregiver status and stress and the extent to which they are modified or mediated by changing neighborhood conditions using HNS survey data. I plan to pursue this line of analysis in the future, but note the limitation of the HNS survey with respect to measuring caregiver status (as mentioned above) as well as the fact that it only has a single measure of stress as part of a

broader mental health battery. These limitations could potentially be overcome through future HNS survey updates, and/or through other research that can better measure caregiver status and stress. With respect to qualitative data, this study could be significantly developed by incorporating ethnographic fieldnotes from participant observation. For example, spending time with caregivers as they go through their daily routines at home and across the city could shed additional light on how caregivers perform the “articulation work” between different components of the urban infrastructure of care, and how care binds emerge when this infrastructure is insufficient (Star & Strauss, 1999). Additional qualitative data from participant observation could also be useful for gaining depth in areas where the interview protocol offered breadth instead.

6.3 Reflections on the HNS PAR model

The HNS’s structure and unique processes as a longitudinal, multi-site PAR project had a number of benefits for this study, which compensate for some of the limitations highlighted above. These include the HNS’ multi-site design, collaborative research design and data analysis processes, the relationships of trust and accountability I developed with Resident Researchers and other HNS colleagues, the opportunity to establish a Community Advisory Committee for this dissertation, and mechanisms for linking this study to action. Below, I share my reflections on how and why I benefitted from these aspects of the HNS over the course of conceptualizing this study, analyzing the data, and writing up the dissertation, and how they have contributed to my development as a scholar more broadly. Based on these reflections, I briefly discuss the importance of an ethic of care in PAR, and the potential of PAR to anchor efforts to plan for care, which I discuss in more detail in the final section.

6.3.1 *Multi-site study design*

The first advantage of the HNS structure for this dissertation was the HNS’s multi-site design and site selection process, which identified nine communities at various stages of development within a broader regional urban system as the study sites. Though this aspect

of the study design precedes the design and implementation of the study's PAR model, it had key implications for how our PAR process has subsequently played out, in ways that came to shape my own analyses and findings. The HNS' multi-site structure meant that my colleagues and I had to create and facilitate collaborative processes for research design that integrated priorities and inputs from multiple communities and stakeholders who had in most cases not previously worked with one another. This reflected our aim of conducting common research that could serve site-specific and common goals. Moreover, steps in collaborative processes were often asynchronous, particularly before the COVID-19 pandemic when we did not work online. In practice, this meant that one community would take a step forward, the next community would review their progress and take the next step, and so forth. We as staff were thus required to engage in constant translation of progress across community sites as the research developed, helping team members in each community understand the different insights, decisions and advances that had been made by other collaborators so they could make the best possible contribution to the group's collective progress. This was an intellectual and practical challenge that forced us to build trust and a shared sense of responsibility across communities for a project that would mutually advance and accommodate multiple goals. The significance of this characteristic of the HNS – multiple goals under a common research umbrella – for my dissertation is that it laid the foundation for me to be able to pursue a project like the dissertation that advanced the common research agenda while meeting a particular need that was not common across the entire Consortium. In this case, of course, my need was to write a dissertation in order to fulfill my degree requirements.

The other advantage of the multi-site nature of the HNS for my own research was that it allowed me to explore patterns of spatial variation in ways that compensated for the limited temporal variation afforded by our cohort at the time of writing. In this way, I could explore trajectories of neighborhood change as in Chapter 4 by comparing across clusters of communities at different stages of change instead of requiring further longitudinal data from each community. Part of what made this possible for me was the knowledge I gained about the various processes of change underway in HNS communities

from Resident Researchers themselves through PAR activities like collaborative research design or data analysis workshops.

6.3.2 Collaborative research design

Collaborative research design workshops represent the next major benefit of the HNS study design to this dissertation. Since the beginning of our research design process in 2016, following the establishment of community partnerships and recruitment of Resident Researchers, I have played a lead role in designing and facilitating multiple series of collaborative research design workshops. Through these workshops, the MIT-CLF team facilitates collaboration between Resident Researchers and across communities to develop research questions, identify primary data appropriate for answering these research questions, and designing and testing tools for gathering quantitative and qualitative data. As I mentioned in *Section 2.3* of this chapter, the fact that the interview guides used to collect the data analyzed in this dissertation were not tailored to my research questions was both a limitation and an advantage for this research. I think that my role designing and facilitating HNS collaborative research design workshops, whether or not they were concerned with the interview tool, was instrumental in helping me overcome this limitation. Through facilitating these workshops, I was able to gain first-hand knowledge about the types of questions and challenges that residents of the study communities were grappling with. Often, these issues are complex and filled with unknowns, and sometimes they are very emotional. They could therefore be challenging to put into language and communicate, and part of my role was to support Resident Researchers in doing so.

Being present for and involved in this process helped me to understand the motivations behind the topics we ultimately came to investigate, and the reasoning behind fine-grained decisions about whether or how to ask specific survey or interview questions, on a deeply personal level rather than a purely academic one. Because the data I have analyzed covers such a broad range of themes that I did not choose for the purposes of analyzing my research questions, it was imperative that I understood why these themes were being investigated in order to interpret the data. For example, my understanding of

how and why the concept of “ownership of change” emerged in collaborative research design workshops informed my analysis in Chapter 4 of how caregivers perceived the gentrification-related changes in the components of the urban infrastructure of care because I knew that it was important to consider how empowered or disempowered caregivers felt with respect to these changes.

Moreover, over the course of my experiences listening to and talking with Resident Researchers across many collaborative research design workshops, I naturally developed my own ideas about themes that could be worthwhile to investigate within the scope of our project, including care and stress. However, I typically held my interpretations and suggestions back; when I offered input, it was mostly in the form of synthesis. I did this partly in order to ensure that my role as facilitator remained clear to participants and that they trusted me in that capacity, given that the collaborative research design process was new to all of us and we were often experimenting with facilitative techniques. Additionally, I have been committed to ensuring that community members held power over the direction of the research, and did not want to risk jeopardizing that during such a crucial stage. Nevertheless, over time I inevitably continued to develop my own understanding of the questions at hand, and themes like care and stress that are at the core of this dissertation were central to that. What I learned through the collaborative research design process gave me the confidence that I could pursue an independent research project like this dissertation that could nevertheless remain faithful to our PAR principles and shared values, and that could build on and contribute to our shared research agenda. In this respect, I see this dissertation as my belated contribution to those discussions, now that we have progressed further along in our research.

6.3.3 Collaborative data analysis

Equally, if not more, important to this dissertation have been the HNS collaborative data analysis workshops, which we held annually from 2016-2020 and which we began holding on a monthly basis in early 2021. I have led the design and facilitation for these workshops for the duration of the study so far, and I might go so far as to say that this

responsibility has been the most important experience in my development as a researcher to date. Data analysis is typically the least-participatory phase of community-engaged studies, and we had few precedents to learn about how to meaningfully and collectively engage residents with varying levels of education and research experience in the act of data analysis. These workshops have been challenging for myriad reasons; sometimes we exceeded our expectations and other times we fell short. Nevertheless, they have consistently been rewarding for Resident Researchers, community partners, and academic team members alike, and I think our model of collaborative data analysis makes a significant contribution to the field of PAR methodology. Many of the benefits of the collaborative data analysis workshops to this dissertation are similar to those of the collaborative research design process discussed above, like learning from Resident Researchers as they apply their life experiences and experiences with data-gathering to key analytical decisions and endeavor to articulate and make meaning from key study findings, and applying what I learned to my own evolving research interests. Below, I want to highlight three additional benefits of my role in HNS collaborative data analysis to my work on this dissertation: learning how to communicate about methodology and findings; learning from, rather than avoiding, emotions that arise during data analysis; and, finally and perhaps obviously, advancing my learning about the subject of our research.

One of the most challenging things about designing and facilitating collaborative data analysis workshops is trying to figure out the best way to communicate information about analytical techniques and results to Resident Researchers so as to enable them to ask critical questions and communicate with one another about how they interpret the topic at hand and connect it to their ongoing work in their own respective neighborhoods. From the perspective of my development as a scholar, it has been extremely valuable to learn about how to communicate to a non-academic audience about how knowledge is produced *while that production is underway*, and not just how to communicate about the final product. Of particular relevance to this dissertation, one of the most significant communication challenges I have faced in collaborative data analysis workshops has been trying to communicate how qualitative coding works, what it works for, and what undermines it. This challenge was admittedly a surprise for me; I had expected that it

would be easier to dive in to qualitative data analysis than quantitative data analysis because narrative data would be more relatable and interpretable than numerical outputs from quantitative techniques.

But relatability and interpretability turned out to be the source of my communication challenge, which was first to make the case for taking respondents' perceptions and feelings at face value, interpreting their experiences without judgement, and avoiding making assumptions about the respondent as a person based on what they said in their interview, and second to ensure that these principles were applied in the act of analysis. One source of this challenge was Resident Researchers' understandable desire to help respondents, which led some to jump to considering what respondents could do differently or do better to improve their circumstances. A second source of this challenge was Resident Researchers' intimate familiarity with the study communities and the lives of their fellow community-members. Sometimes, this led Resident Researchers to jump to conclusions about a respondent's attitudes, attributes, beliefs or actions when they recognized in the data connections to patterns they observed in other aspects of their social lives. Other times, if a respondent said something that conflicted with what a Resident Researcher thought to be true about their community, this would lead the Resident Researcher to doubt the validity and utility of the data. This points to an important tension in PAR more broadly, between the intimacy of Resident Researchers' knowledge of the subject matter and the emotional and material stakes thereof, on one hand, and on the other hand the distance and impartiality that is necessary during certain phases of qualitative analysis to be able to recognize patterns across respondent experiences and do justice to respondents' own voices. Both are important and integral to the unique contributions that PAR can make to knowledge, and in my assessment this tension requires balance and technique rather than alleviation or resolution.

I share this communication challenge because it was an important influence on how I presented my data and findings in this dissertation. Namely, I made a concerted effort to foreground respondent voices in each of my analytical chapters, and to have the data itself do as much of the work of presenting the findings as possible. This is not always encouraged when writing up qualitative analyses. Often, the researchers' interpretation is

expected to occupy center stage, with data used sparingly to illustrate key arguments. From this perspective, my analytical chapters might be regarded as being a bit too cacophonous. But I chose to center respondent voices as much as possible for two reasons. First, because to me it mirrors the ethos of PAR itself of giving power and voice in knowledge production to those most impacted by the issues under investigation, regardless of how this aligns with academic convention. And second, because my experiences struggling to communicate about qualitative analysis made me want to demonstrate how much we can learn from respondent perspectives and experiences, and to prioritize showing how rich and deep of a story respondents' voices themselves could tell.

The second advantage of my experiences with the HNS collaborative data analysis process was that it was a unique and powerful way to learn how to engage, rather than avoid, emotion in data analysis. Emotion is often considered anathema to the objectivity expected from researchers during analysis, but in a collaborative data analysis setting when the subject at hand is personal and its stakes high, emotion is unsurprisingly unavoidable. In facilitating collaborative data analysis workshops, we had to develop ways to not only engage emotion in the analysis process but encourage it; to eschew it would have undermined the quality of both our analysis and the relationships upon which the HNS rests. Working through emotional responses to data was often a means for participants to figure out what they wanted to say, arrive at key insights, and identify commonalities across one another's experiences that were instrumental to arriving at shared interpretations of results.

Applying what I learned through engaging emotion in collaborative data analysis, and even having the facility to do so at all, was crucial to my own analysis process. I had significant emotional responses to the data I analyzed in this dissertation, which to my surprise grew stronger rather than number as the analysis progressed. By the time my analyses were almost complete, the data regularly brought me to tears, and sometimes made me quite angry. Other times, the data made me happy and hopeful, particularly seeing the changes over time during respondents' second interviews. Often, the data made me worried and afraid: conducting my analysis in the middle of the COVID-19 pandemic

made me especially sensitive to respondents' vulnerabilities, and I often found myself worried about how respondents were faring and scared in anticipation of what we would learn upon re-contacting them. I struggled to work out what to do about these feelings; being overcome sometimes felt like it was getting in the way of my progress. But my experience engaging emotions in collaborative data analysis workshops taught me why and how to value my emotions as part of analysis and meaning-making. Doing so was especially helpful when it came to trying to articulate the meaning of my findings in ways that appreciate as fully as possible the weight and significance of respondents' experiences, and the generosity and trust with which they shared them with us. Engaging my emotional responses also helped motivate me, and sometimes helped me realize when I needed to take a break.

Third and perhaps most obviously, I note that my experiences throughout the collaborative data analysis process have profoundly advanced my knowledge of the topics that the HNS investigates. The most relevant example to share here is a pair of workshops on the topic of gentrification conducted virtually in the Spring of 2020, while the COVID-19 pandemic was at its first peak in the U.S. The purpose of these workshops was to interpret and synthesize findings from five different analyses our team conducted about different aspects of gentrification and displacement, and build a conceptual model of the experience of gentrification. This model is summarized in *Chapter 1, Section 5.4*. Those conversations not only deepened but transformed my understanding of what gentrification is and why gentrification matters. The emphasis that Resident Researchers put on stress as a key aspect of the experience of gentrification helped clarify so much of what I was still trying to understand as I sifted through the interview data while developing my dissertation proposal, and motivated me to explore the subject of stress further through my analysis in *Chapter 5*. Resident Researchers consistently framed gentrification and its consequences in intergenerational terms, which helped me see the value of studying the effects of gentrification on the care involved in reproducing life across generations. And they suggested that one of the most important consequences of gentrification could be the loss of the means – be they economic, social, or spatial – to live in accordance with one's values, which inspired me to incorporate the capabilities approach into the theoretical

framework of this dissertation given its emphasis on being able to be or do what one value's as the measure of wellbeing. Those two workshops represent a small slice of what we have accomplished together in collaborative data analysis, but represent the impact that my experiences being part of that process have had on the development of my scholarship.

6.3.4 Relationship development

Given my reflections so far, it should hopefully come as no surprise that the relationships I have developed with Resident Researchers themselves, as well as with site coordinators and other consortium partners, have tremendously influenced this dissertation, my political education and intellectual development as an urban planner, and my mental health and emotional wellbeing over the course of my PhD program. They are the life and breath of the HNS and it is daunting to adequately convey the extent of their influence on me in terms of intellectual and emotional nourishment and the depth of my gratitude to them for their trust in my colleagues and I, for the hundreds of hours of work they have dedicated to carrying out this research, and for all of the work that they do to fight for the wellbeing and empowerment of their neighbors. The first contribution of my relationships with Resident Researchers to this dissertation is that without them, I would have quit well before any of this was written.

Though I am passionate about research and pedagogy as central aspects of transformative urban planning, and though I have been extremely fortunate to have supportive mentors and peers, I have found academia as an institution to be frustrating, disappointing, and often objectionable. Academia's white supremacist elitism, its exclusivity and biases with respect to what and whose knowledge is considered valid and valuable, its rapid precarization under neoliberalism, and the role of universities in facilitating harmful processes of urban change for profit are just some of the ways that I see the institution as detrimental to the public good. I am a white person from a wealthy family and thus have been spared most of the direct personal effects of institutionalized racism, xenophobia, sexism and classism that reprehensibly define the experience of

academia for many. Nevertheless, I have experienced some of the many ways in which these patterns detract from the health, wellbeing and fulfillment of friends and the community at large. Similarly, I myself have experienced, and watched others experience with greater intensity, the frustration and exhaustion that comes from trying to change systems within academia in service of anti-racist, feminist, socialist or decolonial causes. On the whole I see academia in its present institutional form as detrimental to the progress of social justice, and have often felt like my time, efforts and commitments could be better directed elsewhere.

The experiences and observations behind these feelings about academia are many of the same ones that have inspired me to pursue PAR, not so much as a way to open the doors of the ivory tower, but as a way to endeavor to build systems and institutions of knowledge production outside of its walls and in service of collective liberation. And indeed, whenever I entertained the idea of giving up on my PhD, it was my relationships with Resident Researchers and other HNS colleagues who shared my values that motivated me to persist in developing my skills as a researcher. This is because they showed me not only why the work of building more democratic institutions of knowledge production matters, but how much better it can feel. PAR, and the HNS itself, is wrought with difficulties and challenges, but for me at least, the benefits of a deeply relational approach to research far outweigh the costs. And for me, one benefit of PAR, and specifically the relationships I built therein, is that it gave me the grounding and vision I needed to see my training through.

My relationships with Resident Researchers and other HNS colleagues gave me a sense of balance with respect to the demands of academia relative to the rest of life that was crucial to keeping me afloat and focused over the course of my doctoral program. I felt privileged to have such a rich and supportive community of people who shared my values outside of the walls of academia with whom I felt at home and to whom I could be accountable with my research and actions. In retrospect I am certain that I would have only felt more rudderless in my development as a scholar without the relationships I have built through the HNS. As the years and our work together progressed, a foundation of trust developed in many of these relationships. This trust has been crucial to the success of

the HNS as a whole, including processes like collaborative research design and data analysis mentioned above. With respect to this dissertation in particular, these relationships of trust with Resident Researchers and other HNS colleagues were most impactful because they made it possible for me to experiment with establishing a Community Advisory Committee and were the key ingredient in the CAC's success and contributions.

6.3.5 Community Advisory Committee

I was very fortunate to have some of the Resident Researchers whom I have built the deepest relationships with, in some cases over more than five years of collaboration, volunteer to serve on my Community Advisory Committee. The benefits of the CAC were numerous; I am grateful for the opportunity to establish the CAC and for the support and guidance I received from my mentors about how to make it effective and beneficial for everyone involved. Many benefits of the CAC mirrored and enhanced those discussed above, including accountability, balance, cross-community perspectives, and mutual support for engaging with the emotional weight of the data.

The CAC posed a somewhat similar challenge with respect to communication as the one I discussed with reference to collaborative data analysis above, and this challenge proved to be one of the greatest benefits of the CAC. Instead of soliciting feedback on submitted written drafts like I did with my academic committee, I presented my results and arguments from each analytical chapter to the CAC verbally and with slides, and sought feedback via facilitated discussion. In doing so, I benefitted from being able to draw extensively on my experience designing and facilitating collaborative data analysis workshops. After submitting my written draft of each analytical chapter, I would typically spend a total of about three days preparing a facilitation guide, script and slides to prepare for the corresponding CAC workshop. This process itself, prior to even presenting the work, was very beneficial for me. It forced me to step away from the page and away from the academic register and render my work in a different form, which in turn helped me clarify what I was trying to say and where I was still stuck or confused. Often, I learned

about what I most needed to seek the CAC's guidance on through the process of preparing materials for CAC meetings. One additional benefit of this process is that I had a ready-made and audience-tested bank of slides and scripts to draw on in preparing for my defense.

The CAC workshops differed in a key way from other academic workshop settings, where the audience typically has an academic background but is often unfamiliar with the data and study context. Instead, CAC members did not have academic backgrounds and were deeply familiar with the data and study context. This was advantageous in two ways. First, presenting to a non-academic audience at the draft stage forced me to experiment with how my theoretical ideas and arguments could be translated for different settings and audiences in a way that retained their relevance. As mentioned above, this often helped me clarify the essence of what I was trying to say. This, in turn, fed back in to my writing, and I often returned to drafts with a clearer sense of what mattered most about what I was trying to say and how to communicate more clearly about it. A clear example of this for me is the concept of "care insecurity" discussed in *Chapter 4*. I went in to that CAC meeting unsure about how to describe the pattern I was seeing in the data, and left with a conceptual framework that felt sound, clear, and useful, and which helped me explain the significance of the findings of that analysis and connect them back to larger themes like gentrification and theoretical tools like the capabilities approach.

The second advantage of CAC workshops compared to other academic workshop settings was the depth of familiarity with the HNS data and community context that CAC members had. I made it a priority to check at various points throughout these workshops about the extent to which my findings resonated with Resident Researchers' experiences in and understandings of their communities. As far as I can recall, fortunately there were no instances where CAC members said that the findings or arguments contradicted their experiences. However, CAC members made two types of contributions when discussing how the findings aligned with their experiences. The first was by identifying areas for emphasis and specificity. For example, when I presented the urban infrastructure of care framework from *Chapter 3*, CAC members explained that the components made sense and felt comprehensive but should not be treated equally, with the economic component

being of primary importance. Similarly, with respect to the typology of environmentally-dependent caregiving strategies, they specified that while the types of strategies resonated with their experience, I should be clear that these strategies were not freely chosen and instead sometimes represented caregivers' responses to constraints. The second type of contribution CAC members made when interpreting my preliminary findings through the lens of their own experiences in their communities was when they explained how the findings helped them see aspects of their communities in a new light. For example, when discussing the concept of care insecurity, one CAC member explained that it helped illuminate why gentrification felt like it was wearing down the social fabric of their community: rising care insecurity meant people had less care to extend to their community and society more broadly. Prior to this comment, I had not considered the meso-level consequences of individual-level care insecurity.

During the final CAC workshop, I facilitated a reflection conversation about CAC members' experiences on the committee, and their perspectives on how this project contributed to the HNS as a whole. With respect to the first prompt, some members explained that as readers and writers themselves, they enjoyed being able to engage in this aspect of the research process in more depth than is often afforded in other more "hands-on" HNS settings. All participants agreed that participation had felt like a valuable learning process because it afforded an opportunity to "step back" and play a more reflective role, with less decision-making pressure and more space for open discussion than most HNS workshops. They explained that through engaging with this research they were able to see patterns and connections, both in their personal lives and in their community in a new light; one CAC member described the experience as feeling like "déjà vu." Needless to say, it was rewarding for me to hear that participation on the CAC felt that way.

With respect to the contribution of this project to the HNS as a whole, I brought up the fact that I had conceptualized and carried out this analysis mostly alone, which was contrary to how we typically do things on the HNS, and asked them how they felt about that. CAC members agreed that because of the pre-existing relationships of trust described above built through our cumulative experiences working together, they were comfortable

with this and curious to see what would happen. They explained that they saw the final product as a “good match” with the rest of the HNS work, and that the focus on care and caregivers added a dimension to their understanding of the relationship between neighborhood development and community health that hadn’t been substantively considered to date in other HNS settings. One CAC member explained that the infrastructure of care framework felt like a useful resource for interpreting and responding to unexpected events or changes in their community. Others added that they felt like the research contribution was beneficial from an action perspective because it helped orient them towards what needed to be done next in their community, and how to approach problem-solving.

6.3.6 Linking Research to Action

Action is the purpose of research in a PAR framework. While I would argue that I have produced *actionable* research, and while I will eagerly support action based on this research, this study was not undertaken in response to research needs directly stemming from or serving community-driven action. The topic of caregiving was my choice based on my assessment of the body of research at the intersection of urban planning and public health. Methodological choices about data and analytical strategy were made by me in service of my own intellectual goals rather than information needs related to specific plans of action. My recommendations for future research and practice are not based on deliberation with the broader HNS Consortium, nor likely what they would collectively conceive as the most appropriate next steps. So can this dissertation still be called “PAR”?

I would argue that the answer is yes, because of how the HNS Consortium links research to action through our PAR process. The HNS has two primary mechanisms for linking research to action: community action plans, and LinCLab. During my time working on the HNS, I have helped to design and facilitate both of these processes. Community action plans are developed by Resident Researchers following each cycle of data collection, in collaboration with their Community Partner Organization and with financial support from the HNS Consortium. Community action plans serve as a means for Resident

Researchers to use HNS findings to advance goals they have with respect to healthy neighborhood development. These goals vary by community and range in focus from education and awareness to policy and advocacy. Resident Researchers in each community make choices about which HNS data they want to use in their action plans and how, and are provided with technical assistance from HNS staff to ensure that they have the data that they need and are able to share it in an accessible format. The main difference between community action plans and LincLab is that in LincLab, we strive to coordinate action across communities towards a common goal of systems change. In LincLab, Resident Researchers, Site Coordinators, and other Consortium members (e.g. from CLF, MAPC) work together to identify HNS findings that they want to take action on, develop theories of systems change, collaborate and coordinate on common actions to work towards their intended changes, and reflect together on the lessons learned through action, thus endeavoring to close the loop between learning-action-learning. Finally, I note that in addition to these two specific participatory mechanisms for linking research to action, Community Partner Organizations and Consortium members regularly draw on HNS data and findings to advance planning and advocacy agendas.

This relationship between research and action is project-specific and grounded in the HNS PAR process and theory of change; I would not expect the links between research and action to look the same in another study. Not all pieces of the HNS are equal parts research and action, and the connection between research and action in the HNS is not always a straight line. Because of the longitudinal, multi-site nature of the project and the wide range of actors involved, from neighborhood residents to planning authority staff to academic researchers, the links between research and action are a more complex process of convergence and divergence. All HNS stakeholders have their own action priorities, but many overlap with one another or are shared across stakeholders, and all relate to healthy and equitable neighborhood development. During the collaborative research design phase, participants are encouraged to reflect on these priorities when making contributions and decisions. However, the final data collection instruments, including the interview guides used for collecting the data in this dissertation, reflect these priorities, but are common across communities. Thus, action priorities converge into

research design, and diverge again in the application of that research. Members of the HNS Consortium value the balance we are able to strike between conducting research that is collaborative across contexts while remaining in service of context-specific goals. This dissertation joins this system of complex interactions between local needs and priorities and shared resources and decision-making that characterizes the HNS.

Research undertaken in a PAR framework seeks to contribute to context-specific community-driven action, but research in general is also expected to produce generalizable knowledge. Within the HNS, there is a shared understanding that different partners have different goals for the research that overlap in many ways but that also reflect institutional and systemic positionality. As an academic member of the team, my goals include producing generalizable knowledge about the relationship between neighborhood development and health, and methodological innovation in the practice of PAR. While these goals overlap and align with those of other community and institutional members of the Consortium, they are not identical. As a Consortium, we decided to support each other in fulfilling goals that are both unique and shared, recognizing that all members come to the project with different responsibilities and objectives, and we have built a relational foundation of trust necessary to support this decision. The mechanisms for linking research to action in the HNS enable us to produce research that is both generalizable and actionable without being forced to make tradeoffs for one or the other priority.

This study thus constitutes a work of generalizable research that will join the portfolio of HNS data and analyses from which Resident Researchers, Community Partner Organizations and Consortium members can draw to advance their action goals through community action plans, LinC Lab, or other endeavors. This means that they will have access to data and findings, and can call on me or other members of the HNS staff for support in applying them if need be. The findings can be used on their own, or in conjunction with other HNS research products, according to the needs and interests of those seeking to take action. As a continuing member of the HNS team, I intend to advocate for the relevance of these findings to advancing Consortium members' action goals when relevant and support their application when desired, both within the context

of community action planning and LincLab, as well as on an ad hoc basis if need be. Part of that effort will involve making the findings of the study accessible to the rest of the Consortium so that they are familiar with them when the time comes to make decisions about using research for action. Presenting preliminary findings to my Community Advisory Committee and receiving their questions and feedback has helped prepared me to be able to do so.

6.3.7 Care and PAR

My final reflection on my experience of completing this dissertation within a broader PAR endeavor is that over the course of writing it became increasingly clear to me that the process of PAR and the work of care – and planning for care – have much to offer one another. I see an ethic of care, enacted by approaching social life from the premise that we all need and deserve care, as a necessary ingredient of successful PAR regardless of the subject of inquiry. Paying attention to the needs of others, assuming responsibility for helping to meet those needs to the best of our abilities, building knowledge and competence in how to care for one another over time, and navigating power imbalances in caring relationships are crucial both for building working relationships within PAR collaborations and for ensuring that the experience of being involved in PAR helps all involved build their knowledge about how to live a good life (Tronto, 1998). From a certain vantage point, most of the successes of the HNS and the contributions of the HNS to this dissertation can be traced back to our efforts to cultivate and enact an ethic of care in our relationships with one another and with the communities we study. Such efforts took time and involved missteps and relational setbacks along the way; this meant learning from these experiences, retooling our processes and practices, and repairing relationships. To me, this is care in practice, imperfect but effortful, the production of knowledge about how to best meet one another's needs through practice.

As subjects of inquiry, care and caregiving are well-suited for PAR because these activities are the site of considerable embodied and experiential intelligence which hold great potential for application in research about how to improve experiences of giving and

receiving care and the conditions under which care takes place. Most of the most impactful contributions that CAC members made to my analysis came from their knowledge and reflections from their own experiences as caregivers in their families and communities. I believe that PAR should play a central role in planners' efforts to plan for care. Given that planning for care marks a novel approach to planning, it will necessarily entail gathering information to inform plans and actions. Planning for care has as its goal the empowerment of caregivers, and this can and should begin with shaping the knowledge upon which decisions about how to change the conditions of care are made. Moreover, as respondents' visions for community care supports reported in *Chapter 5* indicate, caregivers have rich insight into not only the forces shaping their care work, but the types of changes that would benefit them and people like them. Planners and researchers can bring their skills, relationships, power and other assets into the PAR process, but must be careful to do so in ways that empower rather than marginalize caregivers' knowledge of and control over the forces shaping their circumstances. If they can manage to do so, PAR has the potential to be an important vehicle for the solidarity between professional planners and "kitchen table planners" that is fundamentally necessary to enhancing community control over the means of social reproduction, a crucial task for fulfilling the promise of the healthy and livable city.

6.4 Planning for care: The promise of an infrastructural approach

Based on my findings that the urban environment shapes the work of caregiving in ways that are inequitable, can be harmful, and contribute to the broader crisis of care under capitalism, I argue that it is time for urban planners to take care seriously as a matter of planning concern. While a few planners have recently begun to discuss what planning practice with a more caring disposition might look like; and while many planners have called attention to the ways that the production of urban space produces racist, sexist and classist inequities in who is able to access and benefit from the affordances of cities that help explain why cities shape the work of caregiving the way that my findings show they do; to date planning lacks a framework for attending to and intervening in how care works

in cities. In this section, I sketch out some ideas about what such a framework could entail, why doing so would not only be within the scope of planning but contribute to a range of planning goals, and how planning for care might look in practice.

I propose that “planning for care” involve the production of plans and planning knowledge that prioritize care as a central outcome of interest, and planning interventions that seek to both alleviate and equitably distribute the burden of care work. A central strategy for doing so should be to alleviate the articulation work that cities force caregivers to perform in order to make care possible in the absence of more robust urban infrastructures of care. Accordingly, I recommend that planners take an infrastructural approach to planning for care, treating the urban environment as a social and material technology that makes care possible. Planners are deeply familiar with infrastructural approaches to addressing urban challenges, such as mobility and sanitation. Many planners also concern themselves, in research and in practice, with how urban life is shaped by infrastructures like those for energy or food distribution, and how urban plans and policies can contribute to making these infrastructures better meet the needs of urban residents. And, as planners become increasingly concerned with the relationship between cities and health, we are also turning our attention to how these and other infrastructures that undergird urban life become embodied and with what effects.

Infrastructure is thus familiar terrain for planners, and infrastructural approaches fall well within the realm of how we as a field understand and intervene in cities. Moreover, as the previous chapters in this dissertation show, infrastructure is an empirically-grounded and analytically useful framework for understanding how urban environments shape caregiving and with what results. The urban environment comprises a key background condition that makes care work possible and shapes the possible forms it can take. There are specific components of the urban environment – some physical, some social, some economic – that matter for enabling care work, both in terms of their quality and in terms of the connections between them and how they are organized in urban space. It is possible to assess how these components and the relationships between them change as cities do, and to evaluate how well, where and for whom these components are enabling care to work. The characteristics of the urban infrastructure of care can expose

people to harm and health risks, or help buffer against threats and challenges to health and wellbeing. Finally, the infrastructure of care is something about which all people in cities have experiential knowledge and for which most have visions and desires, thus making planning in this domain particularly amenable to participation and community engagement. For all of these reasons, an infrastructural approach holds promise for planning for care.

What might an infrastructural approach to planning care look like in practice? I see it as entailing coordinated interventions and investments in the urban infrastructure of care that focus on improving the availability and quality of key components of the urban infrastructure of care, and ensuring robust connections between them. Precedents for such approaches include place-based, comprehensive community change efforts like the U.S. Department of Education's Promise Neighborhoods program, or the coordinated efforts of healthcare providers in Central Brooklyn to address the social determinants of health inequities through community development and built environment interventions guided by PAR (MIT CoLab, 2019). Efforts to invest in the urban infrastructure of care should be guided by two primary and intertwined objectives, according to which progress could be evaluated. The first is the reduction and more equitable distribution of the amount of articulation work, or infrastructural labor, that individuals must undertake to ensure that good-enough care is possible given the conditions of the urban environment. The second is the degree of freedom that caregivers have to care in ways that they value, and the range of possible forms that care can take. The goal of planning for care is not to favor or encourage specific forms of care, but to expand the possibilities for care and caregivers' freedoms to take up these possibilities. Following the capabilities approach, it is through the expansion of real freedoms vis-à-vis the ability to give care that investing in the urban infrastructure of care can enhance wellbeing.

In order to determine how to invest in the urban infrastructure of care, I recommend that planners focus attention to caregiving strategies undertaken by people in their communities. Caregiving strategies as I have conceived of them in this project illuminate (a) what caregivers are actually trying to accomplish, (b) how they are trying to accomplish their goals from among the possibilities available to them, and (c) how the

urban environment contributes to or hinders these strategies. By looking only at the infrastructure of care itself, planners risk making interventions that are misaligned with what caregivers are actually trying to accomplish and instead reflect the interests and values of other actors. Similarly, looking at caregivers' goals doesn't provide a clear enough picture of how the urban environment influences caregivers' abilities to fulfill these goals. It is only by focusing on strategies – the work itself – that planners can understand what works, what doesn't, and how the urban environment produces uneven burdens of infrastructural labor. This way, interventions can be focused on shifting the burden of infrastructural labor in caregiving strategies from caregivers to the city itself, thus expanding the range of caregiving possibilities rather than prescribing caregiving possibilities.

Based on my findings about caregiving strategies, I will briefly try to illustrate what planning for care – and specifically planning to reduce the amount of infrastructural labor that comprises the burden of care work -- could look like in two key domains of the urban infrastructure of care: private space (housing) and economic opportunities.

With respect to housing, my data showed that finding, affording, and maintaining good-quality housing commensurate with their dependents' developmental needs required a considerable amount of work on behalf of low-income caregivers. This work reflected the ways that neighborhood- and regional-level housing markets were unable to meet their needs as caregivers for stable, healthy housing. This is a classic planning challenge. My data shows that planning interventions to alleviate the burden of caregivers' labor devoted to housing should address issues of affordability, stability, quality and design. In terms of housing affordability, planners must take into account the devaluation of care in the economy writ large as a key factor shaping why people have difficulty affording housing and how much housing should cost them. The unaffordability of housing in the Boston area was a key factor undermining respondents' residential stability, for two ways: because it raised the risk of displacement and deepened feelings of displaceability, and because it made it harder to make affirmative moves in line with changes in one's caregiving responsibilities or dependent needs. Housing instability, displacement, and homelessness all produced "care binds" and health setbacks for caregivers in this sample.

Often, the only housing that respondents could afford was of poor quality, which caused respondents stress and made it more difficult to preserve their and their dependents' health. Thus, planners must ensure that interventions to enhance housing stability and affordability for caregivers also enhance the quality of housing they have access to. The most effective way to provide affordable, stable, and adequate housing is not via the market. Rather, planners and policymakers should focus their efforts on fighting to vastly expand the provision of social housing, in line with policy proposals like the Homes Guarantee, the Social Housing Development Authority, or the Green New Deal for Public Housing (Baiocchi & Carlson, 2020; D. A. Cohen et al., 2019; Harrison & Kraemer, 2020; H.R.5185 - 116th Congress (2019-2020), 2019; People's Action, 2019). These efforts hold the most promise for reducing the articulation work caregivers must perform vis-à-vis housing because they both decommodify and invest in it.

With respect to economic opportunities, my results showed that low-income caregivers felt to a great degree like they were excluded from both existing and forthcoming economic opportunities in their communities, and felt considerable economic insecurity. From the perspective of economic development planning, I have four recommendations. The first is for planners to strive to ensure that jobs created through urban economic development can accommodate the various needs of caregivers, for example via flexible scheduling and part-time opportunities, as well as with livable wages. The second is to prioritize expanding the local care workforce itself, given many caregivers' interests in contributing to care at the community scale and the skills they possess in this regard. Third, with respect to both of these strategies, planners must fight to ensure that new jobs are good jobs with livable wages. Finally, on a more conceptual level, I recommend that planners expand their understanding of the meaning of 'economy' in economic development to accommodate the fact that social reproduction is crucial to the functioning of any economy, and thus account for it and value it on equal terms as they would production in decisions about economic development for that economic development to truly be equitable. Broadly speaking, it is imperative that planners take all of the steps they can to reduce the economic precarity of low-income caregivers in cities.

Having made these recommendations, I would also argue that what to do to enhance the infrastructure of care in a specific context cannot be pre-determined and cannot be determined by planners alone. It is imperative that caregivers play a central role in the process through which decisions about investing in the urban infrastructure of care are arrived at, including in producing the knowledge about local infrastructures of care based on which such decisions are made. As I suggested in the previous section, PAR holds promise as a means to empower caregivers in the process of planning for care. To disempower caregivers in the planning process would only perpetuate the stratification of social reproduction. However, to empower caregivers in the planning process would mean tapping into an invaluable source of insight into how the urban infrastructure of care works – what the most important components are, how they do or don't fit together, and the way they give shape to what the work of caregiving entails. Caregivers also have valuable insights into how urban infrastructures of care can be improved, as my findings in *Chapter 5* show. Moreover, empowering caregivers in the planning process would provide the grounds for building solidarity between planners and caregivers who are, as I argued in *Chapter 1*, the “kitchen table planners” of the world (Sweet, 2015). This solidarity would ideally serve to broaden and deepen the base of power planners have at their disposal to enhance and proliferate the means of social reproduction, and building such power will be necessary to building more robust urban infrastructures of care because of the obstacles we are likely to face in endeavoring to do so.

The biggest challenges in planning for care are ideological, and thus also concern power and resources. These challenges are making care visible and making care valued (Miraftab, 2019). In practice, making care visible and making care valued entail a large-scale effort to incorporate matters of care into the knowledge we produce and use to intervene in cities, and endeavor through planning interventions to accord value (materially and ideologically) to caregiving as a fundamental form of work upon which our survival depends and without which cities do not function. A key part of this will involve changing and developing our understanding as planners of the scales at which care takes place, moving beyond treating care as a matter of private concern that takes place in the private sphere. Geographers and anthropologists have extensively

documented the myriad ways in which care takes place in all manner of spaces, and the ways in which the distinction between public and private space obscures more than it reveals when it comes to understanding care. In this dissertation, I have demonstrated the many ways in which care takes place at the scale of the neighborhood and city itself, and argued that the urban is a scale at which we need to understand care as taking place. However, the production of scale and our ideas about the differentiation of space is a social process, one governed by the structures that shape how we interact with each other in space, and thus a matter of politics (N. Smith, 1992).

The Biden administration's recent attempt to incorporate care investments into their proposal for infrastructure spending illustrated the broad and potent appeal of infrastructural approaches to care, but their failure illustrated how the interests of those most powerful, and capital itself, are aligned against changing how we understand the taking-place of care to be organized and how much we value care (Tankersley, 2021). As above, so below, as the history of the subordination of social reproduction to the rewards of capital accumulation in the production of urban space that I outline in *Chapter 2* demonstrates. Planners will have to work against the assumptions that care has minimal value, and that what value it does have can readily be exploited in service of capital accumulation, that are ingrained in capitalist ideology as well as cities themselves. This will be an uphill battle, and a matter of amassing enough power to resist and overcome the gravity of the ideological and material interests invested in maintaining the devaluation of care under capitalism. As I argued in the introduction, the only way that this seems possible to me is by beginning to align ourselves and build solidarity with the "kitchen table planners" of the world fighting against the seizure of the means of social reproduction and for their proliferation (Harney & Moten, 2013; Sweet, 2015). This is why it is imperative that we plan for care in ways that center and empower caregivers and result in them gaining greater power over the urban conditions of social reproduction.

These obstacles are obviously considerable given that they pertain to structural aspects of the capitalist political economy, but I contend that the scale of the threat that the crisis of care poses to urban livability now and in the future leaves us with little choice, and moreover that what we stand to gain from learning to plan for care holds

tremendous promise for helping us navigate pressing urban challenges like aging, pandemics, migration and displacement, racial justice, and climate resilience and adaptation. These challenges necessitate both robust urban infrastructures of care and healthy and empowered caregivers. Taking an infrastructural approach to care can help planners make care visible and value care, by helping us see all the ways that care takes place in and through the urban, and all the ways that care is what makes urban life livable. It has the potential to change transform what we understand cities to be for, and see the stakes of planning and development decisions in a new light. Next, I want to briefly illustrate how planning for care might help advance three important planning agendas, planning for health equity and abolitionist planning.

6.4.1 Planning for care as part of planning for health equity

Planning is increasingly touted as a tool for improving public health, and I have argued throughout this dissertation that planning for care is an essential component of planning for health because health is inextricable from care all across the life course. The care we receive shapes how we develop and how we age, and how we are able to navigate, adapt to and recover from the physical and mental health challenges we may face along the way. Professional care we receive in institutions like hospitals, community health centers, or long-term care facilities is just the tip of the iceberg of the care we depend on. We must conceive of planning not only as preventive medicine, intervening in the conditions that make people sick in the first place, but also as a tool for intervening in the conditions that shape how people can care for one another and adapt when they do face health challenges. In this way, planning for care may also open up new connections between planning for health and “therapeutic” or “restorative” forms of planning focused on community healing (Sandercock & Attili, 2014; Schweitzer, 2016).

As planners become more involved in planning for health, it is crucial that we focus our efforts on planning for health equity first and foremost. Health equity is the commitment to reducing disparities in health and its determinants, and is central to the broader project of social justice (Birn et al., 2017; Sen, 2002). Health disparities and their

determinants are rooted in the broader social, political and economic structures that produce racial, gender, and class inequities (Birn et al., 2017). This includes the devaluation of social reproduction and the contradictions in capitalist systems that produce crises of care, as well as their consequences for the unequal distribution of the burden of social reproductive labor (Bhattacharya, 2017; Fraser, 2016; Mullings, 2005). It thus follows that by planning for care in a manner that increases the value of social reproduction and care, empowers caregivers, and contributes to alleviating the crisis of care by shifting as much of the burden of care work from the shoulders of individuals to the city itself, stands to contribute to reducing health disparities, and thus advance health equity, by reducing racial, gender and class inequities in this crucial domain of life. As I have demonstrated, the capabilities approach is one useful tool for evaluating the contribution of planning for care to health equity because it focuses our attention and efforts on the expansion of freedoms vis-à-vis caregiving.

6.4.2 Planning for care as part of climate adaptation and resilience

Climate change is one of the most pressing equity, livability and health issues facing cities today, and adapting the built environment, infrastructure and urban economies to the threats and challenges climate change portends is an urgent task for urban planners (Chu et al., 2017; Goh, 2020; Shi et al., 2016). Climate change threatens to render cities less livable by damaging or undermining components of the urban infrastructure of care like housing and public spaces, and straining the connections between them, as the lasting effects of disasters like Hurricane Katrina, Sandy and Maria in the U.S. show. At the same time, climate change and associated socio-economic and political factors are already catalyzing a growing wave of mass displacement and migration worldwide, with enormous implications for urbanization and demands on urban resources (Kumari Rigaud et al., 2018; Lustgarten, 2020). Climate change is a defining spatial and social justice issue for our time, and attending to and planning for care will be key to planners' efforts to maintain and enhance urban livability in the face of this challenge.

“Care work is climate work,” claims a recent headline (Aronoff, 2021). “A low-carbon economy will be built by nannies, caregivers and house-cleaners,” states another (Isser, 2019). The argument that these and other authors and activists have made is that changing how we value care must be central to the type of economic transformation that can reduce greenhouse gas use, scale up clean energy production, build green infrastructure, and ensure that the economic rewards of these transformations are equitably distributed and benefit the communities who have suffered most from environmental racism and injustice (Palladino & Gunn-Wright, 2021). Valuing care and empowering care workers is increasingly seen as a key strategy for both enhancing our ability to adapt to the disruption and destruction of climate change, repairing and healing from its harms, and addressing its underlying causes in the capitalist mode of production (Klein, 2020). Planners have an instrumental role to play in these efforts: by taking an infrastructural approach to planning for care, we have the power to change how care is valued in decisions about how to adapt and improve the built environment, and in the work undertaken to carry these changes out. We can strive to ensure that communities have the best possible conditions under which to care for each other and for their environment in the face of threats and uncertainty. Due to the role of stratified social reproduction as a key axis of inequality in cities, doing so will in fact be essential for ensuring that adapting to a changing climate advances, rather than hinders, the work of advancing racial, economic and gender justice.

6.4.3 Planning for care as part of abolitionist planning and reparations

Freedom and constraint over the possible forms life can take were major themes in this dissertation. Not only was this the primary axis along which the urban environment shaped the work of caregiving, but the underlying concern of how I defined wellbeing in terms of the capabilities approach. The history of the social organization of care in this country, and the distribution of power over reproduction, has been one characterized by racist coercion, disempowerment and dispossession, in large part because of the origins of the U.S. political economy in chattel slavery. Displaceability and care insecurity were

intertwined features of the slave trade, through which enslaved people were denied the right to establish and maintain family relationships; experienced reproductive coercion and harm; and faced forced separation of parents, siblings, partners and children (Glenn, 2012; Roberts, 1998). Care insecurity has been perpetuated through urban plans, policies and processes like redlining and segregation, predatory lending, urban renewal, the drug war, mass incarceration, austerity urbanism, and as my results show, gentrification. The production of urban space, in which planners have been complicit, has generated and maintained racist inequities in life chances upon which racial capitalism is premised through processes of “organized theft and organized abandonment” (Porter et al., 2021, p. 116). Recently, some planners and geographers have begun to explore the role of spatial projects in the broader effort to make reparations to Black community, a central aspect of which involves the abolition of prisons and policing (Heynen & Ybarra, 2021; Inwood et al., 2021; UCLA Abolitionist Planning Group, 2020; R. A. Williams, 2020). Public health practitioners have also begun to call for their field to ally with the cause of abolition (Clayton-Johnson et al., 2021; Deivanayagam et al., 2021).

I see planning for care as holding potential to contribute to reparations and abolitionist planning in at least three ways. The first is by endeavoring to stop the cycles of displaceability and care insecurity to which Black people in America have been subjected. Only through an infrastructural approach to care that takes seriously the stability and security of housing as a necessary and central component of the urban infrastructure of care can planners address both displaceability and care insecurity at once. The second is by laying the groundwork for community safety without policing or prisons. Abolitionist activists and scholars in planning and public health have highlighted that just as much as abolition requires dismantling harmful systems, it involves creating networks of care through which community safety can be ensured, and investing in housing, social programs, community resources, harm reduction, food security, and economic security (Critical Resistance, 2004; Deivanayagam et al., 2021; Kaba et al., 2021). Third and finally, investing in urban infrastructures of care can help ensure that communities have robust resources through which to undergo the process of addressing historical trauma and repairing its harms.

6.5 Conclusion

Care and social reproduction require planners' attention, skills, resources and power. For too long, these issues have been neglected by planners, and planning has contributed to the obfuscation and de-valuation of care work in ways that have contributed to social and economic inequalities along lines of race, gender and class in cities and across our society as a whole. Care is material and relational work that depends on the context in which it takes place. In this dissertation, I have demonstrated that caregivers depend on the urban environment in order to meet their dependents' needs and ensure their own wellbeing. Urban environments afford caregivers infrastructures of care comprised of components like housing, public space, social cohesion and resources that caregivers rely on to accomplish key caregiving strategies like managing dependents' relationship to the environment and preserving their health. However, these infrastructures are unplanned and unevenly developed: the necessary components of urban infrastructures of care are often inadequate and the connections between them are often weak. Under such conditions, caregivers often find themselves in "care binds" where they are forced to make sacrifices or tradeoffs with respect to resources, capacities, opportunities, goals, and wellbeing in order to fulfill their caregiving responsibilities. Thus not only is care dependent on the urban environment, but the urban environment constrains the possible forms care can take.

As cities change, for example via gentrification, so too will urban infrastructures of care. For caregivers, these changes are both material and experiential: feelings of exclusion or empowerment with respect to the urban infrastructure of care matter just as much as the concrete changes that take place in shaping what forms of care are possible and what toll they take on caregivers to carry out. When the production of urban space renders the urban infrastructure of care unstable in ways that jeopardize people's ability to give care in ways that they value, as is the case with gentrification in the HNS neighborhoods, they can experience "care insecurity." The consequences of care insecurity can include disempowerment, a loss of control, diminished resources and

stress, as well as increased cognitive and material care labor. Care insecurity and its' consequences have historically been unevenly distributed across urban space and this pattern continues into the present. The production of care insecurity for low-income caregivers and caregivers of color, for example via cycles of disinvestment and gentrification, may contribute to economic precarity and vulnerability for these caregivers on the one hand, while contributing to capital accumulation for those who profit from the production of urban space on the other.

Care plays a crucial role influencing the health not only of those receiving care, but those who perform it; care is thus a crucial ingredient for achieving community health. Stress is a well-recognized consequence of high caregiving burdens and changes in the circumstances of care. My research has shown that changes in the urban infrastructure of care can become significant caregiving stressors when they pose threats, harms or challenges to caregivers' ability to fulfill their caregiving goals, or when they undermine the buffers and coping mechanisms available to caregivers to deal with such stressors. The cumulative impacts of caregiver stress can raise the risk of numerous health challenges, over the life course and across generations, and may compound other sources of stress rooted in unequal social structures such as racism, discrimination or exploitation. Caregiver stress is thus an important urban public health concern, all the more reason to incorporate planning for care into efforts to plan for health and health equity.

Protecting and creating public health and achieving health equity are important goals for planners, and I am encouraged by the continued growth of efforts to understand how to do so through research and practice. However, we are certain to fall short of these goals if we neglect care in how we learn and act. Care is not only the most important ingredient for health, but the political economy of care and the stratification of social reproduction are central factors upholding the social and economic inequities along lines of race, class and gender that are fundamental to the distribution of health and disease across the population. Making care visible and valuable in how we seek to change the urban environment is crucial for health equity, as well as racial and gender justice in cities. Doing so will also be crucial to the success of transformative planning efforts to adapt to climate change or abolish prisons and policing to build new forms of community care and

safety. Our goal as planners in making care visible and valuable should be to proliferate possibilities for, and possible forms of care, and maximize peoples' freedoms to give and receive care in ways that they value. This is a daunting task, but the stakes are high and the choice is clear and classic: people over profit. We can either build a world where care proliferates, or one where neglect does. Perhaps today or maybe tomorrow, you or someone you love or someone they love will need care to live as well as possible. When that need arises, will care be scarce or abundant? The answer to this question defines the livability of cities and their contribution to human flourishing, and thus must be the measure of the social, economic and political value of our work as planners.

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Appendix 1: Round 1 Interview Tool

Neighborhood and Belonging
- Can you tell me about why you live in ____[Neighborhood]____? - Do you like living here? - Do you have relatives nearby? - Do you consider any of your neighbors to be good friends? - Do you ever get together with people in your neighborhood? - Do you belong to any community organizations or clubs here? - Are you involved in any projects or efforts to make your community better? - What do you feel like you have in common with people in your neighborhood? - How are you different? - What do you like most about the neighborhood? - What do you dislike most about the neighborhood? - How has living in this neighborhood shaped your life? - Do you feel like people in your neighborhood are connected to one another as a community? How? Why/why not? - What do you think is the biggest change or challenge your community is faced with right now? - Do you want to continue living in ____[Neighborhood]____? Why/why not?
Housing
Can you tell me the story of how you ended up in your current house?
Renters
In the past five years, have you ever felt like you were treated unfairly as a tenant?
People with children under 18
- So you said on the survey that you've got kids. Can you tell me a bit about what your family likes to do together? - Do you ever face any barriers to doing this? For example, is it ever hard to find the time or the money?
Health
- Can you describe for me your state of health these days? - And how are you feeling about your health? - What does health mean to you?

3. In what ways does your home and your life there affect your health? What about your neighborhood, how has it shaped your health?
4. Is there anything you would change about your home and/or your neighborhood that would have a positive impact on your health?
5. What are some of the decisions you make to protect your health and wellbeing?
6. Have you had to make any tradeoffs or sacrifices for your health? Which? How did you decide?

Prioritization

1. On the survey, you mentioned that ___[Priority]___ is your top priority right now. Why is that?
 - 1.1. How do you set your major priorities?
 - 1.2. Which of the most important priorities in your life have been difficult to fulfill? Why?
 - 1.3. When in your life have your most important priorities changed significantly? What happened?
 - 1.4. Does living in your neighborhood help or hinder your efforts to fulfill your most important priorities?
2. What do you think your biggest challenge will be over the next 5-10 years? How do you think you might manage it?

Work and Employment

1. **[If working]** What do you do for work?
 - 1.1. How long have you had that job?
 - 1.2. Are you hoping to keep this job for a while or are you looking for something different? Why?
2. **[If unemployed]** Are you looking for work?
 - 2.1. [If yes] Do you have a sense of the type of job you're looking for?
 - 2.2. What type of work have you done in the past?

People experiencing financial insecurity

1. On the survey, you reported some trouble being able to cover monthly expenses and bills. Does your financial situation feel [insecure/unstable]?
 - 1.1. What do you think the origin of this financial [insecurity/instability] is?
 - 1.1.1. Do you feel like the most important factors have to do with decisions that you made, or with factors out of your control?
 - 1.2. Can you think of ways that your financial situation may have had an impact on your wellbeing?

Social Connection and Support

1. First, can you tell me who are the people in your support network, the people you turn to to discuss important matters or when you need a helping hand?
2. Next, I want to ask you a few questions about people in your life who take care of you and your wellbeing in one way or another. So to start, can you tell me about who in your life plays a role in looking out for your wellbeing?
 - 2.1. Where do they live? Are they a part of your day-to-day life?
 - 2.2. What parts of your life are they usually paying attention to?
 - 2.3. What types of emotional support are [these people] able to give you? What are they good at? Can you give me a recent example?
 - 2.4. And what about more nuts and bolts stuff like a ride or lending a bit of money - when have [these people] stepped in to support you? What are they good at? Can you give me a recent example?
 - 2.5. Overall, how do you think [these people's] efforts to look out for you and support you have shaped and influenced your life? Have they had an impact on your health?
3. Now I want to ask a similar set of questions but about your role in other people's lives. Can you tell me about who else in your life you're looking out for, in terms of their overall wellbeing or specific things?
 - 3.1. And what parts of their life are you usually keeping an eye out for?
 - 3.2. What types of emotional support are you able to give [these people]? What are you good at? Can you give me a recent example?
 - 3.3. And what about more nuts and bolts stuff like a ride or lending a bit of money - if you're able, do you ever step in and help with things like this? When? What are you good at lending a hand with? Can you give me a recent example?
 - 3.4. Overall, how do you think your efforts to look out for and support [these people] have shaped and influenced their lives? What sort of impact do you think your efforts have had on their health and wellbeing?
4. What's a service or program or resource that you wish was present, or that would have made your life easier or better at some point?

Ownership of Change

1. You said that the changes you see in [X and Y] will make your life better; can you say more about what type of improvements you expect to see, and how you think they will impact your life?
2. You said that the changes you see in [Y and Z] aren't going to make your life better; can you say more about why you feel like these changes won't benefit you?
 - 2.1. What does it feel like to see changes happening in your community that don't seem like they will improve your life?
3. You reported that people in your community [are/are not] able to influence most of the changes that you've seen.

- 3.1. [If are] What is their impact?
- 3.2. [If not] Why? Have there been failed efforts, is there a lack of resources, or another issue preventing the community from having a say?
4. Who [else] is influencing the changes you see? Who or what is driving these changes?
5. Overall, do you feel like the changes in your community are fair to people like you? Why/why not?
7. How have these changes affected the identity of your neighborhood? Why?

Stability

1. Sometimes in life, people feel like they've really got things under control and can easily handle their current financial, family, housing, school, health, and job situations. Other times, people feel like things are barely being held together by a thread, and that any unexpected problem could make everything fall apart. Or folks can be somewhere in the middle.
 - 1.1. How would you describe your current situation these days?
 - 1.2. Has there been a time in the last 2-3 years when something unexpected happened that threw things out of whack for you? Can you tell me the story about how it happened and how you dealt with it?

Sense of Control and Direction in Life

1. Do you feel like people have a good sense of who you are and what you have to offer?
2. What do you wish that people could know about you?
3. Do you feel like you have momentum in your life these days?
4. Do you feel like there are opportunities for you to grow in your community?

Wrap-up

1. How has participating in the survey and interview felt for you? What does it feel like to be asked these sorts of questions about your neighborhood and your wellbeing?
2. Is there anything else you would like to share about the changes you're experiencing in the community that you think is significantly connected to health?

Appendix 2: Round 2 Interview Tool

Opening and catch-up	
Checklist	
☐ Major life updates	☐ Personal growth
☐ Notable challenges	☐ Reflections on wellbeing
Questions	
1. How have you been since we last spoke a year ago? 2. Have there been any big changes in your life over the past year? a. [Any relevant catch-ups, e.g. kids, parents, moving] 3. What problems or issues in your life are you currently trying to solve? 4. How do you feel like you have changed as a person over the past year? a. How have your goals or priorities changed? 5. Since our last interview, have you been thinking about the relationship between your wellbeing and your neighborhood? If so, how?	

Pace of Life	
Checklist	
☐ Description of pace of life	☐ If change, what happened?
☐ Whether/how pace is changing	☐ If no change, what's in the way?
Questions	
1. Last time we talked, it sounded like you [were really busy/ had a lot on your plate/were looking for more to fill up your day/had plenty of time for yourself...]. How about now? Have things felt just as [hectic/busy/calm/slow...]? 2. How would you describe the pace of your life these days? [By pace we mean the tempo, speed and/or rhythm of your day-to-day life in general] a. How do you feel about it? Why? b. Have you made any sacrifices or tradeoffs as a result of the pace? 3. And it sounds like [that is a big change/that's the way things have been for a while now]. Do I have that right? 4. [If recent change] Can you tell me how this big change happened? a. Did this change come at a cost, or provide you with some benefit? b. How did it affect your relationships with the people closest to you? c. How did it affect your health? d. What did it take to adjust to the new pace? 6. [If not] And are you happy with the fact that things have stayed this [busy/rushed/relaxed/slow], or are you looking for a change? a. How does that feel? b. What changes have you been hoping for or working toward? What happened? c. What are you trying to do about it? d. What's getting in the way of change/ keeping things the same? 7. [If balanced] Balance is rare! How do you manage that?	

Immigration	
Checklist	
☐ Migration story ☐ Persistence (or not) of challenges	☐ Experience as immigrant in community of residence
Questions	
1. When we last spoke, you mentioned that you moved here [when and from where]. Can you tell me the story of what it was like to move here? - What has it taken to feel like you and your family were settled and oriented? - Do any of these experiences/challenges/patterns continue today?	
2. How do you think immigrating, and living here as an immigrant, has shaped your health and wellbeing?	
3. What's it like living in [community] as an immigrant now? - Do you think you have it better or worse than people who were born here? - Why?	

Living in the Economy	
Checklist	
☐ Perception of local economy ☐ Recent changes in local economy	☐ Perception of recent changes ☐ Effect of changes on life and neighborhood
Questions	
1. How do people in your community make a living? What do people do to make ends meet?	
2. What types of financial challenges do you notice people in your community facing? - Why are people being faced with these challenges? - Do you think it's the same in other neighborhoods or are things unique here?	
3. In the past few years, have you noticed any big changes in the neighborhood's economy – for example, who's running the businesses around here, how people do business, or the kinds of jobs that people do? - What do you think of those changes? - Why do you think these changes are happening? - Have any of those changes affected your life? - Have your daily routines changed? - How have they shifted your priorities/what you are planning for or working toward? - What feels like it's in/out of your control? - Have you had to make any sacrifices? - Do you feel like these changes are benefiting you? How? - How have these changes affected the way you think about your neighborhood?	

Access to Resources	
Checklist	
☐ Community center brainstorm ☐ Resource needs	☐ Resource access experiences

Questions

1. If you were to design a new community center for your neighborhood, what would it be like? What would be offered, why? Who would go there, what would they do?
2. Were any of those ideas coming from experiences you've had trying to access resources in your community? Can you tell me about that?
 - a. What's it like accessing and using the resources you need here in your community?
 - b. Are there resources you have difficulty accessing? Why?

Financial Security

Checklist

☐ Sense of financial situation	☐ Strategies to make ends meet
☐ Changes in cost of living	☐ Financial goals

Questions

1. How are you feeling about your financial situation these days?
 - a. What's getting more difficult? What's getting easier? Why?
 - b. What parts of your financial situation feel like they are in or out of your control?
 - c. Are you an outlier? Or is this happening to everyone you know?
 - d. Do you talk about this with other people?
2. How has your cost of living been changing?
 - a. Is your income keeping up with the changes in your cost of living?
 - b. What sorts of changes have you had to make as a result – for example how you shop?
 - c. Are you an outlier? Or is this happening to everyone you know? Why?
3. What sorts of things do you do to help stretch your resources when money is tight?
4. What are some of your big financial goals? Why? What will it take to achieve them?
How do you think achieving them would make you feel?

Social Support and Caregiving

Checklist

☐ Who depends on respondent	☐ Costs of being a caregiver
☐ Experience as caregiver	☐ Experiences depending on others

Questions

1. Last year you told me that [summary of who respondent supports]. Is that still the case?
 - a. How has the work of supporting/caring for them changed over the past year?
 - b. Is there anybody who's wellbeing you've taken on additional responsibility for, for example an aging parent or relative?
2. Can you tell me about your experience of being a caregiver? What types of things would you share with someone else who found themselves in a similar situation?
3. What are some of the costs associated with being a caregiver [or parent, or source of support] – whether it's money, other resources, time, relationships...?
4. How have you relied or depended on others for support over the past year?

Health

Checklist

☐ State of health and relevant changes ☐ Efforts to protect health	☐ Barriers to better health ☐ Health-environment connections
Questions 1. What is the status of your health these days? 2. Have there been changes in what you do/don't do, as a result of your health? 3. Are there any examples of things you're doing to protect or maintain your health that you could share? 4. What is preventing you from being as healthy as you want to be? 5. Is there anything about the neighborhood that makes people [kids; seniors; working people outside] sick? a. Is there anything about the neighborhood that causes people stress? 6. What about the neighborhood keeps people healthy? 7. What would you change about your neighborhood to make it healthier [for kids; for seniors]?	

Stress	
Checklist ☐ Main stressors ☐ Experience managing stress	
Questions 1. What are the main things creating stress in your life these days? Why? 2. What helps you relieve or manage your stress?	

Housing	
Checklist ☐ Desire to stay in neighborhood ☐ Hypothetical housing search ☐ Sacrifice threshold	
Questions 1. How important is it for you to stay in this neighborhood? Why? 2. What would you be willing to compromise on or sacrifice to stay? 3. Say you had to look for new housing – how would you go about doing that? a. What would your priorities be? b. What do you think the process would be like? c. What would someone need to know about you and your family to be helpful?	

Neighborhood Interaction	
Checklist ☐ Changes in neighborhood social dynamics ☐ Changes in personal relationship to neighborhood ☐ Effect of changes on identity and experience of living in neighborhood ☐ Advice to hypothetical new resident	
Questions 1. What changes are you noticing in terms of how different people in your neighborhood interact with one another? a. How have these changes shaped what it feels like to live here? b. What have you learned about yourself from living through these changes?	

2. How has your relationship with your neighborhood changed over the past year?
 - a. How connected do you feel to your neighborhood? What is influencing this?
3. Say there was someone like you moving into this neighborhood for the first time, what would you tell them about living here over coffee or a meal?

Looking ahead/Wrapping up

Questions

1. What's on the horizon for you? How are you feeling about the year ahead?
2. Is there anything you want to add that you didn't get a chance to say?
3. How did the interview go for you?

Appendix 3: Variables used in hierarchical cluster analysis

Source: Unpublished analysis by Sebastian Olascoaga, 2021

The variables used for the analysis are (source in parenthesis when available):

- Percent population change. (ACS 2009-2013, 2014-2018)
- Percent change in renters who spend more than 30% of their income toward rent. (ACS 2009-2013, 2014-2018)
- Percent change in median gross rent. (ACS 2009-2013, 2014-2018)
- Percent change in units which are owner occupied (Zillow)
- Percent change in median home value (ACS 2009-2013, 2014-2018)
- Percent change in poverty rate. (ACS 2009-2013, 2014-2018)
- Percent change in vacancy rate. (ACS 2009-2013, 2014-2018)
- Percent change in total number of units (ACS 2009-2013, 2014-2018)
- Percent change in sales price between 2009 and 2019 in HNS ZIP Codes. (Warren Group)
- Average Assessed Value for homes in 2020 for HNS ZIP codes. (Warren Group)
- Number of Brownfield Sites by HNS ZIP code (EPA)
- All active Superfund Sites in HNS ZIP Code (EPA)
- All Superfund Sites in HNS ZIP code (EPA)
- All TRI permitted sites in HNS ZIP code (EPA)
- Average number of EJ Criteria for HNS Tracts (Commonwealth of Massachusetts)
- Subsidized Housing Inventory for Chapter 40B calculations. (MAPC)
- Chapter 40R laws ratified by municipality. (Commonwealth of Massachusetts)
- Number of Chapter 43D projects by municipality

- Whether municipality has a Just Cause Eviction law.