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Global care, local configurations – challenges to conceptualizations of care

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Abstract   *Driven by the increasing density of linkages between the North and South, the 'global' has increasingly been adopted as the scale at which the analysis of care occurs. However, much of the empirical work that underpinned this analysis was done at particular sites and had specific emphases that are now being adopted in the analysis of care globally. In this article, I suggest the need for empirical research from other parts of the world that informs, challenges and builds on existing theorizations of transnational care. Using examples from India, I highlight some ways in which existing care chain analysis may be enriched: by looking at the genealogies of care; and by exploring what the differences in the infrastructural architecture of care mean for how we theorize care in the context of migration. I outline some elements of a new research agenda, not just for research on India but also for recognizing the importance of heterogeneous care arrangements in a globalizing world of care.*

Keywords   CARE CHAIN, CARE DIAMOND, TRANSNATIONALISM, GLOBAL, LOCAL, GLOBAL SOUTH, INDIA, ETHICS, POLICY

In the last decade, there were intense debates on the transfer of care from the global South to the North. The geographical pole for this research has often been the global North, where a drop in the number of people actually available to do caring work accompanied the demographic pressures and attendant labour demands brought about by ageing. As increasing proportions of women, who globally predominate in care-giving, enter the paid labour force, a care deficit emerges that requires drawing in the labour of other women, many of whom are international migrants from the global South. In what has become an oft-repeated story, these migrant women leave behind a care deficit in their own households. Migrant women, however, continue to organize care in the sending context, while providing care in the destination countries. This has resulted in sophisticated analytical formulations (Razavi 2007), theoretical interventions (Hochschild 2000) and policy work (UNRISD 2006) addressing questions of distribution, recognition, value and reward for care. Asia, especially the Philippines, has provided the empirical crucible for some of this work at the intersection of

gender, migration and care regimes but the insights have formed the basis for theorizations on care *globally*. The 'global' has become an increasingly significant scale at which the provision of care is conceptualized.

However, care is adopted somewhat unquestioningly as the lens through which to make sense of the social reproduction of households, communities and economies in different, even dissimilar, parts of the world without reflecting adequately on what might be locationally specific about care in diverse geographical contexts. Thus, a variety of studies has adopted the concept of care (Datta et al. 2009**[NOT IN REFS]**), elaborated on its institutional architecture through concepts such as the care diamond (Ochai 2009) and analysed it theoretically (as through a care-chain) (Isaksen et al. 2008), without interrogating the distinctiveness that place offers to the definitions of care and how it is performed. Yet, the history of care and its current infrastructural setup varies hugely across place and affects its nature and content.

In this article, I explore two lacunae arising from this geographical insensitivity to the distinctive dimensions of care in different parts of the world. The first relates to the extension of a relatively unvariegated concept of care to the migration literature, despite the concept's different historical precedents and local configurations. Second, despite the emerging literature detailing differences in the infrastructures of care in different countries (see, for instance, Razavi and Staab 2010), there is little engagement with how these differences influence the migrant world of care. The provision of care is differentially embedded in cultural, political and economic formations such as the family, the market, the state and the community sector in different countries. The meanings of formations such as the family and the extent to which the state, market and community sector are transnational vary within and across countries. Yet, the literature detailing these differences still integrates poorly into that on migration. The concept of care chains, which provides analytical depth to understandings of global care and opens up a vital field of study, is used to explain diverse sets of situations without adequately taking on board the differences in care arrangements across the globe, or, indeed, how these differences might urge us to rethink care chains.

These issues have particular resonance when carers are themselves living transnational lives, simultaneously engaging in caring activities both in the North and in the South. The meaning of care does not stand still over these two geographical areas; and understandings of care should not be distributed and shared across different providers of care. Taking the locational specificities of the genealogies of care as a concept, and observing how care is organized, can help us to enrich global analyses of care conceptually and improve policymaking around the responsibility and rewards for caring. By mobilizing the situated experiences of the South, in this case India, I argue that a perspective from the South can contribute to conceptual, theoretical and policy measures around care. I draw on insights from the literature on India to highlight variations in the concept of care (section 3) in the configuration of care diamonds, and observe how different care arrangements articulate to care chains (section 4). However, before that I look at why the global has become a favoured scale of analysis for care (section 2). The conclusion turns to the question of why this globality itself necessitates paying greater attention to local variations.

Why is care analysed globally?

Care can be defined as the work of looking after the physical, psychological, emotional and developmental needs of one or more people (Standing 2001: 17). As such, it has an inherent spatiality – many aspects of it require co-presence because care is usually seen as the terrain of intimate relations, with the basis for caring lying in privatized gendered relationships. The pull of affective relations is strongest with those with whom you are the most intimate. However, for a number of reasons the spatialities through which care is conceptualized, enacted and regulated are altering. The global has become an important frame for care.

Feminist theorization on ethics of care has gone some distance in this context, arguing for a universalizing notion of care that should be seen as fundamental to our existence. The ethics of care was first set out by Carol Gilligan (1982) and Nel Noddings (1984) but has been adopted and adapted by a range of philosophers (Held 2006; Sander-Staudt 2006; Tronto 1993). Feminist work critiqued the individualistic conception of the self (Gilligan 1982) and of caring relations highlighting interdependency as the basis for an ethics of care, debunking the mythical autonomous subject of much sociological thinking. It highlighted how both carers and the cared-for (Beasley and Bacchi 2007; Hollway 2006) were vulnerable and how both were defined by this interdependency. Caring intersubjective relations set the basis for the production of all humans and, thus, laid the foundation for a *global* ethics of care (Sander-Staudt 2006). Moreover, feminists also relocated care from the personal to the public realm and from individuals to a universal direction for an ethical world. Both because of the constitutive nature of care in shaping every individual irrespective of location and because of the teleology of ethics that underpins this thinking, the claims that care ethics make are not localized. They stretch to encompass both how humans exist and how they should – globally. The spatial ambit of the feminist ethics of care and its emphasis on interconnectedness globalize care. That is to say, it makes the language of care available for analysing care globally.

Theorists of space too have been concerned to 'stretch' care globally, highlighting how care relationships are central to living responsibly in an increasingly interconnected world. Thus, geographers are concerned that the grounded sense of responsibility (Lawson 2007) and the 'moral motivations that emerge from an emotive and proximate connection to a particular people' (Gerhardt 2008: 914) are not dissipated with distance. Rather, they want to route those motivations into a global sense of responsibility and point out how this is already being done in charitable schemes such as 'Adopt a Granny' (Silk 2004; *Social and Cultural Geography* 2003, 2004). Hence, they suggest that the 'global' should be, and is being, productively reshaped through place-based attachments and the proximate care relations that underlie this.

There are also empirical reasons for extending discussions of care globally – most notably because of the ways in which mobility has increased distances among those who may be involved in affective relations (Parreñas 2005). For example, many older people find that they are far away from children who might have cared for them (Baldassar 2007). However, it is the migration of women that has, above all, led to the

adoption of the 'global' as the scale at which care is discussed. Concerned over the global redistribution of care resulting from female migration – migrant women from the global South care for families in distant countries of destination, typically in the North, while leaving behind a care deficit in the source countries – feminists have scrutinized what this means for care globally (Isaksen et al. 2008; Yeates 2008).

Analyses have also drawn on global theories in different ways. One move has been to draw on Marxist inspired core–periphery theories to show the ways in which global circuits of care are embedded in households, in the reproductive sector and in gender relations. For instance, Saskia Sassen (2000) suggests that the working out of the forces and processes of economic globalization (structural adjustment pro-grammes, opening up to foreign capital and removal of state subsidies) have squeezed the lives of women in the global South, forcing them to pursue alternative survival strategies. They have moved as sex workers, entertainers, marriage partners and industrial cleaners working in offices where 'the real work' of globalization is often seen to occur. Her work thus offers insights into alternative global circuits and embeds migrant women and their caring work in the globalization process. Another related move has involved theorizing care redistribution as a global care chain. The global care chain literature identifies a hierarchy of places that are involved in pro-viding care in a Northern context. The growth of the two-wage family, underlain by a shift in welfare policies from the family wage to adult worker model has catapulted more and more women into the workplace and has led to a care deficit in some households that is then filled through the care chain. Drawing on Rhacel Parreñas's work (2001) on the migration of nannies from the Philippines to the USA, Arlie Hochschild (2000) argues that such migration simply transfers the care deficit from households in the USA to households in the Philippines. The next link in the chain is generated when women move from poorer parts of the Philippines to look after the families of these international migrants. Yeates (2004, 2008) usefully compares these chains with the links that make up the commodity chain where both caring work and the affect involved in care are extracted and redistributed upwards along the care chain. However, it was increasingly realized that women were using global communi-cation technologies to continue to care for distant families, especially children. Trans-national caring practices span the globe. Transnational theories, thus, offer another perspective for theorizing care globally (Williams 2010a).

Social policy to address these issues is also increasingly being played out at a global level. Organizations such as the European Union, UNRISD, the ILO and OECD (Razavi 2007) are leading the policy initiatives on how best to stretch social policy concerning care to take account of the globality of care. Thus, UNRISD (2006) is enquiring into the multiple institutions of care (households and families, states, markets and the not-for-profit sector), their gender composition and dynamics, and the implications for poverty and social rights of citizenship (Razavi 2007) in different countries (Budlender 2008; Palriwala and Pillai 2007). The ILO has also considered the significance of care for income security and the changing mix of care provision in several countries around the world (Daly 2001). The epistemic community facilitates these transfers of policy. For instance, the attempt to harmonize global social policy

on care was also taken forward at the Commission for the Status of Women meeting in 2009 where 'the value of care as a "coin" in terms of policy Entrepreneurship' was confirmed (Bedford 2010: 15). Hence, global institutions like the OECD, whose agendas on care are being pushed through (Mahon and Robinson 2011), are increasingly leading the social policy initiatives on care. Although there are attempts made to build up knowledge of diverse care arrangements in different countries, policy making often involves either a transfer of policies from the North to the South or the identification and promotion of 'successful Southern models' by global players. For instance, the system of 'conditional cash transfers' developed in Mexico has been promoted as a model worthy of adoption in other countries by organizations like the World Bank (Fiszbein and Schady 2009). Transfers too are rarely straightforward. These transnational care discourses form another vector in the global political economy of care (Williams 2010a).

The global thus becomes an increasingly salient scale at which to discuss care. Feminist theorizations of the ethics of care, because of their attempt to embed it as a virtue and as a universal ethic, have adopted the global as their (implicit) spatial referent. Moreover, the empirical practices of giving and receiving care have themselves encompassed the world. This has led theoretical understandings of care too to adopt the global as the scale for theorizing – either phenomenologically, as in some of the literature on transnational caring, or driven by political economy perspectives, as in the work of Hochschild (2000), Sassen (2000) and Yeates (2008). Finally, policy initiatives and theorizations of policy have also moved up to the global scale, with international organizations spearheading discussions on how to organize care globally.

One implication of this globalization of care is, conversely, that we need to pay great attention to the local configurations of how the global is being made up. When intimate care is globalized, what are the genealogies that are being brought forward from all the different places that make up the globe? What are the different institutional architectures of care that are folded into the global and how should our version and vision of the 'global' take the claims of these multiple localities to the 'global' on board?[1] How is globalizing policy translated in different places in recognition of local understandings of care (McCabe 2007). Globalizing care can involve various universalist moves that embed particular visions of care. For instance, Northern research and policy-making interests in the international redistribution of reproductive labour have led much of the research on global care. It also draws on well-documented narratives of particular streams of migration, such as those from the Philippines. Other local stories have been folded into the conceptual architecture and theorizations already set in place in these global studies of care. This is problematic because it does not enable us to do justice to actual developments and realities.

The empirical bases of the theorizations had always been made clear and were appropriate to the theorization that ensued. Moreover, there have been calls to diversify this empirical base (Yeates 2008) with a resultant multiplication of the empirical studies. Thus, a number of European studies have shown how care chains operate among female migrants from Eastern to Western Europe (Deneva 2009), or

from Latin America to Spain (Escriva 2004). The different policy environments for care in diverse European countries have also been spelled out (Williams 2010a). Yet, despite the ensuing diversity of local studies that have come into circulation, empirical insights from the original care literature have failed to enrich the concepts, models and theories. There have been very few place-based interrogations of whether and how care might be differently configured in each place and, even where empirical variations are noted, they have not helped to reformulate global theorizations of care as it relates to migration. Rather, adaptation if not repetition of the insights gained from the Filipina studies have marked these studies.

The rest of this article is based on the surmise that it is insufficient simply to gather more empirical data from diverse locations; rather, we need to take on board what these different localities can contribute to questioning and expanding our conceptualizations and theorizations. This is especially important because most current analysis is based on the transference of care from one site to the other due to mobility. Migrants are the key actors in care chains but place-based analysis of care diamonds suggests that people will have different expectations, norms and ideologies of care. As a result, when migrants move they take with them their own understandings of how four elements of care architecture could or should be involved in care. These variations are particularly important in the context of care because the delivery of labour – physical, emotional and affective – involves political and economic infrastructures as well as social and cultural values and formations. In particular, they envisage the particular forms of familial care provision that influence not only how they provide care but also their own expectations of care when they return. They also influence who should be responsible for migrant carers, as well as for those who are left behind, and the nature of relationships that are forged during and after migration.

For example, Datta et al. (2010) call the values that migrants express in their care relations a 'migrant ethic of care'. However, their own empirical analysis suggests that these ethics do not necessarily arise from their migrant experience. Rather, the values and expectations that arise from the institutional architecture of care in the pre-migration situation imbue much of this ethic. Hence, *pre-migration configurations* of care and the ideas of giving/receiving are present in the sending contexts that seem to be influencing how migrants care. Yet, there is little research on this thus far. This needs further consideration in a world of globalizing care.

Migrants bring these different understandings of care – how to care, towards what purpose, who should be cared for, how care should be shared or paid for – when they move. These issues also affect how the care of those left behind is distributed and who looks after migrant carers when they are abroad. Local understandings and infrastructures of care deeply influence the claims that migrants can make in both these contexts.

Reframing the concept of care from a Southern perspective

The concept of care varies in different countries. However, the globalization of the care debate has meant that the concept has been transferred relatively unreflectively to

different parts of the global South without recognizing that in doing so one inherits the very different histories of development policy, care arrangements and gender regimes that influence the notion of care. Some of these variations in the history of care, exemplified from the Indian case, are laid out below.

First, the historical context of care can itself vary. For countries that are chasing economic development, social care has remained of marginal interest and where it exists may be targeted towards identified vulnerable groups who are seen as being left out of development. In India, for instance, government policies have funded the development of various target groups, like women, scheduled castes and scheduled tribes alongside the development of special targeted areas. Developmentalism is the normative framework that surrounds care, but because modernizing notions of development haunt such social policy programmes, 'care' may not be the frame within which the delivery of social policy is conceptualized.

The ideologies of the other major precursor to care in India – social work – reinforce the situation. For instance, social workers were one of the early groups to be concerned with the welfare of domestic workers. However, social work too was set within the modernizing rhetoric so the target was to modernize both the institution of domestic work and the domestic workers, drawn largely from rural areas, the working classes, the lower caste and tribal populations. This modernizing legacy and the normative principles inherited from social work continue to influence and shape the debates that form part of the remit of social care in other countries too (see for instance, Keezhangatte 2007). Another formative influence on care in many countries of the South has been the history of colonialism and the role of missionaries therein. Religious institutions, especially the Christian Church with its strongly professed ethic of 'compassion' and 'care', alongside its civilizing mission in the colonial project meant that it had a defining role in rearranging whom to care for and how to deliver care (George 2005). Thus, the first national survey of domestic workers, for instance, was conducted on behalf of the Catholic Bishops Conference of India in the late 1970s (Roshni Nilaya 1983). Here again, the model of care did not question the class boundaries that enable the continuation of domestic work – rather, the emphasis was on modernizing the conditions of labour, better pay and holiday entitlements. This was accompanied in many cases by sewing classes for domestic workers run by members of the church, thus leaving the rules of femininity intact. They came up against a more rights-based domestic worker movement led by feminists in interesting ways (Raghuram 1993). Thus, both the nature of the care providers and the quality of what was deemed to be care were set within very different frameworks, although these frameworks are themselves changing – neither religion nor care is fixed. For instance, in recent years the Church has become involved in organizing domestic worker unions (Chigateri 2007). One implication of this history of care is that particular teleologies, aspirations and aims, depending on who exactly inhabits the field of care, are likely to tinge the goals of care. Differences that were, for instance, apparent in the organization of protection for domestic workers in India will be taken abroad as care became globalized. The complex mixture of benevolence and rights is likely to vary across countries, influencing not only how care is conceptualized in

terms of policy but also to whom carers feel they can turn, and for what, when in trouble abroad.

Second, just as there are differences within care systems, there are also differences in who is seen worthy of care and by whom. For instance, while legislation and provision of certain forms of care existed, even in the pre-independence era (for example health including mental health), the extension of care policies to children was largely institutionalized in the post-independence period. Following the social investment model of the state, childcare has always been an important aspect of government welfare programmes in India (see Palriwala and Pillai 2007 for an overview), although this state-run provision, as in other forms of state care, is targeted at the poorer sections of society. In effect, care services have diversified in terms of quality with state-run services often seen as offering a poorer quality of services, and usually thus, taken up only by those who have few other choices. However, other groups, such as older people, are new entrants into the ambit of care by the state (Brijnath 2008) but arguably have more socially instituted mechanisms for receiving care through intergenerational power hierarchies, played out through women. When women migrate, older people not only lose carers but also lose those whose labour can be called on through these power relationships in the context of limited state-led care provision. Care policies, therefore, do not have the same remit or the same requirements as they do in other countries.

Moreover, in India different traditions of care coexist, each having different skills, accreditation processes, recognition and rewards. For instance, in the context of health care at the time of independence, there were significant differences between the experiences of different health carers. The Indian Medical Service (IMS) was at the top of the medical hierarchy in India and the forms of care that those involved in this service provided were different from that of other medical providers. There were also differences in India between allopathic and ayurvedic providers, between the government and the private sectors, and between military and civil medical services. The role of religion in therapy meant that the suite of private care providers also extends beyond the remit seen in many Northern countries and includes soothsayers and priests with different skills and abilities. Even in one of the better-regulated care sectors – health – a range of skills and caring relations are being established. When they all profess to care, how should one incorporate the different traditions of these different inhabitants of the landscape of care?

These variations mean that global social policy will have different effects in different countries. For example, states that are adopting social policies and expanding their welfare remit are doing so without going through the history of state-led welfare seen in many parts of the North. The geo-histories of care are inherently different in different parts of the world (Green and Lawson 2011). As a result, India is adopting a regulatory form of state welfare for older people in India, legislating on how care should be provided, but is not taking responsibility for the provision of elder care.

In sum, the legacy of the term care and the care systems in which care is embedded are complex and often contested so that the term care should be applied with some sensitivity to geographical context as well as historical legacy. Does the

language of care travel? Moreover, if there are limitations to how transposable care is, then does this open up the possibility that migrants who are defined as carers may not define their work as caring. Cognizant of the histories and hierarchies of care, do they rather reserve the language of care for their own familial relationships, shedding that identification in their working lives (Amrith 2010)? The differences in the *definitions*, *beneficiaries* and *constituents* of care suggest the need for mapping out the topographies of care (Katz 2001), namely that place-based knowledge about care that 'sustains and enables the exercise of power at various geographic scales' but also transcends 'the specificities of the locality in which it was gathered' (Katz 2001: 721).

Articulating care diamonds and care chains

It is not only the meanings and traditions of care that are diverse but also the infrastructures of care provision, often analysed through the concept of a 'care diamond'. The notion of a 'care diamond' has been useful for understanding the infrastructure of care, namely how care is organized and delivered. Razavi (2007) extends the terminology of the 'welfare diamond' (Evers 1996) to care in order to highlight the multiple institutions involved in its provision. These institutions are families and households, markets, communities and the state. The four institutions have different models for transacting care, although these may overlap. For instance, altruism may be the basis for families as well as the community sector, while payment may occur not only within the market sector but also between family members, in kind if not in cash. The four institutions also vary internally and compete with each other in the provision of some forms of care.

Despite this, it is analytically useful to distinguish the four nodes of the diamond. Families, the first node, are the primary source of care globally, largely providing unpaid care. Families usually provide care in the household, though the two are not coterminous. However, the family may also depend on both privatized and state-funded care in certain contexts. The second node is markets. The market has always been an important source of care, although the nature and extent of commodification of care has meant that it is an increasingly important player in delivering care. In some countries, distinctions between the market and voluntary organizations may blur. Communities, the third node, comprising not-for-profit and voluntary/third sector organizations, include a large range of providers – self-help groups based around neighbourhoods, NGOs both large and small and using both paid and unpaid resources, and volunteers working within and outside formal schemes. Both the state and the market may also provide funds to support this sector. The fourth node, the state (national, regional and local), provides funds and/or regulates care through a range of departments, for example health, social security or education.[2]

All four nodes have received considerable attention in the now extant literature on care (UNRISD 2006). However, there have been fewer attempts to map the complexities of the care diamond onto migration research on care. As outlined above, the care chain is the primary mode for analysing the transfer of care from one part of the globe to the other, but linkages between the literature on care

diamonds (which is varied and geographically sensitive) and care chains have, thus far, been insufficient.

In this section, I draw on the example of India to argue that a richer analysis of care chains requires greater sensitivity to the differences within the care diamond, to the diversity of the stratifications that surround the care diamond and to a new emphasis on the different elements that go towards making up the care. In the article, I focus on selective aspects of these differences driven by two concerns. The first is the overwhelming focus of the care chain thesis on the transnationalization of the migrant's family and the influence on it of the marketization and communalization of the state provision of care in the destination (but increasingly the sending) contexts. The second is the relative neglect of other aspects of the care diamond in the sending contexts. In this section, I therefore highlight first the extent to which diverse family forms are implicated in migration and second, the increasing globalization of other aspects of the care diamond. I suggest that sensitivity to these differences is necessary if we are to understand the complex stratifications that underpin care.

Diversifying the family

Most care-chain analyses conceptualize the migrant's family as nuclear and familial relations as predominantly altered through migration. However, the shape, size and nature of the family, its social rules and ideological dimensions as well as the interconnections within and between families all vary globally. In many countries the nuclear family may not be the norm – extended families may be commonplace (almost a fifth of families in India contain more than two married adults (Palriwala and Pillai 2011**[NO SUCH REF]**)). Women may thus be part of existing forms of care redistribution, which mean that their migration does not have as great an impact on care. Moreover, conjugal division in care provision may not be normative or ideologically important, especially in areas with high male migration.

In India, a range of factors influences the norms around who cares for whom, including lineage, where one lives after marriage, religion and type of marriage. Different parts of India have different kinship and family structures, although patriliny and neolocality, patrilocality or virilocality are the common modes of family formation. However, arguably, in Kerala (the state on which much research on migrant women has focused) family forms have been less markedly patrilineal with considerable sections of some communities (for example Nairs) practising matriliny in some form. Christian and Muslim families in Kerala, however, tend to be patrilineal so the lines of care responsibilities, giving and receiving may be slightly different. Even in patrilocal formations, urbanization has resulted in shrinking the distance between women and their natal families (whom they may easily call upon). This can lead to a shift away from patriliny to more neolocal models for receiving and giving care, increasing the role of women in the care of their natal family and vice versa. The state too has stepped in to strengthen these care relationships – in an explicit shift from the implicit rules of patriliny the Supreme Court of India ruled in 1986 legally to permit married daughters to support 'parents who cannot support

themselves' (Ramu 1989: 92 cited in Singh 2006: 385). Finally, women in arranged marriages appear to provide a stronger basis for women to make claim on their own families than those in love marriages (Grover 2009), although it is not clear how this influences migrant families.

This diversity in family forms is an important area for further research on migrant families as the transnational family forms the basis for problematizing care giving and receiving in a mobile world. As Bedford (2010) argues, these variations are crucially elided in policy discussions on care, for it is difficult to get policy agreement on issues of sexuality and diversity of family beyond the norms of the sharing couple. It is important, therefore, that academic research on migrant families identifies these diverse family forms and takes care away from normative notions of nuclear families and their conjugal relations.

Moreover, researching this diversity in family forms highlights not only differential care arrangements before migration but also the impact of the *lack* of such arrangements on causing migration. Migration may be a result of the breakdown of conjugal relations and subsequent abandonment by the rest of the family (Raghuram 2005), questioning the implicit reification and mourning of the breakdown of families that underpins some of the literature on the female migration of care workers.

Other transnational care actors

While most research on transnationalism focuses on care relations in the transnational family, the family is not the only point on the care diamond that is transnational. On the one hand, the nodes may stretch out from source countries to destination areas. On the other, transnational actors in the different nodes may influence care provision in source countries. The nodes also overlap.

The Indian state is increasingly adopting transnational strategies – including those associated with the provision of welfare for its migrant population. For example, the Kerala state government has introduced a range of policies for migrants in recognition of the importance of temporary migration in Gulf countries, one of the major receiving areas for Keralite migrants. A new pension scheme for migrants was created because the migrants' fragmented work histories in other countries meant that often they could not access work pensions upon their return. The Kerala government also offers its women migrant workers insurance through the Pravasi Vanitha Suraksha Scheme, covering the issues that women are more likely to face such as workplace harassment (when certified by an Indian consulate abroad), theft of jewellery, and death due to female-specific medical problems. Thus, the state is increasingly acting as a social regulator of care, underwriting care or in some cases providing social protection for carers in other states. The central government offers identity cards to those who register with the Pravasi Bharatiya Bima Yojana Scheme, which provides migrants insurance cover of up to Rs 200,000 (around US$ 4440) in the event of death or disability during the period of overseas employment. It also offers maternity benefits to expatriate women workers (Ministry of Labour 2003).

Transnational actors are also increasingly involved in care provision in India.

Between 1984 and 2004/5 the number of Indian voluntary associations receiving foreign funds increased from 3612 to 18,540 (over half of all such organizations in India) and the amount they received increased from 2.54 billion to 62.57 billion rupees (Jalali 2008: 169). Interestingly, a large number of organizations receiving external funding are religious. In 2001/2, five of the top ten receivers of funds were Christian organizations while two were Hindu organizations.

NGOs are sometimes seen as a threat to national security, however, rather than as contributors to development or welfare. As a result, the state regulates them through the home ministry's Foreign Contributions Regulation Division (established in 1976). The government influences all the rights to operate and nature of activities, such as the transfer of funds. An important mode of intervention is to block access to foreign funds for those who might threaten national security, or upset existing hierarchies. Consequently, organizations that favour Muslims are perhaps more likely to be designated politically problematic and to have their access to foreign funds blocked. Christians make up 2 per cent of the population but receive relatively large amounts of aid. By comparison, Muslims make up 12 per cent but receive very little. On the other hand, Christians in the politically sensitive states of Nagaland, Mizoram, Assam and Manipur also receive very little aid. The state alters the transnationalization of care provided by NGOs.

The market is the other important node in care provision. In India, it is extant in all forms of care, and indeed in other forms of social reproduction. For example, India has one of the most privatized health systems in the world – about 80 per cent of all outpatient health visits are done privately (Baru 1998, cited in Mackintosh 2007; Narayana 2003; also see Palriwala and Neetha 2011).[3] Global companies are increasingly important actors in this field. Moreover, the relative cheapness of social and health care in India is also encouraging some migration to India by older people from other parts of the world (Goering 2007).

However, because the role and acceptability of money in smoothing care relationships can vary, we need to specify exactly what we mean by marketized relations. Singh's (2006) study of the meaning of remittances in India suggests that, unlike in much of the North, money is seen as an acceptable form of gift, to have affective qualities and to be marked as an act of care. Hence, money transfers between migrants and to those who care for the ones left behind do not necessarily imply the marketization of caring relations. Parts of the state, as well as the NGO sector, are also 'marketized' because of pervasive corruption. Either patronage relations or money may be necessary for accessing public sector care. For the poor, for whom such money may be harder to access, personal services may replace cash payments, thereby exchanging formal care for informal servitude. Care relations in all four nodes may then depend on the same sets of principles – familial and communal obligation, patronage and marketization.

The findings from India highlight the spatial particularities of individual nodes of care provision, the transnationalism of all the nodes (not just the family) and the overlap between nodes arising, in part, out of this transnationalism. It suggests that there are important specificities in how the globalization of the four elements of the

care diamond is proceeding. However, this analysis has not yet been adequately tied into the global care chain analysis. The role of transnational actors begs a number of questions. What links are there between transnational NGOs and migrant women – do the former shape migration patterns by their presence and activities in source countries? What, if any, is the role of global corporations in shaping migrant care? What role does the transnational state play in providing care for migrant care workers, one of the least studied elements of the care chain (Kofman and Raghuram 2009)? What are the implications for care chains of the transnational state and its concerns about migrant carers? Are loop backs and different kinds of connections missing from our our analysis because of the South–North orientation that much care chain analysis offers? These are questions that arise from the Indian example – undoubtedly, other questions will be evoked from an analysis of other locations.

Diverse stratifications

It is not only the variety of families and the transnationalization of the other nodes of the care diamond that deserves attention, but also how the care diamond is incorporated into the care chain analysis. The care chain analysis has focused unequally on the household as the site for care transfers and deficits in the Southern context, but other sites and spaces in the North mediate it. The role of the state, private sector and civil society, the other elements of the care diamond in care provision in the South, is underspecified. The overwhelming significance of the family as the provider of care in the South can in part explain this. However, one effect of such a focus has been that, while the unequal gender divisions of care in sending households and the impact of patriarchy in producing the care deficit has been scrutinized in the Southern context, patriarchy in the North has been less well researched. The research that exists is inadequately integrated with that on migrant care chains (but see Parreñas 2008; Perrons et al. 2010). Rather, at the other end of the chain, concerns over carers has been primarily used to leverage for better state and market care provision and the household receives less attention. Yet, this ignores the excellent work that was done on the unequal gender divisions of caring labour in the North in the 1970s and 1980s, especially in the precursor of the care debate – the domestic labour debate (see for instance, Hartmann 1981). In that period, it was precisely these gender inequalities in caring that received attention.

This differential emphasis on patriarchy and the household between the higher rungs of the chain and the lower rungs of the chain is symptomatic of wider imbalance in academic and policy emphasis on the four aspects of the diamond at the two rungs. It also has the unfortunate effect of individualizing the narratives of Southern women by embedding them largely within the family, while state and market structures seem to influence Northern women much more. For instance, Orozco (2009: 10) argues that although 'care chains are led by women, we must consider the places that other actors, especially men, public institutions and businesses occupy, in order to identify the absence of these actors in terms of accountability and in terms of receiving the benefits of care that results from the

chains.' Yet, the effects of these services in source countries in shaping migration have been much less interrogated. We need to be wary of repeating, yet again, an obsession with the resultant figure of the subaltern woman – the object of many academics' fantasies and anxieties as many postcolonial authors have convincingly pointed out (Mohanty 1984; Puwar 2003).

Care chains also require a more locationally sensitive and intersectional analysis. While in destination contexts gender is often analysed alongside class, race and ethnicity, in sending countries gender is usually only analysed alongside class. However, in India not only class but also other social divisions such as caste and religion differentiate the extent and nature of dependence on the different sites and spaces of the care architecture. Caste can have an unusual effect on care. On the one hand, the delivery of personal care usually respects caste boundaries with the lowest castes not permitted to care for those of a higher caste. On the other hand, only lower castes may be allowed to deliver non-tactile forms of care, especially certain kinds of domestic work. Upper caste/class older people may have greater care requirements because their children are more likely to have professional jobs abroad and are thus less able to provide care for older parents. This has resulted in the establishment of caste-based care homes in many cities in India where both carers and the cared-for are from the same (usually high) caste and care arrangements not only provide physical and emotional care but also spiritual care. Finally, particular religious groups may dominate some aspects of caring – for instance, Christians are over-represented in professional care such as nursing (George 2005). These differences will alter who is suitable or available for what care when familial care arrangements alter through female mobility. It will also affect what kinds of care relationships can be established and to what ends within the care chain.

Conclusions

In this article I have argued that care has only recently emerged as a global concern, but that its transnational stretch has become increasingly significant because of theoretical, empirical and policy imperatives. For Green and Lawson (2011), care is a Eurocentric concept with a particular geo-historical basis, but it is being extended and used globally. As a result, the 'global care' that is predominantly visible is limited and does not really take into account its local variants across the globe. I use the case of India to suggest that diversifying the empirical base for theorizations raises new questions for research on migration and care. I explore the specific challenges to theorizations of care that arise from two issues that emerge from the Indian case – differences in the concept of care and diversity in the institutional architecture of care. In India, issues of religion, the nature and responsibilities of the state, including its priorities for growth and equity, and histories of colonialism all influence the conceptualization of care. Moreover, different aspects of the Indian care architecture, conceptualized as a care diamond, are drawn differentially into a globalizing world of care. An emphasis on the globality of the household, which has driven much global care theorizing, is inadequate because the family is not the only node of the diamond that is

globalizing. The household is also more variable than is often considered in existing theorizations of migrant chains of care. Taking these seriously highlights the complex stratifications that are part of and that embed the care chain.

The need for geographical sensitivity to these versions of care becomes marked in the context of globalizing care. As migrant carers move and the different links in the chain play out in different spatial settings, the four aspects of the care diamond that migrants traverse will also alter. These spatial settings are cultural, social and political terrains with different definitions and modes of recognition of care as well as varying models of dividing the responsibility and rewards for care. The institutions involved in these processes will also vary. Moreover, when migrants mix in global cities they bring these varied understandings and expectations of care (both work and affect) into the mix. It is therefore imperative to understand how global care is constituted by asking what migrants understand by care. How do their pre-migration experiences of care influence it? Moreover, not only care provision but also the *absence* of actors in care in source countries needs attention. Therefore, did a failure of aspects of care arrangements in source countries lead some women to migrate? What does this mean for how they conceptualize care, who cares for them, and who cares for those whom they leave behind?

Analytically, the changes and differentiations between the four nodes of the care diamond raise the question of whether we should be thinking of the relation of markets, states, families and communities through the metaphor of a care diamond at all. Moreover, in a world of networks (Yeates 2012**[(this issue)?]**) and topological connections (Allen 2003) are chains too unidirectional a concept to cover the complexities of care arrangements? By articulating care diamonds more thoroughly with care chains, do we see a greater diversity in the directions of flows, loop backs across and within countries and unexpected connections between the different nodes that go beyond the chain? This needs further thought.

The 'localization' of global care has important policy consequences. Understanding the history, definitions, actors and institutions in the field of care is necessary for identifying how care is framed and how claims to care and to being cared for are mobilized in different countries (Williams 2010b). The extent to which carers demand recognition or redistribution will vary with the genealogies of care and, hence, how their claims are recognized. Moreover, in the context of increasingly transnational states, the material circumstances with which they are familiar in pre-migrant situations will affect migrant carers' rights and responsibilities. It is therefore, imperative that the meanings and architecture of care in sending countries is understood in all its complexity while designing care policy. Besides, in a globalizing world of care, it is not only migrants who are moving; those who require or want care also move. Migrants who buy in care are likely to come across these different definitions and frameworks of care. How do we incorporate this mobility of the cared-for into an analysis of global care? What challenges does this throw up for global social policy? Social policies around care also inhabit a mobile world – policies are transferred and translated globally. Here too, some sensitivity to the local configurations of care is essential in order to understand which policies will work and why.

This sensitivity to the particularities of others is an inherent part of care ethics. Feminist theorizations of ethics of care aim to recognize the specificities of the demands and requirements of others, rather than prescribing universal rules (Held 2006). This locational sensitivity is necessary for care to be understood and grasped as morally significant, to impress on both carers and those who are cared for what is and what is not morally salient (Friedman 2008). The recognition of the importance of theorizing care ethics in tune with different philosophical traditions has also led to attempts to theorize care comparatively (see for example, Dalmiya 2009, on care ethics and comparative philosophy). We could then ask where do care ethics come from philosophically in different countries and how does this interfere with or add to a feminist ethic of care that has largely been theorized in the global North? What challenges do the local philosophies pose for analysing migration and care?

Methodologically, I have used the example of India to show some 'local' contributions to how to conceptualize and theorize care globally. My purpose is not to push for geographical exceptionalism, which is to suggest the need for replication of stories of local variation with an emphasis on difference, local moral values, or geographically determinist cultural explanations on care. Doing so would mean that they are always in danger of being treated only as local variations. As Subrahmanyam (1997: 744) argues, these 'area specialists will merely find themselves either "fitted in" to a big picture or "left out"'. Rather, it is to urge us as researchers to rethink how global care is being made up differently through the multiple forms of care arrangements and conceptualizations that make up the globe. Each locale has its own distinctive way of thinking care but this multiplicity must play a constitutive role in making the global. The narratives of global care as it exists today needs undoing and redoing if we are to globalize care effectively and appropriately. We need to recognize the complex genealogies, commitments and claims (Tsing 2005) that make up the globalizing world of care.

Acknowledgements

Notes

1. This thinking draws on geographical understandings of the global as made up through relations between multiple places (Massey 2004). The globe here suggests the spatial scale of the analysis; it does not imply the uniform spread of thinking around care across the globe (Mahon and Robinson 2011). The move to decolonize concepts by exploring local configurations is an important aspect of postcolonial theory (Jazeel and MacFarlane 2010).
2. The boundaries between the points are often fuzzy and the points multi-layered (Kofman

and Raghuram 2009). Moreover, each point contains spatial as well as institutional arrangements (which are not necessarily coterminous), adding another layer of complexity.

3. Extensive privatization has often driven down the quality of public care although in states like Kerala, the existence of public health provision has provided a floor on quality of private care (Mackintosh 2007).

References

Allen, J. (2003) *Lost geographies of power*, Oxford: Blackwell.

Amrith, M. (2010) '"They think we are just caregivers": the ambivalence of care in the lives of Filipino medical workers in Singapore', *Asia Pacific Journal of Anthropology*, 11 (3–4), 410–27.

Baldassar, L. (2007) 'Transnational families and aged care: the mobility of care and the migrancy of ageing', *Journal of Ethnic and Migration Studies*, 33 (2), 275–97.

Baru, R. V. (1998) *Private health care in India: social characteristics and trends*, New Delhi: Sage.

Beasley, C. and C. Bacchi (2007) 'Envisaging a new politics for an ethical future: beyond trust, care and generosity towards an ethic of "social flesh"', *Feminist Theory*, 8 (3), 279–98.

Bedford, K. (2010) *Harmonizing global care policy? Care and the commission on the status of women*, Geneva: UNRISD.

Brijnath, B. (2008) 'The legislative and political contexts surrounding dementia care in India', *Ageing and Society*, 28 (7), 913–24.

Budlender, D. (2008) 'The statistical evidence on care and non-care work across six countries', Gender and Development Programme paper No 4, UNRISD, December.

Chigateri, S. (2007) 'Articulations of injustice and the recognition–redistribution debate: locating caste, class and gender in paid domestic work in India', *Law, Social Justice & Global Development Journal*, 1.

Dalmiya, V. (2009) 'Caring comparisons: thoughts on comparative care ethics', *Journal of Chinese Philosophy*, 36 (2) 192–209.

Daly, M. (ed.) (2001) *Care work: the quest for security*, Geneva: ILO.

Datta et al. (2009) **NOT IN REFERENCES**.

Datta, K., C. McIlwaine, Y. Evans, J. Herbert, J. May and J. Wills (2010) 'A migrant ethic of care? Negotiating care and caring among migrant workers in London's low-pay economy', *Feminist Review*, 94, 93–116.

Deneva, N. (2009) 'The *young–old* transnational travellers – strategies of care giving and the transformation of the family in migration context: the case of Bulgarian Muslims in Spain', paper presented at the workshop 'A Caring Europe? Care, Migration and Gender', Milton Keynes, 11–13 November.

Escriva, A. (2004) *Securing care and welfare of dependants transnationally: Peruvians and Spaniards in Spain*, Working Paper Number WP404, Oxford Institute of Ageing.

Evers, J. (1996) 'Part of the welfare mix: the third sector as an intermediate area between market, economy, state and community', *Voluntas*, 6 (2), 159–82.

Fiszbein, A. and N. Schady (2009) *Conditional cash transfers: reducing present and future poverty*, Washington: World Bank.

Friedman, M. (2008) 'Care ethics and moral theory: review essay of Virginia Held "The Ethics of Care"', *Philosophy and Phenomenological Research*, 77 (2), 539–55.

George, S. (2005) *When women come first: gender and class in transnational migration*, Berkeley: University of California Press.

Gerhardt, H. (2008) 'Geopolitics, ethics, and the evangelicals' commitment to Sudan', *Environment and Planning D: Society and Space*, 26 (5), 911–28.

Gilligan, C. (1982) *In a different voice: psychological theory and women's development*,

Cambridge, MA: Harvard University Press.

Goering, L. (2007) 'Outsourcing the elderly: low-cost care, made in India', *Seattle Times*, 3 August, available at: http://seattletimes.nwsource.com/html/nationworld/2003819509_indiahomes03.html.

Green, M. and V. Lawson (2011) 'Recentring care: interrogating the commodification of care', *Social and Cultural Geography*, 12 (6), 639–54.

Grover, S. (2009) 'Lived experiences: marriage, notions of love, and kinship support amongst poor women in Delhi', *Contributions to Indian Sociology*, 43 (1), 1–33.

Hartmann, H. (1981) 'The family as a locus of gender, class, and political struggle: the example of housework', *Signs*, 6 (3), 366–94.

Held, V. (2006) *The ethics of care: personal, political, global*, Oxford: Oxford University Press.

Hochschild, A. (2000) 'Global care chains and emotional surplus value', in W. Hutton and A. Giddens (eds) *On the edge living with global capitalism*, London: Jonathan Cape, 130–146.

Hollway, W. (2006) *The capacity to care*, London: Routledge.

Isaksen, K., S. Umadevi and A. Hochschild (2008) 'Global care crisis: a problem of capital, care chain or commons', *American Behavioural Scientist*, 52 (3), 405–25.

Jalali, R. (2008) 'International funding of NGOs in India: bringing the state back in', *Voluntas*, 19 (2), 161–88.

Jazeel, T. and C. McFarlane (2010) 'The limits of responsibility: a postcolonial politics of academic knowledge production', *Transactions of the Institute of British Geographers*, 35 (1), 109–24.

Katz, C. (2001) 'Vagabond capitalism and the necessity of social reproduction', *Antipode*, 33 (4), 708–27.

Keezhangatte, J. (2007) *Indian household workers in Hong Kong: resilience and transnational family relationships*, Saarbrücken: VDM Verlag.

Kofman, E. and P. Raghuram (2009) *The implications of migration for gender and care regimes in the South*, UNRISD, International Futures Society and International Organization for Migration, available at: http://www.unrisd.org/80256B3C005BCCF9/%28httpPublications%29/9C17B4815B7656B0C125761C002E9283?OpenDocument.

Lawson, V. (2007) 'Geographies of care and responsibility', *Annals of the Association of American Geographers*, 97 (1), 1–11.

McCabe, L. (2007) 'Translating policy and practice: day care for people with dementia in Kerala, India', *Global Social Policy* 7 (2), 203–21.

Mackintosh, M. (2007) 'Planning and market regulation: strengths, weaknesses and interactions in the provision of less inequitable and better quality health care', working paper commissioned by the World Health Organization's Commission on the Social Determinants of Health, Health Systems Knowledge Network, available at: http://oro.open.ac.uk/10083/1/CSDH_paper_Mack_as_posted.pdf.

Mahon, R. and F. Robinson (2011) 'Introduction', in *Feminist ethics and social policy: towards a new global political economy of care*, UBC Press: Toronto.

Massey, D. (2004) 'Geographies of responsibility', *Geografiska Annaler*, 86 B (1), 5–18.

Ministry of Labour (2003) *Annual Report – 2002–2003*, New Delhi: Government of India.

Mohanty C. T. (1984) 'Under Western eyes: feminist scholarship and colonial discourses', *Boundary 2*, 12 (3), 333–58.

Narayana, K. (2003) 'The role of the state in privatisation and corporatisation of medical care in Andhra Pradesh, India', in K. Sen (ed.) *Restructuring health services: changing contexts and comparative perspectives*, London: Zed books.

Noddings N. (1984) *Caring: a feminine approach to ethics and moral education*, Berkeley: University of California Press.

Ochai, E. (2009) 'Care diamonds and welfare regimes in East and South-East Asian societies', *International Journal of Japanese Sociology*, 18 (1), 60–78.

Orozco, A. (2009) *Global perspectives on the social organization of care in times of crisis: assessing the situation*, UN-INSTRAW Working Paper 5.

Palriwala, R. and Neetha, N. (2011) 'Stratified familialism: the care regime in India through the lens of childcare', *Development and Change*, 42 (4), 1049–8.

Palriwala, R. and N. Pillai (2007) *Political and social economy of care: Indian proposal*, Geneva: UNRISD.

Palriwala and Pillai (2011) **NOT IN REFERENCES**

Parreñas, R. (2001) *Servants of globalization:* w*omen, migration and domestic work*, Stanford: Stanford University Press.

Parreñas, R. (2005) *Children of global migration*, Stanford: Stanford University Press.

Parreñas, R. (2008) *The force of domesticity: Filipina migrants and globalization*, New York: New York University Press.

Perrons, D., A. Plomien and M. Kilkey (2010). 'Migration and uneven development within an enlarged European Union: fathering, gender divisions and male migrant domestic services', *European Urban and Regional Studies*, 17 (2), 197–215.

Puwar, N. (2003) 'Melodramatic postures and constructions' in N. Puwar and P. Raghuram (eds) *South Asian women and the diaspora*, Oxford: Berg Publishers, 21–42.

Raghuram, P. (1993) 'Coping strategies of domestic workers: a study of three settlements in the Delhi Metropolitan Region, India', unpublished Ph.D. dissertation, Department of Geography, University of Newcastle-upon-Tyne, UK.

Raghuram, P. (2005) 'Global maid trade: Indian domestic workers in the global market', in S. Huang, N. Abdul Rahman and B. Yeoh (eds) *Asian transnational domestic workers*, Singapore: Marshall Cavendish, 146–74.

Ramu, G. N. (1989) *Women, work, and marriage in urban India: a study of dual- and single-earner couples*, New Delhi: Sage.

Razavi, S. (2007) *The political and social economy of care in a development context: conceptual issues, research questions and policy options*, Gender and Development Paper no. 3, Geneva: UNRISD.

Razavi, S. and S. Staab (eds) (2010) 'Underpaid and overworked – a cross-national perspective on care workers', special issue of *International Labour Review*, 149 (4).

Roshni Nilaya (1973) *A national socio-economic survey of domestic workers*, Madras: CBCI. **NO Roshni Nilaya (1973) IN TEXT. WHICH DATE IS CORRECT**

Roshni Nilaya (1983) **NOT IN REFERENCES**

Sassen, S. (2000) 'Women's burden: counter-geographies of globalization and the feminization of survival', *Journal of International Affairs*, 53 (2), 503–24.

Sander-Staudt, M. (2006) 'The unhappy marriage of care ethics and virtue ethics', *Hypatia*, 21 (4), 21–39.

Silk, J. (2004) 'Caring at a distance: gift theory, aid chains and social movements', *Social and Cultural Geography*, 5 (2), 229–51

Singh, S. (2006) 'Towards a sociology of money and family in the Indian diaspora', *Contributions to Indian Sociology*, 40 (3), 375–98.

Social and Cultural Geography (2003) 4 (4) **[The whole issue? – is this right? articles listed at: http://www.tandfonline.com/toc/rscg20/4/4]. NEED AUTHOR NAME AND TITLE OF ARTICLE. PLEASE SUPPLY**.

Social and Cultural Geography (2004) 5 (2). **[ditto]**

Standing, G. (2001) 'Care work: overcoming insecurity and neglect', in M. Daly (ed.) *Care work: the quest for security*, Geneva: International Labour Office, 15–32.

Subrahmanyam, S. (1997) 'Connected histories: notes towards a reconfiguration of early modern Eurasia', *Modern Asian Studies*, 31 (3), 735–62.

Tronto, J. (1993) *Moral boundaries: a political argument for an ethics of care*, Routledge: New York.

Tsing, A. (2005) *Frictions: an ethnography of global connection*, Princeton: Princeton

University Press.

UNRISD (United Nations Research Institute for Social Development) (2006) *Transformative social policy*, UNRISD Research and Policy Brief 5.

Williams, F. (2010a) Migration and care: themes, concepts and challenges, *Social Policy and Society*, 9 (3), 385–39.

Williams, F. (2010b) *Claiming and framing in the making of care policies: the recognition and redistribution of care*, Geneva: UNRISD.

Yeates, N. (2004) 'Global care chains: critical reflections and lines of inquiry', *International Feminist Journal of Politics*, 6 (3), 369–91.

Yeates, N. (2008) *Globalising care economies and migrant workers: explorations in global care chains*, Basingstoke: Palgrave.

Yeates, N. (2012) 'Global care chains (GCCs): a state-of-the-art review and future directions in care transnationalization research', *Global Networks*, 12 (2), **[Page numbers to be added]**