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The Implications of Migration for Gender and Care Regimes in the South

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Acronyms

AIDS	acquired immunodefiency syndrome
CARICOM	Caribbean Community and Common Market
ECOWAS	Economic Community of West African States
GDP	gross domestic product
HIV	human immunodefiency virus
ILO	International Labour Organization
Mercosur	Mercado Común del Sur *(Southern Common Market)*
NAFTA	North American Free Trade Association
NGO	non-governmental organization
OECD	Organisation for Economic Co-operation and Development
SAR	Special Administrative Region
UAE	United Arab Emirates
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNIFEM	United Nations Development Fund for Women
UNRISD	United Nations Research Institute for Social Development

Summary/Résumé/Resumen

Summary

In the past decade there has been considerable interest in issues of funding and provision of care in public and social policy. The almost universal domination of women in caregiving, the growth in number of women in waged labour and the resulting withdrawal of some women from caregiving has led to opening up new fields of paid care work for other women. Women have migrated across the world to take over these tasks, leaving care gaps in their own households and thus fuelling further migration. Yet, the analytical focus of much of the literature on caring activities, concepts and models has largely been limited to the global North with the result that knowledge of migration, gendered labour and care regimes has significant gaps and omissions, especially as they relate to the global South. Migration is taking place not just from the South to the North, but also between contiguous countries in the South, where income levels between countries may not be much higher, and especially to some of the migration poles in middle-income countries, such as Argentina, Jordan, Malaysia and parts of Eastern Europe. Internal migration within countries may also be a significant element of migratory flows. Whatever the reasons and direction of migration, the mobility of women has raised concerns about the resultant rearrangements of care in sending contexts. This paper extends discussions of migration and care to the global South and lays out some questions that need to be addressed to help reflect local realities in discussions of care in the South.

The notion of care does not travel easily across contexts. In much of the literature, there is a distinction between more formalized types of care, such as health and social care, and the more informal versions of domestic care. While the formalization of health care has a long history, social care is much more restricted to particular welfare regimes and models of government. The actual provision of these forms of care is also significantly influenced by histories of care provision, household arrangements, familial entitlements, and responsibilities and variations in community arrangements across the South. Pinning down the actual practices of caregiving and care receiving as well as the different institutional and spatial arrangements of state, public sector, community and households, which influence care provision, is therefore necessary for understanding the social implications of migration for gender and care. These diverse arrangements, which have been theorized through the notion of the care diamond, are multifaceted and dynamic, so that the nature of the relationships between the four points of the care diamond vary regionally and temporally. This paper explores these issues as they relate to the global South.

The increasingly popular concept of the global chains of care is one way of theorizing the links between the global South and the North simultaneously. However, most of the work on this issue does not unravel the different chains generated by migratory movements and their implications for gender and care regimes in the South. This paper highlights the complexity of care chains and the need to take into account familial structures, the diversity of sectors and skill levels, including the migration of skilled workers who are often omitted from these studies, the role of the state and immigration regulations, community involvement and remittances. Furthermore, not only does care involve the interplay of households, communities, markets and states but it also encompasses different qualities and social relations in the giving and receiving of care. These qualities are inherent to the *ethics of care*. Drawing on the ethics of care literature this paper argues that the intrinsic and emotional qualities of care too need recognition. They should not be seen as inherently feminine qualities but should be extended to the social organization of production and reproduction globally.

In sum, this paper examines the implications of migration for gender relations and care provisioning in the countries of the global South, in particular through the use of the notion of the care diamond and the interplay between its spatial and institutional dimensions. It explores some of the ways in which the care diamond needs specifying and moderating in relation to a Southern context. The paper also assesses the applicability of key concepts such as the global

care chain and the ethics of care for migration in Southern countries. Finally, it draws lessons for policy makers with regard to the care-related needs of migrant families and households in different regions. Too often the importance of migration as a buffer securing a cheap care workforce has meant states have not recognized the economic and social importance of care; this paper argues for the need to correct this imbalance.

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Résumé

Au cours de la dernière décennie, les politiques publiques et sociales se sont beaucoup intéressées aux questions du financement et de la prestation des soins et de l'assistance aux personnes. La domination quasi universelle des femmes dans le secteur des soins non rémunérés, le nombre croissant des femmes salariées et la moindre disponibilité qui en résulte pour les tâches de soins et d'assistance aux personnes ont eu pour effet de créer des emplois pour d'autres femmes. Des femmes ont émigré dans d'autres régions du monde pour assumer ces tâches, ce qui a laissé un vide dans leurs propres foyers et suscité ainsi de nouvelles migrations. Pourtant, la littérature consacrée aux soins et à l'assistance aux personnes s'est en grande partie bornée à analyser les activités, concepts et modèles du Nord. Il en est résulté des omissions et des carences dans la connaissance des domaines de la migration, de la main-d'œuvre féminine et des régimes de soins et d'assistance aux personnes, en particulier au Sud. Les migrations n'ont pas lieu seulement du Sud vers le Nord, mais aussi entre pays voisins du Sud, où les niveaux de revenu ne sont pas forcément très différents, et surtout à destination de certains pôles d'immigration dans des pays à revenu intermédiaire comme l'Argentine, la Jordanie, la Malaisie et certaines régions d'Europe de l'Est. La migration interne peut aussi tenir une place importante dans les flux migratoires. Quelles que soient les raisons et la destination de la migration, la mobilité des femmes a obligé à réorganiser les soins et l'assistance aux personnes dans les pays d'émigration. Ce document traite de la migration, des soins et de l'assistance aux personnes au Sud et met au jour certaines questions dont il faut tenir compte pour témoigner des réalités locales dans les débats sur les soins et l'assistance aux personnes au Sud.

La notion de soins et d'assistance aux personnes voyage mal d'un contexte à l'autre. Une grande partie de la littérature fait une distinction entre les soins de santé et l'assistance sociale officiels, d'une part, et les soins et l'assistance dispensés dans les ménages. Si l'organisation des soins de santé a une longue histoire, l'assistance sociale est beaucoup plus limitée à des régimes sociaux et politiques particuliers. La manière dont ces formes de soins et d'assistance sont dispensées dans la pratique tient aussi à l'histoire, aux arrangements au sein des ménages, aux responsabilités et aux droits dans la famille et aux dispositions prises dans les collectivités locales à travers le Sud. Il faut donc mettre en évidence les pratiques réelles en matière de soins, de ceux qui les dispensent comme de ceux qui les reçoivent, ainsi que les différentes dispositions institutionnelles et spatiales prises par l'Etat, le secteur public, la collectivité locale et les ménages, qui influencent la fourniture des soins, pour comprendre les conséquences sociales de la migration pour le genre et les soins. Ces divers arrangements, qui ont été théorisés par la notion de "carré des soins", sont multiformes et dynamiques, de sorte que la nature des relations entre les quatre angles du carré varie selon les régions et avec le temps. Ce document approfondit ces questions en ce qui concerne le Sud.

La notion de plus en plus populaire de chaînes mondiales des soins est une façon de théoriser simultanément les liens entre le Sud et le Nord. Cependant, la plus grande partie des travaux sur cette question ne démêlent pas les différentes chaînes créées par les mouvements migratoires ni leurs conséquences pour le genre et les régimes de soins au Sud. Ce document met en lumière la complexité des chaînes de soins et la nécessité de tenir compte des structures familiales, de la diversité des secteurs et des niveaux de compétence, y compris de la migration

de travailleurs qualifiés, souvent omise dans ces études, du rôle de l'Etat et des lois sur l'immigration, de la part prise par les collectivités locales et des fonds envoyés par les migrants dans leurs pays d'origine. De plus, non seulement les ménages, les collectivités locales, les marchés et les Etats interviennent dans les soins mais introduisent chaque fois des qualités différentes dans les rapports sociaux entre ceux qui les dispensent et ceux qui les reçoivent. Ces qualités sont inhérentes à l'*éthique des soins*. Se fondant sur la littérature qui traite de cette éthique, ce document fait valoir que les qualités intrinsèques et affectives des soins doivent aussi être reconnues. Elles ne devraient pas être considérées comme essentiellement féminines mais étendues à l'organisation sociale de la production et de la reproduction à l'échelle mondiale.

En résumé, les auteurs de ce document examinent les conséquences de la migration sur les rapports sociaux entre hommes et femmes et les dispositions prises en matière de soins et d'assistance dans le Sud, en se servant en particulier de la notion de carré des soins et de l'interaction entre ses dimensions spatiales et institutionnelles. Elles explorent certains des aspects sur lesquels le carré des soins a besoin d'être spécifié et modéré dans le contexte du Sud. Elles analysent aussi l'applicabilité de concepts tels que ceux de chaînes mondiales des soins et d'éthique des soins à la migration dans les pays du Sud. Enfin, elles explicitent, pour les responsables politiques, les conséquences à tirer des besoins des familles et des ménages de migrants en matière de soins dans différentes régions. L'importance de la migration comme tampon et source de main-d'œuvre peu coûteuse pour le secteur des soins a trop souvent conduit les Etats à négliger l'importance économique et sociale des soins et de l'assistance aux personnes; les auteurs de ce document plaident pour un meilleur équilibre entre les deux.

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Resumen

En los diez últimos años, ha habido considerable interés en los temas relacionados con el financiamiento y la provisión del cuidado en la política pública y social. La predominancia casi universal de la mujer en la prestación del cuidado, el aumento del número de mujeres en la fuerza laboral asalariada y, como consecuencia de ello, el retiro de algunas mujeres de las actividades del cuidado han conducido al surgimiento de nuevos campos de trabajo remunerado en el área del cuidado para otras mujeres. Hay mujeres que han migrado de un extremo del mundo al otro para hacerse cargo de estas tareas, con lo que han producido carencias de atención en sus propios hogares y, al mismo tiempo, fomentado nuevas migraciones. No obstante, el énfasis analítico de buena parte de los estudios relacionados con las actividades, conceptos y modelos del cuidado se ha limitado en gran medida al Norte en general. Esto ha resultado en importantes lagunas y omisiones en los conocimientos sobre la migración, el carácter femenino de la fuerza laboral dedicada al cuidado y los regímenes de cuidado, especialmente en relación con el Sur en general. La migración no sólo se da del Sur al Norte, sino también entre países contiguos del Sur, donde los niveles de ingresos entre los países quizás no se diferencien mucho, y en especial hacia algunos de los polos de migración en países de medianos ingresos, como Argentina, Jordania, Malasia y partes de Europa Oriental. La migración interna (dentro de un mismo país) también puede ser un elemento importante de los flujos de migración. Independientemente de las razones y la dirección de la migración, el desplazamiento de las mujeres ha generado inquietud en torno a la resultante reorganización del cuidado en los países de origen. En este documento se amplía el análisis de la migración y el cuidado hacia el Sur y se formulan algunas preguntas que deben responderse a fin de reflejar las realidades locales en los debates sobre el cuidado en el Sur.

La noción del cuidado no se traslada con facilidad de un contexto a otro. En buena parte de la literatura sobre el tema se hace una diferenciación entre, por una parte, tipos más formales de cuidado, como el cuidado de la salud y el cuidado social y, por la otra, las versiones más

informales del cuidado doméstico. Si bien la formalización del cuidado de la salud data de muchos años, el cuidado social se circunscribe mucho más a determinados regímenes de previsión y modelos de gobierno. La provisión real de estas formas de cuidado recibe también una marcada influencia de los antecedentes de la provisión del cuidado, los derechos y responsabilidades familiares y las variaciones de las soluciones comunitarias en todo el Sur. Es, por lo tanto, menester precisar las prácticas reales de la provisión y recepción del cuidado, así como los distintos arreglos institucionales y espaciales del Estado, el sector público, la comunidad y los hogares, todos los cuales influyen en la provisión del cuidado, para poder comprender las implicaciones sociales de la migración para el género y el cuidado. Estos arreglos diversos, que se han conceptualizado a través de la noción del "diamante del cuidado", son multifacéticos y dinámicos, de forma que la naturaleza de las relaciones entre los cuatro puntos del diamante varían con cada región y tiempo. En este trabajo se examinan estos aspectos en el contexto del Sur.

El concepto, cada vez más popular, de las cadenas mundiales de cuidado es una forma de conceptualizar los vínculos entre el Sur y el Norte simultáneamente. No obstante, es poco lo que los estudios sobre esta materia han hecho para reveler las distintas cadenas generadas por los movimientos migratorios y sus implicaciones para el género y los regímenes de cuidado en el Sur. Este documento resalta la complejidad de las cadenas de cuidado y la necesidad de tomar en cuenta las estructuras familiares, la diversidad de sectores y los niveles de destreza, incluida la migración de trabajadores calificados que a menudo quedan excluidos de estos estudios, el papel del Estado y las normas de inmigración, la participación de las comunidades y las remesas. Además, el cuidado implica no solo la interrelación entre hogares, comunidades, mercados y estados; abarca también diferentes cualidades y relaciones sociales en la provisión y recepción del cuidado. Estas cualidades son inherentes a la *ética del cuidado*. A partir de lo que se ha escrito sobre la ética del cuidado, en este documento se sostiene que también es necesario reconocer las cualidades intrínsecas y emocionales del cuidado. No deben interpretarse como cualidades inherentemente femeninas, sino que deben extenderse a la organización social de la producción y reproducción en general.

En resumen, en este documento se examinan las implicaciones de la migración para las relaciones de género y la provisión del cuidado en los países del Sur, sobre todo mediante el uso de la noción del diamante del cuidado y las interrelaciones entre sus dimensiones espaciales e institucionales. Se analizan algunas de las formas en que debería especificarse y moderarse el diamante del cuidado en relación con el contexto del Sur. También se evalúan la aplicabilidad de conceptos clave como la cadena mundial del cuidado y la ética del cuidado para la migración en países del Sur. Finalmente, se extraen lecciones para los responsables de la formulación de las políticas sobre las necesidades de las familias migrantes y los hogares en regiones diferentes relacionadas con el cuidado. Con excesiva frecuencia la importancia de la migración como elemento amortiguador que garantiza una fuerza laboral barata para el cuidado se ha traducido en que los estados no reconocen la importancia económica y social del cuidado; en este trabajo se afirma la necesidad de corregir este desequilibrio.

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Introduction

In the past decade there has been considerable concern over issues of funding and provision of care in public and social policy (Razavi 2007b). Although there is an increasing interest in this field, so far there has been little research on social policy and care provisioning in the global South, especially as they pertain to migration and gender relations. However, migration, especially that of women, is changing care landscapes the world over, including in Southern countries, and there is an urgent need for research in this area in order to guide the setting up of effective and appropriate social policy. This paper looks at some conceptual issues that could steer new research in this field.

One of the major concerns of social policy is social reproduction and the distribution of tasks in ensuring reproduction between different institutions, sites and actors. Within social reproduction, one of the core aspects is care and the economic and social relationships that it subtends (Yeates 2005). Social policy also maintains and transforms gender, racial and generational social relations in this process (UNRISD 2006). In particular it influences the lives of men and especially women by either broadening their capabilities and choices, or by confining them to so-called traditional roles (UNRISD 2006:3).

The analytical focus of much of the literature on caring activities, concepts and models has been limited to states in the global North (Esping-Anderson 1999; Hill 2007). However, the acknowledgement of the importance of the "social" realm in mitigating some of the effects of neoliberal economic policies in the global South (Cornia et al. 1988; Mkandawire 2004) is now being extended to a recognition of the role of social policy in development processes more generally. As a result, as Razavi (2007b:383) argues, "ideas about welfare have travelled across countries and regions" and been adapted to specific social and geographical contexts. In particular, they have had to take account of the differences across countries in the global reach of neoliberal policies, which alter the shift in the mix between private and public provision of welfare, and lead to a diminution of the role of the state in direct care provision (Munday 2003; Molyneux 2007). States combine different forms of care provision in different ways (Hill 2007).[1] But they also define who is to be cared for; who cares; who pays; relationships through which care is organized; the sites of care provision and the skills required.[2] The forms of provision are also varied and include services, employment and social security (Daly 2001). Moreover, the relationship between social policies and care can also be less than straightforward. Thus, social policies may not directly address care but may nevertheless have implications for access to and purchase of care services. For example, availability of pre-school nurseries, increased school attendance and the provision of midday school meals enable women to devote less time to the care of children and to enter the labour force.

Yet, underlying this variation is the near universal dominance of women in caregiving so that the effects of the rolling back of state provision have been felt most acutely by women. Women in many parts of the world have become incorporated into both the formal and informal labour markets as caregivers. At the same time, the rising labour market participation of women has also resulted in substantial labour shortages in unpaid informal care provision that women had often provided, intensifying demand for paid caregivers.[3] This demand is increasingly being met by migrant female labour.

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[1] Based on Esping-Andersen's (1999) reworking of his three welfare regimes to include family roles and the household economy, Hill (2007:189) has set out seven logical alternatives including state, market and family alone; the involvement of two of these; and the significant presence of all three in the delivery of social care in European societies.

[2] Daly 2001; Folbre 2006a; Jenson 1997.

[3] The United Nations Research Institute for Social Development (UNRISD) Programme on the Political and Social Economy of Care is intensively studying unpaid care within the household and its intersection with the paid economy in seven countries; non-household institutions involved in providing care for specific groups of people; and quantitative time use surveys of the total amount of paid and unpaid care work (www.unrisd.org/research/gd/care).

Globally, the number of female migrants was estimated at 94.5 million (or 49.6 per cent of total) in 2005. The share of women among migrants in Southern countries was about 38.9 million (or 51 per cent) in 2005, compared to 46.2 million (or 51 per cent) in the high-income countries belonging to the Organisation for Economic Co-operation and Development (OECD) and 8.7 million (or 40 per cent) in the high-income, non-OECD countries (Ratha and Shaw 2007). The provision of care in its myriad forms underlies much female migration. Thus large numbers of female migrants move to provide care in a range of contexts and sites. They find employment as domestic workers and as care professionals, such as senior carers, nurses and social workers, and facilitate the care of children, adults, disabled and elderly within households, in residential homes and hospitals. Women also move for other reasons—as family migrants, petty traders, agricultural workers, manufacturing, sex work and entertainers, and in a range of other professionalized occupations. However, the mobility of these women also leaves care gaps to be filled in the areas they leave behind.

Hence, care demands are both being created and met through women's employment, highlighting the complex causal relations that tie together migration, gendered labour and care regimes. Initially the relationship between gender and care was the focus of feminist economics (Folbre 2002; Himmelweit 2005), the sociology of work (Glucksmann; 2005) and social policy (Razavi 2007a, 2007b). More recently the transfer of labour from the South to the North has captured the attention of migration researchers who explore the nexus between the three, especially through the concept of global chains of care (Hochschild 2000). However, the knowledge of these three fields has significant gaps and omissions, especially as they relate to the global South. Many aspects of the care and gender regimes of the North have been implicitly assumed to be universal or have been extrapolated to other geographic and political contexts without recognition of the limited applicability of these concepts. Moreover, conceptual questions around the nexus of migration, gender and care have also been framed and models developed with a primacy of South-North migration in mind. This paper aims to unsettle some of the assumptions that underlie this analysis and to lay out some questions that might need to be addressed to make questions of care in the South reflect local realities. The paper focuses on social care, taking into account that this often intersects with health care.

The main aim of this paper is to analyse the implications of migration for gender relations and care provisioning in the countries of the global South. This paper contributes to this through the development of the model of the care diamond which can be applied to very different kinds of welfare provision—ranging from the familial, the community, the market and the state—and extends the application of the concept of "global chain of care" to the South. Hitherto much of the analysis has focused on the impact of transfers of care services on wealthy countries in East Asia, Europe and North America. In developing the implications, it should first be noted that there is inadequate empirical data to achieve any kind of comprehensive understanding and that we can only hope, in the context of this chapter, to suggest some partial insights. Second, although this paper refers to the global North and South, both are highly heterogeneous in terms of their welfare regimes, wealth and migratory patterns. In particular, the South includes middle-income countries which serve as poles of migration and have begun implementing active social policies and/or intervened in the provision of care; countries largely exporting care labour; and countries where care systems have been overwhelmed by the HIV/AIDS pandemic.

The paper begins with a brief discussion of the notion of care and care regimes. The following section provides an overview of gendered migrations covering South to North and South to South, including from low- to middle-income countries, while the third section offers an analysis of the intersection between care, gender and migration, and in particular, the concept of the global chain of care in relation to the South. The final section suggests some conceptual and policy outcomes arising from these moves.

What is Care?

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). In practice, care can be qualified in terms of quality, quantity, type of caregiver, care receiver and so on, but underlying these is an ethic of care that represents a set of values and norms guiding human action and the interdependent relationships established with others.[4] It embraces a range of human experiences and relationships of obligation, trust, loyalty and commitment concerned with the well-being of others (Graham 1983). Such a definition eschews the narrowness of social policy perspectives (Sevenhuijsen 2004; Williams 2001) which limit care to those who are dependants, such as children, elderly, disabled and those with learning difficulties (Daly and Lewis 2000; Daly and Rake 2003); instead it embraces the able-bodied such as spouses and the self and a wide range of activities (Folbre 2006a; Yeates 2005). It also defines care as occurring on different temporal registers—ranging from long term to intermittent in response to emergencies or on specific occasions.

Care may be seen as emerging as a key category around which social policy discussions are cohering. In the European Union, care has come to be seen as fundamental to the well-being of society but it is a relatively recent exigency in the analysis of welfare states. Thus, Esping-Andersen's (1990) conceptualization of different types of welfare regimes, based on the extent of decommodification (freedom from the market, stratification produced by the welfare state and relationship to the market), focused on the transfer of benefits and subsidies (pensions, social security, child benefits) in its classification of welfare regimes.[5] It omitted personal social services and gender divisions in sustaining welfare. The subsequent gendering of analyses of welfare regimes introduced the role of families (Daly and Lewis 2000) but failed to address the significance of care which varied across welfare states (Sainsbury 1994, 1999).

Yet more recently, care is gaining ground on the political and policy landscape, and there are a number of reasons for this. Feminists have brought it to the fore in public and social policy, pointing out both the invisibility and the universality of care (as ethic) and the importance of women in care provision around the globe. Furthermore, paid caring activities are highly stratified, and because it is usually "undervalued, invisible, underpaid and penalized", it is relegated to those who lack economic, political and social power and status (Nakanao Glenn 2000). Thus racialized[6] and subordinated groups are often assigned caring roles while their own needs for care are neglected (Nakano Glenn 1992). Caring may result in financial hardship and contribute to the carer's poverty during their working lives as well as in old age. For feminists then, care is a significant aspect of citizenship and needs to be recognized through rights and entitlements for both those providing and receiving it (Knijn and Kremer 1997).[7] However, it is not gender or racial equality (Daly and Rake 2003) but rather the economic impact of the expansion of active participation in the labour market in the shift away from the male breadwinner model toward the adult worker model (Guilari and Lewis 2005) that has preoccupied policy makers in states that have come to recognize care as an important part of social policy.

There have also been a number of demographic and socioeconomic developments globally which have contributed to its increasing salience. These include changing family structures, such as the increasing nucleation of families, the growing numbers of female-headed households, and separated and divorced households, ageing populations, especially the growth in the number of frail older people. Additionally, regionally significant factors include the

[4] Fisher and Tronto 1990; Sevenhuijsen 1998, 2004; Tronto 1993.

[5] These are social democratic states with widespread universal provision; highly stratified conservative regimes and liberal regimes with marked means testing. Later the Southern Rim category was added, but this could probably be now classified as southern conservative (Kofman 2007).

[6] For Duffy (2005) the racial divide in who gets to participate in the affective and nurturance work of care and who only provides reproductive labour sends warning bells about the increasing theoretical emphasis on care.

[7] It should be noted that care has not been considered an issue in the context of non-Western migration.

reconfiguration in care provision because of the impact of HIV/AIDS, especially in sub-Saharan Africa, which has led to high mortality rates among young adults, who are often the most active carers in a society (Upton 2003). In some parts of Asia, high rates of female migration have led to a similar absence, albeit temporarily of young adult women who bear much of the burden of care (Parreñas 2005). Even in areas without migration increases in the number of women working outside the household means that care can no longer be taken for granted. Care work is now, therefore, increasingly being recognized as an occupation and a growing source of employment.[8]

Care has also moved up the policy agenda with the increasing salience of social policy. Notions of developmental social policy and the social investment state,[9] espoused by European and OECD policy makers, both focus on active social policy and investment, especially in the human capital of children. International organizations too have shown interest in the social and political economy of care as it involves "the reconciling of the burden of reproduction with that of other social tasks as well as sharing the burden of reproduction between members of society" (UNRISD 2006:3). Thus, UNRISD is enquiring into the multiple institutions of care (households and families, states, markets, and the not-for-profit sector), its gender composition and dynamics, and the implications for poverty and social rights of citizenship (Razavi 2007b) in different countries. The International Labour Organization (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; Standing 2001).

However, the notion of care within social policy does not easily travel across contexts because, in expanding the notion of care to the global South, one inherits the very different histories of development policy, care arrangements and gender regimes that influence the notion of care. The history of social work in many countries of the South has been bound up with 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). Finally, although the social sector has undoubtedly become a point of intervention for many international organizations, as noted above, it is less clear that this focus has begun to frame national policy makers in states that are increasingly adopting neoliberal policies. For many countries that are chasing economic development, social care has remained of marginal interest; where it exists, it may be targeted toward identified vulnerable groups who are seen as being left out of development. It is the normative framework that surrounds modernizing notions of development that haunts such social policy programmes. Care may, thus, not be the frame within which the delivery of social policy is conceptualized. In sum, the legacy of the term care is likely to be complex and often contested, and the term should be applied with some sensitivity to geographical context as well as historical legacy.

Care regimes

Care regimes can be conceptualized as the institutional and spatial arrangements (locations) for the provision and allocation of care. Regimes[10] differ according to the relationships and mix between the component sources of welfare, which for Esping Andersen (1999:35) consists of the "intercausal triad of state, market and family". The community sector, which includes a range of third sector providers such as voluntary agencies (religious and secular) and neighbourhood actions, also needs to be taken into account (Hill 2007; Graefe 2004).

The organization of care within the four points of a regime has been captured by the metaphor of the diamond (Evers 1996; Jenson 2003). The model of a care diamond enables one to examine

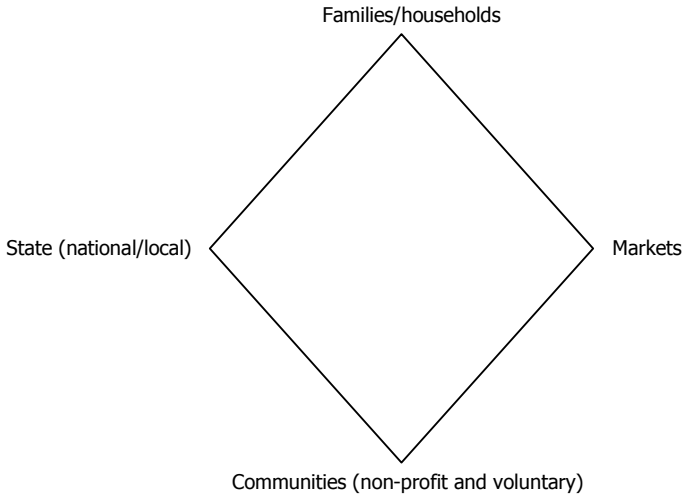
[8] Cancedda 2001; European Foundation for the Improvement of Living and Working Conditions 2006; Simon et al. 2005.

[9] Jenson and Saint Martin 2003; Lister 2006; Razavi 2007a.

[10] The term does not imply the existence of a strong state sector either in direct provision or regulation.

the articulation of different processes across institutional arrangements and sites or what Glucksmann (2005) terms a "total social organization of labour" across space and time. The empirical realities and dynamic situations can be taken into account through the diamond. However, in using the diamond, it is important to remember that the boundaries between the points are often fuzzy and the points multilayered. Moreover, each point contains spatial as well as institutional arrangements (which are not necessarily coterminous), adding a further but necessary layer of complexity. In particular, the interplay between institutional and spatial aspects has important ramifications for the conceptualization of the family and household node where the latter increasingly acts as the nexus of diverse forms of paid and unpaid care labour and contracts (Esping Andersen 1999). The diamond also enables us to interrogate common assumptions about care provision in the South. For instance, it is often assumed that the family continues to carry the burden of care to the same extent as it did in the past in most countries. But to what extent do different countries depend on a familial care regime? And in what ways, if any, have care regimes been modified as countries have become wealthier (Japan, Singapore) or experienced a political regime shift as in the Republic of Korea (Peng 2006)?

Figure 1: The care diamond



Source: Adapted from Razavi (2007b).

The following schema briefly outlines the way this paper applies the care diamond institutionally and spatially.[11]

- *Families and households:* They mostly provide unpaid care. Their contribution is difficult to quantify but remains the main source of social care in all countries. Caring activities usually take place in the household although the two are not coterminous. Thus households have, in the past decade, increasingly become the site for paid caring work both in the North and among the expanding middle classes in the South. In the North, international migrants have largely replaced internal migrants as the source of this labour. Home care provided by the community has also been encouraged by many governments in the South although this is not without its critics (Akintola 2008).
- *Markets:* This may be provided by an individual, an agency, a small enterprise or a large corporation. It is growing in size and importance in some countries,

[11] Unlike the literature on the mixed economy of welfare (Powell 2007), we have included a spatial dimension and considered the use of migrants as providers of care.

although it may be difficult to distinguish between organizations in this sector and the third sector. Often families can only afford to purchase market services where these are cheap, as with migrant labour.

- *Communities comprising not-for-profit and voluntary/third sector:* The range of provision is considerable, including self-help groups based around neighbourhoods, large as well as small non-governmental organizations (NGOs) that use a mix of paid and unpaid resources, and volunteers working within and outside formal schemes. In recent years new types of not-for-profit organizations have appeared. Remittances from diasporic populations have also supported developments in this sector, such as child care centres.
- *State (national, regional, local):* Care may be provided by separate government departments and/or as part of larger departments such as health, social security and education. The state may be the provider and/or funder of services. It may subsidize care services or transfer payments for their purchase (Pfau-Effinger and Geissler 2005; Ungerson 2005). Following its increasing withdrawal from direct provision, the state has also developed its regulatory role more fully.

The mix of care accessed also differs across different social strata. As Palriwala and Pillai (2007) point out, in India the care diamond is accessed and used in different combinations according to class, caste, religion and region. Middle-class and rich urban families can hire domestic workers and baby-sitters (market or household-located) or access private services such as day-care nurseries (market or non-household). Rich rural households could ensure that a female member of the household remains at home, while in poor households older girls or parents undertake care. Migration of females is likely to alter the operation of the care diamond to the extent that remittances inject finances which may expand recourse to paid labour and commodification in the household. The payment may not be at the full market rate but represent some recognition or compensation for caring activities, especially by family members and extended kin. Paying extended kin and domestic workers is likely to be one of the ways in which remittance are used.

The institutional architecture of the care diamond is outlined above, but the *sites of care* and the relationship between the sites and institutional arrangements need to be incorporated in order to understand care arrangements. Caring requires a setting or physical space to embody caring tasks (Statham and Mooney 2005:71). These sites include the private space of the household as well as public spaces such as crèches, nurseries, residential and nursing homes and hospitals. Another household (such as that of a childminder) may also become the site of care, especially in relation to child care. The spatial mix of where care is provided is also dynamic—when women leave a household, dependence on non-household sites for care often increases. Regulation of labour also depends on the location of labour (Statham and Mooney 2005:85-7). In the majority of countries, household labour is either unregulated or weakly regulated, while the extent of regulation will vary between public institutions and across countries. Indeed in some countries, the relationships between members of the family may be more highly regulated than that with workers in the household.

In much of the literature, the site of care is often seen as consonant with particular care relationships with, for example, households providing familial care and nursing homes through paid labour. Neither of these holds true. Employment of paid labour within the household exists both in the South and the North, especially the former, where, paradoxically, the low cost of labour makes privatized care arrangements the norm even in many lower middle-class households. However, the depth of commercialization varies based on a range of factors such as the cost of labour, relative wage differentials and cultural practices. Moreover, in rural areas in the South, the incomplete separation between productive and reproductive relations that are a mark of industrialization, and the transferability of labour from one category to the other, has meant that the household is not just a space of decommodified labour provided by family and relatives but is also a space of paid labour.

Moreover, the historical and cultural variations in the nature of the household also require interrogation.[12] Feminist writers have been insisting that household members and relationships vary depending on whether households are identified as units of resource-pooling (both income and outgoings), co-residentiality or kinship. These differences can be critical in care provision because lines of reciprocity often draw on some mixture of the three. For instance, kinship ties may be used to invoke caring responsibilities among those who are physically proximate on a regular basis so long as no costs are incurred. However, where acute care is required (such as hospital care) and care has to be purchased, payments may be made by the resource-pooling household, including (sometimes especially) those who are living abroad but are seen as part of the resource-pooling unit.

Sites of formal care also often depend on informal provision. Thus, hospital-provided nursing in many Southern countries is limited to the provision of ancillary medical care, so that those who are sick are "naturally" expected to bring someone to hospital with them to assist them in all normal activities. This still exists in Northern countries based on familial welfare regimes, such as Greece, where quasi-nurses or what Lazaridis (2007) calls "*infirmières exclusives*" are hired by individual patients in the hospital to make up for gaps in care in the public health system.

Care recipients include children, disabled people, and sick and older people. There are large differences in the social recognition of the needs of each group. Care of children, for instance, has become much more recognizable as a state good, as children come to be seen as social investments (Jenson 2003; Lister 2006). These distinctions are often critical within the global South as the relationship between the state and care may be recognized within the context of more formalized forms of care—such as health care—which have a long history of being associated with the duties of a state. Social care is much more restricted to particular welfare regimes and models of government. In particular, countries with a low gross domestic product (GDP) may have little money to extend for social care.

Care providers include family members in the household who are not expected to have formal skills. Instead, their skills are often gender-based; in other words, tacit skills that they have picked up. This is also true for many migrant domestic workers, although other desirable qualities may add to the their cultural capital, such as the ability to speak English or the language of the country. Racial preferences may also be important in defining who is allowed to do what work (Duffy 2005). Some care work outside of the household and in public spaces may demand qualifications, for example, nursery nurses or carers in residential homes. Caring professions have been a major source of employment for middle-class women, whether in education, health or social work, and a means of South to North migration, especially for nurses (Kofman and Raghuram 2006). Many countries in the South are experiencing labour market shortages in nursing as numbers are reduced by emigration (Mackintosh et al. 2006).

Care relationships are usually seen to vary between those that are broadly altruistic, those mediated by social contract and those reinforced through economic contracts. In the Southern context, most care is seen to be provided through some mix of the first two. Less well recognized is the extent of commodification of care, which appears to be spreading, albeit unevenly, across the globe. Significantly, in the context of the global South, where the family does indeed play a critical role in cementing care relationships, it is also important to recognize that care relationships are, however, often based on some notion of reciprocity (see also earlier discussion of the household). Hence, there may be some familial care relations that are based on strong sense of social obligation and are less bound by reciprocity, while others have to be secured through social effort, promise of help in return or even goods in kind. Moreover, these relationships also change over time. Thus, while care for the child was accompanied by an expectation that the parents will in turn be cared by the children in their old age (and was therefore bound up in notions of reciprocity), changing social norms around the care of older

[12] Molyneux 1979; Harriss 1981; Hartmann 1981.

people as well as increasing mobility means that the expectations and, more importantly, the delivery of reciprocal care have definitely loosened up, leaving a care deficit among older people in many countries. Hence, stark differences between care arranged through cash payments and those mediated through the family break down, especially in the global South (Raghuram 1993). Finally, caregiving relationships may be horizontal, that is, as among kin and friendship or neighbourhood groups (Roseneil 2004) or vertical such as those between patrons and clients. These too may be marked by reciprocity, although the lines and terms of reciprocity blur as notions of charity mute the calculations that often mark notions of reciprocity. Such vertical relations are particularly significant in contexts where household care provision breaks down (Raghuram 1993).

Caring skills vary on a spectrum from implicitly assumed domestic skills that are seen as inherent to femininity (see also care providers) to those that are professionalized and regulated as in nursing (Yeates 2005). Importantly highly skilled care providers such as doctors may also be seen as participating in care regimes. Moreover, it is not only the technical skill required but also the ideological commitment to care which may be differentially distributed among caregivers, defining who can care for whom. Thus, van der Geest et al. (2004) describe the case of one family in Kwahu-Tafo in Ghana, where the migrant children pay for a male migrant worker to come from Burkina Faso to take care of their ailing father. However, intimate bodily tasks continue to be done by the mother as handing these over to a paid employee would be considered inappropriate.

Thus, given the complexity of care relationships, it may be surmized that care needs careful unpacking in discussions in order to understand how it is viewed within society, how it is regulated and how it draws on migrant labour. The paper will return to some of these issues in the critical examination of the application of the chains of care analysis to origin countries. What is perhaps universal in discussions of care is the centrality of women in caregiving, making care a central concern for feminist theorizations. However, it is recent marked increases in the mobility of women that has sparked concern about the care arrangements that women leave behind (Pyle 2006).

Women and Migration

As stated in the introduction, the proportion of women in migration flows globally has increased in the last few years (UN Population Division 2005; UNFPA 2006). By 2005, women formed 53.4 per cent of migrants in Europe, 50.4 per cent in North America and 45.5 per cent in the global South (Martin 2007). However, the international migration of women is not new, although there appears to be a demographic shift in the age groups. There have been both continuities and shifts in the pattern of South-South migration (Ratha and Shaw 2007). Historically, there has been considerable migration between contiguous regions, especially where the boundaries of the postcolonial state cut across existing social groups (as in Africa) (Dodson 2007). In the lowest-income regions (sub-Saharan Africa and South Asia), almost all identified intraregional migration from lower- to higher-income countries is to countries with only slightly higher income levels. Regional wage differentials have led some countries to become both origin and destination countries while others have become "migration poles". The major middle-income migration poles are Argentina, Jordan, Malaysia, the Russian Federation, Thailand, Venezuela, and parts of Eastern Europe. United States, and more recently Europe—especially Spain—and Japan also remain major destination countries. Latin America was the first region where the number of women migrants equalled men (Staab 2005). On the other hand one of the most feminized flows of migrant labour is that from the Philippines.[13] The country has sent approximately 1.5 million overseas foreign workers throughout the Asian region—many of whom find employment as domestic workers.

[13] Asis 2006a,2006b; Parrenas 2001a, 2006b; Santo Tomas 2005.

Spatial patterns of female migration are influenced by a range of factors, particularly labour demands. For example, the entry of women into the workforce in some middle-income countries has created a growing need for domestic workers. Environmental disasters (Ratha and Shaw 2007) and difficult economic conditions following economic structuring have also led to outflows of migrants (Sassen 2000). Seasonal migrations to meet agricultural labour demands (Agunias and Newland 2007) and cross-border (or in the case of the Caribbean islands, inter-island) trading occur across many parts of the South. Political conflicts, as in Latin America, too have generated outflows (Celade 2007). Finally, regulations and regional agreements that operate to facilitate inter-regional mobility have also shaped migration, although different agreements vary in the extent to which freedom of movement, residence and settlement are given to citizens of participating countries. For instance, the Economic Community of West African States (ECOWAS) has provided freedom of movement but so far the right to set up and establish businesses has not been extended (Adepoju 2002). There is also increasing movement between the countries that are part of the Mercado Común del Sur, or Mercosur, (Brazil, Argentina, Paraguay, Uruguay) but these countries have not yet integrated into a single labour market. Most agreements are operating through a mode of labour circulation without offering settlement. However, labour movements are selective, even within regions. Within the North American Free Trade Association (NAFTA), free movement between Canada and the United States is limited to those with college degrees but there are quotas for migration from Mexico (Weisner and Cruz 2007). Similarly, the free movement of people within the Caribbean Community and Common Market (CARICOM) (Fuchs and Straubhaar 2003) was initially restricted to those with university degrees, and then extended to artists, media persons, sports persons and musicians.

Concerns over the vulnerability of female migrant women centre on their possible exploitation as workers, migrants and as women. Unorganized sectors such as domestic work are, in some cases, being brought into the remit of bilateral agreements and memorandum of understanding in order to improve the conditions of migrant workers. However, some sectors, such as sex work, remain unrecognized, although they offer job opportunities for migrants (Agustin 2007). Limited efforts to address these sectors have come from the specificity of women's experiences. Thus, in an attempt to control the spread of HIV and other infections, migrant women, who are highly susceptible to such diseases (Haour-Knibe 2005), may, ironically, gain recognition.

The available data and literature indicate that migrants who travel to other Southern countries enjoy much lower increases in income, are more likely to be irregular, are subject to greater risks of exploitation, and are more likely to be expelled than are those who migrate from Southern countries to the North (Ratha and Shaw 2007). Nevertheless, if the benefits from South-South migration are limited, it is also likely that many South-South migrants are poor, or are forced to migrate because of war or ecological disaster. Even small increases in income can have very substantial welfare implications for people in such circumstances. Differences in country incomes are likely to be much greater, on average, for migrants travelling outside their native region than for intraregional migration, partly because larger income differentials are required to overcome higher costs associated with travelling over greater distances (geographic and cultural).

Whatever the reasons and direction of migration, the mobility of women has raised concerns about the resultant rearrangements of care in countries of origin. There has been considerable concern about children left behind but it is difficult to determine the numbers in this situation (Yeoh and Lam 2007). Some have sought to estimate the percentage of households with at least one member who is a migrant worker. The proportion of households is particularly high in rural areas, for example, up to 40 per cent in Bangladesh, 50–60 per cent in Tanzania and 80 per cent in Mali (Whitehead and Hashim 2006). Of the 60,000–80,000 legal population migrating each year in Sri Lanka, 75 per cent were married, 90 per cent of whom had children (Yeoh and Lam 2007). Older people too are left behind and need to be taken into account in the

examination of responsibilities and arrangements for care resulting from migration.[14] This issue is discussed in the following section.

Gendered Migration and Care: Issues Raised

There are four different ways in which migration of people affects gendered care, although in practice a mix of all four may occur in any context. Care issues arise when:

i. people migrate as care providers;
ii. people migrate and leave some care responsibilities behind;
iii. people migrate and bring some care responsibilities with them;[15] and
iv. people migrate and have either daily or emergency care requirements, particularly as they get older.

Most current analysis has focused on the relationship between the first two categories. Large-scale migration for care purposes characterizes South to North (OECD and non–OECD countries such as Hong Kong Special Administrative Region (SAR), Saudi Arabia, Singapore and the United Arab Emirates/UAE) flows, and from low- to middle-income Southern countries within a region, for example to Argentina, Chile, Costa Rica, Jordan, Malaysia, the Russian Federation, Venezuela and parts of Eastern Europe. There are also marked internal variations within countries of the global South as well as between them. Yet, these differences are often elided in current analyses.

The first type of mobility—of those who move to care—is increasing, as women enter the paid labour market in growing numbers handing over familial care work to migrant workers. It is most marked in states where welfare is usually provided by the family, such as those of many middle- and low-income states as well as some higher income states in the South (and also Southern Europe). The commodification of care work (skilled and less skilled) is also occurring across a number of institutional settings and sectors in response to the low remuneration of care work or inadequate numbers of care professionals (such as doctors and nurses). Thus, paid care in many Southern countries pursues a "low-road strategy" (Folbre 2006b) based on market provision of an informal kind together with some public provision of health care and (in some countries) pre-school education (Razavi 2007b:17).

The second type, female migration and the issue of the care of those left behind, has become analytically and politically important in recent years. However, it is worth remembering that these issues of care have a longer history than the recent theorizations of care chains.[16] In Africa, for instance, there is a long history of circular migratory strategies that involved mothers and grandmothers sharing childcare responsibilities in rural areas while taking turns to do domestic work in towns. Transnational family strategies have also been common in the Caribbean, which means that Caribbean families are resilient to shifts in care practices due to adult female migration (UNICEF 2003). In Africa, sharing arrangements have also existed between co-wives, with one wife staying in the town with the migrant husband while the other wife goes back to the village to look after the older generation and to oversee the harvest, for instance.[17] However, what might be considered new is the geographical spread of these phenomena to different parts of the world—the extent to which these care relationships now stretch across international borders and the larger numbers of people involved in such global care regimes.

[14] Nguyen et al. 2006; Save the Children in Sri Lanka 2006; Toyota et al. 2007.

[15] Looked at from the perspective of children or elderly, this could be reframed as people who migrate because of their care needs. The latter approach is analytically powerful as it sees those who require care as agents who direct and shape the mobility of the migrant by influencing where women migrate to, when they return and so on. It also suggests that children can lay claims to be cared for by other relatives, not just mothers.

[16] See for instance Izzard (1985).

[17] Dorte Thorsen, personal communication, 2 November 2007.

In relation to the third category, those who bring care responsibilities with them, normative notions of family mean that migrants are sometimes allowed to bring children with them but rarely elderly relatives such as parents, except as visitors. Although countries of the North with family migration policies allow dependent children, they place restrictions on the age of such children. They also often disallow migrants from bringing older relatives under family reunification or sponsorship (Kofman and Meetoo 2008). In some countries, such as the UAE, migrants have to earn a minimum income before they are allowed to sponsor children. Moreover, women may also face harsher rules around family reunification than men. Thus, in the UAE, women are not allowed to sponsor children unless they are employed as doctors, nurses or teachers. However, refugee movements remain an exception to this as whole families may move under conditions of political and environmental stress.

The care needs of migrants are the least well considered of the four categories. In South-South migration, such care is complicated by the fact that most migration is temporary, albeit over long periods. Are the migrants going to go back when they themselves require care, and what does this mean for the countries to which they return? What about children who migrate as paid carers as in many parts of Africa—should there be schools for such migrants that take account of their working lives? This is an issue that has long had purchase in the South, as migrant child workers have generally played a dominant role in delivering domestic work as well as care of the elderly (Mehta 1960). Hence, several children's NGOs, for instance, have spent time trying to meet the care needs of the children, who themselves act as paid carers in employing households (Anderson and O'Connell-Davidson 2003). It is also unclear as to what forms of mobility ensue when the adult worker is killed or dies. For instance, do the grandparents of children orphaned due to the death of their parents from HIV/AIDS become incorporated into economic systems that have been based on adult worker migration, as in Southern Africa? Do these older people now migrate in order to provide for the grandchildren? And what forms of caregiving are being organized when older people are forced to migrate and to take up jobs in order to pay for care for young grandchildren who are found to be HIV positive? The difference between demographic displacement that happens when women move and the demographic gap when women die needs much more study. It acquires political urgency in most countries where women have no insurance of any kind as in many parts of Africa.

Analysing Care, Gender and Migration

There have been many studies on the impact of male migration on those left behind. For instance, the social consequences of a heavily male-dominated migration stream on society in Kerala were explored by Leela Gulati's seminal study *In the Absence of Their Men* (1993). The findings of this as well as later studies suggest that loneliness was a key problem faced by women left behind, especially if they were young. Women had to shoulder a considerable degree of responsibility, particularly with regard to children's education. The women left behind, often called Gulf wives, either set up, or stayed in, their nuclear households or returned to their parents' or parents-in-law's households, but the choice of where to stay was often dictated by children's educational needs. Zachariah et al. (2003a, 2003b) suggest that women's status and authority increased due to remittances, with about half of the Gulf wives surveyed in their study owning land, 70 per cent holding and managing their own bank accounts, and 40 per cent having their own income which they controlled. The studies show that while women had increased stresses and responsibilities, their sense of autonomy also increased in the absence of men, so that the gender selectivity of migration was not wholly detrimental to women.

However, the migration of women is raising certain concerns. This has led to a range of analytical studies linking gender, migration and care. One of the most cited of these is the conceptualization around "global chains of care". This is a concept that has rapidly become

highly influential in analysis of the transfer of physical and emotional labour from the South to the affluent households of the North, and was defined by Arlie Hochschild (2000:131), "as a series of personal links between people across the globe based on the paid or unpaid work of caring". The chains may vary in their number and connective strength. For example, the emigration of a woman to care for a child or an elderly person in a wealthier country may generate another link in the chain, either bringing in someone from a poorer area to look after her own children and parents or entailing another member of her own family, such as a sister, being remunerated to do the caring. It may also involve hiring migrants from other countries (van der Geest et al. 2004). This analysis has the scope to connect the different migratory movements; however, current analyses tend to be premised on a narrow range of relationships, institutional arrangements and care regimes (Kofman forthcoming; Yeates 2004, 2005), privileging transnational motherhood and the centrality of the household in care arrangements in destination countries. Moreover, the concept of global chains of care has primarily focused on the international aspect of migratory movements and does not examine the cascade of effects generated by migratory movements or the implications of gender and care regimes in the South. As Zimmerman et al. (2006:19) comment, "we know very little about how care deficits are addressed in sending communities and kin networks". This section suggests a number of ways of broadening and deepening the analysis of global chains of care in the South.

Care chains and countries of origin

Care chains have become important conceptual tools because unlike in the late eighteenth century, today's migrant workers perform domestic work not as a stage in the life course prior to marriage (McBride 1974), but as a full-time and life-long occupation which may involve their movement from one country to another. Mature-age migrants may be engaged in this work full-time. What happens as their children grow up? Furthermore, there are regional variations in the extent to which paid domestic work was feminized. Now that domestic tasks have become more clearly defined and associated with the private space of the household,[18] more of the workers, including migrants, entering such fields are women. While in countries such as Thailand, it is primarily fathers who leave children behind, in the Philippines and in Sri Lanka, it is mostly women who do so (Yeoh and Lam 2007).

This raises particular questions about what happens to the care tasks left behind. In the Philippines, Parreñas (2005) found that when migrant women leave, fathers rarely picked up caring responsibilities. In working class families, other women usually took over the work; in middle-class families, fathers usually relied on paid domestic labour, other kin and family members such as older daughters. Yet based on a detailed study (Episcopal Commission et al. 2005), Asis (2006b) suggests that in about half the cases where the mothers have migrated, children identified men as the primary caregivers, a finding at odds with that of Parreñas. Elsewhere in South Asia, there appears to be much less redistribution of child care. Thus, a range of studies[19] suggest that men rarely take up the responsibility for caregiving but rather, appear to need care when women migrate.

As a result, women's migration generally reconstitutes the division of labour among women such that extended female kin absorb some of the caring activities.[20] Thus, "other mothering", defined by acts of nurturing and care giving rather than biological relationships between mother and children, becomes significant in assisting in the raising of children and looking after other family members who require care (Schmalzbauer 2004).[21] Other mothers are the grandmothers, sisters, aunts, older daughters (Estrada 2006), friends and neighbours. Thus a non-migrating woman may provide care for her own children, nieces, nephews and cousins. Their duties of physical care and emotional support may extend beyond close family and kin

[18] Mehta 1960; Hansen 1989; Moya 2007.

[19] Gamburd 2000; Ramji and Uma Devi 2003; Keezhangatte 2007.

[20] Although some of these forms of redistribution of care have always occurred, migration intensifies the process (Raghuram 1993).

[21] Leah Schmalzbauer's study of 157 people in poor transnational Honduran families used multiple methods, including weekly care diaries for 34 of her respondents in the United States.

into the community to forge a collective survival strategy for poor families. On occasion, these responsibilities may also engender resentment and strain relationships among extended kin.

Finally, migrant women frequently maintain their emotional concerns and advice from afar, sustaining an active, though distant, transnational mothering. As a result, mothers may contest the myth of the male breadwinner but retain the myth of the female homemaker**.** Hence, the range of care arrangements in the chain may be varied.

Family members and family formation

The emphasis on child care, transnational motherhood and children left behind in most analyses of care chains simplifies female migration and transnational family dynamics. As noted above, older people, both as care receivers and care givers, too have their place (Escrivá 2005; Kraeger 2006). Moreover, not all migrants are necessarily mothers, and many may be unmarried or without children. An Italian study of domestic workers revealed that 41.6 per cent were married and 69.6 per cent had migrated alone (Fondazione Andolfi cited in Chaloff 2005), although this is likely to vary according to nationality, class, age and so on. The Philippine government claims that women are less likely than men to leave their families, based on figures showing that more than half of women migrants were unmarried, compared to 72 per cent of men. But of course women migrants may be unmarried and have children; many are single mothers.

Gender and sexual differences

Most analyses of care chains presume particular gender divisions of care within heterosexual kin arrangements. However, domestic labour has only become heavily feminized in many regions in recent years. Feminization has proceeded with the expansion of the domestic worker-employing class, but the very wealthy with several domestic workers still employ men who perform tasks such as gardening, repairs as well as caring for the elderly and disabled. Manalansan (2006) has also critiqued the heternormative assumptions of global chains of care and its focus on heterosexual mothers, thus neglecting men (gay and straight) and single women. The maternal and affective labour is thus embodied in married, separated or divorced mothers. Despite the fact that the field research often includes men and single women (see Parreňas 2001a), the analytical framework is reduced to the maternal relationship as the chain connecting origin and destination households. Manalansan (2006) suggests a need to complicate these accounts by including male domestics, and women as sexual and gendered agents.

Sectors and skills

One of the strengths of the global chains concept has been to highlight the role of households in the global economy but it also becomes a weakness unless it is connected with the other sites in which care takes place. Care may also require different levels of skills because many professional occupations, which have experienced severe shortages, require care in the form of relational and personal interaction. In sum, it is not only households but also health and community services that employ migrant labour in private, voluntary and public sectors.

The impact of female migration too has usually been studied within the context of the family. However, the locus of the care deficit is not just the family but also state institutions, the market and NGOs. This is particularly clear in the case of some skilled sectors such as nursing (Ball 2004; Mensah et al. 2005) where under-resourced health systems and poor working conditions act as "push" factors for nurses to migrate, while the huge global demand for their services in the North "pulls" them. This care chain (Yeates 2004, 2005) has meant that unfortunately, sub-Saharan African countries, with some of the highest rate of infectious disease in the world (25 per cent), retain only 1.3 per cent of the world's health-care practitioners. Other services too face the impact of care loss, as for example, teaching (Voigt-Graf 2003), where the effects of large-scale migration have been felt as deteriorating provisions. Most of the literature as it pertains to female skilled migrants focuses on feminized sectors, although such care chains and their

impact on care provision in origin countries may also be traced through the more male-dominated care sector such as doctors (Raghuram 2008a). At the same time nursing has in recent years become more masculinized, and there is evidence that male Filipino doctors are retraining as nurses to find employment in Europe and the United States (Manalansan 2006:240).

On the other hand, the impact of skilled migration is not only on institutions but also on families, although this has so far largely been ignored. Although skilled migrants are more likely to be able to bring their families with them, immigration regulations in Southern countries often limit the scope of reunification, leaving a care deficit within the household. However, the impact of such migration may be quite specific as women can access private care for children, such as boarding schools. Organized care for older people is, however, still in its infancy although it has become a growth area in some countries precisely because of the purchasing power that skilled migrants hold. Moreover, such migrants also return and set up care facilities as they identify gaps in existing provision as a market niche.

Role of the state and immigration regulations

The role of the state in producing supply and demand for caring labour has a significant, if underrecognized role in how care chains are configured—it is not only markets that have a role in labour transfers between transnational households. States such as the Philippines produce exportable skills, such as nursing and also encourage emigration. Some other countries, particularly in Asia, may prevent certain people, such as less skilled women, from legally emigrating. During the late 1970s, Sri Lanka was among the first countries in Asia to allow women to migrate to work in the Middle East and the only country to do so without any restriction. Women now account for nearly 65 per cent of its migrant population.

Remittances

Remittances play a central role in maintaining the family and local communities and need more exploration in the context of care chains. Each year, women working abroad send hundreds of millions of dollars in remittances back to their homes and communities.[22] These contributions pay for feeding and educating children, providing health care and generally improving living standards for kin in sending contexts. Because women typically receive less pay for equal work (or labour in sectors that offer poor wages), the amount that women remit may be less compared to men, although they often send a higher proportion of their income. Thus, a major study showed that Bangladeshi women working in the Middle East sent home 72 per cent of their earnings on average and that 56 per cent of female remittances were used to cover daily needs, health care or education (Ratha and Shaw 2007).

There is little literature on the ways in which gender differences in remitting (Orozco and Lowell 2006) also extend to how this money is actually used in the household (Martin 2007) and the community to sustain caring activities and remunerate family members. In one study Walton-Roberts (2001) found that male remittances were often used for infrastructural development of care institutions while female remittances would lead to personal provision of care.[23] Orozco and Lowell (2006) also note that women are more likely to remit to a wider range of family members and assume this is altruism, although we would argue that this is more to do with recompense and support for caring activities.

Not much is known about the extent to which remittances reshape or modify the relationships between and within the different nodes in the care diamond. One might ask how non-kin domestic workers, other family members and extended kin split the physical and emotional labour of care. In cases where kin or neighbours are remunerated, is it at a market rate or is it a

[22] There is a growing literature on women and remittances (Kofman 2006; Ramirez et al. 2005; Sorensen 2005).

[23] See Singh (2001) for an interesting discussion on the meaning of money sent by migrants and for an anthropological research agenda on remittances.

partial recompense for their caring, thus reflecting to some degree the commodification of household labour (see previous discussion of other mothering)? To what extent do kin or non-kin migrant workers come from other areas, or are they recruited from within the locality? In many countries of the South, rural migrants continue to supply a large or major share of domestic labour, for example, in almost every major city of Latin America and the Caribbean (Moya 2007). In Calcutta, almost all come from rural Bengal (Ray 2000). In sum, remittances influence social dynamics in both positive and negative ways, leading to individualized benefits but also to rivalries and new inequalities that can have wider social effects on care arrangements in areas of emigration (Walton-Roberts 2004, 2001).

Questions may also be asked about what happens when remittances stop. For instance, when migrants become infected with HIV, remittances often dry up—either because of job loss or because of higher health care expenses. Botswana, a country with one of the highest HIV prevalence rates in the world (33.5 per cent), is witnessing decreased remittances from husbands with AIDS–related illnesses. As men return home and spread HIV to their wives, women too may die, leaving a smaller pool of women shouldering the care of orphaned children of their own kin as well as others (Upton 2003). According to Joint United Nations Programme on HIV/AIDS (UNAIDS), women may also resort to paid sex work or migrate to make up for the lower remittances so as to provide for family members.

Community involvement

NGOs are a relatively neglected node in analysis of care chains but they are playing an increasing role in making care arrangements. Migrants are not only directly responsible for care arrangements but their payments also help to pay for care for myriad others, both routinely and in emergencies. Thus, they have funded the establishment of care centres for older people and for those with specific disabilities in the absence of stronger state provision (Viswanath 2000). However, the state has found new roles in this particular nexus of the care diamond, emerging as a regulatory body in managing care, though not providing or paying for it (Raghuram 2008b). For instance, the Planning Commission of India, along with Charities Aid Foundation, has attempted to improve the credibility of the voluntary sector by engaging in a validation programme of all voluntary organizations in 2000. This is part of a response to engender confidence in the migrant population who were reluctant to engage with the voluntary sector because of their anxieties about corruption and misuse of funds by NGOs. It is hoped that enhancing standards of accountability in voluntary organizations will encourage the diasporic population to further engage in philanthropic activity (Viswanath 2000; Gopa Kumar 2003).

Caregiving and receiving and ethics of care

Finally, as suggested above, care giving and receiving extends beyond intra-household connections and the transfer of labour from South to North or between Southern countries. Not only does it involve the interplay of households, communities, markets and states but it also encompasses different qualities and social relations in the giving and receiving of care captured by the notion of the *ethics of care*.[24] Care helps us rethink humans as interdependent beings and to consider values that guide human actions; it concerns not just those who depend on others most directly, such as the disabled or frail older people. For both givers and receivers, it involves the physical, the emotional and the symbolic. It is a central concern of everyone's life and should not be relegated to women. An ethic of care has the capacity to balance an ethic of work as the core of contemporary citizenship (Sevenhuijsen 1998; Williams 2001).

Fisher and Tronto (1990) outlined four competencies of care:

- *Attentiveness*—caring about people, that is, noticing the needs of others;
- *Responsibility*—taking care of, and through that, assuming responsibility to care;

[24] Fisher and Tronto 1990; Sevenhuijsen 1998, 2004; Tronto 1993; Williams 2001.

- *Competence*—caregiving, and the activity of caring involved in this (one of the more common meanings of the word); and
- *Responsiveness*—care receiving, which involves an awareness of one's own vulnerabilities as well as an appreciation of the different positionings of the care giver and care receiver.

These ethics may be played out not only in relation to global chains but also through the many personal, familial and work relations in which people engage both in countries of origin and in sending countries. Williams (2001:488) effectively brings these elements together (thus going beyond tracing normative principles of policy) by mapping work and care within three connected areas of life: personal time and space or what we need for the care of self and maintenance of body, mind and soul; care time and space or what we need to care for others; and work time and space or what we need to enable us to gain economic self sufficiency and balance these other areas (Sevenhuijsen 2004). This takes into account the needs of the migrant carer in all stages of their life cycle—that is, the self both as carer and cared for in the destination and origin countries. However, one cannot presume what care needs an individual may have (Ramji and Uma Devi 2003) as care is more diffuse than what is captured in the direct engagements suggested by the metaphor of chains of care. Care needs can be defined differently not only in terms of legislation but also in insurance packages, cultural practices and so on (also see Raghuram et al. 2009).

Gender, Migration and Care Regimes: Conceptual and Policy Agenda

Williams' engagement with the political ethics of care through the discourse and practices of work/life balance or the reconciliation of work and home is particularly pertinent. These discourses have been adopted and disseminated not just within the European Union but also among international organizations like the ILO (2004) and the OECD (2004–2005) and therefore have a wide reach. Moreover, international organizations have adopted some of the Northern, and especially European, frameworks, such as the improvement in the balance of work and family. For example, an ILO report used this framework to study the impact of intensified work on family life and care for poor working families in Thailand (Kuskabe 2006). It found that grandparents are frequently called upon to take care of grandchildren, often without any financial support. There is also little support (state and non-state) for the care of children and the elderly, and there is no widespread recognition of the role that the state could play in such provision. Some recommendations for the improvement in the balance between work and family include: ratification of the Workers with Family Responsibilities Convention, 1981 (No. 156) and the Maternity Protection Convention, 2000 (No. 183); improvement of child care services accessibility and standards; provision of child allowances regardless of employment and directly to the care provider; reduction of working hours and provision of a living wage as minimum wage; increase in leave entitlements; promotion of the sharing of household work between women and men; improved data collection and statistics on family and work; and increased public awareness on how to create a better work-family balance. The recommendations clearly reverberate with the ways in which these issues are perceived in the global North.

Within this context of globalizing notions of social policy, it is worth reiterating the gendered impacts of such policy. For instance, the extent to which states recognize unpaid work as a contribution and the design of various family and child benefits all have clear gender implications that need bearing in mind (Razavi 2007b).

Equally, the shift toward more liberal welfare states and the encouragement of monetary benefits may support particular kinds of family and gender relations and the use of migrants at a relatively low cost. Frequently the objective has been to shift provision into the home and reduce expenditure on collective and public provision. In Southern countries there is still

considerable reliance on the extended family for care of children, the sick and the elderly. Few public or private services have emerged in response to the consequent demand for care. There is limited public action or legislation that seeks to harmonize work and family duties, even in areas where the impact of HIV/AIDS has increased the burden of care on poor working women. There is still little recognition of the contribution of household work to national economic outcomes[25] and therefore little change in the corresponding economic and social policies for care work being promoted (ILO 2006 Millennium Development Goals).

And though the reconciliation of home and work has been the one of the most commonly adopted strategies for promoting care services, it fails to adequately address a number of considerations that will be relevant for the North and South alike. These concern issues of citizenship for carers and the cared-for throughout their lives, and the rights of care workers. While care activities have not been recognized in social policies in most countries in the South, the continuing emigration of women—not just for care activities—in the North and wealthier countries of the South, will also increasingly raise issues of care provision in the South.

Many care workers only enjoy partial citizenship (Parreňas 2001b) at best. Even for those who are documented, some benefits—for example, maternity benefits—are limited to citizens, permanent residents or those with a stipulated duration of residence in countries of the North. In many Asian countries, the circulation of labour is imposed and thereby reinforces broken social protection. Their fragmented work histories in other countries may mean that they cannot access pensions upon their return. Some countries have established an insurance scheme for overseas workers. In India, the Pravasi Bharatiya Bima Yojana provides identity cards to those who are registered with the scheme and offers them insurance cover of up to Rs. 200,000 (around $4,440[26]) in the case of death or disability during the period of overseas employment. It also offers maternity benefits to expatriate women workers. The establishment of an overseas workers' welfare fund and a manpower export promotion council are also being debated (Ministry of Labour 2003). The Kerala government offers its women migrant workers insurance through the Pravasi Vanitha Suraksha Scheme. It covers 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.

However, these are changes that only affect documented workers. Undocumented workers are not protected by any laws, which is a primary concern in a sector dominated by them. Most domestic workers are more likely to be influenced by the blasé attitude adopted toward maltreatment of domestic workers as reflected in the report of the high-level committee on the Indian diaspora (Raghuram 2005). It recognizes that there are occasional cases of assault and maltreatment but sees its incidence as sporadic and not of major concern. Attempts at regulating the working conditions of Indian domestic workers more specifically have primarily come from other sources. For instance, the United Nations Development Fund for Women (UNIFEM) pressurized Jordan, a major destination country for domestic workers, to regulate the employment conditions of domestic workers. Some progress has been made toward this with the implementation of the Special Working Contract for Non-Jordanian Domestic Workers. It augments coordination between the countries of origin, and Jordan, as a destination country to increasing numbers of migrant workers from Asia, guarantees migrant workers' rights to life insurance, medical care, rest days, repatriation upon expiration of the contract, and reiterates migrant women's right to be treated in compliance with international human rights standards.[27] This contract followed the signing of the memorandum of understanding between UNIFEM and the Ministry of Labour in August 2001, marking the beginning of the project Empowering Migrant Women Workers in Jordan.

[25] A major project is being undertaken on the Political and Social Economy of Care by UNRISD. It examines the value of total paid work in the economy versus value of total unpaid work (www.unrisd.org/research/gd/care).

[26] All $ figures refer to US dollars.

[27] See for instance, www.december18.net/web/docpapers/doc631.pdf, accessed on 27 June 2009.

Countries that have become dependent on the emigration of domestic workers will in the future need to take account of the care needs presented by ageing care workers who are distanced from their own families. Thus, while transmigrant practices may bind domestic workers to those whom they have to help, and to those who care for their children, the dissolution of transnational relations provides an even more frightening scenario. The welfare of the domestic workers themselves, especially in their old age, may not be assured through these relations, so that they are left without social protection in both destination and origin countries.

Globally, conditions of employment and the regulation of labour vary considerably. The rights of domestic and care workers need to be improved, and labour legislation should be extended to these workers, including to those who are working within a household. In many states, the household is exempt from normal labour legislation. In the United Kingdom, for example, the Race Relations Amendment (2000) Act does not apply to the household unless the worker is employed through an agency. The problem is exacerbated by the lack of acknowledgement in immigration policies of many Northern European states of the demand for domestic care labour, which leads to the refusal to offer work permits (Lutz 2007). The eastward enlargement of the European Union has led some of these countries (Ireland and the United Kingdom) to believe they can source care labour from Eastern Europe. Even in countries with official recruitment policies as in Southern European states, many women work without a regular status and employment contract and are unable to access civil and social rights. In most countries in the South little regulation exists to protect migrant workers, especially if they work in the lesser paid, less recognized caring sectors (Teo and Piper 2009). In Bahrain, the likelihood of the inclusion of domestic workers under Bahrain's Labour Laws will help to improve their working conditions. The Asian Migrant Centre has campaigned on behalf of domestic workers in Hong Kong SAR. The demand for domestic labour, however, continues to expand, and new theatres for exploitation are being opened up.

Although gender differences in remittances is beginning to be recognized, it is important to advance beyond identifying differences and to probe more deeply into how these remittances are used in the household and the community, as well as ask questions about redistributive outcomes in a community. Caring as an activity is not captured by the broad categories of education and health. So while remittances fill in for social expenditure and replace the "skinny" reproductive role of the state (Herrera 2005), they also redistribute income among women carers—the "other mothers" who look after children. In addition, the impact on care services of diasporic investment should be investigated, including those of skilled migrants who might be looking into investment opportunities and who cater for the expanding middle classes in their country of origin. After all, caring is becoming a big business (Williams 2007).

Conclusion

Care is a significant aspect of social policies seeking to produce a more equitable distribution of reproduction in society. This paper has sketched out some aspects of the architecture of institutional and spatial arrangements of care and the ways in which migration has influenced the gendered redistribution of care. This has been analysed through the rubric of the care diamond which shows both overarching global processes and the heterogeneous local arrangements involved in procuring care. Neoliberal policies, demographic changes such as ageing, increasing significance of international organizations such as the World Bank in shaping policy agendas, all provide a shared framework within which caring is undertaken across the globe. Care also refracts and reproduces existing social hierarchies. For example, the gendered division of care activities and the significance of class in defining who actually does the caring and who gets cared for are reproduced across the globe. At the same time, there are also a number of differences within both the North and the South. For instance, the North comprises a number of welfare regimes which are continually being reshaped by neoliberal restructuring of the welfare state as well as the dissemination of regional norms and policies, especially in relation to child care. The South includes middle-income countries as poles of migration and

which have begun implementing active social policies and/or intervened in the provision of care, countries largely exporting care labour, and countries where care systems have been overwhelmed by the HIV/AIDS pandemic. Hence, the analysis of care arrangements needs to be attuned to local specificities, and the usefulness of the South as a single category in analysing care may be limited.

Second, this paper has highlighted the multifaceted and dynamic nature of the relationships between the four points of the care diamond. For example, the household is growing more complex due to commodification, the changing presence of the private, community and state sectors, and the increasing deployment of migrant labour to undertake care labour under different kinds of employment contracts. Hence unpaid and paid labour increasingly coexist in the same space, at times generating hybrid forms of formal and non-formal work relations. However, the household is weakly regulated and the state is often more concerned, especially in certain Asian states, with ensuring the rapid circulation of labour. The community and voluntary sector have also stepped in to fill care gaps, including those organized by religious and specialist associations or by neighbours, which has altered the relationship between family and community. The role of the state continues to be important in shaping care, although the form that this may take will vary across countries. Development of social policy and care in countries of the South is more likely to take the form of subsidies and regulation of voluntary and private sector than any direct provision. It will also be driven by care deficits generated by women working outside the home both in the country in question and in countries where they have emigrated, primarily, but not exclusively, in the care sector as domestics and carers in the home, or as carers and nurses in the formal sector (private, voluntary and public). And the market continues to be a major provider in all these contexts. Given the complexity and different combinations of forms of care, there is a need to conduct more local and national studies, such as those being undertaken by UNRISD, of the changing institutional and spatial arrangements for care provision and the relationship between paid and unpaid care.

Third, migration offers states a buffer from recognizing the economic and social importance of care by securing a mobile, often cheap care workforce. For origin states, the possibility of remittances has meant that the migration of careworkers is often recognized, although their own care or the unpaid care arrangements (often drawing on internal migrants) they leave behind are seen as less important. This paper therefore argues for the need to evaluate the economic contributions of care both in countries of destination and origin countries. It also suggests that care draws on both internal and international migration and that the two need to be seen in tandem in the re-evaluation of care.

Finally, the paper suggests that not everything that care offers can be easily evaluated. Drawing on the ethics of care literature, it argues that the emotional and intrinsic qualities of care also need recognition. These qualities should also not be seen as inherently feminine qualities but should be extended to the social organization of production and reproduction globally.

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