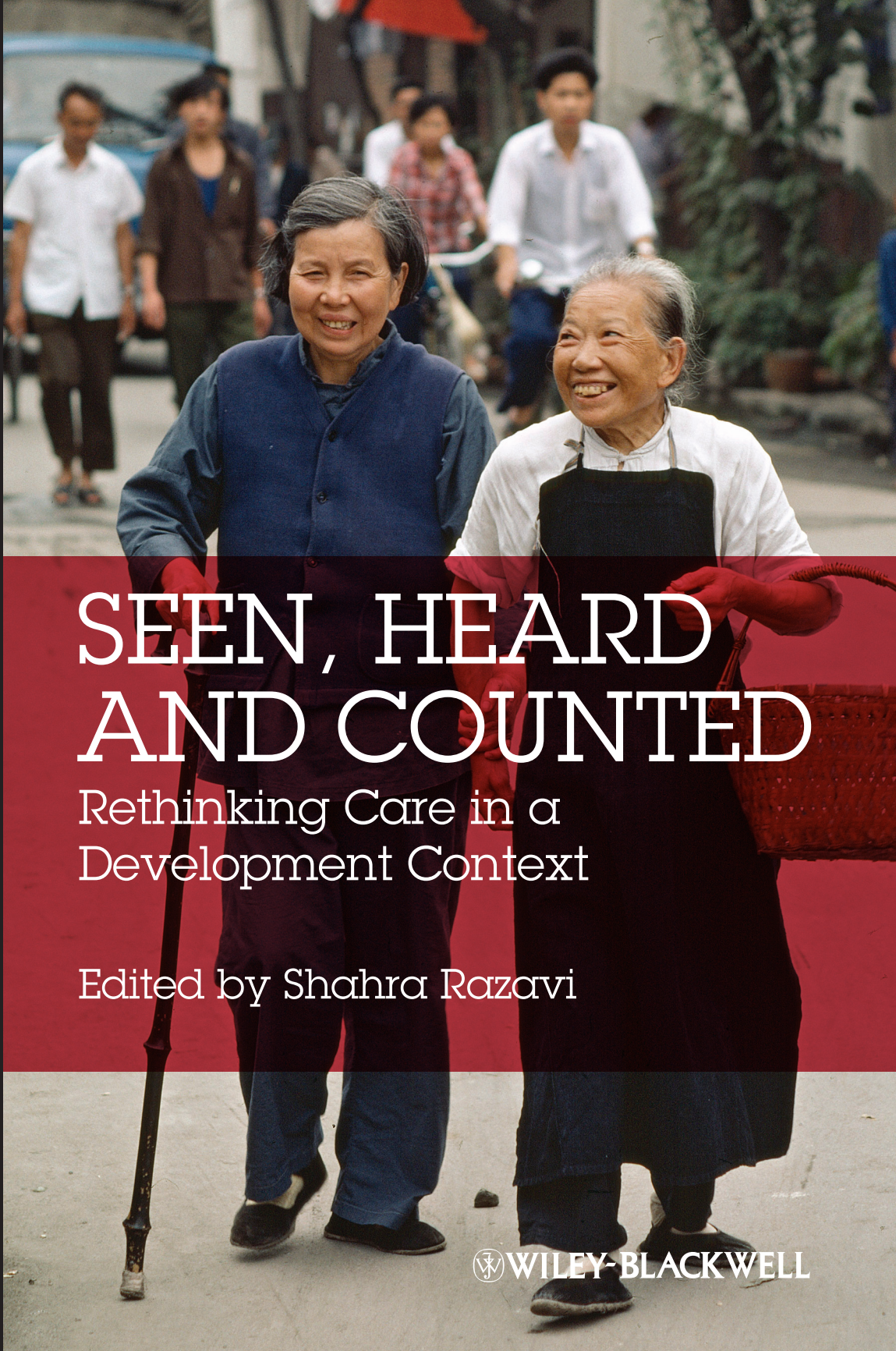

SEEN, HEARD AND COUNTED

Rethinking Care in a Development Context

Edited by Shahra Razavi

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Rethinking Care in a Development Context: An Introduction

Shahra Razavi

INTRODUCTION

The restructuring of production systems on a global scale and the recurrent financial and economic crises to which liberalized economies are prone, have received considerable attention, both scholarly and policy-oriented, in recent decades. While it may not have made it to the front page of *The Wall Street Journal*, a great deal has also been said about the social disruptions associated with the ascendancy of the neoliberal agenda — reminiscent of Polanyi's (1957) analysis of the 'disembedding' of markets from social priorities in eighteenth and nineteenth century Europe (Beneria, 1999; Standing, 1999). One long-standing critique originating in response to the stabilization and adjustment measures of the 1980s came from feminists who pointed to women's intensifying unpaid work as 'shock absorbers' of last resort (Elson, 2002). While bankers and governments have periodically worried about how to respond to the crises of finance, including the most recent episode that erupted in Wall Street, others have voiced concern about the long-term repercussions for social reproduction (Bezanson and Luxton, 2006).[1] It is indeed tempting in this context to think about a generalized crisis of social reproduction, or a 'crisis of care',[2] as some have framed it (Beneria, 2008).

I would like to thank Chantal Stevens and Ji-Won Seo for excellent research assistance during the preparation of this volume. I am also grateful to Debbie Budlender, Sarah Cook, Silke Staab, Nicola Yeates and two anonymous referees of the journal for their useful comments on previous drafts of this paper. This volume draws on research commissioned by UNRISD under the project, 'The Political and Social Economy of Care'. The project was funded by the United Nations Development Programme (UNDP) Japan/WID Fund, the International Development Research Centre (Canada), and the Swiss Agency for Development and Cooperation (SDC).

1. Social reproduction has been defined in a variety of ways. We understand the concept to include the social processes and human relations associated with the production and maintenance of people and communities on a daily and generational basis, upon which all production and exchange rest (Bakker, 2003: 67); it involves 'the provision of food, clothing, shelter, basic safety and health care, along with the development and transmission of knowledge, social values and cultural practices and the construction of individual and collective identities' (Bezanson and Luxton, 2006: 3; see also Elson, 1998).
2. Care is defined as the activities and relations involved in meeting the physical and emotional needs of dependent adults and children, and the normative, economic and social frameworks within which these are distributed and carried out (Daly and Lewis, 2000). It is thus one important component of social reproduction.

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However, as the contributions to this volume show, even if the care crisis is global, it is far from homogeneous. Moreover, care arrangements in developing countries have not received the same level of scrutiny as those in advanced industrialization countries — a lacuna that the present collection of papers seeks to address. Hence, our assessment of care systems and public policy responses is largely focused on these under-studied contexts in Africa, Asia and Latin America.

Women's entry into the paid workforce — a near global trend[3] — may have reduced the time hitherto available for the provision of unpaid care. But this shift has taken place alongside many other changes, some of which may have intensified care burdens, while others may have had a more favourable impact on the capacity of households to meet such needs. A clear illustration of the former is the pressure brought to bear on family care providers by the HIV/AIDS pandemic, especially in Southern Africa where prevalence rates are high and health systems under enormous strain (Budlender and Lund, this volume).

Care systems are also under stress where families are reconstituted, whether through internal or cross-border migration. In China, due to the residential registration system (*hukou*) and land use rights, migration remains temporary and results in a large 'left-behind' population. Cook and Dong (this volume) cite estimates suggesting that close to one-third of rural children are 'left behind', either living with only one parent (mostly mothers), or with grandparents or other relatives. This resonates with the growing literature on 'transnational families', also covered in the contribution by Yeates (this volume), which draws attention to care deficits experienced by children in migrant-sending peripheral countries like the Philippines while their mothers seek paid work elsewhere in the world (Ehrenreich and Hochschild, 2003; Parrenas, 2005). There are clearly hidden costs of migration that are not easy to capture, not only those involved with the dislocation of families but also psychological ones (Beneria, 2008). Yet it is also important not to assume that 'abnormal' family arrangements necessarily result in a care deficit.[4]

The rising prevalence of households with young children maintained by women who have to manage both income earning and care giving, whether in Uruguay (Filgueira, Gutiérrez and Papadopulos, this volume) or in South

3. That is, if developments in the previously planned economies of East and Central Europe, Central Asia and China are excluded.
4. As Parrenas's (2005) research in the Philippines shows, ideologies of gender and the naturalization of motherhood frame both the practices and the discourses of loss and deprivation in these households: children constantly complain about the deprivation they experience in terms of lack of maternal love, and the inadequacy of the love they receive from fathers and grandmothers — even where fathers are very present in their lives and other kin (grandmothers, aunts) provide support and care. Migrant mothers, likewise, often justify their work overseas as a household strategy to meet family goals (e.g. putting children through school or lifting the family's circumstances), even though in reality family and personal goals are often interwoven in the migration project (see also Asis et al., 2004).

Africa (Budlender and Lund, this volume), presents yet another scenario where the demand on women's time is enormous. It is also among this cluster of largely lower-income households that access to care services, whether public or market-provided, remains limited. It is important again not to assume that children in these households are necessarily more deprived, for example in nutritional terms, than children in families where both parents are present (Moore, 1994). There is nevertheless a tendency over time towards what Chant (2010) has called 'the feminization of responsibility and/or obligation', whereby women with young children are having to assume an increasing share of the responsibility for meeting household needs with little or no support from the fathers of their children.

However, the past two decades have also seen rapid fertility decline in many parts of the developing world (which may mean fewer children and less time devoted to childcare),[5] the increasing availability (though at rates that are far from adequate) of amenities such as clean water, electricity and time-saving domestic technology, and increasing rates of enrolment of children in primary and — to a lesser extent — pre-primary education and care services. Taken together, these developments may well have reduced the drudgery of domestic work among some social groups, and shifted at least a small part of care to institutions other than the family. It is not clear therefore that the overall need for the provision of unpaid care has increased over time in all places, although in some contexts and for some groups it clearly has.

While the present moment may not necessarily be marked by a generalized care crisis, as we have suggested so far, there is nevertheless something new about the current juncture. Care has emerged, or is emerging, as a legitimate subject of public debate and policy development on the agendas both of those making claims — be it through social movement activism or NGO advocacy — and of many governments, not only in the advanced industrialized countries, but also in developing countries.[6] The contributions in this volume present a first picture of differences and commonalities in these trends across a series of developing countries, and the ways in which care dynamics across developing and developed countries are interlinked.

How is this change — the eruption of care onto the public/policy agenda — to be explained? Many would argue that the period of state roll-back and retrenchment which marked the 1980s was superseded in the late 1990s by a reorientation in mainstream thinking, with the shift to the 'post-Washington Consensus'. This entailed a tacit recognition, at least by the international financial institutions, that effective governance was not simply

5. Demographic variables alone do not determine care needs and burdens. Rather, they are filtered through social, cultural and economic factors which, in turn, shape what is considered to be 'sufficient' or 'good' care. For example, time allocated to adult–child interaction tends to increase as ideas of what constitutes 'good care' change. Another implication of fewer children may be that they cannot look after each other.
6. Perhaps indicative of 'the moment', the United Nations Commission on the Status of Women that meets annually in New York, selected as its theme for 2009 the issue of care, with particular reference to HIV and AIDS.

about shrinking the state.[7] There was also a willingness to recognize the need for social expenditure — now recast as 'social investment'[8] (Jenson, 2010; Jenson and Saint Martin, 2006) — if the liberalization agenda was to stay on course. In the context of a more enabling ideational environment, regional and global development agencies called for social policies that could restore the social fabric 'through activating greater participation, more "community level" networks and ties of social solidarity' (Molyneux, 2002: 173), and agencies such as ECLAC, OECD, UNICEF and the World Bank advocated in favour of both cash transfer programmes and early childhood education and care services (Bedford, 2007; Mahon, 2010).[9]

As is evident from the contributions in this volume, these global policy pronouncements have been taken up enthusiastically in several Latin American countries where governments have developed social policies to address the needs of children, women and the family through care-related policy innovations. These have included conditional cash transfer schemes, different modalities for expanding the availability of early education and care services, and the introduction of child-rearing credits in pension schemes. One suspects that beyond the ideational shifts associated with the social investment approach, which have had particular traction in this region (Jenson, 2010), there has also been some contagion or 'spill-over' effect across countries (in the form of 'best practices' and the like). Emblematic of a new wave of social policy and based on the pioneer schemes in Brazil (*Bolsa Familia*) and Mexico (*Oportunidades*), cash transfer programmes, largely targeted to mothers, have been piloted and/or institutionalized in at least fifteen countries in Latin America. We return to some of the gender implications of these schemes below.

Less remarked on, but no less significant, is the extent of experimentation in childcare policy and programme development — historically a priority area in national women's movements advocacy. Given the declining efficacy of stratified social security systems in Latin America, there has been little effort to implement or expand the scope of earlier legislation that had made childcare a right for formally employed mothers (Mahon, 2011). Instead, states in the region have taken significant steps to expand both formal and

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7. The neoliberal reform agenda has been criticized by some of its own architects for its failure to unpack the different dimensions of 'stateness' and distinguish between state scope and state strength (e.g. Fukuyama, 2004).
8. Jenson (2010) suggests that it is the polysemic character of 'social investment' that facilitated its diffusion, i.e. that it was open to multiple interpretations. As she argues, 'the ideas that spread most are ones that can draw together numerous positions and sustain a moderate to high level of ambiguity' (ibid.: 71).
9. It is legitimate to ask if the world is not entering a new 'roll-back' phase given the austerity measures being taken in many developed countries. The gender implications of the budget cuts in the UK have been amply analysed by the UK Women's Budget Group (2010). The global repercussions of these measures, both ideological and economic, are yet to become clear.

non-formal or 'community-based' forms of care and pre-school education. This is covered in some detail by several contributions to the present volume, most notably the comparative paper on Chile and Mexico (Staab and Gerhard), and the single country analyses of Argentina (Faur) and Nicaragua (Martinez Franzoni and Voorend).

Social policies responding to care needs have also been at the centre of public debate and policy experimentation in South Korea and South Africa, energized and facilitated by processes of democratization. In South Korea a combination of both 'progressive and pragmatic' motivations, namely a stated concern for gender equality and worries about the very low fertility rates coupled with economic slowdown, has catalysed a relatively sizeable state response over a short period of time (Peng, this volume). The extent of state social provisioning in South Africa since the end of apartheid has also been remarkable for a developing country (Budlender and Lund, this volume). State response seems to have been elicited, in part at least, by the tragic scale of the AIDS pandemic, combined with the historical legacy of family disruption and high levels of structural unemployment. Great anticipation that the post-apartheid state would address the injustices of the past, especially in a context where macroeconomic policy has remained fairly orthodox and incapable of tackling unemployment, has been another critical trigger.

Yet care needs have not uniformly 'broken out of the domestic' (Fraser, 1987: 116) and onto the public agenda. The meek policy responses in the highly diverse contexts of Nicaragua, China and India are an important reminder of the multiple forces and structural impediments that stand in the way of making care a legitimate public policy concern. China and, to a much lesser extent, Nicaragua share a history (albeit short in the case of Nicaragua) of socializing care needs through their state-socialist projects. The rejection of that model by pro-market forces — whether of the heterodox (in the case of China) or neoliberal kind — has led to the 'reprivatization' (Haney, 2003) of care. Indeed, comparative work on the family in post-socialist Eastern Europe shows how 'the familial' was deployed to assist states' reform of, and often retreat from, social life (Haney and Pollard 2003).[10] In India, meanwhile, strong notions of familialism undergirding state discourse and policy have placed serious limits on the state's willingness to entertain the idea that care giving could be made, even if only partially, a public responsibility (Palriwala and Neetha, this volume).

Most of the contributions to this volume provide country-based analyses of the social economy of care and relevant policy developments. As such,

10. It is important to note that while in Hungary, according to Haney (2003), 'familialism' was deployed to rationalize welfare retrenchment, in the Czech Republic 'familialism' was appropriated to justify welfare expansion. The argument in the Czech Republic was that precisely because the family served as a site of refuge and social anchor under state socialism, it should be supported with public funds in the post-socialist era.

they are grounded in methodological nationalism — a feature they share with social policy analyses following the welfare regime approach. This is not to suggest that they are necessarily blind to global forces, whether in the form of care personnel (nurses, domestic workers) who migrate in and out of the country, or the role of global ideational factors in framing national policy options, or indeed the far less subtle role of donors in dictating 'policy conditionalities' on macroeconomic lending or in shaping social programmes. But their focus is on national-level processes: the institutional dynamics of care provision, its gendered/class/racial character, its intersection with policy processes, and its interactions with broader trends of social differentiation and polarization.

Taking a different methodological approach — one that privileges the 'border-crossing webs of socio-economic relationships' — the contribution by Yeates examines the diverse contours of care transnationalization in the contemporary era. By putting care in a global context, she examines the connections between internal policy processes and what happens in other countries, between internal and transnational migration, and the impact of developed country policies (e.g. international recruitment strategies) on developing countries. In doing so she takes the reader beyond the well-trodden theme of care worker migration. What her contribution illustrates is not only a facet of economic and social restructuring that tends to be neglected by mainstream literatures — the 'invisible' or 'other economy' as Donath (2000) calls it — but also the ways in which social relations and practices of welfare and care are being 'stretched' over long distances across national borders. We include this contribution in the hope of furthering the dialogue between these methodologically divergent perspectives.

The rest of this introductory paper is structured as follows. The first section provides a general background to the special issue, explaining its country selection and working hypotheses. It then turns to the family as the institution that stands central in defining and mediating the actual tasks of caring and its gendered character. However, as the subsequent section shows, we need to avoid the 'ghettoising of care' (Daly, 2009) in the family. The notion of a 'care mix' (Daly and Lewis, 2000) or 'care diamond' (Razavi, 2007) has been used to draw attention to the diversity of strategies, institutions and practices for providing care.[11] Moreover, what goes on inside families is not hermetically sealed from developments in the broader context. Processes of economic and social change, as well as policy developments, play a key role in how care needs are defined, who is seen

11. The 'care diamond' metaphor, which draws attention to the four ideal-typical institutional sites mediating care — families, markets, states, not-for-profit sector — was used as an *organizing* device in the UNRISD research project from which this collection originated, since the project included research on unpaid care provided by household and family members, market-based and state-based care provision, as well as the role of the not-for-profit sector in the countries where it was most pertinent. The care diamond was not meant to provide an analytical scaffolding or serve as a conceptual framework.

as needing care, and how their needs are to be met. The concluding section reflects on the politics of care, and what the analysis of care in developing countries can say about care in developed countries.

ABOUT THIS VOLUME

It is often assumed that care policies are a relatively late development in a country's welfare architecture. Daly and Lewis (2000), for example, argue that care policies provide a fruitful point of entry for analysing welfare state change, and Daly (2011) argues that policy relating to family life is one of the most active domains of social policy reform in Europe. Morel (2007) likewise sees care policies as part and parcel of the current restructuring of the welfare state, a restructuring that involves both a recasting of the overall relationships between family, market and state, and a transformation of gender relations and norms.

Where does this leave developing countries (clearly a heterogeneous group)? Is there an evolutionary pattern in the development of social policies, whereby care policies appear at a relatively advanced stage of welfare state development? If this were the case, then developing countries with nascent social policies would have to wait some time for care to become an active domain of policy experimentation. However, evidence from other policy domains suggests that countries can leap-frog and that there can be institutional learning (Mkandawire, 2001). Looking at the relationship between late industrialization and welfare development, Pierson (1998) for example notes that after 1923 there was a tendency for 'late starters' to develop welfare state institutions earlier in their own individual development and under more comprehensive terms of coverage than the pioneer countries. He also notes that in general 'the larger and more entrenched a welfare state becomes, the more difficult it is to change. . . . The move toward an active social policy is easier where there are fewer with an immediate interest in the maintenance of passivity' (Pierson, 2004: 15).

Encouraging as this may be, there are a number of factors that are likely to prove important, if not decisive, in shaping a country's capacity to respond effectively to care needs. Although not a determining factor in itself, the availability of resources at the national level will always affect the state's provision of services, infrastructure and transfers/subsidies that can facilitate care giving. However, the translation of resources into the pre-conditions for care will be mediated by specific historical and conjunctural factors, including both political and ideational ones. On the political front, while the presence of gender equality lobbies within both the state and society may help turn care issues into a public policy concern, it is not likely to be sufficient for eliciting policy response. Gender-equality issues that include a redistributive dimension, such as the provision of public care services, invoke questions of socio-economic inequality as well as gender inequality,

and may therefore be shaped by patterns of class politics, such as the power of left parties or trade unions (Htun and Weldon, 2010; Huber and Stephens, 2001). However, state response to care needs can also take a more top-down form, driven by political elites and technocrats, and underpinned by more instrumentalist or 'productivist' motivations, such as building 'human capital', generating service sector employment, and ensuring 'family cohesion'. It may also be driven by more mundane concerns such as appearing more 'modern' or enhancing state legitimacy in the eyes of both domestic and international constituencies. What we see emerging from the contributions to this volume are not linear processes of policy development, but a more messy picture punctuated by both horizontal movements indicative of institutional learning/borrowing as well as policy reversals and institutional disarray.

Apart from the prerequisite of having a time use survey, countries in the UNRISD project were purposefully selected from three different regions to include from each region one country with a relatively more developed system of social welfare (e.g. Korea, Argentina, South Africa), and one that was considered to be a welfare laggard (e.g. India, Nicaragua, Tanzania).[12] The aim was to have maximum variation in terms of social policy development so as to have some policy development in the area of care, and to capture some variation in policy responses to care. While the project intended to include policy developments with respect to different groups of care recipients (young children, those with severe illnesses/disabilities, the frail elderly), at the country level researchers focused on areas of care around which more significant policy developments were taking place. Childcare, as is evident from the contributions to this volume, turned out to be a significant area of policy experimentation across all the countries included in the project, while care for people living with HIV/AIDS became a research focus in the case studies on South Africa (this volume) and Tanzania (see Meena, 2010).

Elderly care is a neglected area in the countries included here (with the exception of South Korea and China). Policy debates on population ageing often focus on financial issues, such as pensions. Meanwhile, the need for practical support in carrying out daily activities and the demand for long-term physical care are often neglected. In many middle-income countries these are now urgent issues requiring policy attention (but perhaps less so in those countries where populations are skewed to young ages). The contribution on Uruguay in particular draws attention to the urgent need to develop a system of elderly care, almost from scratch, in a context where the 75+ age group, which is more prone to disability, is increasing rapidly. China has also seen interesting demographic shifts: while the ratio of the population aged 0–14 to the working population fell sharply from 1990 to 2006 (from 41.5 to 27.4

12. The UNRISD project, 'The Political and Social Economy of Care', commissioned original research in seven countries: Argentina, Nicaragua, India, Korea, Japan, Tanzania and South Africa. This was complemented by desk studies on Chile, Mexico, Uruguay and Switzerland. Most of the papers included in this volume were part of the UNRISD project, the two exceptions being the contributions on China and on transnationalism.

per cent), the ratio of the 75+ age group to the working age population rose (from 2.5 to 4.7 per cent). The burden of elderly care is particularly acute in this context in the aftermath of the 'one-child policy' (though not implemented in rural areas).

Despite the diverse trajectories, periodization and authorship of economic reform packages, all countries in our cluster have seen the promotion and consolidation of a market-led development path, albeit with notable variations in the specific templates followed. These reforms have been marked by rising levels of income inequality almost everywhere, and poverty levels that have remained persistent in some contexts. The contributions to this volume are particularly interested in how social policy provision for care has emerged, evolved and is changing in line with altered political and economic conditions. The tension between patterns of economic development that are largely exclusionary and polarizing, and processes of social and family change that raise new risks and demands forms the backdrop. Many of the tensions are being addressed (though not resolved) in the messy realm of social policy formulation and implementation where policy elites (sometimes in conjunction with external actors) interpret, appease, deflect or subvert the articulated 'needs'. 'Needs' are always interpreted through the existing forms of political power distribution so that those who are the most marginal are the least likely to have their 'needs' recognized (Fraser, 1987). Unequal care in turn reinforces inequality (Tronto, 2006). Masquerading under different banners — poverty reduction, social protection or community participation — a broad range of social programmes has been put in place to address the needs of the most disadvantaged, yet without abandoning the neoliberal basics centred on economic liberalization and a nimble state that facilitates the integration of people into the market.

FAMILIES AND THE PROVISION OF UNPAID CARE

Families are clearly central to the welfare regimes of many developing countries, as they are elsewhere. In fact one of the early criticisms directed at Esping-Andersen's (1990) *Three Worlds of Welfare Capitalism* was his neglect of the family and of women's unpaid work as important contributors to societal welfare (Lewis, 1992). Nearly a decade after the publication of his classic study, Esping-Andersen (1999: 11) explained this oversight in terms of 'the blindness of virtually all comparative political economy to the world of families. It is, and always has been, inordinately macro-oriented' (and gender blind!). In his more recent work he argues emphatically that the revolution in demographic and family behaviour, spearheaded by women's embrace of personal independence and lifelong careers, has triggered the proliferation of new and less stable household and family arrangements, which in turn demand a new welfare state (Esping-Andersen, 2009). A similar position has been adopted by several other welfare state analysts who distinguish between 'old' and 'new' social risks and argue for the adaptation

of welfare states to the latter (Bonoli, 2006).[13] This resonates with the approach taken by Filgueira et al. in their analysis of welfare, care and gender in Uruguay in this volume, which underlines that the failure to adapt to the new social conditions is even more devastating in middle-income countries such as Uruguay which are marked by very high levels of inequality.

Household and family arrangements are heterogeneous and unstable in the contexts we are concerned with, as well as being unable to meet welfare needs without support from other sectors of the economy. However, the forces underpinning change have been far more insidious, associated more with persistent economic crises and lop-sided development models, and less with women's embrace of personal independence and lifelong careers, as Esping-Andersen puts it (for Europe). Work on welfare regimes in Latin America has underlined the point, overlooked in much welfare regime analysis and theorizing by feminists and non-feminists alike, that the heterosexual nuclear family form may not be the norm everywhere, and has attempted to integrate more complex family forms into such analysis (Martinez-Franzoni, 2008). In countries such as Nicaragua, India and South Africa a significant proportion of households are complex and extended, and a substantial number of children continue to grow up with adults other than their parents, who possibly share childcare and other care work among themselves. Even in South Korea, where the economy has undergone massive structural transformation, high levels of co-residency amongst the elderly and their adult children allow multi-generational family members to share housing, pool resources and exchange child and elderly care services. In many of these contexts, families and extended kin networks remain important cultural and survival resources. Feminist social policy analysts by no means argue for a notion of individuals as atomized and autonomous beings. Yet even the limited forms of 'de-familialization' that have been proposed (for example, women's capacity to uphold a socially acceptable standard of living independently of the family) are difficult to apply in contexts where family and kinship networks remain important to people's livelihoods and security, and where non-familial provision of social security is weak (Hassim and Razavi, 2006).

This kind of social embeddedness is not only a primary source of identity, but also structures women's entitlements by offering them some access to resources such as land, housing and childcare even if only as a consequence of their conjugal or maternal status. In the midst of economic crisis, when jobs disappear and the little state provision that there is becomes eroded, these networks take on an even more critical role. In the context of recurring crises in Latin America during the 1980s and 1990s, the proportion of extended households increased in some countries as a response to the economic

13. The 'new' risks invariably include tensions between work and family life (due to women's entry into the labour market), single parenthood, having a frail relative, possessing low or obsolete skills, and insufficient social security coverage (due to labour market changes away from full-time lifelong employment) (Bonoli, 2006).

privations that lower-income sectors experienced and as a means of pooling resources and meeting needs such as shelter (Jelin and Diaz-Munoz, 2003). Similarly, household strategies, such as the tendency for women to take on paid work, the out-migration of younger and able-bodied members, or pooling and sharing of resources across extended kin networks can change, sometimes very rapidly, in response to the broader context within which these networks are embedded (Cerrutti, 2000; Gonzalez de la Rocha, 1988). This underlines the critical point that the family is not an isolated institution (Jelin and Diaz-Munoz, 2003). Nor is it autonomous. Domestic units, whatever their composition and form, are rooted in social networks which provide support and solidarity, sometimes across national borders, as well as being connected to the wider political economy through the flow of goods and services (Moore, 1994). However, while households and families play a crucial role in social protection and reproduction, the extended nature of economic crises in many developing countries, as well as structural changes associated with migration and HIV/AIDS, may have exhausted kinship solidarity networks (Therborn, 2004: 180).

Another feature exemplified by several countries in our cluster, most notably South Africa, Uruguay and Nicaragua, is the relatively high incidence of households with children that are maintained primarily by women (mostly mothers and grandmothers) without male support. As the evidence from Uruguay shows, it is among the lower-income strata that the presence of such households is particularly high (around 21 per cent) — more than double the rate found for higher income groups. A similar pattern can be seen in Argentina, and also in South Africa if race is used as a proxy for social class. There may be certain advantages for women of forming such households, in terms of greater decision-making power, freedom from violence, or more control over assets (Chant, 2008). It is nevertheless a constrained choice which leaves mothers in the difficult position of having to both earn a living and care for their dependants, in a context where income-earning opportunities are limited and family networks already strained.

A stark illustration of how broader political and economic processes shape and disrupt families comes from the South African contribution. Here the legacy of colonial domination and apartheid/racial capitalism has left a deep mark on family structures and gender relations, with important implications for the organization of care. The migrant labour system, which was most formalized in the country's mining industry,[14] effectively removed men from their families for most of the year while they worked in mines and lived in single-sex compounds. Women and children were for the most part restricted to an increasingly impoverished hinterland of subsistence agriculture. As is well known, the migration routes from these mines and

14. There is a tradition of both functionalist (anthropologist) and Marxist analytical work on the migrant labour system in Southern Africa; in a review of this work, O'Laughlin (1998) reiterates the importance of seeing the labour migrant system in Southern Africa as a regional labour system.

colonial construction projects also became paths for the spread of venereal disease and more recently AIDS (Caldwell et al., 1992).

These patterns, Budlender and Lund suggest, are still visible fifteen years after the end of apartheid: the majority of children are still living apart from their biological fathers. In 2005, only 35 per cent of children (0–17 years) were resident with both their biological parents while 39 per cent were living with their mother but not their father. South Africans continue to have lower rates of marriage and higher rates of extra-marital childbearing than most other countries. Women in South Africa are likely to end up responsible for providing for their children both financially and in terms of care.

Budlender and Lund are reluctant to claim any causal relations between the patterns of residence and marriage, on the one hand, and the persistently high rates of male unemployment, on the other. For Botswana, however, O'Laughlin (1998: 24) has argued that the reason many women and men do not marry and establish common households 'is because they cannot and not because they do not wish to do so'. In the context of long-term structural unemployment — which afflicts the southern African region — many poor men do not form households at all and effectively 'disappear'. Both rural poverty and the high incidence of households maintained by women, O'Laughlin suggests, derive from the dominant model of accumulation in the region that continues to be exclusionary and polarizing.

Beyond the political economy, 'the family' also embodies strong ideological and normative dimensions or a social imaginary that defines the rights and responsibilities of its members, and identifies who should provide care, as well as the legitimate recipients, and the best location for such provision. Across the wide range of countries included in this cluster, regardless of cultural and religious traditions, political configurations and socio-economic variations, the actual tasks of caring are defined as family responsibilities, and within families, as quintessentially female/maternal duties. In China, the care of the elderly by the family is even endorsed by several pieces of legislation and the Constitution, and it is a criminal offence for an adult child to refuse to support an aged family member (Cook and Dong, this volume). Women, however, tend to experience stronger pressures to care than men do in most societies, as the experience of caring is very often the medium through which they are 'accepted into and feel they belong to the social world' (Graham, 1983 cited in Giullari and Lewis, 2005: 11).

The inequalities in the provision of unpaid care work — unpaid housework, care of persons and 'volunteer' work — are captured in the time use survey data referred to in many of the contributions to this volume.[15] It should

15. Much of the literature on the developed world has tended to focus on the relational aspects of care, i.e. the face-to-face activities that strengthen the physical health and safety and the physical, cognitive, or emotional skills of the care recipient. This emphasis on nurturing, face-to-face interactions has sidelined domestic work that provides the basis on which personal care giving can be carried out. In developing countries where time-saving domestic

not come as a surprise that, in all countries, women's hours of paid work are less than men's, while men contribute less time to unpaid care work. Among six of the countries in our core cluster (India, South Korea, South Africa, Tanzania, Nicaragua and Argentina) the mean time spent by women on unpaid care work was more than twice the mean time spent by men (Budlender, 2008a). When paid and unpaid work were combined, women in all six countries allocated more time to work than men — meaning less time for leisure, education, political participation and self-care. In general, therefore, it is fair to say that 'time poverty' is more prevalent among women than men. But this statement relates to averages calculated across the population. In fact, the distribution patterns for men and women are very different, with low variability among men (that is, men seem to do a consistently low amount of unpaid care work) and high variability among women (some women do significantly more unpaid care work than others). As a consequence, there is a notable level of in-group inequality among women. Age, gender, marital status, income/class, race/caste and the presence of young children in the household are some of the factors that influence variation in the time people spend on unpaid care work. Being male tends to result in doing less unpaid care work across all countries. As far as the age of the care giver is concerned, the common pattern is an initial increase, with age, in the amount of unpaid care work done, followed by a decrease. Household income, meanwhile, tends to have an inverse relation with women's time inputs into unpaid care work. In other words, in low-income households women allocate more time to such tasks than in high-income households, possibly a reflection of the fewer possibilities of purchasing care services, the absence of infrastructure and larger household size. Having a young child in the household has a major impact on the amount of unpaid care work assumed by women and men.[16]

Yet despite the construction of care work as deeply familial and maternal, care is not and has never been confined to the family and family-mediated relations. Many of the intimate tasks associated with care slip out of the unpaid domain of family and 'go public' (Anttonen, 2005). This happens in a variety of ways, for example when households resort to market-mediated relations to access care assistance provided by domestic workers or child minders, or through public sector or not-for-profit sector service provision. In some instances the 'publicness' of care is straightforward, for example when families resort to a public old age home or crèche for the care of an elderly parent or a young child; here both the location of care and the

technology and basic social infrastructure are not readily available, domestic tasks can absorb a huge amount of time, leaving little time for the more 'interactive' part of care. Even in the developed countries, domestic work continues to absorb a significant share of women's time among low-income households who are not able to hire help or purchase market substitutes. The contributions to this volume have therefore tended to include non-relational aspects in their analysis of care.

16. Detailed analyses of the time use data for the UNRISD project countries can be found in the edited volume by Debbie Budlender (2010), *Time Use Studies and Unpaid Care Work*.

relations mediating it, as well as the source of funding, partially shift away from the family. In other instances, families can make their own financial arrangement for hiring care that is provided in the home or in another location (for example a private crèche). The relations can become even more complex and fuzzy where states show a propensity to give financial support to families to provide childcare at home, either by the parent or through the employment of a home-based childcare worker. In this case, as in the case of child-oriented cash transfer schemes already referred to, while the state assumes some financial responsibility for childcare, 'the bottom line is that the family [mother] is still seen as the appropriate provider of care to young children, although not as the sole provider' (Daly, 2011: 15).[17]

Notions of familialism[18] and maternalism[19] resonate across the countries covered in this issue, regardless of how families arrange their actual tasks of caring. These normative assumptions are often carried over into the policy domain where almost by default it is women/mothers who are seen as the ones who have to bear responsibility for the care of other family members. In periods of rapid change, as in the case of China with the declining influence of socialist ideology that accorded at least formal equality to women and men, traditional patriarchal values can see a revival: the growing references to China's Confucian cultural heritage in policy circles, Cook and Dong suggest, not only frees the government from assuming fiscal responsibility for welfare provision, but is also likely to reinforce traditional gender norms and/or simply leave care needs unaddressed.

Even when it is not mothers or other family members who provide care — when care is shifted out of the family — the workforce tends to be predominantly female and workers often face significant wage disadvantages *vis-à-vis* workers with comparable skill levels in non-care related occupations (Budig and Misra, 2010; England et al., 2002).[20] Caring seems to be widely devalued, no matter where it takes place and who performs it, the low pay often justified by constructing such work as 'low-skilled' and/or as work which carries its own rewards.

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17. Daly's paper deals with European policies only; however, the point being made can be extended to the cash transfer schemes in developing countries as well.
18. Familialism can be understood as an ideology that promotes family as a way of life and a force for social integration. A familialist welfare system, more specifically, is one that relies heavily on the family for the provision of welfare and care.
19. Maternalism has been defined by Koven and Michel (1993: 4) as a variety of ideologies that 'exalted women's capacities to mother and applied to society as a whole the values they attached to that role: care, nurturance and morality'. Unlike the papers on India and Argentina in this volume that use the term maternalist to describe state policy, Koven and Michel's analysis was grounded in women's social movements and *their* engagement with welfare policies. However, they also drew attention to 'the protean character of maternalism, the ease with which it could be harnessed to forge improbable coalitions' and the 'subtle shift from a vision of motherhood in the service of women to one serving the needs of paternalists' (ibid.: 5).
20. An analysis of workers in the care economy of UNRISD project countries appears in a Special Issue of *International Labour Review* (Razavi and Staab, 2010).