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What is a transformative approach to care, and why do we need it?

Valeria Esquivel

The meanings of care are contested – the approaches to care in the development and feminist literature have varied greatly. At the same time, care is a common word, loaded with moral meanings concerning notions of duty and love, and care is commonly associated with women. These associations are not innocent; they have concrete effects in shaping different policy agendas and institutional responses to care and care work. While the feminist meanings of care stem from feminist philosophy, feminist economics, and feminist social policy research, these meanings compete with the more conservative and traditional meaning of care in the development discourse. This article provides a conceptual introduction to care, and aims to show how the different understandings of it affect the ways policymakers approach the issue. Depending on the way care is framed, policies and practices can be designed and implemented in transformative ways, in the sense of supporting carers – predominantly women – and lightening their care burdens, while challenging the notion that this work is intrinsically 'female' and of lesser importance than work seen as 'productive'. The article invites development practitioners to reflect on their own views about care, and to identify what can be done to recognise, reduce, and redistribute care at multiple levels.

Les significations des « soins » sont contestées – la façon dont les soins sont abordés dans les écrits féministes et de développement a présenté d'importantes variations. Dans le même temps, le mot « soins » est commun, chargé de significations morales liées à des notions de devoir et d'amour, et les soins sont fréquemment associés aux femmes. Ces associations ne sont pas innocentes; elles ont des effets concrets sur la formulation de différents ordres du jour de politiques générales et d'interventions institutionnelles relatives aux soins et au travail dans ce domaine. Si les significations féministes des soins émanent de la philosophie féministe, de l'économie politique féministe et des recherches en politique sociale féministe, ces significations entrent néanmoins en concurrence avec la signification plus conservatrice et traditionnelle des soins dans le discours du développement. Cet article propose une introduction conceptuelle du concept des soins, et cherche à montrer comment les différentes manières de l'appréhender ont une incidence sur les façons dont les décideurs abordent la question. Selon la façon dont les soins sont formulés, les politiques et les pratiques peuvent être conçues et mises en œuvre de façons transformatives, dans le sens de la

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prestation d'un soutien aux personnes chargées de dispenser les soins – principalement des femmes – et de l'allègement de leur fardeau de soins, tout en mettent en question l'idée selon laquelle ce travail est intrinsèquement « féminin » et moins important que le travail perçu comme « productif ». Cet article invite les praticiens du développement à réfléchir à leurs propres points de vue sur les soins et à identifier ce qui peut être fait pour reconnaître, réduire et redistribuer les soins à des niveaux multiples.

Las acepciones acerca de la noción de cuidado se encuentran en disputa. En este sentido, tanto la literatura de desarrollo como la lectura feminista dan cuenta de la gran variedad de enfoques que han sido aplicados a este concepto. Al mismo tiempo, cuidado es una palaba de uso común, cargada de significados morales vinculados a las concepciones de deber y amor, asociadas generalmente a las mujeres. Estas asociaciones no son fortuitas; por el contrario, ejercen efectos concretos al moldear las distintas políticas y respuestas institucionales en torno al cuidado y al trabajo de cuidar. Las acepciones feministas del cuidado surgen de la filosofía feminista, de la economía feminista y de las investigaciones sobre políticas sociales feministas, contraponiéndose a las acepciones más conservadoras y tradicionales surgidas del ámbito de desarrollo. El presente artículo brinda una introducción conceptual en torno a la noción de cuidado e intenta mostrar hasta qué grado las distintas percepciones que existen en torno a este concepto afectan las maneras en que los formuladores de políticas enmarcan esta cuestión. Dependiendo del marco teórico que se le dé al tema, las políticas y las prácticas pueden ser diseñadas e implementadas de maneras transformadoras, por ejemplo, para apoyar a los cuidadores –la mayoría mujeres—, aliviando la carga que implica el cuidado, y cuestionándose al mismo tiempo la percepción de que este trabajo sea concebido como intrínsecamente "femenino" y menos importante que el trabajo considerado "productivo". El artículo invita a los operadores de desarrollo a reflexionar sobre sus propias concepciones en torno al cuidado y a identificar qué se puede hacer para reconocer, reducir y redistribuir el cuidado en distintos ámbitos.

Key words: unpaid work; care; gender; social policy; economic policy

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Introduction

Care is a crucial dimension of human well-being. People need care throughout their lives in order to survive. Care has long been considered to be the 'natural' responsibility of women: around the world it is still the case that women provide most of the unpaid care in households and communities (Budlender 2010), and the majority of paid care workers are female (Razavi and Staab 2010). However, providing care is not costless. The costs of providing care, which fall disproportionately on women, include foregone opportunities in education, employment and earnings, political participation, and leisure time.

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The word 'care' is used every day by all of us, and is loaded with moral overtones concerning both duty and love. But beyond its common usage, 'care' is also an analytical category in economics and the social sciences more widely, and it has recently become prominent in the discourse of United Nations (UN) agencies, multilateral funding institutions, and donors. For instance, in 2009, the Commission on the Status of Women (CSW) chose 'the equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS' as a priority theme for its work – a move that increased the visibility of care within the UN, and supported various stakeholders to mobilise around care (Bedford 2010). Later, the Brasilia Consensus – the outcome of the 11th Regional Conference on Women in Latin America – established 'care as a universal right, which requires strong policy measures to effectively achieve it, and the co-responsibility of the society as a whole, the state, and the private sector' (ECLAC 2010, 2, cited in Esquivel 2011b). The *World Development Report 2013* on jobs applauds the adoption of the International Labour Organization's Domestic Workers Convention and Recommendation, a conquest that will help protect the most vulnerable and feminised group of care workers; and identifies the shortage of care services as hindering female labour force participation, suggesting that 'public provision or subsidisation of childcare can reduce the costs women incur at home when they engage in market work' (World Bank 2012, 30).

Most recently, the Special Rapporteur on extreme poverty and human rights has forcefully argued that the 'heavy and unequal care responsibilities are a major barrier to gender equality and to women's equal enjoyment of human rights, and, in many cases, condemn women to poverty' (Sepúlveda Carmona 2013, 2). She reiterates this message in an article in this issue of *Gender & Development*. The 58th Commission on the Status of Women agreed conclusions:

> *…recognise that caregiving is a critical societal function and therefore emphasize the need to value, reduce and redistribute unpaid care work establishing a very concrete and detailed policy agenda, which includes social protection policies, including accessible and affordable social services, including care services for children, persons with disabilities, older persons, and persons living with HIV and AIDS, and all others in need of care; the development of infrastructure, including access to environmentally sound time- and energy-saving technologies; employment policies, including family-friendly policies with maternity and paternity leave and benefits; and the promotion of the equal sharing of responsibilities and chores between men and women in caregiving and domestic work in order to reduce the domestic work burden of women and girls and to change the attitudes that reinforce the division of labour based on gender.* (UN Economic and Social Council 2014, 15, point gg)

These examples illustrate the enormous progress made in getting care on to the international development agenda as a public policy issue. Yet, in all cases, care continues to be considered as a women's issue, as if the fact that most caregivers are women means that care is a concern only for them. (It is similarly widely considered to

be a children's and elderly people's issue, as if dependants were the only ones needing care.) In other words, care remains 'woman-specific', as Daly and Lewis (2000, 283) have long pointed out.

The examples above also show that the meanings of care are contested. Different understandings of care as a concept result in disagreements about how it needs to be addressed, and this has shaped different policy agendas (Eyben 2012). Actors adopting a *social justice* perspective may consider care to be a 'right', while those adopting a *social investment* perspective may view care as a poverty-related issue (Williams 2010). Diagnoses that emphasise gender, class, and race inequalities in care provision highlight women's costs of providing care. They call for the redistribution of care responsibilities, in particular through active state interventions with universal scope (United Nations Research Institute for Social Development (UNRISD) 2010). Diagnoses that focus on the role of care in the production of 'human capital', or the efficiency gains of women's partaking in the labour market when care services are publicly provided or subsidised, usually justify interventions that are focused on 'vulnerable' or dependent population groups. Such focused interventions may sideline women's (and others') equality claims (Jenson 2010, cited in Razavi and Staab 2012, 20).

In conversations about the role of care within development, *transformative* meanings of care compete with those more *conservative*, associated with views that restrict the place of women in society to their role as mothers and carers. Currently, there is growing interest on the part of development policymakers and practitioners in care. Yet, this interest most frequently converts into timid remedial measures, like solving basic infrastructural problems here and there or helping women to reduce 'their' caring workloads. The challenge for women's rights advocates is to ensure that development actors understand and address care as part of a broader, progressive, gender-equality agenda. The care agenda needs to be broad enough in scope to be taken up as a priority by many organisations and individuals involved in different policy areas. All this demands 'a strong commitment from gender advocates – to make a compelling case for the importance of care, to get the issues heard, and to generate sustained pressure for action' (Esplen 2009, 2).

What is 'care'?

'Care' as a concept overlaps with similar concepts like care work, domestic labour, reproductive labour, unpaid work, social care, the care economy, and so on. This reflects a conceptual evolution that has taken place in the feminist economics literature and in the feminist social policy literature over the last 40 years (Esquivel 2013). The variety of conceptual legacies, names, and understandings that characterise debates about care can be confusing to those not familiar with them. A lack of shared understanding of terminology and concepts can create difficulties for development

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conversations around care. In what follows, the different terms that are used in debates about care are explained in detail.

Care

Care activities are face-to-face activities that strengthen the physical health and safety, and the physical, cognitive or emotional skills of the care recipient (England *et al.* 2002, cited in Razavi and Staab 2012). Caring for people always takes place within a *care relationship*, between a caregiver and a care receiver (Jochimsen 2003). The limits of care are, however, contested, with some analysts taking a broad definition and others a narrow one. Joan Tronto (2012, 33) has expanded the definition of care to the activities 'that we do to maintain, continue, and repair our "world" so we can live in it as well as possible', not only including care for people (ourselves, dependants,[1] and others), but also caring for objects, and caring for our environment. At the opposite extreme, the most frequent understanding of caring activities within development debates has narrowed down the focus of care to caring for dependants, excluding the care of people who are not dependent on the carer. Self-care is not usually seen as part of this understanding of care as it occurs outside care relationships. For example, Daly and Lewis (2000, 285) define care as 'the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and the normative, economic and social frameworks within which these are assigned and carried out'.

Unpaid care work

'Unpaid care work' refers to care of persons and housework performed within households without pay, and unpaid community work. Each of these components is discussed further below. As a term, 'unpaid care work' is used similarly to the 'older' terms 'reproductive work', and 'unremunerated work', as named by the Beijing Platform for Action (United Nations Fourth World Conference on Women 1995). As a concept, unpaid care work has gained currency among development policymakers and practitioners because as a concept it carries many meanings.

Unpaid care work is *unpaid* because it arises out of social or contractual obligations, such as marriage or less formal societal relationships. It is *care* because it is a group of activities that serves people in their well-being. And it is *work* because it is an activity that has costs in terms of time and energy (Elson 2000). This definition of care based on work *activities* – or quantifiable ways of spending time – makes unpaid care work particularly amenable to being measured using time-use surveys.

Unpaid care work sustains our standard of living (the food we eat, the clean dwellings we inhabit, the care we receive), and the fabric of relationships within families and communities. Its sheer volume indicates that it cannot realistically be

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replaced – at least never fully – by market or state-based care services. The benefits it brings to households and communities can be thought of as an 'in-kind' income that 'comes into a household' and produces well-being (Folbre 2009). However, providing unpaid care work is also *costly.* It is not always 'lovely', even if it is performed 'out of love' (Elson 2005). It might involve drudgery and overwork, and it might not be the result of autonomous individual choices but of social pressures, which particularly oppress women and girls.

Care of persons

The 'care of persons' component of unpaid care work – mostly but not uniquely devoted to the care of dependants – focuses solely on the *material dimension* or work content of care relationships. This focus on care work highlights 'care as a verb and carers as actors, but implicitly begs a comparison with other forms of work and labour. Emphasising care as a particular form of labour also draws attention to the conditions under which it is carried out' (Daly and Lewis 2000, 285). Indeed, it is the work content of care work – the time actually needed to sustain the care relationship – which overburdens and poses limits for gainful employment and/or leisure time to women (and men) who engage in care relationships. In other words, it is in this work content that the costs of providing care can be measured.

Housework

The 'housework' component of unpaid care work refers to household maintenance activities – household chores like cleaning, cooking, and clothing family members, which can also be understood as 'indirect care'. The gender division of housework, and the impact that housework has on women's choices, are determined by several factors. These include the technology available within the household; the availability and cost of substitutes to undertake housework; the structure of families and households; the economies of scale derived from different family arrangements; and the role of income in bargaining in/out of housework.

Unpaid community work

The 'unpaid community work' component of unpaid care work refers to unpaid working activities provided to households beyond one's own. It includes work undertaken for friends, neighbours, or next of kin, and work undertaken out of a sense of responsibility for the community as a whole. The activity content of unpaid community work is very broad and may include care for friends, relations or community members; housework – such as cooking in a community kitchen; or activities that are closer to paid work, such as unpaid community works.

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The care economy

The 'care economy' captures the idea that unpaid care work produces 'value' (and can therefore be considered to be *productive* or *economic*), but is invisible to standard valuations of the size of the economy. This is because most care 'services' are produced outside market exchanges. As a concept, the 'care economy' is almost interchangeable with 'unpaid care work'. By applying prices to unpaid care work, analysts can determine a monetary value for the 'care economy'. This value can then be compared to the value of the 'paid economy' (Gross Domestic Product).

Going beyond such valuation exercises, analyses of the 'care economy' can help to characterise the ways in which the care economy and the paid economy relate to each other; the work and money transfers that occur between the two; and the consequences of these transfers in terms of well-being (Commission on the Measurement of Economic Performance and Social Progress 2009; Picchio 2003). This 'structural' type of analysis has created opportunities for macro-economic modelling of the effects of different types of policy on the interactions between the care economy and the paid economy. For example, trade policies may target women as a workforce in export industries, and they then have less time for unpaid care work; transportation and public infrastructure polices can reduce the need for unpaid care work; and anti-crisis employment programmes might take into account that women's employment can increase when public social infrastructure is provided, in the form of care services, among others.

Other approaches to the 'care economy' within feminist economics tend to use more micro-economic arguments. These include the idea that unpaid care work is an 'externality' to the economic system, because families produce the next generation of workers without being able to 'charge' for them (that is, their production is a 'public good') (Folbre 2004). Another idea is that in sectors where paid care work is carried out, for example offering personal care to elderly people in nursing homes, labour costs will go up in relation to productivity as it is not possible to do such work more efficiently – that is, employing fewer carers – without jeopardising the quality of care provided (Folbre 2006; Himmelweit 2007).[2]

More recently, the emphasis on the role of unpaid care work in creating well-being has led to the proposal of new well-being indicators that take unpaid care work into account. Among those is the 'extended income measure', which recognises that household consumption is higher than actual expenditures on goods and services (income), because the unpaid care work performed within households creates expanded consumption possibilities for household members (Folbre 2009). 'Services' provided by unpaid care work complement monetary income, and provide an 'extended' measure of well-being. Time-use surveys show that unpaid care work is greater amongst low-income households, lending support to the idea that the poor, more than the rich, partially compensate their lack of monetary income by engaging in more unpaid care work.

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Even though the 'extended income' of a household could be greater than its monetary income, it does not mean it is sufficient to care and provide for all the household's members. To determine sufficiency, an independent measure of household needs is necessary. Usually, *absolute poverty incidence* (the number of households and persons that are poor) is calculated based on an income poverty threshold, defined as the income necessary to purchase a basic bundle of goods and services. However, for a household to live with such income level, some unpaid care work is always required. Unpaid care work 'converts' purchased groceries into meals, washing powder into cleaned clothes, and so on, and enables dependants (and others) in the household to be cared for. In certain households this minimum level of unpaid care work cannot be provided due to high household production requirements (too many dependants, too few adults, too much of the burden on women's shoulders), extensive hours of paid work, or both. If the household cannot buy out replacements for these requirements, then it does not attend the welfare level that is implied in the poverty threshold and becomes poor, or further impoverished, as a result. Based on this idea, 'time and income poverty' estimations point to the fact that the size, depth, and profile of income poverty changes when the unpaid care work requirements are factored in income poverty calculations (Antonopoulos *et al.* 2013).

Social care

Building on the argument that care produces well-being, a vast literature in developed countries has used the concept of 'care' as an analytical category for the analysis of 'welfare states'. Because 'care' concerns gendered social relations, care as an analytical category has 'the capacity to reveal important dimensions of women's lives … and at the same time capture more general properties of societal arrangements around personal needs and welfare' (Daly and Lewis 2000, 284). Care is understood as a relationship (the *material* and *relational* dimensions of care noted earlier in this paper), and also as a socially constructed responsibility (the *normative* dimension of care) that takes place within particular social and economic contexts (the *institutional* dimension of care). In this context, the concept of 'social care' allows us to focus on how the gender norms that mean women remain the main care providers interact with the particular ways in which the state regulates and shapes (by action or omission) the provision of care.

Care regimes

The concept of 'care regimes' can be used to typologise various types of 'welfare states' –that is, ways in which country states support their citizens' well-being – according to the ways in which care responsibilities are assigned, and the costs of providing care are assumed (Razavi 2007). In building a picture of a 'care regime' in any given context, we can consider the following dimensions:

- Where does care take place? Does care happen within households; in public institutions such as schools, hospitals, day-care centres; or in community institutions?
- Who cares? Are carers primarily women, because they are mothers; parents; or are workers?

and

- Who pays for the costs of providing that care? Is it the state through cash transfers to women? The state through the provision of free care services? Families who can afford private services? Employers? (Jenson 1997, cited in Razavi 2007).

A clear analysis of the care regime that a state promotes can be a starting point for influencing policy change in that country, and for development organisations to consider how they might address particular aspects of care in their work in advocacy, campaigning, or community development work.[3]

The care diamond

The 'care diamond' (Razavi 2007) is a concept which supports analysis of how care responsibilities are distributed across four different welfare pillars: families, the state, the market, and the community. It can be used to consider how responsibility for the care of particular groups of dependants such as girls, children, older people, or people who are sick, is allocated across the four pillars. The performance of the 'care diamond' architecture, as Shahra Razavi has called it, can be judged from the perspective of both care receivers and caregivers. It is important to pay particular attention to whether the design and application of 'care policies' reduce or exacerbate inequality between women and men in relation to care work.

Care policies

'Care policies' are policies that assign resources to care – time and/or money to existing caregivers, and/or deliver care services to reduce the workload of carers and transfer responsibility for delivery from the private household or family space to the state. These range from payments to caregivers or to people who need care; to care services and labour regulations, such as maternity/paternity leave. The concept of care policies therefore encompasses policies developed in different sectors – for example, the health sector, the education sector, the 'social' sector (anti-poverty policies), and labour market regulations.[4] The concept of 'care policies' enables us to analyse how a range of policies

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across different sectors have implications for care, and to consider how the totality of these policies is working – for example, using the care diamond approach.

Care policies include, but go beyond, *social protection* policies. Taking the examples above, it is clear that care policies overlap with social protection policies. However, the definition of social protection as the 'minimal level of income or consumption guaranteed by the state as a right for all citizens and residents' (UNRISD 2010, 136)[5] implies an adherence to a traditional conception of welfare as equivalent to a minimum level of consumption (or which measures the lack of welfare as income poverty). Within this understanding of social protection, the availability of the unpaid care work necessary to ensure well-being is taken as given, and income transfers do not include 'money to care', but only aim to provide income to support the consumption of a basic basket of minimum goods and services that does not include this care in a broad sense.

Within the social protection framework, the care work that is covered is exclusively that which households cannot provide, either because it requires expert knowledge (such as health or educational training) or because it is a response to extreme dependence (for example, disability). For the majority of care services, including those aimed at dependent groups such as young children or the elderly, the social protection definition assumes the families will provide the care required. For those of us concerned about gender equality in livelihoods and about social protection, differentiating between truly universal care policies and social protection policies that only guarantee minimum incomes is important. This includes policies and programmes that are justified with a 'care rhetoric', such as Conditional Cash Transfer Programmes which include care conditionalities but neither pay nor compensate for care (examples are discussed in *Gender & Development*'s issue on Social Protection, of July 2011).

The social organisation of care

In developing countries, care policies may not assign care roles, and subsidies and care services may benefit families and women from different social strata differently. These differences in the way in which different population groups benefit from care policies may not support gender equality, and may even increase (rather than compensating for) income inequities – for example, poor households may pay high costs (when considered as a proportion of their total income) for poor-quality care services. For some, the absence of the state might be as ominous as its presence, or, as pointed out by Faur (2011, 969), 'the state itself presents different faces and different outcomes in its various activities' to different population groups. As a result, a growing feminist literature in Latin America has abandoned the care regime concept, and chosen to use the 'social organisation of care' instead. This term refers to the 'dynamic configuration of care services provided by different institutions, and the way in which households and their members benefit from them' (*ibid*). It reflects a less monolithic or 'regimented' approach to social policy.

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Care workers

Care workers are wage or self-employed workers whose occupations involve engaging in a care relationship. This typically includes the work of doctors, nurses, and other health professionals; early education, primary and secondary school, and university teaching staff; therapists; and nannies. It includes domestic workers, who are expected to do housework (that is, to perform 'indirect care'), but who also mind children and take care of elderly or infirm household members when required. Like unpaid care workers, domestic workers are women in the majority of cases. The association of unpaid care work with 'natural' female characteristics – and not with skills acquired through formal education or training – also implies that most domestic workers have low formal educational qualifications.

Research on care work within the paid economy has identified that some types of care workers are, in some contexts, relatively low paid (Budig and Misra 2010), and their working conditions deficient as compared with those of other groups of workers (Folbre 2006).

In the remainder of the article I will focus on the question of making care policies and programmes as supportive to women's rights and gender-equality agendas as possible.

What is a transformative approach to care?

The discussion above has shown that a wide range of terms and concepts relating to care are used within development discourse. Some are more currently used, and preferred to others used in the past. In recent international debates, *care* is more widely used than *care work*, because it conveys broader meanings. The *care economy* is the preferred term among feminist economists. The *care regime* is used by social scientists from the North, and the *social organisation of care* is commonplace among social scientists from the South.

The *care economy* insists on the fact that care is the bedrock of economy and society. The *social organisation of care* offers a detailed critique of the role of the state in shaping access to care. Irrespective of the different emphases of their disciplines, the two conceptual perspectives have contributed to the removal of *care* from the purely private realm. Instead, care has been reframed as a concept that is heavily intertwined with *the* '*economic*' –the way that economies benefit from work that its neither recognised nor paid for; *the* '*social*' –the class and gender relations that permeate social interaction; and *the* '*public*' –the policies that directly or indirectly shape the provision of care.

Beyond the analytic questions that arise from these conceptual frameworks, though – who provides care, for whom, at what cost, and why this is the case in different contexts – lies the important political question of *what a feminist, transformative care agenda is.* In other words, who *should* provide care, for whom, and bearing which costs,

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for progress to gender equality and the full realisation of women's rights to be a reality, and which institutions, economic structures, gender norms, and public policies would be conducive to such an outcome.

A transformative approach to care

Our starting point is the fact that far too many people (men more than women, the rich more than the poor) *could not care less.* In our societies, care is *unrecognised* and *undervalued*, as if the fact that it is unpaid (or lowly paid) meant it is provided for free – that is, without costs involved. However, care provision is costly, and the costs of providing care are shared unequally between women and men, within households; between households; and within society at large. This raises both cultural and distributive justice considerations (Esquivel 2011b).

Paraphrasing Nancy Fraser (1995, 82), a transformative approach to care is one that remedies the inequalities associated with care provision 'by restructuring the underlying generative framework', as opposed to 'affirmative remedies … aimed at correcting inequitable outcomes of social arrangements without disturbing the underlying framework that generates them'. A transformative approach to care means *radically changing* care provision (and possibly, care benefits' accrual) by *recognising*, *reducing*, and *redistributing* care: the Triple R Framework.[6] The 'economic', the 'social', and the 'political' realms of life, and their relationship to each other, would also radically change as a consequence.

Recognition of care work

Recognising care work means acknowledging the nature, extent, and role of unpaid care work in any given context. In other words, taking care seriously means understanding the whole of its contributions to human development, without losing sight of *who* is making those contributions. Recognition of care work goes beyond crude aggregate measures of unpaid care work. It requires the development of detailed accounts and analyses that can inform precisely who it is doing unpaid care work, and how much (Esquivel 2011b). Recognition also means avoiding taking unpaid care for granted, and understanding the social norms and gender stereotypes that make women the primary providers of unpaid care work. Recognition also means challenging power relations. These may be reflected in discourses that undervalue care, either explicitly or because they omit discussion of care from development conversations (Eyben 2013). One particular effect of undervaluation of care is care workers' low pay and poor working conditions, which recognition should help to change (Razavi and Staab 2010).

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Reduction of care work

Reducing care work has implications for the time of the caregiver, and for her health and wellbeing, when providing care involves drudgery, or it is done in unsafe environments. When the costs of providing care are excessive as the result of lack of social or household infrastructure – such as long travelling distances to buy groceries or access care services; having to collect fuel or water; having to process food manually; or cooking with dirty stoves – individual households, communities, and society as a whole all stand to gain from care work *reduction*. It is important that an understanding of these potential gains is integrated into the planning and implementation of labour-saving infrastructure investment projects. By doing so, development projects can contribute to a reduction of the time, and other, costs incurred by those who engage in unpaid care activities – poor women in particular.

Redistribution of care work

Redistribution of care work may take place within households – for example, between women and men – or within society as a whole, through the development of policies supporting provision of or access to care services.

Redistributing care provision between women and men within households means challenging the gender stereotypes that associate care with femininity. It means challenging the customary law, institutions, norms, and regulations in which these stereotypes are deeply embedded. This will involve challenging the distribution of tasks and roles that are socially defined as 'feminine'; for example, cooking and fetching water, the balance of maternity versus paternity leave, or the societal pressures on women to find ways to reconcile work and family responsibilities. As Rosalind Eyben (2013, 2) points out, this means 'challenging the natural order'.

Changes in economic incentives also play a part in intra-household redistribution of care responsibilities. As long as gender wage gaps and labour opportunity gaps exist, the opportunity costs for women to assume unpaid care roles will remain lower than for men. This makes it economically 'rational' for families and households to maintain a male-breadwinner/female-carer arrangement. Indeed, these various areas of intervention underscore the fact that even in the intimacy and privacy of the household and family, care provision is indeed 'social' (Daly and Lewis 2000).

However, focusing action on redistribution of unpaid care work only at the household level would create the risk of overlooking family contexts in which the redistribution of responsibilities is not possible (because there is no other adult to share them with), or in which the care burden is so much that even when equally shared, the care needs are not met. For this reason, redistributing care means taking action beyond households. Care is not only provided in households and communities, but also in the public sphere of markets and the State. *Who and for whom* care is provided beyond

households and communities alters the care provided by these two spheres, reducing their total care work and changing women's and men's shares in care within households and communities in the process. For example, by facilitating care through workplace nurseries or crèches for working parents, care work is redistributed from households to the public sphere. Workplace child care makes it easier for women with children to choose to take up employment, and this in turn may increase their 'bargaining power' within their households. Providing social infrastructure in the form of care services serves to redistribute care responsibilities and create job opportunities. Such opportunities may particularly target women workers, since care services are usually staffed with female carers.

Conversely, where markets play a major role in care provision – for example, when fees must be paid for care services, or paid domestic workers are hired – access to care services beyond households becomes a function of purchasing power. In such cases, the distribution of care services will typically reflect income inequalities, exacerbating the difficulties that poor women face in accessing job opportunities and generating income. Social policies can also reinforce gender stereotypes, for example when cash transfers are tied to conditionalities relating to children's health check-ups or school attendance that mothers are expected to enforce.[7]

Failing to reduce or redistribute care imposes costs on women that are inequitable and impoverishing, and further disempowers women by making it harder for them to earn a decent living. It is inequitable because care is actually distributed along income lines; that is, poor households provide more unpaid care work than rich households, while the latter have access to paid care services that the former cannot afford. Therefore, taking no action means exacerbating existing income inequalities. In addition, failing to redistribute care is impoverishing, because women are poorer than current poverty measures indicate. The nature and extent of women's poverty cannot be captured by these measures, since their time poverty makes them poor (or poorer) as a result of not being able to provide (and receive) the unpaid care work that they require. A failure to reduce or redistribute care is disempowering, too, because it hinders women's participation in the labour market, which has both short-term and long-term welfare impacts. In sum, failing to reduce and redistribute care, and only taking compensatory or remedial measures that help women cope with 'their' care burdens, means addressing care within a conservative policy agenda. We need to reduce and redistribute care to transform gender relations and the whole of humanity as a result.

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Notes

1 Dependants can be defined as those in most need of care, such as young girls and boys, older people, or people who are sick or disabled. In all these cases, the care receiver *depends* on the caregiver for her/his subsistence and development. However, dependants are not deprived of autonomy. Autonomous adults may also give and receive care on reciprocal terms, such as the care that occurs among friends, significant others, and family members. In effect, dependency, as well as care, is a continuum, as we are all (inter)dependent and in need of care along our lives (Esquivel 2013, 26).

2 I have elaborated elsewhere that this 'cost-disease' argument is only valid in a 'full employment' scenario, one in which neither the developed nor developing economies find themselves at the moment (Esquivel 2010).

3 It must be noted that the vast majority of states in the global South do not provide a level of state resourcing or direct provision recognisable as a 'welfare state'. Some have never done so; others have reduced their provision in response to economic conditions.

4 See Esquivel (2011a) for an outline of how to evaluate 'care policies'.

5 One of many definitions: this definition in particular implies universalism.

6 The Triple R Framework in relation to unpaid care work was put forward by Elson (2008), after Fraser *et al.* (2004). It is further developed in Esquivel (2013).

7 Even if they are framed as 'cash for care', it should be stressed that these policies are not meant to pay for care but to sustain minimum consumption through income transfers. See Esquivel (2011b, section 2.2) for further elaboration.

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