READING PAPER SERIES ON CARE ECONOMY

UN WOMEN TRAINING CENTRE

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CHAPTER 1

CARE: BASIC CONCEPTS

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CARE: BASIC CONCEPTS

TAKE AWAY POINTS

Following are the principal ideas that will be discussed in this first session.

I. All of us need care... but is it a shared responsibility?

Care is comprised of all those activities necessary to recreate, day after day, the physical and emotional well-being of people. It embraces:

- Tasks that involve direct interaction between people in the interest of physical and emotional health (direct care);
- Tasks that lay out the material conditions which then allow for direct care to take place (preconditions for care); and
- Coordination, planning and supervision (mental management).

Approaching care from a life-cycle perspective allows us to recognize that care is an ever-present reality in our lives, although the conditions under which we provide and/or receive it change. We must deal with the crosscutting character of care as well as with its changing concrete manifestations.

Discussing care implies focusing on daily well-being. There are specific care policies targeted to certain population groups, such as children or the elderly. Beyond that, care crosscuts the entire set of public policy. The broad priorities of any given development model can be identified by asking about the priority that care is granted.

Care illustrates that life is a relationship of interdependence, but that this interdependence is not equally distributed:

- Every one of us needs (different types of) care at all moments of our life, but the resources available to cover this need are unfairly distributed. Social groups are differentiated in terms of their ability to access decent care;
- During the majority of our lives most of us are able to assume our share of co-responsibility for care. However, because care is undervalued we usually delegate it if possible. Care work is distributed around relationships of inequality based on gender, social class, migration status and race-ethnic differences.

Care is a question of the utmost importance when considering gender inequalities:

- Women perform the majority of care tasks, most of which are not paid. When care enters the labour market it is characterized by poor labour conditions. Care work does not usually provide access to economic and social citizenship;
- Additionally, that unequal distribution has a negative effect on other aspects of life: taking on a large number of non-remunerated tasks means that women have less time and fewer opportunities to get involved in other activities. It also undermines their intra-household bargaining power.

II. The present social organization of care is unjust

The way care is organized varies widely in different societies and contexts. While in some we find that the State participates significantly, in others the State is hardly present at all and the burden falls almost entirely on extended households. The presence of the community and the non-profit sector also varies greatly.

Despite the large geographic and historical differences, there is one factor that most care systems share: they are unjust (although this varies widely):

- Social responsibility in the provision of care is lacking or weak: the State sometimes takes on responsibility for the provision of care. Nevertheless, often the bulk of care requirements are delegated to households, to the domestic-private sphere. Citizens are asked to act as self-sufficient subjects, especially when entering the labour market. Interdependence, which urges building social co-responsibility between all citizens, public and private actors, is concealed.
- Women are assumed to hold the responsibility for care: while care-giving is not conceived as a man's responsibility, women are considered to be born willing and skilled care-givers. These gender stereotypes are the basis for the gender division of labour, for women assuming the bulk of unpaid care work and for the devaluation and feminization of the domestic employment sector.
- There is a systemic nexus between care and inequality: a vicious cycle is created between care and exclusion, vulnerability or poverty. The existence of asymmetrical flows of care from those who are in a lower socio-economic position toward those who are in a higher one - from women to men, from lower to upper classes, from some countries to others - is a common pattern.

Building care as a collective responsibility assumed by all citizens and institutions is urgent in order to reverse this unequal access to care and to advance toward gender equality. Care must be considered a right, which facilitates the further exercise of other rights.

III. Care and women's economic empowerment

There are six changes related to care that must take place in order to achieve women's economic empowerment:

- Reduce the barriers women face in gaining access to employment: especially those related to the unfair share of non-remunerated care work that they undertake;
- Identify and improve intra-household power dynamics: the unbalanced bargaining power of men versus women affects the unequal distribution of care responsibilities; at the same time, the unfair share of care-giving tasks that are undertaken by women reduces their bargaining-power;
- Engage men in all types of care work, increasing their involvement in non-remunerated care work and encouraging their presence in the care sector;
- Shift the place that care occupies in the development agenda: care should be granted top priority in development and should not be misused as a tool for development. This requires redistributing and recognizing care;
- Dignify working conditions in domestic employment and professionalize the care sector;
- Make visible the effects that economic policies have on the care economy: one of its concealed consequences that should be avoided is to overburden women with care work.

IV. Policy interventions toward universal decent care

The mandate for action on care is grounded on:

- The human development approach: care is made up of a set of activities that allows life to exist, life being at the heart of human development. Therefore, assuring universal access to decent care must be a critical component of development. Decent care refers to situations in which individuals access care that is sufficient (satisfies needs), is freely chosen (individuals have decision-making power) and is satisfactory (fulfils what the individual considers as important);
- The rights-based approach: there are diverse recognized labour rights that are often violated in the domestic employment sector; at the same time, many human rights intersect with what we could recognize as a right to care (both to receive and provide care).

Advancing toward fair care systems requires a threefold transformation:

- From the current lacking or weak social responsibility for care toward co-responsibility: between women and men within households and between all socioeconomic actors in the public sphere (the State, private companies and the third sector);
- From care as a women's responsibility toward gender equality;
- From the care-inequality nexus toward the recognition and full enjoyment of:
    - Labour rights in the care sector;
    - A universal and multidimensional right to care, including (1) the right to receive the care needed in different circumstances of the life-cycle, and (2) the right to decide if one wants to provide care or not, with the possibility of caring in decent conditions.

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Chapter 1

CARE: BASIC CONCEPTS

1. What is care: concept and evolution

Care is comprised of all those activities necessary to recreate, day after day, the physical and emotional well-being of people. To care is to concern oneself with the bodies of others as well as their emotions. To better understand what we are referring to when we talk about care, we can examine its different components:

- Direct care: tasks that involve direct interaction between people in the interest of physical and emotional health;
- Preconditions for care: tasks that lay out the material conditions which then allow for direct care to take place. We sometimes call this (unpaid) domestic work;
- Mental management: tasks of coordination, planning and supervision. Though this is not easy to quantify in terms of time, it can cause mental and emotional strain.

Let us see a few examples to better identify the diverse tasks that care comprises:

	Direct care	Preconditions for care	Mental management
To ensure that a baby is adequately dressed, one must:	Change the baby's clothing when it is dirty, put a hat on her if it is cold.	Wash the baby's clothes.	Plan: wash the clothes beforehand so they are not wet when needed, take clothing with you if you will be away from home.
In order for an elderly person who cannot take care of himself to be well fed, one must:	Give him food.	Buy the food, cook it and wash up afterwards.	Organize a balanced diet; remember that this person is allergic to eggs.
For an adult to go to a doctor's appointment one must:	Take her to the health centre because she wants to be with someone when she hears the test results.	Make breakfast for two people.	Make an appointment with the health centre; ask for permission at work to go with her.

Care has a gratifying and pleasant side as well as a difficult or tedious side, because the lives of human beings always have this double dimension of enjoyment and hardship. How difficult or how gratifying this work is depends on different cultural and material factors. It depends on the needs to be covered. Providing care to children in general is much more pleasant than providing care during illness or aging. It also depends on the conditions surrounding care. Cleaning a house with no windows and an earthen floor may be much more difficult than cleaning a modern home. If adequate infrastructure is not available, if time is short, or if one does not have any choices, care can be an enormous and arduous task.

1.1. Public policy implications

The concept of care is recent and partly for this reason it is still a matter for debate. Which definition of care we opt to use will have repercussions in terms of the public care policy to be implemented. The narrowest definition holds that care is the set of tasks that are carried out to maintain the well-being of persons in a situation of dependence, that is, those that cannot care for themselves because of a disability (due to age, congenital factors, accident or others). In this definition, emphasis is placed, above all, on the set of actions and services provided to assist elderly persons and adults with disabilities. It is sometimes argued that the three classic pillars of the Welfare State (education, healthcare and social security) should be complemented by a fourth pillar: assistance in situations of dependency.

A somewhat broader definition also includes those tasks undertaken to maintain the well-being of children. From this perspective, care policies would include, in addition to the former, those policies related to maternity and paternity (policies for work-life balance directed toward mothers and fathers, policies that protect maternity, amongst others), as well as childcare services and other child protection policies.

The broadest definition of all considers that care encompasses all those tasks that need to be performed to guarantee our day-to-day well-being. Many of these tasks can be performed by us, butin other cases, for diverse reasons we cannot do so and we need someone else to perform them for us. Or we prefer not to because we have the capacity to delegate them. From this perspective, all of the policies mentioned above are included, but so is a more diverse set of policies:

- We are frequently asked for such a dedication when we are active in the labour market that assuming responsibilities for our own or others' care becomes impossible. So we need someone else to do it. Broadly speaking, the more available for paid work we are, the more dependent we are on other people for covering our care needs. This is why policies that organize living time (especially policies that define the interaction between paid work and unpaid work) must be taken into account.
- The use of this definition implies an analysis of the relationship between care and the other pillars of welfare, and points to the conclusion that guaranteeing good conditions for care must be a transversal goal for all policies.

In this course, the broadest definition is used. We emphasize measures that provide assistance to dependent persons and children, but in a broader sense we look at the interrelation between care and a wide spectrum of economic and social policies, as well as its relevance to models of development.

"Levels" of care and relevant policies

Let us look a bit more closely at the political repercussions of different definitions. We invite you to look at the following public policies regarding care:

- In Ecuador in 2009, a study on disabilities was carried out that identified persons with severe disabilities. The Joaquín Gallegos Lara program was subsequently launched, providing an economic subsidy of 240 dollars to the person registered as the caregiver of each of these persons.
- In the Korean Republic (South Korea), the approval of the Maternity Protection Act in 2001 increased maternity leave from 60 to 90 days.
- Directive 2003/88/EC establishes the maximum workweek of 48 hours in the European Union, although as of 2010 no country had established a workweek of over 40 hours per week.
- In Mbale, Uganda, an initiative was introduced to improve the infrastructure for access to running water, guaranteeing that water is found within 400 meters of any home. This measure allowed women and girls to save 660 hours of work per year (Barwell, 1996).

If we consider caregiving to be assistance to the elderly and those with disabilities, we would only take into account the case of Ecuador. Policies directed toward minors, such as in the Korean Republic, would be excluded. There are perspectives on care that also take into account the situation of children and adolescents. It is only from a broad perspective of care that:

- We can take into account the organization of work time. We would include this because, as we shall see in this course, the regulation of the workday effects the amount of time available for caring for others and for one's own needs.
- Likewise, it is only from a broad-based perspective that we can ask ourselves about the impact that the lack of basic infrastructure has in terms of time use and availability, of work hours dedicated to unpaid activities such as carrying water.

1.2. Diverse terms to bring to light women's work

The concept of care has not always been used and is not always used today. In fact, we sometimes see other terms, such as "unpaid domestic" work and "reproductive work". Each of these terms places emphasis on a different aspect, but all are mutually complementary. All of them have a common underpinning: they bring to light those jobs historically associated with women that are performed free of charge or for scant wages, and which sustain the lives of others.

Historically, the first term used to refer to all the free tasks performed in a household was (unpaid) "domestic work". This term served to point out that in any given household, family members allocate their time so as to go out and earn a salary as well as to stay in and perform unpaid tasks. The unequal distribution of these forms of work upon gender was denounced: most of the paid work was done by men and most of the domestic work by women.

Thus a key element in gender inequality was revealed, the gender division of labour. While the term domestic work places emphasis on material tasks, the term care focuses more attention on the affective or immaterial dimension of well-being, something which is hard to cover in the market because the market produces for an abstract consumer. In the domestic context, we care for specific people that we know, whose story, personality, likes and dislikes, among other things, we are familiar with. Another difference between care work and paid employment is that the principle motivation for the work is achieving well-being. In a market situation, economic activity seeks profit. A job is undertaken because some benefit is expected. In the sphere of care, however, the motivation for doing something is generally the perception that someone has a need that must be met.

An additional possible approach is to recognize that in order for any society to continue, it must produce goods and services but must also reproduce people, day after day and generation after generation. When we bring the work of care in the home to the forefront, we bring to light this whole sphere of social reproduction. The organization of reproduction is based on kinship systems and commonly assigns unequal roles to women and men. For this reason, if we do not understand gender relations, we cannot understand how the socio-economic system works on the whole.

In any case, it is important to understand that all these concepts are linked to making two phenomena visible, the existence of deep gender inequality and the non-commercial dimensions of the socio-economic system that usually go unnoticed. Throughout this course, we shall use the concepts of care, caregiving, domestic work, unpaid work and reproduction alternately, according to the aspects we wish to emphasize at any given moment. Another key concept that will be used is domestic employment, which refers to the situation in which such domestic or care work is done for a wage. We shall see that paying someone to undertake these tasks that are essential for every household is a frequent phenomenon.

2. Approaching care

Acting on care is crucial for promoting gender equality. But what are we talking about when talking about care? There are two entry points for approaching care: (1) it must be recognized as the base of development that goes frequently unacknowledged; and (2) care must be approached as an ever-present reality that changes throughout the life-cycle.

2.1. The (invisible) base of development

Let us look at that figure walking down the street in the early hours of any given day. That person is headed to work. When we look at him/her, diverse questions arise:

- That person is wearing clothes. How did s/he manage to do so? S/he might have bought the clothes, or maybe someone sewed them at home. Who washed them? How? When? Was it she herself/he himself? Was it a family member? Is a domestic employee in charge of cleaning the clothes?
- That person has three children. Who is taking care of them right now? Are they in a nursery? Who will pick them up and cook their dinner? Maybe the youngest one is cared for at home all day long. Maybe the oldest is in charge of the younger ones.
- That person has been sick and feverish, confined to bed for the past week. Who was in charge of healing her/him? Did s/he go to the health centre? Was s/he prescribed drugs? In this case, who bought and administered them? Who provided food and changed her/his sheets?

We do not know what that person's employment is. Does s/he work on a farm, in a bakery, at a bank, at a chemical laboratory? Perhaps that person is a politician or a union leader. In any case, for her/him (and for anyone) to produce, he or she must first be reproduced: raised, fed, cured, clothed. Who is in charge of that process? Who is in charge of caring for that person? Is it the responsibility of an individual? Of Institutions? Of the State? Do men and women share equally in this responsibility? To inquire about care is to inquire about the social processes that reproduce the human factor instead of taking for granted that the human factor simply appears spontaneously, as if by magic.

Far from it, millions and millions of hours are devoted to unpaid work worldwide. This work tends to remain invisible. Nevertheless, people would not be able to enter the labour market without it. Women work for free between two and five hours a day more than men do. If these unpaid tasks were assigned a monetary value it is estimated that they would count for 10 to 39 per cent of the GDP of any given country.[1]

As stated by the UN Secretary General: "Care is an essential, universal need and supports the engagement of both men and women in paid work. Unpaid care work contributes to individual and household well-being, social development and economic growth, but it often goes unrecognized and undervalued

1 These data refer to six countries, studied by the UNRISD project on the Political and Social Economy of Care. Findings are explained in Budlender (2008).

by policymakers, as does the fact that its costs and burdens are unequally borne across gender and class. Care is primarily provided by women and girls and has important implications for gender equality" (UN/Secretary General, 2013: 4).

Indeed, the lack of access to basic goods and services provoked by insufficient purchasing power and by a State's non-responsibility in providing them tends to be compensated through unpaid care work. Public spending cuts that are usually implemented during crisis transfer the costs of adjustment onto households. This is what has happened in the last global recession, "Cuts to social protection and social services as a result of the crisis, together with austerity measures adopted by many governments, have increased the burden of unpaid care work on women, thereby reinforcing and exacerbating existing gender inequalities" (UN/Secretary General, 2013: 16).

Finally, domestic employment must be recognized as the second pillar of care provision together with unpaid care work: "Employing domestic workers is a growing global trend for families seeking to reconcile household responsibilities with employment demands. [...] However, labour laws in many countries do not cover domestic work and its hidden nature makes it more difficult to enforce legislation where it exists" (UN/Secretary General, 2013: 6).

In this course we shall examine this base of the economic system and of development processes, which frequently remains invisible and is not granted the priority that it deserves.

When defining or designing a given welfare system, we should think about who is in charge of generating well-being, and where and how they do so. This means thinking about how, in each context, the actions of the State, of markets, of households and other social networks (e.g., the community, the third sector, NGOs, religious entities, etc.) fit together to provide people with the resources they need to live. Often only the State/market dyad is taken into consideration and the role that households and social networks play is overlooked. In this course we will reflect upon the role that these hidden spheres play in achieving well-being day after day and reproducing life generation after generation.

Welfare may be socially achieved with greater or lesser levels of decommodification and defamilization. The notion of decommodification refers to the dissociation of well-being from the position that a person occupies in the labour market, or his or her purchasing power of goods, services and insurance in the market. That is, the possibility of being disconnected from the market and from remunerated work and to maintain an acceptable standard of living, particularly, to access needed care. The notion of defamilization refers to the dissociation of well-being from the availability of unremunerated (female) work, or the norms of reciprocity and distribution that occur within families. In the context of care, defamilization means ensuring that needed care will be received regardless of the availability of family or affective ties:

- We shall say that well-being - and care - is commodified when citizens highly depend on market consumption for accessing what they need to live;
- We shall say that well-being - and care - is familized when we highly depend on family networks and on unpaid work done in households; and
- Another possibility is that the strong role played by the State lessens our dependency on market consumption and families. In this case, we shall say that well-being - and care - is more decommodified and defamilized.

2.2. A life-cycle perspective for a lifelong reality

Let us stop a minute to think about the world. Around 7 billion people of very different ages are its inhabitants:[2]

- There are 642 million children aged 0-4. They need permanent attention. A baby cannot be left alone. Who is in charge of providing such care and under what conditions? Another 1.2 billion are aged 5 to 14. They also need a lot of care, although maybe not constant care. They need food and supervision, and they have other needs as well, such as emotional support. In many places of the world children are no longer subjects to be cared for when they grow up

2 Data source: UNDESA, Population Division (2013).

and become a little more autonomous; they rather engage in household tasks and become active carers of younger brothers and sisters. This happens especially to girls.

- The majority of the world's population is aged 15 to 64. In that range we are potentially autonomous and can take charge of our own lives. But we need time and adequate resources to care for ourselves. Do we have them? It should also be noted how many persons are sick or have a disability. At that age we can also take care of other people who need it. But do we do it? Men too frequently disregard their care responsibilities, both towards themselves and towards others. Women are thus overburdened. How would the situation change if every man were co-responsible, given that there are 2.245 billion women and 2.298 billion men?
- An increasing proportion of the world's population is aged 65 or over: 321 million people are aged 65-74 and 210 million people are aged 75 or over. At that age we usually have more intensive care needs because our ability to take care of ourselves is reduced; or because we need specialized care to face illness or disability. Ageing intensifies care dependencies. Nevertheless, the elderly are frequently active carers, for example, when they are in charge of grandchildren whose parents have migrated.
- It should be stressed that the composition of population varies widely between countries. The need for elderly care in Europe is high, while in Africa children require the bulk of care efforts (the following data can be introduced using an animation: 15.8 per cent of the African population is aged 0-4; versus 5.3 per cent of the European population. Just 3.4 per cent of the African population is aged 65 or over while in Europe it is 16.3 per cent).

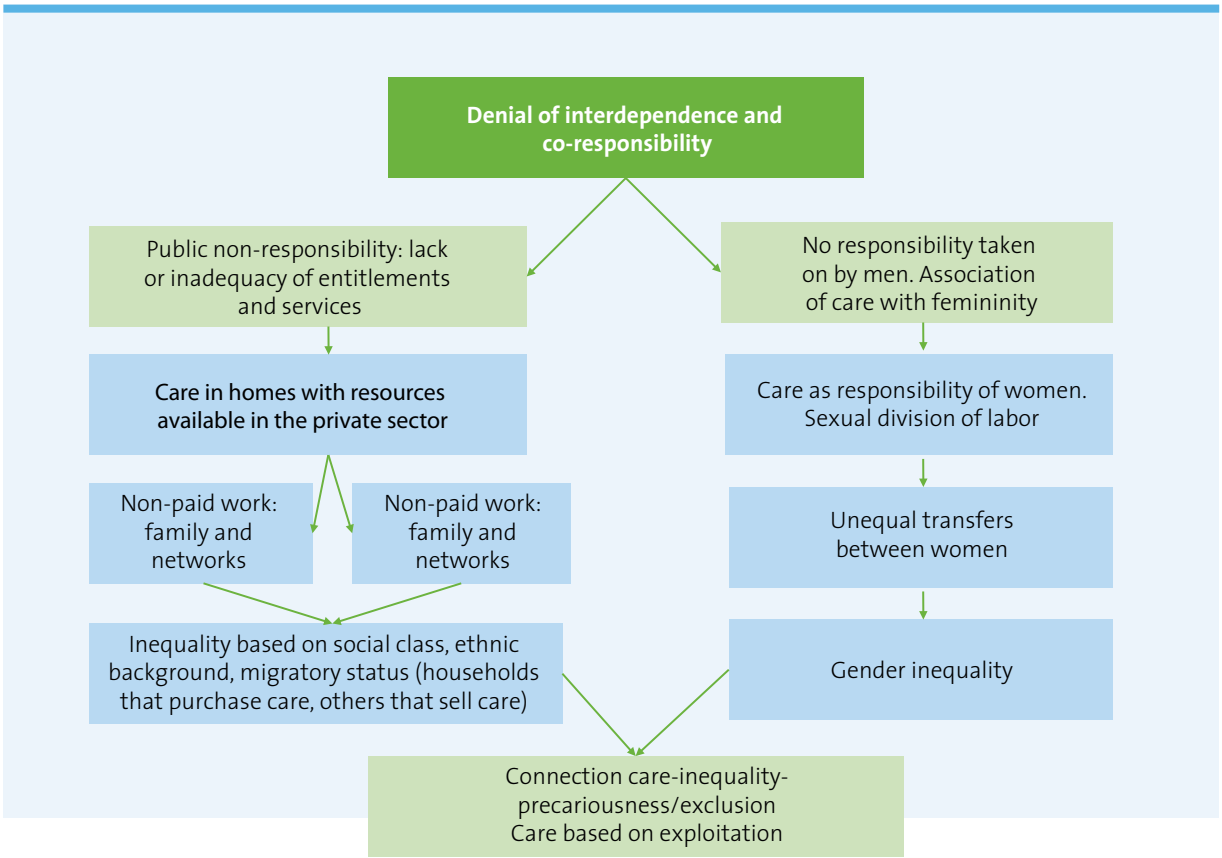
Care is a ceaseless reality, a need that we always have and a job that we can undertake during most life periods. But the changing conditions along the life-cycle must also be recognized. Therefore, care must be approached from a dynamic life-cycle perspective. This perspective must also be two-fold, asking about the changing need for care and the diverse ways in which it is satisfied.

We can think principally of the individuals that need care. We might ask about their different needs along the life-cycle. What does an elderly person need? What if s/he has dementia? And a young person? What types of care are appropriate during childhood? We might also ask to what extent the person in question can cover these needs on his/her own: Is s/he potentially independent or does s/he need external assistance (status as dependent). If s/he is potentially autonomous, the next question is whether s/he covers her own care needs or delegates them to others. In this case, why? Does delegating mean having more free time, living better, being more available for professional advancement? Finally, another crucial question is how the cost of the care needed by each person is covered. When care is delegated, is it paid for or is it received free of charge?

We can look at it the other way around too, starting our inquiry with those who perform the tasks of care. In what conditions are these tasks performed? In exchange for what? Care can be paid for when it is performed in exchange for a salary. The remuneration of paid care services may be organized in many ways: hiring may be direct (as in the case of domestic employment), it may be provided through public services, it may be done through a company (as in the case of cleaning staff) among other scenarios. Care can also be unpaid, when it is provided free of charge. In general, unpaid care occurs in close networks, on the basis of affinity or kinship, with care provided by family members, friends or neighbours. Finally, there are also mixed formulas that can't be considered strictly paid or unpaid: work carried out by volunteers in an association that cares for the sick, the work done by an adolescent in the home of a wealthy distant relative in exchange for schooling, etc.

3. Critical questions about care: unjust care systems

The way care is organized varies widely in different societies and contexts. While in some we find that the State participates significantly, in others the State is hardly present at all and the burden falls almost entirely on households. In some contexts, care is highly commodified and there is a considerable range of household services available for hire, normally at very high prices; in other contexts, there are hardly any private care services beyond domestic employment. Sometimes, the community or the extended family plays an important role, while in other cases the management of every-day living takes place in small households in which there is less flexibility in the distribution of tasks. Nevertheless, and despite these differences in how the burden of care is distributed in different scenarios, there is one factor that most care systems share: they are unjust. What do we mean when we say that care systems are unjust? Three characteristics shape the injustice in systems of care (see Figure 1).



- The social responsibility in the provision of care is lacking or weak: the State sometimes takes on responsibility for the provision of care. But often it does so only partially or inadequately, delegating the bulk of care requirements to households. Faced with this lack of public participation, the issue of care is resolved with the resources privately available, either drawing upon the unpaid labour of family members or using monetary resources to purchase care services, especially domestic employment. This weakness or lack of social responsibility arises from the failure to recognize that care is a need of all individuals and that all of us should be held responsible, in other words, that we are interdependent.
- Care is understood as a woman's responsibility: gender roles and stereotypes cause an unequal share of caregiving between women and men. Men only infrequently take on responsibilities in households. Rather, it is women that are in charge of providing care. Care labour sectors are also highly feminized and they tend to present worse labour conditions than other employment sectors. Domestic employment is deeply marked by social class, as it is a sector of the workforce of that comes mainly from lower classes. The two pillars of the social organization of care in most contexts on a global scale usually are unpaid work done by women in families and domestic employment performed by women who have no other opportunities.
- Systemic nexus between care and inequality: in the same way that there are social inequalities in access to education, healthcare and adequate food, among other things, there are also inequalities in the access to decent care (sufficient and quality). The comfortable position of some is based upon the exploitation of others. There is commonly an asymmetrical flow of care from those who are in a lower socio-economic position toward those who are in a higher one. From women to men, from migrant population to host population, from working classes to wealthy, from some countries to others. Inequality characterizes the social organization of care and this is related to the weak social responsibility.

3.1. Lack of social responsibility for care

There is a lack of social responsibility for care whenever care is not considered a public, collective issue, but something relegated to the private-domestic domain. Then, public institutions do not design policies that are adequate to addressing the needs of individuals in situations of dependency, nor do they guarantee the availability of sufficient resources to allow society to establish provisions for adequate care. This lacking responsibility is linked to the articulation of citizenship in contemporary societies, which fits those persons that emerge every day washed and ironed, rested, emotionally recovered and fully ready to go into the public domain (the realm of companies, public institutions and politics). The latter is conceived for self-sufficient subjects who have no need for care, nor have they any responsibility for the well-being of others that might interfere with or obstruct their public activity.

If we believe that citizens are self-sufficient subjects, we fail to recognize the need for care as an aspect of well-being in which everyone must take responsibility collectively. Therefore, we conceal all the care work that sustains these subjects and meets their unacknowledged needs, taking for granted that these needs will be met and that somebody will meet them. Finally, we end up normalizing the processes that allow some people to delegate the care they need, and even to delegate their share of co-responsibility in caring for other individuals.

We are interdependent and hence all individuals should take on co-responsibility for care. Every one of us needs care at all moments of our life, because our lives are vulnerable. This means that we can live, but we don't live in an automatic or miraculous manner; we must take care to fulfil the conditions that make life possible. It is true that we do not need the same type of care in all circumstances. At times we need intensive attention (in childhood much more so than as adults) or specialized care (if we are sick we require different attention than if we are healthy).

Moreover, in almost all moments we can care for ourselves and care for others. A baby can care for no

one, but most elderly people can take on certain care tasks for themselves or for others. In effect, we can approach care as a continuum that ranges from situations of potential autonomy, in which we can fend for ourselves and care for others, to situations of dependence in which our ability to care for ourselves and for others is reduced, getting to situations in which we may have no ability at all. Most of us are placed somewhere between these extremes. And this raises two questions:

- Do all individuals with the capacity to care for themselves and others accept co-responsibility for care or do they delegate it?
- Do we provide care to assist dependence or to promote autonomy?

We always need care. During most of our lifetime we can both give and receive care, which is why we say that care is a relationship of interdependence. Accepting that we are interdependent implies recognizing care as both a need and a job. It also implies that care should be redistributed throughout the entire social fabric. This would entail that we all take on the responsibility for caring for ourselves and co-responsibility in caring for those who cannot fend for themselves; and that we design collective structures to manage this co-responsibility, with the State as the backbone of this structure.

Do we provide care to assist dependence or to promote autonomy?

- In many parts of the world there are inadequate assistance and public services available for people with disabilities. When these services do exist, they are frequently criticized by those who receive them because they don't allow them to live in an independent manner and exercise the same rights as the rest of the population. People with disabilities are considered passive subjects in need of protection, even at the expense of taking away their rights. For example, in many countries, women with mental disabilities have been subjected to forced sterilization, a practice that still occurs in some places.
- For these reasons, many of these people call for sufficient resources to permit them to lead independent lives. There are collectives that propose putting an end to the use of the term "disability" in favour of talking about "functional diversity" or "different capacities": individuals have different ways of functioning in the world, so why are some of these ways discriminated against and taken as justification for the denial of their rights as individuals?
- We encourage you to see the trailer of the film Lives Worth Living, about the struggle of persons with disabilities in the United States. Or if you prefer, you can see some of the experiences in these centres that promote independent living in Brazil, Cambodia, Mexico or Zimbabwe. Or visit this link where you can find diverse resources: Independent Living Resources.

The disturbing fact is that, broadly speaking, there are no collective structures that organize this co-responsibility. Public institutions, the main structure for organizing life in common, do not provide sufficient mechanisms for guaranteeing care. On the contrary, the current articulation of citizenship conceals care, removing it from the public domain and organizing it around relationships of inequality. Nevertheless, this varies widely depending on the contexts. There are countries in which the State plays a role, while in others care is performed by families with almost no public support. The relative strength or weakness of collective structures impacts greatly on the levels of social inequality, the citizens' ability to exercise their rights and even on the feasibility of the development model.

3.2. Care as a woman's responsibility

Despite differences in each context, care is normally associated with women, in both a symbolic and material sense. In a symbolic sense, gender stereotypes construct a different relationship for women and men with regards to care.

These gender stereotypes do not always work the same way. They vary greatly, for many reasons, including social class. For middle-class women, being in charge of care may mean managing it and hiring domestic employment. For lower-class women this may mean caring for their own homes and often being employed at low wages to care for others' families.

The stereotype that care is a women's issue frequently finds its way into public policy, where these differentiated gender roles are taken for granted and reinforced. Frequently, policies associate the responsibility for care strictly with women. We can perceive that in the following examples:

- The use of the maternal role to reach goals in the struggle against poverty or the well-being of children;
- The recognition of women's rights only in the context of their condition as mothers;
- The approval of cuts in public spending that transfer the responsibility of making up for public services onto households;
- -The recognition of poorer labour rights in domestic employment than in other labour sectors.

	Care-giving	Receiving care
Men	Care-giving is not conceived as a man's responsibility. Their responsibilities are thought to be related to the public domain, specifically fulfilling their breadwinner role.	It is considered a given that somebody will care for them, but this task that is carried out and received is invisible.
Women	Women are frequently considered to be born willing and skilled care-givers. It is taken for granted that women care out of love, in exchange for nothing. Care-giving is understood as the natural activity inherent to good women. It s not seen as a work requiring time, energies and a learning process.	Women's needs for care are usually overlooked. It is assumed that a woman cares for others at the expense of her own well-being. A good woman is supposed to sacrifice her needs for those of her family.

Broadly speaking, the economic system is based on those assumptions about gender roles, which have serious implications in terms of work sharing. In a material sense, women undertake most of the tasks of care. This unequal distribution of tasks has been long decried in criticisms of the gender division of labour and we speak of three interrelated things when we speak about the gender division of labour. First, there is an unequal distribution of tasks depending on one's sex. Second, this distribution has to do with social relationships and mechanisms that operate on levels beyond what individuals negotiate. And third, women are assigned tasks considered of lesser value.

The concrete shape that the gender division of labour takes varies, but its defining feature of inequality remains constant. In capitalist economies, work which is less valued is not remunerated and the bulk of care is performed free of charge by women, at home. When care is introduced into the market, certain characteristics are maintained: it is still an activity linked to women and it is still undervalued. It is for these reasons we say that the care sector is feminized and suffers penalizations in terms of salaries and working conditions. In the opposite sense, when men become involved in care they tend to do so in the most gratifying, least repetitive or least stressful activities, and those that enter into the least conflict with other tasks (employment, leisure time and other public activities). Likewise, those care tasks that are transferred to the market which have a high level of masculine participation are much more highly valued. A clear case is the vertical segregation in the health sector, where being a doctor is much more valued than being a nurse.

Table 1 shows how much time per week women and men devote to paid and unpaid jobs in different Latin American countries.

TABLE 1

Time devoted to paid and unpaid jobs, by sex, LAC countries (hours per week)

	Men		Women	
Country	**Paid work (hours per week)**	**Unpaid domestic work (hours per week)**	**Paid work (hours per week)**	**Unpaid domestic work (hours per week)**
Brazil 2008	43	4	35	18
Colombia 2009	48	6	39	25
Costa Rica 2004*	7	1	6	4
Ecuador 2008	45	7	38	28
Guatemala 2006*	6	2	4	6
Honduras 2009*	9	1	7	3
Mexico 2009	48	16	40	46
Peru 2010	47	15	33	36
Uruguay 2007	40	19	38	43

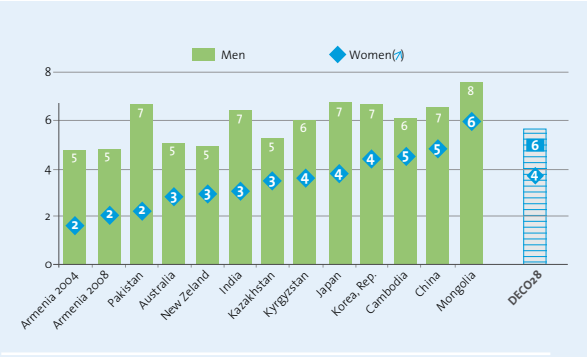
* In hours per day

Source: CEPALSTAT(based on national time use surveys), http://estadisticas.cepal.org

Figures 2 and 3 reveal how, in most Asia and the Pacific countries, women work more hours for free than do men and men work more paid hours.

FIGURE 2

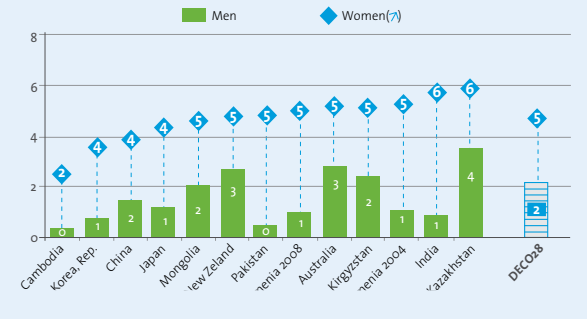
Time spent on market and earning activities in hours per average day, by country and gender



Note: time spent in paid work includes time devoted to study

FIGURE 3

Time spent on non-market/unpaid work in hours per average day, by country and gender



Source: OECD (2011)

Figures 4 and 5 show similar findings for European countries.

FIGURE 4

Work, men, hours and minutes per day, by country and type of work

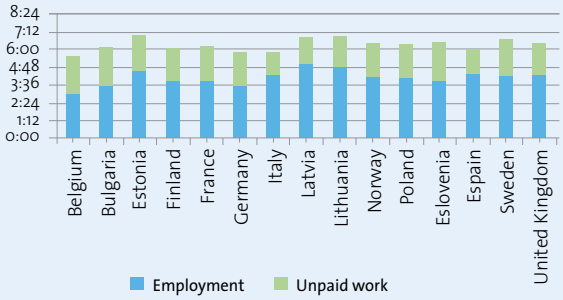
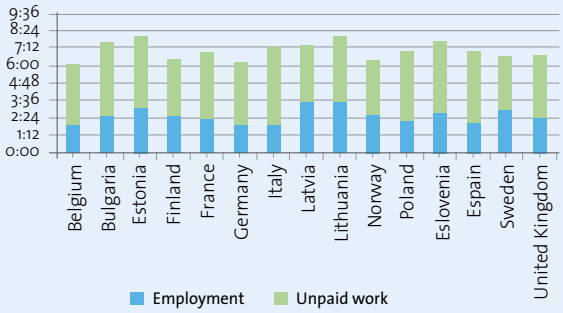


FIGURE 5

Work, women, hours and minutes per day, by country and type of work



Source: Harmonized European Time Use Surveys (based on national time use surveys) https://www.h2.scb.se/tus/tus/Default.htm

Finally, the situation in some Middle Eastern countries is quite similar (see table 2)

TABLE 2

Time devoted to paid and unpaid work, by sex

	Paid work		Mujeres	
	(hours per day)	Unpaid domestic work	Paid work (hours per day)	Unpaid domestic work (hours per day)
Oman	(hours per day)	Paid work	1	4,6
Palestine	(hours per day)	Unpaid domestic work	0,5	5

Fuentes: Para Omán: http://css.escwa.org.lb/sd/1551/TUS-Oman.ppt . Para Palestina: http://www.escwa.un.org/divisions/sd/docs/Dataanalyis.ppt

Despite the great differences between countries, the same characteristic is present in all of them: women are mainly responsible for unpaid care in the home. Thus, we must implement policies to advance towards greater equality. But this entails profound change in cultural patterns that cut across social and economic structures. What these data do not tell us is that greater gender equality in non-remunerated tasks is sometimes achieved by outsourcing these jobs (meaning, for example, purchasing services externally, hiring domestic employees). These in turn are jobs that are usually performed by women.

Thus, care is a question of the utmost importance when considering inequalities between men and women, because care is unequally distributed according to sex: women give more and receive less, men receive more and give less. Women perform the majority of care tasks, most of which are not paid and do not provide access to economic and social citizenship. Care-giving also takes place in markets, mainly through domestic employment. When care enters the labour markets it carries the invisibility and undervaluation that characterize unpaid care work. Thus domestic employment tends to be a highly feminized sector with poor labour conditions.

Additionally, unequal distribution of unpaid care tasks has a negative effect on other aspects of life: taking on a large number of non-remunerated tasks means that a person has less time and fewer opportunities in the labour market, as well as less opportunity to intervene in politics, to participate in decision-making positions or to access education. It also undermines a person's capacity for negotiation and may bar women from severing abusive family relationships or situations of violence because they feel they have no alternatives. Indeed, it diminishes women's time for leisure, rest and self-care. For this reason, women have historically been described as second-class citizens.

Second-class citizens are those responsible for resolving care needs in the private sphere, out of sight. This can happen through free work and/or transfers between women based on inequality relationships. In order to be able to fully exercise citizenship rights, a person has to act as self-sufficient subject, with neither care needs nor care responsibilities that hinder this presence in public spheres. Hence, second-class citizenship, which is of the same essence as citizenship, has historically being assigned to women.

The negative impacts of the unfair distribution of unpaid care work

Excerpts from the Beijing Platform for Action:

Action 52: [...] where social security systems are based on the principle of continuous remunerated employment. In some cases, women do not fulfil this requirement because of interruptions in their work, due to the unbalanced distribution of remunerated and unremunerated work. Moreover, older women also face greater obstacles to labour market re-entry.

Action 71: Girls undertake heavy domestic work at a very early age. Girls and young women are expected to manage both educational and domestic responsibilities, often resulting in poor scholastic performance and early dropout from the educational system. This has long-lasting consequences for all aspects of women's lives.

Action 152: [...] inadequate sharing of family responsibilities, combined with a lack of or insufficient services such as child care, continue to restrict employment, economic, professional and other opportunities and mobility for women.

3.3. The care-inequality connection

If we do not recognize that care is both a dimension of well-being that must be covered and a form of work that must be undertaken, we allow the following situations to take place:

- Some people receive the care they require but neither value it nor give anything in exchange. For example, many men believe it is normal for their wives to cook for them and they do not recognize this as work. Another possible result is that they do not pay a fair price for it. This is the case for domestic employment, which is characterized by unfair wages. When hiring a person for domestic service some employers think they do that person a favour by giving her a job rather than duly valuing the services she renders;
- Some people do not receive the care they require, yet this is not being recognized as a social problem. For example, women caring for persons with severe disabilities often suffer serious physical and psychological effects due to the difficulty of the work, which is done without support. They are only seen as care-givers, not as subjects who are also in need of attention;
- Some people provide essential care but their work is not valued and does not give rise to any social and economic rights. For example, a man is more appreciated for cooking a meal on a holiday than a woman is for cooking every day, or devoting one's whole life to taking care of children, the spouse, elder parents and/or other relatives still does not earn a retirement pension. Similarly, domestic employment confers poorer rights than do other jobs;
- Some people perform no tasks involving care, yet are not seen to be "shirking their responsibilities". This is not the case for women. For example, it is a matter of concern what happens to children when mothers migrate, but it is not an issue when it is the father who goes.

Just as we question socio-economic inequalities in access to education, health and housing, and other things, we must also question inequality in access to decent care. When we speak of decent care we refer to situations in which individuals access care that is sufficient (it satisfies needs), it is freely chosen (one may decide how one wants to care/be cared for and how, how much and whom one wants to care for) and is satisfactory (it fulfils what the individual feels is important).

The opposite situation is "precarious care", meaning care that is inadequate (it does not fully meet the needs involved), is not freely chosen (when one has scarce margin for making decisions regarding how to care or be cared for, and how, how much, and whom to care for), and is not satisfactory (it does not fulfil what the individual feels is important).

The reality of precarious care frequently verges on exclusion and poverty: when one element fails there is no ability to react and care collapses. We encounter situations of collapse in the case of minors who are under the care of very elderly women due to the absence of their parents - because of death, migration or prison - when the elderly caretakers die or fall ill. Other situations of collapse occur in families overburdened with care-giving, in which older sisters are forced to leave school to take care of younger siblings. Leaving school at an early age can converge with adolescent pregnancies of these young women - due to lack of sex education or lack of sexual and reproductive rights - that perpetuate the cycle of poverty. In areas of sub-Saharan Africa that are heavily hit by HIV/AIDS, the time devoted to caring for minors is drastically reduced because care must be given at home to the ill, in the absence of public services.

We can say that care systems are unjust when access to decent care is given to some groups at the price of making other groups' access to care precarious. This is to say that asymmetrical flows are produced from women to men, from lower to upper classes, from migrants to native individuals and/or from some countries to others. Those in the worst socio-economic situations tend to resolve the needs of those in better situations, but the latter do not assume their part of co-responsibility. This overload makes it difficult for them to satisfactorily meet their own needs. As a consequence, a vicious cycle is created between care and exclusion, vulnerability or poverty.

Let us describe how this cycle works, approaching it from the departure point of care needs. First, an

unfavourable social position implies greater care needs. This is in part because one's state of health is an aggregate indicator of inequality (for example, if basic medical attention is not obtained, an illness worsens). Moreover, an identical situation can cause greater dependence (for example, short-sightedness can cause a dependency to a person if s/he cannot afford glasses, not to mention the person who is paraplegic and cannot even get access to a wheelchair). Second, likewise, there are fewer resources available to obtain the care needed. As long as there are no public services, one must resort to the purchase of private care services. If there is not enough income, all of the burden of care will fall on non-remunerated work. Third, having unmet care needs means that one is not in a condition to try to improve one's socio-economic status, thus an inferior social status is perpetuated.

From the departure point of performing care work, we can see the following cycle. First, caring does not provide access to economic, political or social rights. Non-remunerated care provides neither income nor access to benefits. On the contrary, caring for the home has a direct negative impact on women in terms of insertion into the public domain (the labour market and also political and educational spheres, among others) and consequently on their empowerment. Remunerated care, especially domestic employment, is characterized as being a very precarious and vulnerable labour sector in which gross labour rights violations occur.

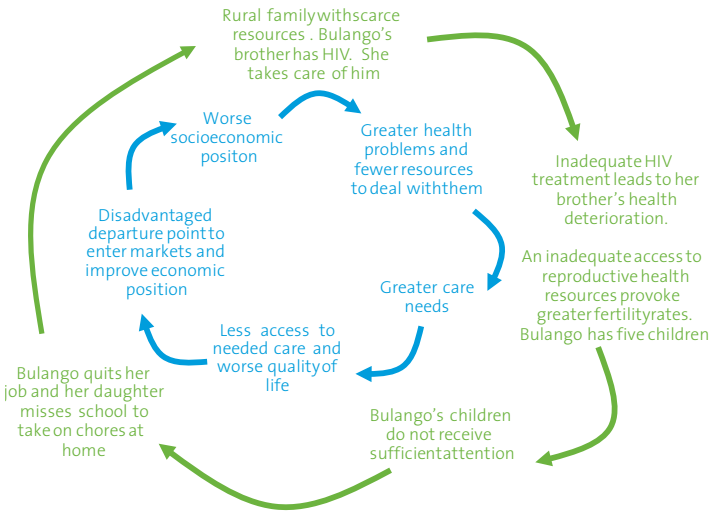
Care-giving therefore places one in a more vulnerable socio-economic position. Second, as care is an undervalued job, it tends to be performed by those who are in the least favourable social and economic positions, those with no other alternative. In the home, non-remunerated care is carried out by those who have the least capacity to choose in terms of sex and age.

On the market, care work constitutes a sector that is penalized in terms of wage and labour conditions. Those working in this sector may have no other labour opportunities for many reasons: not having had access to education; being denied regulated migration status among others.

Third, this same undervaluing prevents the base situation from improving. One accepts an undervalued job because one has no ability to choose. This work in turn does not improve that ability to choose.

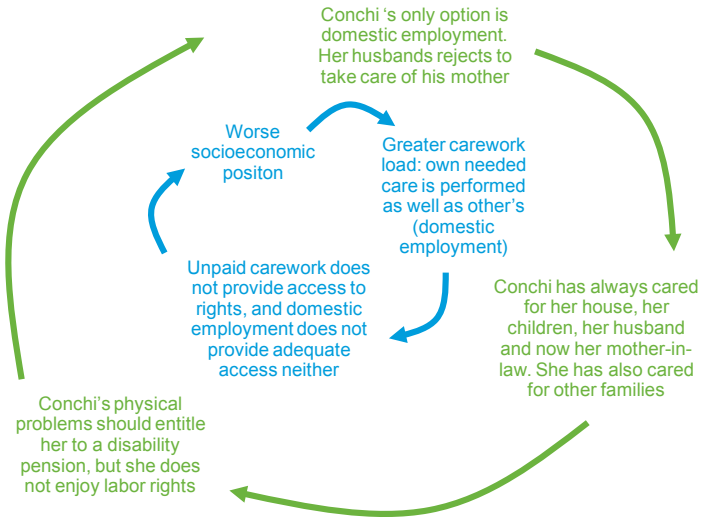
The vicious cycle between care, exclusion, vulnerability and poverty

Bulango had to leave her job in the fields because her brother's health had gotten much worse. Her brother has HIV, and inadequate access to treatment has caused many complications. Her eldest daughter, age 11, has recently had to miss school more often to help her mother and take on chores at home.



The vicious cycle between care, exclusion, vulnerability and poverty

Conchi began to work at age 15 as a live-in domestic employee. At age 21 she married and had three children and continued to work part-time in several homes. She is now 53 years old and suffers from severe lower back pain. She has been diagnosed with a herniated disk but cannot take medical leave because she has no legal contract. She also takes care of her mother-in-law, who lives in her home; her husband believes that it is not his job to care for her.



3.4. Changing unjust care systems

Before finishing such a short description of different care systems, it is crucial to point out that these systems are currently undergoing profound changes. Diverse countries, with different levels of human development, are experiencing a so-called "care crisis". This term refers to a situation in which the social organization of care is changing, and also to the precarious and unsatisfactory ability to meet care needs. The lack of adequate care encourages households to turn to domestic employment. These jobs are increasingly held by migrant workers. Migrants transfer their care responsibilities to other relatives when going. This process leads to the creation of the so-called global care chains. They are one of the most important factors in understanding the gender dimensions of globalization. The implementation of care policies is now even more urgent due to these changing paths. At the same time, these policies must have a transnational scope because care is being globalized.

4. Care and women's economic empowerment

This course comes under the UN Women Focus area of Economic Empowerment of Women, which strives to enhance the economic options women have and also to increase their access to income. Care is a question of the utmost importance for gender equality and women's rights. More specifically, there are six changes related to care that must take place in order to achieve economic empowerment.

The first change is to reduce the barriers that women face in gaining access to employment. These barriers are numerous, but are especially related to the work performed almost exclusively by women: non-remunerated care work. The responsibility for care reduces women's time to engage in productive activity; it is an obstacle for full-time participation in the labour market and/or fosters part-time or discontinuous engagement. It also hampers their access to education and training, their time devoted to professional promotion and their participation in decision-making processes. This unequal distribution of domestic tasks has an impact on the type of businesses women launch (such as those linked to care, which are undervalued

and often overburdened). Lastly, this is a crucial factor that keeps women bound to the informal economy. For all these reasons, the redistribution of care work, including the participation of the State and of men, is an indispensable condition to the advancement toward the economic empowerment of women.

The second change is to identify and erode intra-household power dynamics. Households are not harmonious entities. Diverse processes take place within them: cooperation and joint solving of needs, as well as conflicts and negotiations. Diverse household members have different bargaining power, and this is a key issue affecting the unequal distribution of care responsibilities. Intra-household power relationships are frequently the reason why women become overburdened with care work, which negatively affects their economic empowerment. Thus, public policies must recognize that households act as cooperative conflict units and must promote an equal distribution of resources and work tasks, particularly of care work, among all their members.

The third change is to engage men in all types of care work. Care work is disproportionately performed by women, and since men do not assume care responsibilities or assume an unfair and lower proportion than do women, they are able to access the labour market at more advantageous terms. Men also have a scarce presence in care-related employment sectors (domestic employment, geriatrics, child education). These jobs tend to be characterized by poor labour conditions and low wages. Achieving an equal presence of women and men in both unpaid care work and paid care jobs is a step toward equality. Moreover, this would encourage the identification of public policies aimed at enabling economic empowerment for every citizen and at improving labour conditions in care-related sectors.

The fourth change is to shift the place that care occupies in the development agenda. Care is rendered invisible, is undervalued, is not recognized as work and is poorly paid, when paidat all. Despite being an essential cog without which the socio-economic wheels would not turn, care does not take priority in development models. Moreover, guaranteeing the provision of care is considered something that should be resolved at home (and within the home, by women) in a private manner. At the same time, engaging in care work does not entail access to social rights. We can say that the care that a large part of the population receives is obtained to the detriment of the rights of another part of the population.

Currently, this inequality takes on a global dimension: the lack of change in public policy and the attitude of men means that the advances made in women's employment in some parts of the world occur at the expense of other women who take on the task of care and migrate because of the lack of job opportunities in their countries of origin. Thus, the reformulation, revaluation and redistribution of care throughout the entire social makeup are imperative conditions for reaching socio-economic systems in which all women can achieve economic autonomy in equal conditions.

The fifth change needed is to dignify the working conditions in domestic employment as a sector representing an important source of employment for women on a global scale. Millions of persons work in domestic employment, and the greatest part is women. It is a sector that, instead of guaranteeing economic independence and enjoyment of rights, is often a source of exploitation, violation of rights and perpetuation of poverty. Convention 189 on Decent Work for Domestic Workers was adopted in 2011, and on the 5th of September2013, it came into force. It is a roadmap for Member States to protect labor rights in the sector. At the same time, improvement in the conditions of women engaged in domestic employment will not take place if women have no labour alternatives. The professionalization of the care sector can be a key element in opening up job opportunities with decent conditions for women; work must be done simultaneously to involve men in these tasks to stop the perpetuation of current occupational segregation.

The sixth and last change is to make visible the effects that economic policies have on the care economy. Decisions regarding public expenditure and revenue, the type of labour policies to implement and the lines and directions to take in trade policy all have a direct impact on care. Subsequently they have an impact on the possibilities for economic

empowerment of those who perform care on the whole, that is, on the economic empowerment of women. Attracting capital and containing public expenditure are often achieved by overloading women with care tasks, thus impeding their economic independence. The gender biases denounced in economic policy are directly related to how the impact on the care economy is concealed. This is one of the critical elements that come to light when gender-sensitive budgets are elaborated.

5. Care from a human development, rights-based approach

Human development is the approach to development that defines the work of the United Nations System. From that perspective, it is imperative to approach the issue of care and to attempt to correct both the undervaluing of care and its unfair distribution. Human development is the freedom to live a life considered valuable. The 2010 Human Development Report presents the following reaffirmation of the concept: "Human development is the expansion of people's freedoms to live long, healthy and creative lives; to advance other goals they have reason to value; and to engage actively in shaping development equitably and sustainably on a shared planet".

Care is made up of a set of activities that allow for life to exist. Thus care is a basic dimension of human development. When we speak of sustainable development we must understand that the first condition for sustainability is the reproduction of people. This means not only biological reproduction but also cultural and social reproduction. The development process must allow for advancement in universal access to decent care, respecting at the same time the different notions of care held by different subjects and social groups. Achieving this is not an individual issue affecting each household, but rather a public responsibility, a question of "co-responsibility".

The United Nations System argues for using a rights-based approach. From that perspective, it is equally imperative to approach the issue of care. A rights-based approach is a conceptual framework for the process of human development that, from the regulatory point of view, is based on international norms of human rights. From the operational point of view, it is oriented toward the promotion and protection of human rights. Its purpose is to analyse the inequalities at the core of development problems, and correct discriminatory practices and the unjust distribution of power impeding developmental progress. From a rights-based perspective, care is a crucial issue for two reasons. First, care intersects many other

Care from the human rights-based approach	
From a regulatory standpoint: It is based on international rules regarding human rights.	From an operative standpoint: It is directed toward the promotion and protection of human rights.
Care transects human rights.	The right to care must be considered a human right. Labour rights in the care sector must be promoted.
Purpose: To analyse inequalities found at the core of development problems.	Purpose: To correct discriminatory practices and unjust distribution of power that hinder progress in development.
Inequality in the distribution of care affects the possibilities of individual, community and country development. Universal access to decent care and advancement toward fairer care systems must be promoted.	

(OHCHR 2006)

recognized human rights that must be fostered and protected. Second, looking at care highlights the need to understand and combat inequalities.

As we shall see, the current organization and distribution of care is characterized by deep inequalities between men and women, as well as between people of different social classes and countries.

From a rights-based approach, it is important that we ask ourselves which rights will allow access to decent care. We have seen that the inequalities that cut across the organization of care today imply that the access to quality care for one part of the population jeopardizes the care of another part. In other words, regarding care, rights are not being exercised but rather privileges are being accessed. The rights relevant to the care sphere include labour rights in the care sector as well as the right to access care.

The most important issue regarding labour rights in the care sector is labour conditions in domestic employment. With the adoption of Convention 189 in the 100th Session of the International Labour Conference in 2011, which establishes minimum conditions for guaranteeing rights in the sector, the minimum goals are the following: guaranteeing that the applicable regulations in each country meet the standards established by the Convention; and guaranteeing compliance with these regulations. Additionally, another goal beyond the scope of regulation is to dignify domestic employment, which requires the existence of alternative labour opportunities, that care cease to be an issue solved strictly in the household setting, and that avenues be designed to recognize and exercise the right to care, allowing care to be externalized beyond individual relationships within the home.

There is another big question linked to this latter idea too, which has to do with labour rights: how to bring about the professionalization of domestic employment. In other words, how can care be disaggregated according to the different tasks it entails, tasks that require specific knowledge and that constitute different professions with their respective regulations and rights.

We understand the right to care to be the universal right to:

- Receive the care needed in different circumstances and moments of the life-cycle; that this care meet the individual sense of what is needed;
- Decide if one wants to provide care or not, with the possibility of caring (for others and for oneself) in decent conditions, with a guaranteed right to delegate the care of persons in situations of dependence.

Can we say that today this right is recognized? Yes and no. On the one hand, among the universal human rights there is a set of recognized rights that touch upon the notion of the right to care: food, decent housing, health, education, social security and others. This means that the right to care is part of the set of human rights and especially economic, social and cultural rights. On the other hand, the right to care is not explicitly named, so advocating that it be recognized (and therefore that it can be demanded) is an important step to take. Approaching care from a rights-based perspective allows us to recognize the existence of persons who have rights they can demand rather than social sectors with unmet needs. It allows us to confront the inequality between women and men that cuts across care issues from the perspective of empowerment, avoiding treating women as a special collective.

Throughout this course, care is approached in terms of rights and from the perspective of human development. It means that we consider care a constituent element at the heart of development processes. And that we understand that there must be collective responsibility for providing care and we pay special attention to the absence of this collective responsibility and its consequences in terms of inequalities that hinder development.

Finally, it should be stressed that care is an infrequent priority subject. It is not discussed at public or political levels in which it could be articulated as a human right. No decisions are made regarding the priority it should take in development models and it is still not articulated as a human right. Therefore, making care more visible on the development agenda is a critical first step. And there are several international instruments that mandate action on care and the organization of care. The Convention on the Elimination of All Forms of

Discrimination against Women (CEDAW) also obliges states to "take all appropriate measures (...) including legislation, to eliminate discrimination against women" (Article 2). The Beijing Platform for Action also looks in detail at the connection between the organization of care and gender inequality and establishes goals accordingly, ranging from the provision of services to shifts in cultural patterns, from the establishment of indicators to the revision of macroeconomic policies that do not take care into account.

Also,

- The Convention on the Rights of the Child (CRC) also recognizes the right of minors to receive adequate care and establishes that parental responsibility be shared equitably between mothers and fathers.
- The Convention on the Rights of Persons with Disabilities protects persons with disabilities to fully enjoy all human rights. It establishes individual autonomy as a guiding principle.
- The Convention on the Rights of All Migrant Workers and Members of their Families protects the labour rights of migrant domestic workers as well as the right to education for migrant children.

Millennium Development Goal 3 also refers to women's unequal access to remunerated employment. This is directly linked to women's disproportionate responsibility in matters of care. Moreover, the UN Millennium Taskforce makes various references to remunerated and non-remunerated care in its revision of the steps necessary to reach the rest of the Goals.

In the context of the debate on the Post-2015 Development Agenda and on the definition of Sustainable Development Goals, UN Women also proposes a transformative, stand-alone goal on achieving gender equality, women's rights and women's empowerment. This proposal is included in the UN WOMEN position paper (2013).

This goal has three target areas: freedom from violence, capabilities and resources, and voice, leadership and participation. In achieving these targets the same elements relevant for the MDGs must be addressed. Additionally, the capabilities and resources area establishes:

- Target: reduce women's time burdens
- Proposed indicators
  - Average weekly number of hours spent on unpaid domestic work, by sex
  - Proportion of children under primary school age enrolled in organized childcare

Finally, Convention 189, which expands basic labour rights to domestic workers worldwide, came into force in September 2013.

Summing up, the following international instruments referred to during the course are:

- Millennium Development Goals (MDGs)
- Post 2015 Development Agenda and Sustainable Development Goals
- Beijing Platform for Action
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- Covenant on Economic, Social and Cultural Rights
- Convention on the Rights of the Child (CRC)
- Convention on the Rights of Persons with Disabilities
- Convention on the Protection of the Rights of All Migrant Workers
- Convention 189 on Decent Work for Domestic Workers & Recommendation 201
- Workers with Family Responsibilities Convention 156
- Maternity Protection Convention 183
- Convention 182 on the Worst Forms of Child Labour
- Social Protection Floor Initiative
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
- Quito Consensus (10th Regional Conference on Women in LAC)

6. Conclusion

We have discussed care as a critical issue that includes all the activities necessary to recreate, day after day, the physical and emotional well-being of people. Approaching care from a life-cycle perspective allows us to recognize that care is an ever-present reality in our lives, although the conditions under which we provide and/or receive it change. Discussing care implies focusing on daily well-being. There are specific care policies targeted to certain population groups, such as children or the elderly. Beyond that, care cuts across the entire set of public policy.

The whole economic system is based on care: in order to produce, we must first be (biologically and socially) reproduced. Thus we need to recognize care as both a need that must be met and a form of work that must be undertaken. Nevertheless, frequently care is not visible on the development agenda. Currently, the lack of proper co-responsibility implies that unpaid work within households and domestic employment are the two pillars of care. Women lead both types of work. International migration is reshaping the social organization of care at a global scale.

Broadly speaking, it could be said that care is unjustly organized. Despite important geographic and historical differences, care systems are commonly shaped by three characteristics:

- The social responsibility in the provision of care is lacking or weak: citizens are considered to be self-sufficient, without any care need or responsibility. Because interdependence is concealed, co-responsibility for care among all of us, as well as public and private institutions, is not enforced. Care arrangements are finally sorted out in the private-domestic realm;
- Women are assumed to bear the responsibility for care, while caregiving is not conceived as a man's responsibility. These gender roles cause a gender division of labour. The bulk of unpaid work is performed by women and domestic employment is characterized by poor labour conditions and its feminized workforce;
- There is a systemic nexus between care and inequality: the ability to access decent care is a major factor in inequality. There is also a vicious cycle between care/exclusion, vulnerability or poverty.

There are also several international instruments that establish the mandate for action on care, aimed at building social co-responsibility on care and assuring that all persons can access decent care. The following are the most relevant: CEDAW, the Beijing Platform for Action, the MDGs (and most probably SDGs), and the Conventions on the Rights of the Child, of Persons with Disabilities and of Migrant Workers and their Families. ILO Convention 189 also calls for an improvement in domestic workers' rights on a global scale.

It is imperative to approach the issue of care from a perspective of human development and from a rights-based approach. Care is made up of a set of activities that allows life to exist, life being at the heart of human development. And labour rights are often violated in the care sector, as are other rights that concern the right to care (to both receive and freely decide on care provision).

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List of terms used in this Reading Paper that are expanded in the Glossary

(Remember that you can come back to the glossary to check these definitions whenever you need it.):

- Care
- Care policies
- Co-responsibility
- Crisis of care
- Decommodification
- Defamilization
- Gender
- Gender division of labour
- Gender role of women (with regard to care)
- Human development
- Interdependence
- Production/reproduction
- Public/private-domestic domains
- Remunerated/unremunerated work (paid and unpaid work)
- Right to care
- Rights-base approach
- Self-sufficiency (self-sufficient citizen/worker)
- Social organization of care

CHAPTER 2

IDENTIFYING CARE NEEDS AND CAREGIVING SCENARIOS

CHAPTER 2

IDENTIFYING CARE NEEDS AND CAREGIVING SCENARIOS

TAKE AWAY POINTS

In order to comprehend the social organization of care in a specific context, we must look in a dynamic way at two crucial issues, the need for care and the ways in which this care is provided.

1. How much care is necessary in a particular context on the whole?

- All of us need care during our entire life and there are three factors that affect the relationship between the need for care and the corresponding fulfilment of that need:
  - To what extent society distributes the responsibility of caregiving among all potentially autonomous persons (particularly whether women are assigned the main or sole responsibility, or if it is fairly distributed);
  - To what extent those persons with potential autonomy have time to care for others and themselves (particularly, how workers are expected to act in the labour market, whether as self-sufficient or interdependent workers); and
  - Whether collective structures exist in society to guarantee care, or if the provision of care is considered the private responsibility of each household.
- In addition to the general population, what age groups with specific care needs are especially present?
  - During childhood and old age the need for care is greater, therefore the age composition of a population is extremely important;
  - Care needs associated with age vary according to social class as well as to cultural conceptions of care; and
  - The age composition of the population must be addressed from a dynamic perspective, allowing for predictions in order to anticipate future care needs that public policy should address.
- A critical demographic path that should be acknowledged is population ageing, which is a global - and feminized - phenomenon that represents major challenges in terms of care policy.
- A critical question is whether unusual or urgent care needs exist requiring a specialized or intensive response, such as with high incidence of disability, a care emergency, conflict situations, large sex imbalances or large age imbalances.
- The final issue that determines the care needs of each society has to do with models of existing households and the transformations they undergo. These models might significantly differ between social classes.

2. Actors who can provide care

There are four institutions that can provide society with care:

- The State:
  - The State plays a critical and three-fold role: ensuring the conditions that allow people greater ease in establishing care arrangements; ensuring adequate standard of living and facilitating the preconditions for care; and prioritizing social reproduction when defining the relationship between market and non-market spheres; and
  - Beyond that, the State might assume direct care responsibilities through the implementation of care policies: the provision of public care services; the transfer of economic benefits, and particularly benefits linked to the fulfilment of care tasks; and granting families time to provide unpaid care without a negative impact in terms of labour market position.
- The market:
  - The market influences three issues that profoundly affect care: definition of working times; payment (or not) for the social reproduction of labour; and definition of the acuteness of the conflict between production and reproduction;
  - Supply of "commodified" care services: this is a rather underdeveloped reality in most contexts due to the prevalence of a "familist" discourse, which considers the family the natural, best and/or only place for care; and
  - Domestic employment: a reality between the market and the family; it is the most expanded form of paid care work. It is increasingly linked to international migration and is characterized by its poor labour conditions and its feminized workforce.
- The community: a variety of civil society organizations - community organizations, grassroots organizations, religious entities and non-profit organizations - might assume an active role in care provision. There is a serious challenge in supporting their work while assuring that it perpetuates neither equity deficits between social groups nor the negligence of public institutions.
- Households: in most contexts, the bulk of care that a given society requires falls on households. Households go beyond the nuclear family. We need to understand the multiple models of existing households and the transformations they undergo. Intra-household dynamics and power relationships must also be identified, specifically gender power relations that overburden women and girls with care responsibilities.

3. Systems of care

The social organization of care - or "care system" - is the way in which in each society establishes a correlation between its specific care needs and the ways in which the four social actors that can play a role in care provision combine to provide it, and the role each one assumes:

- The social organization of care determines who cares for whom, within what structures, how, and in exchange for what;
- When understanding how these four actors interact we must keep in mind that they might overlap - there are mixed actors, State-market or State-civil society, for example - and that this articulation is neither static nor limited to the nation-state;
- The leading role that the State can play defines the degree to which care is:
  - "Decommodified": when access to decent care is dissociated from a person's labour market position and/or purchasing power;
  - "Defamilized": when access to decent care is dissociated from a person's family networks.
- Currently, care systems move between two extremes: highly "familist" systems and significantly defamilized and decommodified systems. There are few care systems that present a high degree of decommodification and defamilization, which means that the main responsibility for care is assumed by households - and mostly by women within them;
- In most contexts, co-responsibility is not an achieved reality but an aspiration to promote. Achieving it

would imply that the responsibility for the provision of care is shared equally and simultaneously among the four agents - as well as between, women and men; indeed, between all citizens.

- This would require:
  - The existence of collective structures for care provision, either State-based or community-based (or in-between);
  - A two-fold change in the role that the markets play in care provision: not asking workers to act as self-sufficient subjects; and fairly assuming the cost of the reproduction of the labour force;
- Diverse care systems entail diverse degrees to which citizens and social groups access the care they need. Any given care system must be judged in terms of its ability to guarantee the whole population access to decent care and to enjoy the right to care.

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1. Introduction

In this session we will delve deeper into how care is organized in our societies. As we saw in the previous session, we all need care throughout our lives. Therefore, each society has established a certain way of distributing the tasks of caregiving required and the resources available to address them. In other words, there is a system established - in most cases not an explicit one - that organizes care provision and determines who cares for whom, in what framework, how, and in exchange for what. This system is called the "social organization of care".

We must keep in mind that all societies have specific and particular care needs. For example a society with a low birth rate does not have the same care needs for childhood as one with a high birth rate; other societies may have a specific demand for care due to many persons with disabilities resulting from recent armed conflict; in others, the demand for care may be influenced by a high incidence of HIV.

In order to comprehend and evaluate the social organization of care in a specific context, we must look at two crucial issues, the different care needs and the different caregiving scenarios. The first aspect refers to the needs for care of the population on the whole. In addition to the general population, we must ask other questions: What age groups with specific care needs are especially present? Are there other social groups besides these with particular care needs? By answering these questions, we might get a quite acute notion of care needs.

The second aspect we must address is, what are the different scenarios in which care needs are met and the proportion of the entire burden of care provision met in each of these scenarios. In other words, what actors take a role and assume responsibility for guaranteeing the care that society on the whole needs? How do these different actors operate? Which ones take on the greatest burden?

The way care needs are met also varies greatly between countries and very much depends upon the public policies implemented.

There is always a correlation between the care requirements that each society has and the way the provision of it is organized. The manner in which this correlation is established not only determines and conditions significantly the welfare of a society, such as to what extent its need for care is met sufficiently and adequately, but it also has consequences in terms of gender equality and the development of rights.

Let us examine in further detail both of these issues, what each society needs in terms of care and the identification of scenarios and actors who provide the care needed.

2. Specific care needs for every context

It is each society's challenge to satisfy the care needs of each and every one of its members throughout the entire life-cycle. As we observed in the previous session, care is the set of actions that all of us require to enjoy day-to-day well-being, whether we ourselves provide them or whether we cannot and thus require that someone else do them for us. Even when a person enjoys personal autonomy, she needs to care for herself and others. Thus, the social organization of care must meet the care needs of the entire population and at the same time take into account the existence of specific social groups that, because of their characteristics or circumstances, have the most acute needs for care.

The care requirements of each society can be seen by zooming in closely and focusing, perceiving very clearly which social groups have particular care requirements (the groups that are included within the intermediate definition of care that focuses on elderly, persons with disabilities and children); then by zooming out to not lose sight of the fact that all of us need care during our entire life (the broad definition of care that we use in this course).Let us review the care needed with this wide-angle lens to get a broader perspective first, then gradually zoom in on specific social groups.

2.1. Care requirements of the population as a whole

From this broad perspective that encompasses persons with potential autonomy to care for themselves and others, there are three factors that affect the relationship between the need for care and the corresponding fulfilment of that need; that is, factors that determine a society's ability to meet the total burden of caregiving it faces.

The first factor is to what extent society distributes the responsibility of caregiving among all those potentially autonomous persons, or only assigns these tasks to one segment of society. Care is often seen as a woman's issue, while men do not assume (or do not fully assume) their share, as we have seen in Session 1. These gender stereotypes and roles imply that women assume three kinds of care work:

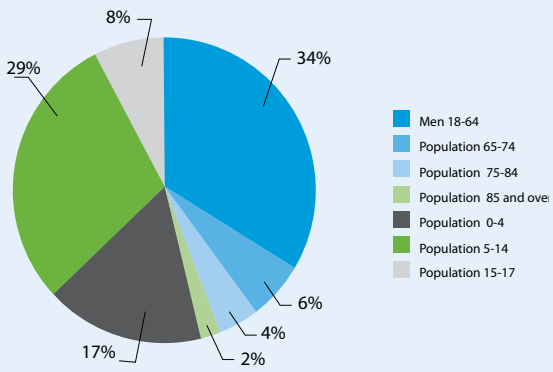
- They provide care for those persons who cannot take care of themselves: women assume their share of responsibility as well as the workload that would be assumed by potentially autonomous men if care work was equally distributed;
- They take on the care of potentially autonomous men;
- They take care of themselves, although they frequently overlook their self-attention and prioritize others' needs.

Let us look at some data from Costa Rica (Figure 1). These figures show the composition of the demand for care placed on Costa Rican women between the ages of 18 and 64. These data rely on the assumption that that only women aged 18 to 64 provide care (these postulations: that this is the age group where most people enjoy full potential autonomy and that men aged 18 to 64 are not co-responsible). Then, estimations are made on the social groups who demand care from those women. As we can see, the greatest percentage, 34 per cent (much higher than other demands for care) comes from men between 18 and 64. This means that the demand comes from potentially autonomous persons who are able to care for themselves and others, but who do not do so. By failing to do so, they exponentially increase the care load that potentially autonomous women must assume.

This image is slightly distorted, in that there are probably women below age 18 and above 64 who care for themselves and others, and there may be men of diverse age who are able to care for themselves and others, and do so. Nevertheless, the latter distortion is not great, as we shall see later, since studies done in many countries in the world show the time that men devote to caregiving is very small compared to that which women devote.

FIGURE 1

Units of care demanded from women ages 18-64 by third persons



Source: Carcedo et al. (2012)

The second factor is to what extent those persons with potential autonomy have time to care for others and for themselves. Time availability and flexibility tends to be a critical requirement to enter the labour market, both in the formal sector and the informal sector - indeed, time spent trying to make a living in the latter is usually even higher than in the former. Persons within the labour market are frequently regarded as self-sufficient subjects with neither care needs nor responsibilities, as we discussed in Session 1. This implies that the same volume of caregiving becomes a greater relative burden to those sectors that assume the responsibility of unpaid care work - either if they are totally dedicated to unpaid work or if they combine this with paid work, thus becoming overburdened.

A third and last factor is to what extent collective structures exist in society to guarantee care, or if the provision of care is considered the private responsibility of each household, enormously increasing the burden of care on households.

2.2. Care requirements according to age group

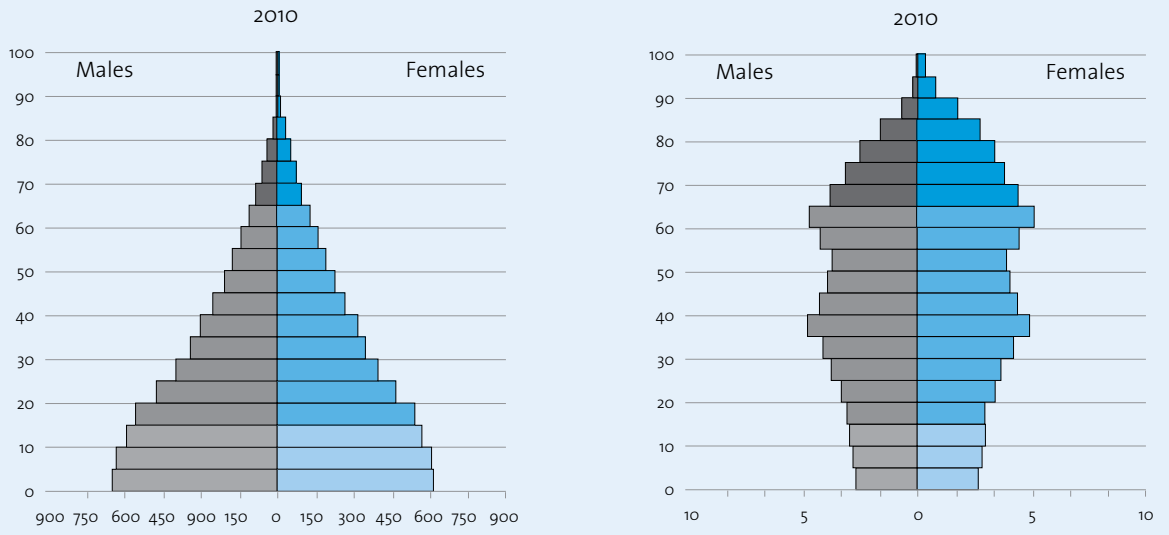
While the care requirements of the entire population must be covered, each society must face the care needs in the periods of life when autonomy is most limited. This is very important, since care needs are closely linked to a person's life-cycle. While care is needed all throughout one's life, especially in the case of illness or sudden disability, during childhood and old age the need for care is greater, meaning one is less capable of caring for oneself and thus needs the assistance of another person or people. For this reason, when we look at the relationship between a society's care needs and the way it addresses them, the age composition of a population is extremely relevant. Pakistan and Japan, two countries with very different population ages, provide a good example (see figures 2 and 3).

In the case of Pakistan, we see that between the care needs of childhood and old age, those related to childhood have much more weight. In the case of Japan, we see that among the care needs related to childhood and old age, those associated with old age carry much more weight. The high rates of young or old population entail very different types of care. In both cases (for age and for infancy) the care load can be high, as occurs in the examples we have just seen, but the type of care needed in each case - and the response that public policies will need to provide, as we will see in Session 7 - are very different.

We must bear in mind, however, that care needs associated with age are cross-cut by cultural conceptions of care. That is, in every society the prevailing idea of dependence and autonomy can vary widely between cultures, as well as between different social classes within any given culture. Notions of autonomy and dependence are cultural constructions. For example, while in some contexts, at 12 years old, children's only obligation is to attend school, in others they are expected to take responsibility for certain care tasks such as washing and ironing clothes, fetching water or attending other children or the elderly.

FIGURES 2 AND 3

Population by sex and five-year age groups, Pakistan (left) and Japan (right), 2010



Source: UNDESA, Population Division (2013)

Also, living and working conditions throughout the life-cycle can strongly influence the health conditions that aging people can later expect. This means that the age at which the elderly begin to need care from others can vary greatly between contexts. For example, the aging populations of the upper and middle classes have better health and a lower prevalence of debilitating diseases than populations of the same age in the lower classes or in ethnic groups that experience discrimination. In the United States, a 75-year-old, middle-class White woman may be in optimal condition to enjoy autonomy and care for her grandchildren, but also may not be obliged to do so. At the same age, a lower-class Australian Aboriginal woman may have health problems that severely limit her autonomy, while at the same time she may have no choice but to take care of her grandchildren.

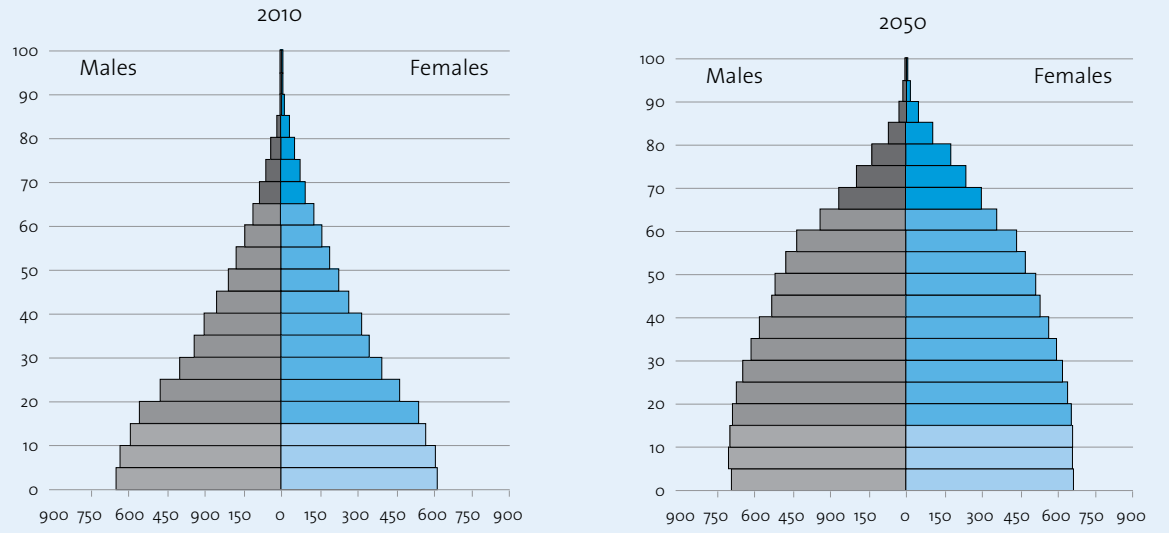
The distribution of ages we see in the population pyramids of each country is dynamic too. When assessing the extent to which care needs correlate with the way they are covered in a specific context, we cannot settle for a quick snapshot of the current moment, but must understand the trends for upcoming decades shown by the population projections. These forecasts are of particular importance when thinking about public policy, as these should influence the current situation as well as anticipate situations in the medium term in order to act accordingly.

Think about a society that is currently young and whose greatest care necessities are therefore related to children, but where, in coming decades, an increase in the aging population is anticipated. Look once more at the previously mentioned case of Pakistan (figures 2 and 4). As can be observed, Pakistan's population is beginning to age, and within 40 years, the age distribution - as well as needs associated with age groups - will have changed markedly, with the elderly making up the largest segment. This means that public policy in Pakistan should begin planning how to address these needs in the medium term.

See also the case of Japan (figures 3 and 5). As noted, at present Japan is already an older society. But if we look at the projections for the next 40 years, the elderly population will have peaked and the proportion of the young and adult population at an appropriate

FIGURE 2 AND 4

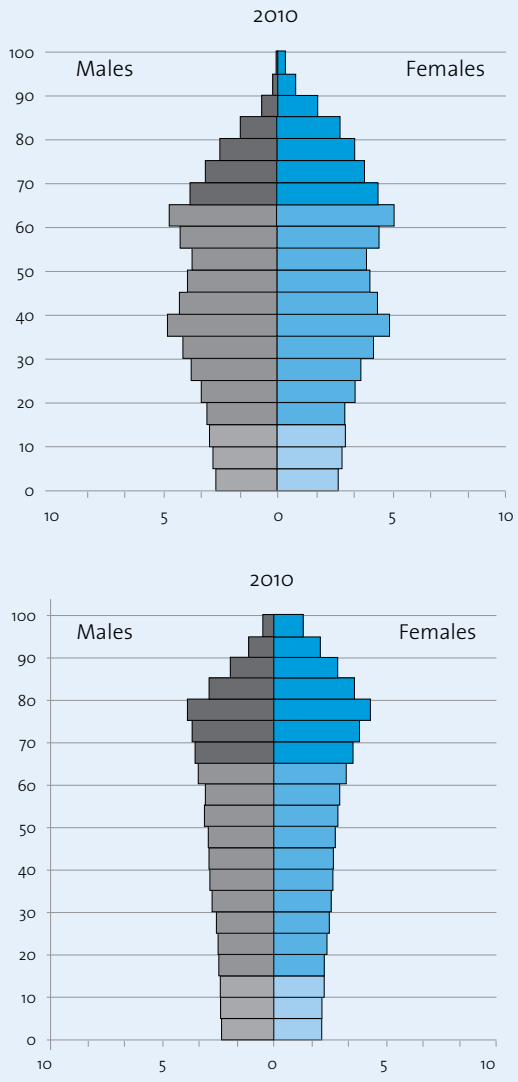
Population by sex and five-year age groups, Pakistan 2010 (left) and 2050 (right)



Source: UNDESA, Population Division (2013)

FIGURES 3 AND 5

Population by sex and five-year age groups, Japan 2010 (left) and 2050 (right)



Source: UNDESA, Population Division (2013)

age to be caregivers will have declined. This means that Japan's public policy should begin to plan how to address, in the medium term, this lack of people at the age to give care.

In other contexts, as the young population spikes, different developments can be anticipated. For example, places can receive significant immigration flows, bringing along with them an increase in population, both of young and middle-aged people, e.g., more people available to act as caregivers. There are also more children: in many migrant destination countries, the recovery of birth rates is directly related to the presence of an immigrant population. Whatever the predictions may be for any given place, the key idea is that they allow for anticipating future care needs that public policy should address. Other aspects that have significant influence on the care needs within a given context are (1) the unmet demand for family planning. When this is very high, care needs are also higher and in such cases, care needs are connected with gaps in sexual and reproductive health policy. And (2) the influence of poverty on the aging population. In such cases, care needs are connected to gaps in social policies, such as pensions. This then brings us to population ageing.

2.3. Population ageing

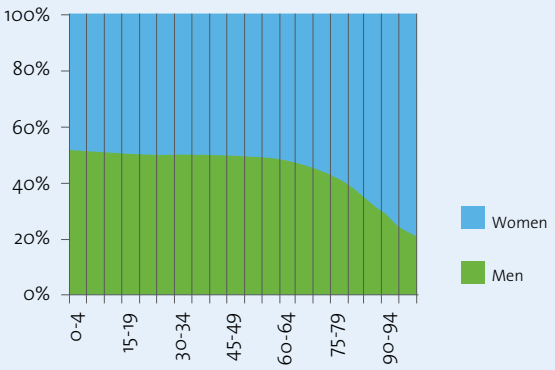
Population ageing is happening in all regions and countries, andit is happening faster in developing countries. In 1950, there were 200 million persons aged 60 or over. In 2012, the number had risen to 810 million and it is projected to reach 2 billion by 2050. This is a critical demographic path that should be acknowledged when dealing with care issues.Population ageing is a feminized phenomenon, too. From the age of 50 and over, women make up a bigger proportion of population, with their share of population increasing in every age group thereafter (see figure 6).

Older women frequently suffer from highly vulnerable living conditions and the prevalence of illnesses linked to ageing is greater among women than among men. For example, women's risk of osteoporosis is three times that of men. Their financial situation tends to be worse than the situation of men or younger women as well. Discrimination due to age is also intertwined with gender discrimination throughout the life-cycle. Especially relevant is the fact that their working life tends to be marked by their role as primary caregivers.

The gender gap in poverty increases at older ages as well. Women's risk of poverty is as much as 43 points higher than men's for those over 75, and according to Peaker (2012), "Older women are more likely to suffer

FIGURE 6

World Population by Age and Sex, 2010



Source: Peaker (2012)

from blindness than are older men, and they also experience more difficulty in accessing the care they need. This health problem is exacerbated in low-income countries where women over the age of 60 are 9 times more likely to be blind than in high-income countries. This is shocking when we consider that 44 per cent of these cases of blindness are caused by cataracts, which can be cured at a relatively low cost".

Among the other challenges associated with population ageing are: implementing measures that avoid or delay the disability creation process; providing adequate care to the elderly and thus avoiding a situation where their care needs rely primarily or solely on their families; and guaranteeing income security. It should also be taken into account that older persons too commonly keep on caring for others when it is they who should be cared for because of their frail health. This is especially the case for women.

2.4. Unusual or urgent care needs

In order to have a complete view of the care needs within a context, it is necessary to ask whether there are any unusual or urgent care needs that require a specialized or intensive response, necessitating more urgent intervention.

So far we have looked at two life-stages with specific care needs that are more generally visible: those close to the beginning of life and those close to the end of it. However, there are other situations that also involve great care needs or that affect how a particular context can address its care needs. These situations include:

1. High incidence of disability, especially if linked to a high incidence of poverty or a number of other situations, such as a post-conflict zone;
2. Existence of a care emergency in which care needs skyrocket and the number of caregivers is depleted: this is the case in many countries experiencing the HIV/AIDS pandemic, especially in Africa;
3. Conflict situations: conflicts have diverse negative impacts on health thus multiplying care needs. Simultaneously, the State's ability to provide care is seriously diminished during conflict. As a consequence, civil society, and particularly women in civil society, is overloaded;
4. Large age imbalance, in which the middle-aged population - autonomous and at a caregiving age - has decreased significantly, for example due to outward migration, especially if it is feminized, or due to armed conflict. This implies the emergence of the so-called "skipped-generation households": "Over 10 per cent of older women live in skipped-generation households in most sub-Saharan African countries and in some Latin American and Caribbean countries. In Malawi, Rwanda, Zambia and Zimbabwe, from 21 to 25 per cent of all older persons - and from 30 to 34 per cent in the case of older women in Malawi and Rwanda - live in households with their grandchildren, but not with their children" UNDESA (2005);
5. Large sex imbalances, which appear whenever there is a disproportionate presence of either

Africa, HIV and care

"The caregiving tasks resulting from having a household member affected by HIV/AIDS are numerous. Having a family member with HIV/AIDS increases the burden of other domestic activities, such as housework, shopping and transportation (Akintola 2005).

A qualitative study of a farming region of southern Zambia finds that women were forced to abandon their agricultural work because of caregiving responsibilities stemming from HIV/AIDS. The study concluded that the rigid division of labour in that environment was a limiting factor in household responsiveness (Waller 1997). Caregiving responsibilities can also have intergenerational impacts as found by Yamano and Jayne (2004) in rural Kenya. In their study of working age, adult mortality and primary school attendance, the authors find that adult mortality negatively affects children's, and in particular girls', schooling even in the period directly before mortality, most likely because the children are sharing in the burden of caregiving (Yamano and Jayne in Gillespie and Kadiyala 2005). Hansen et al. (1994) studied four home care programs in Zimbabwe and estimated the cost incurred by households in caring for a bedridden patient for three months. The study concluded that the time spent on caring, diverted from other activities such as food production, employment, education and care of other household members, was the highest cost burden incurred by these households. Elsewhere, in Kagabiro, Tanzania, the labour loss of households affected by HIV/AIDS is on average 43 percent (Tibaijuka 1997)."

Source: Blackden and Wodon (eds.) (2005)

women or men in any given population. These imbalances can be due to unbalanced child sex ratios or to ulterior population movements. Biological and environmental factors as well as factors linked to gender preferences (usually, a preference for baby boys) might generate a skewed child sex ratio (UNFPA, 2012: 16) that can in turn lead to sex imbalances in the adult population. Migration can also cause sex imbalance in the grown-up population and these imbalances have serious effects on women's workload and/or in the ability to provide the necessary care, given that gender roles assign the main or sole responsibility on care to women and that social co-responsibility for care tends to be weak or lacking.

Sex imbalance

Sex imbalance at birth

The phenomenon can be observed in China and India. It has not yet impacted adult population sex ratios, except in some small regions. Thus it is not still possible to properly discuss future consequences. Nevertheless, it is a very relevant issue with serious implications in terms of care policies. For example, the one-child policy in China will mean a familiar overburden in elderly care if no public care services are established. See the table below.

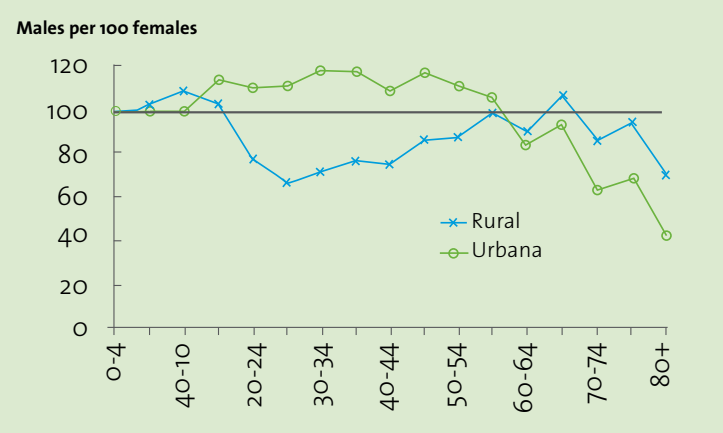
Country	Sex ratio at birth	Period
East and Southeast Asia		
China	117.8	2011
Singapore	107.5	2009
South Korea	106.7	2010
Viet Nam	111.2	2010
South Asia		
India	110.5	2008.10
Pakistan	109.9	2007
Central Asia		
Azerbaijan	116.5	2011
Armenia	114.9	2010
Georgia	113.6	2009-11
Southeastern Europe		
Albania	111.7	2008-10
Montenegro	109.8	2009-11

Source: UNFPA (2012)

Sex imbalance due to population movements

Feminized adult population

Due to male migration to urban zones and to other countries, there is a high prevalence of households composed of just women and children in rural Burkina Faso.



Source: United Nations Demographic Yearbook, 1992

Men's absence, together with the lack of social response, implies that women in those households must simultaneously accomplish their traditional caregiver role and assume the total amount of productive tasks that they used to share with men.

Source: Meares (1994)

Masculinized population

Industrialization and urbanization led to the so-called "rural bachelor's marriage problem" in the Republic of Korea (South Korea). As a response to it, marriages of Korean men to foreign women - ethnic Korean Chinese, Vietnamese, Philippinos, Mongolians -became a trend. By 2010, this kind of mixed marriage accounted for 10.5 per cent of all marriages and labour activity rates were particularly low for women living in these multicultural families. This is due precisely to their dedication to care tasks. 86.2 per cent of them would like to have employment, though. So why do they not look for it?

- 49.1 per cent of them state "childcare needs" as the reason for not engaging in paid employment.

	• They take care of other members of the extended family. These women live in households with higher prevalence of dependency - due to age or disability- than the average Korean household. 27.5 per cent of them live with their parents in law (4.7 per cent for the rest of Korean society). 17.9 per cent live with someone with a disability (the prevalence of disability is 4.6 per cent for the Korean society as a whole). This solution to the care crisis has been promoted by the State itself (Act to Support International Marriage for Rural Bachelors (2006-7), Act on Regulation of Marriage Brokerage Agent (2007) y Support for Multicultural Families Act (2008). Source: Lee (2012)

2.5. Household composition

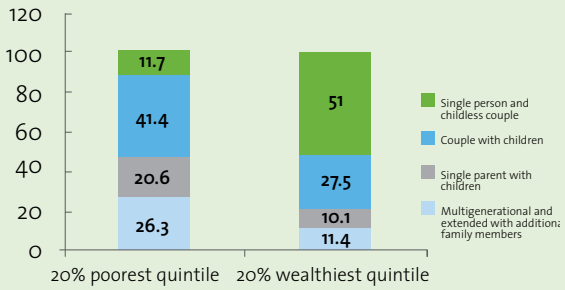
A final issue that determines the care needs of each context has to do with models of existing households and the transformations they undergo. In a growing number of countries, there is a trend toward the decrease of extended households, such as where two or more generations cohabit, and also toward a gradual and steady increase in nuclear households and single-person households. This implies that it is more difficult for families to rely on intergenerational support for care - grandmothers caring for their grandchildren within the context of an extended household, for example.

With regard to single-person households it is important to know their composition, as the implications for the organization of care will be different depending on whether the members are younger or older. For example, the increase of single-person homes made up of one aging person poses specific challenges for public policy in terms of care provision. Similarly, the significant presence of single-mother homes, or, those headed by single women, means another challenge, especially if the mothers belong to poorer strata of society.

In the following example (Figure 7), unremunerated care work can be observed exerting higher pressure on poor households and on women. For example, smaller households (singles and couples without children) account for almost half the households in the highest income quintile. By contrast, nuclear households consisting of couples with children and single-mother households account for 62 per cent of the lowest income quintile.

FIGURE 7

Percentage distribution of households by type, according to wealth quintile in Argentina, 2006



Source: Eleonor Faur, taken from Sanchís et al. (2010)

3. Actors who can respond to care needs

Once we have understood the care needs of a given context, we need to understand how these needs are met. Who is responsible for taking on these care needs, how they are taken on and in exchange for what?

There are four institutions that can provide society with care, the State, the market, the community/non-profit sector, and households. Just as we have done to observe the care needs of a given society, we can see elements of care provision by using a sort of zoom function. If we enlarge the frame of the picture, we see broader issues that affect care provision from the perspective of each one of these actors. If we reduce it, we can focus on how specific groups meet their care needs and also clearly see how one part of the population delegates care needs that it could take responsibility for itself.

Let's briefly review how each one of these actors can participate before moving on to focus on how specific groups meet their care needs.

3.1. The State

What role can the State play in the provision of care? The State's role is critical mainly in three aspects:

- In ensuring the conditions that allow people greater freedom to define how they organize their time;
- In ensuring access to an adequate standard of living in general - above all, guaranteeing income security - and in particular to means that facilitate the preconditions necessary for care, such as running water, sanitation, energy, adequate housing, etc.;
- In defining what the relationship between market and non-market spheres should be, that is, when defining what sort of priority is given to social reproduction, a topic that will be discussed in more detail in Session 4.

At the same time, the State can respond in multiple ways to care needs, as discussed in more detail in Session 7, on political intervention. For now we will briefly review the kinds of care policies that the State can deploy or not, giving us an idea of their participation in the social organization of care in a specific context:

- The provision of direct services, such as nurseries or day care centres, and nursing homes for the elderly or persons with disabilities, as well as other support services such as home care. These services can be distributed widely or can be concentrated in urban zones, and depending on how their provision is conceived, e.g., the factors determining access to them, they can be used by all of those that need them or just those belonging to certain social classes; they may be universal services or part of targeted policy aimed at mitigating situations of poverty;
- Transfer of economic benefits such as retirement pensions, pensions for those with permanent disabilities, benefits for taking care of persons in a situation of dependency (e.g., a child with disabilities), income transfers that are conditioned to the fulfilment of care tasks, tax deductions for dependent children or other relatives, child tax credit, etc. The existence and effective use of these rights are sometimes influenced by gender factors, for example, benefits for birth or adoption applying only to mothers;
- Time given to families for care: these measures are aimed at easing the simultaneous or consecutive performance of unpaid care work and paid employment in accordance with Convention 156 on workers with family responsibilities. Among them are the following: personal leave of absence for taking care of children; reduced working hours for those who must attend to children or family members with disabilities; maternity and paternity leave; paid leave in case of accident or serious illness of a family member. Such rights, if they exist, are usually used by women and are only relevant for those working in the formal labour market. They can even apply differently to women and men. For example, maternity leave lasts much longer than paternity leave when the latter exists at all.

In some contexts, care is one of the more dynamic areas of public policy; major changes are taking place and there is a trend toward increasing the role of the State, in contrast to the reduction of State participation in healthcare or education. There are various care-related measures too: the expansion of nurseries; leave of absence for care; the extension of maternity

and paternity leave; home help services and so on. But despite the above, there are still several problems:

- Rights are only implemented partially. Due to barriers to access, they only cover a portion of the population, such as rights associated with formal employment; strict rating systems for qualifying as a dependent, etc.;
- Unremunerated or badly paid care work: measures promoting the hiring of domestic employees in precarious conditions, services supported by semi-voluntary work (e.g., passing off tasks to the non-profit sector, promotion of community services where work is not normalized), monetary benefits to partially employ relatives, etc. The classic nuclear family model continues to be at the basis of many benefits, for example, conditional cash transfers for mothers;
- Care benefits and rights are among the expenditures most vulnerable in times of crisis and are often the first to be cut.

3.2. The market

From a broad perspective, the market impacts care in two ways. On one hand, companies have an influence on three issues that essentially affect care:

- How people's personal time and schedules are organized, e.g., whether companies take into account that their workers have care responsibilities for themselves and others;
- The extent to which companies pay for the reproduction of labour. That is, whether they provide money that can be spent on care services; and
- The influence that companies have in defining how the system as a whole functions; how much do their interests play a role in resolving the conflict between production and reproduction?

On the other hand, they do play a role in providing care. At the moment, this mainly occurs via two channels. First, in the domestic employment sector, e.g., labour supply for care work in private households, which will be discussed in detail in Session 5. The percentage that employment in this sector represents in total employment of a country, especially among women, is a good indicator of the level of a society's commodification of care. There are also recruitment agencies that contact domestic workers and families, both at the national level or even by organizing workers' migration. Second is the offering of nurseries for children, daytime care centres and residences for the elderly or for those with disabilities; these are generally with very high prices or with more affordable prices but with very low quality.

The degree to which care is commodified varies greatly between contexts. Domestic employment is a sector that historically has had a strong presence associated with a "familist" conception of care as a resource; it implies a personalized way of caring in the home environment that is associated with "familism"[1] because, ultimately, care is personalized in the home. What is still underdeveloped - although with differences depending on the context - is the commodification of care in settings outside the home, such as homes for the elderly, nurseries, etc. However, this is a process that is still underway in several parts of the world, and constitutes a booming trend.

1 This term refers to a social conception of care that considers the family the natural, best and/or only place for care. It is often connected to a narrow conception of family, understood as family by blood and/or a legally constituted family rather than as a set of people who may make up a household based on different kinds of ties, although notions of family may vary from the nuclear family (heterosexual couple and their offspring) to the extended family. It is a discourse that individual subjects may bear but which also shapes the functioning of public institutions and other organizations such as companies, NGOs and religious groups.

3.3. The community

In some contexts, the participation of community organizations, grassroots organizations, religious entities or non-profit sector organizations in the provision of care is significant. We see for example:

- Meal centres organized and managed by community organizations, especially women's organizations, for whose services there is usually no remuneration;
- Child daycare centres or nurseries run by groups of mothers. In many countries, the State supports groups of mothers organizing childcare services in their own houses. Normally the participation of these women is not recognized as a real job. They are usually classified as volunteers and instead of a wage they receive tips or bonuses, also without their labour rights being recognized;
- Nurseries, day centres and homes for the elderly and persons with disabilities run by non-profits or religious organizations. This is usually free or with low-cost services subsidized by the State, international cooperation or private foundations or entities. Generally they focus on offering services to populations in situations of poverty or social vulnerability.

The role played by civil society organizations is also particularly relevant in some regions. But there is a serious challenge in supporting their work while assuring that it perpetuates neither equity deficits between social groups nor the negligence of public institutions. The presence of civil society is robust in the countries in Western Asia (Economic and Social Commission for Western Asia - ESCWA). Religious entities play a critical role in the provision of educational services too[2]:

Community care work and women

In Peru, food programs such as the "Glass of Milk" program, and the work of public health leaders or mothers' groups, are possible thanks to the unpaid labour of thousands of Peruvian women distributed over thousands of poor urban settlements and rural communities. Participating as a volunteer in one of these programs can take a few hours a week, as in the case of a public health leader who sells medicine out of her home and occasionally makes local home visits when there is known to be, or there is suspicion of, tuberculosis. In other cases, especially in meal centres, volunteering can become an eight hour-plus commitment for the purchasing of ingredients, fetching water, the processing and preparation of food, distributing rations to the line of neighbours that form for breakfast or lunch or both, washing pots, ordering the accounts, coordinating with the group to plan menus and assigning shifts for the following day.

Source: Anderson et al. (2010)

The program Madres Comunitarias de Costa Rica (Community Mothers of Costa Rica) is promoted by the Instituto Mixto de Ayuda Social (IMAS). It is based on the contributions of women who, in different communities of the country, provide care services for children of working women in their community. However, the State also plays a major role, as it is responsible for subsidizing the service through cash transfers to the families so they can pay Community Mothers for the service—or the State pays the Mothers directly. The pay received is very low, however, and over time the institutionality of the program has become blurred, leaving Community Mothers quite alone when it comes to the direction the program should take.

Source: Carcedo et al. (2012)

2 Data obtained from the Arab Forum "Towards a New Welfare Mix: Rethinking the Roles of the State, Market and Civil Society in the Provision of Basic Social Services", ESCWA, 19 to 20 December 2012, Beirut. Documents are available from http://www.escwa.un.org/information/meetingdetails.asp?referenceNum=1980E

- This role is more widespread in primary education than in secondary education;
- Important regional differences must be mentioned as well. Civil society is greater in Lebanon Egypt and Jordan. It is greatest in Palestine, where it covers 95 per cent of primary enrolment, and weaker in the Gulf States; and
- This role is frequently linked to refugee, exile and migrant populations, above all in Palestine.

Civil society's role is also critical in health provisions, although it varies significantly between countries: a community role in Gulf States is almost non-existent (0-1 per cent) because of the broad State coverage and the political climate. While in countries such as Egypt and Lebanon it reaches 15-25 per cent of the total population, and it is much higher in Palestine if international organizations are taken into account.

Also, there are distinct funding mechanisms that coexist with regular fiscal systems, such as the zakat, the donation of a certain proportion of the personal wealth that will be used for charity purposes, and the waqf, a religious donation. But whatever the case, the experience in this region is crucial to understanding the strengths of community care provision as well as its weaknesses:

"It is clear that CSOs [civil society organizations] play an extremely important role in provision of basic social services within the ESCWA region, a role which has been overlooked until recently. However, much of the potential for civil society involvement is being hampered by restrictive legal and regulatory environments while much existing provision is insufficiently monitored, regulated and supported by governments. Moreover, it appears that some CSO provision is serving to reinforce and perpetuate existing inequality in service provision within the region" Brooks (2012: 34).

3.4. Households

As we saw in Session 1, in the absence of social programmes, care is delegated to households. These are the key scenarios in which care needs are addressed, through either unpaid care work or the hiring of domestic employees. This is why we shall dedicate the next session to looking into their role in the provision of care and to discussing how care work is distributed within them. It must be mentioned too that care tasks are not equally distributed between their members. Households should not be understood as a single, harmonious unit, but as a scenario in which both conflict and cooperation take place. Households are a critical locus of the gender division of labour that assigns the responsibility for care mainly/solely to women and girls.

4. Articulations between the four actors and systems of care

How do these care-providing actors work? When answering that question, it should not be assumed that the four aforementioned actors proceed in isolation from each other. Mixed actors, somewhere in-between two scenarios, are usually found. Public-private entities are particularly relevant, both those connecting public institutions to community entities and those that operate in a profit-making environment. The degree to which this cooperation is formalized varies significantly, though, and the convenience and effects of this kind of mixed system are still up for debate. Nevertheless, it is still important.

Bear in mind also that how these four actors relate to each other in responding to care needs within a specific context is not static. The limits of their action in any given scenario are not determined and the relations and interactions between them are not inalterable; rather they can vary greatly depending on the specific situation and especially on the public policy that each context decides to implement. The functioning and participation of these four actors providing care thus resembles a network with multiple nodes that are more or less present, subject to various contingencies, and that serve to guarantee the care required - or that do not manage to guarantee it at all!

Mixed actors in Western Asia

ESCWA countries provide rich examples of mixed actors. For example:

- Private hospitals are the backbone of the Lebanese health care system. They provide services for persons covered by private or public insurance.
- Semi-private suppliers are common in Egypt, Iraq and Bahrain. They charge users for their services but at the same time receive public funding, which reduces the prices.
- Zakat in Yemen: this is a religious tax on surplus personal wealth (see table). It is collected by the local administration, civil society organizations and religious organizations. It reached 70 million dollars in 2012 (0.71 per cent of total public income).

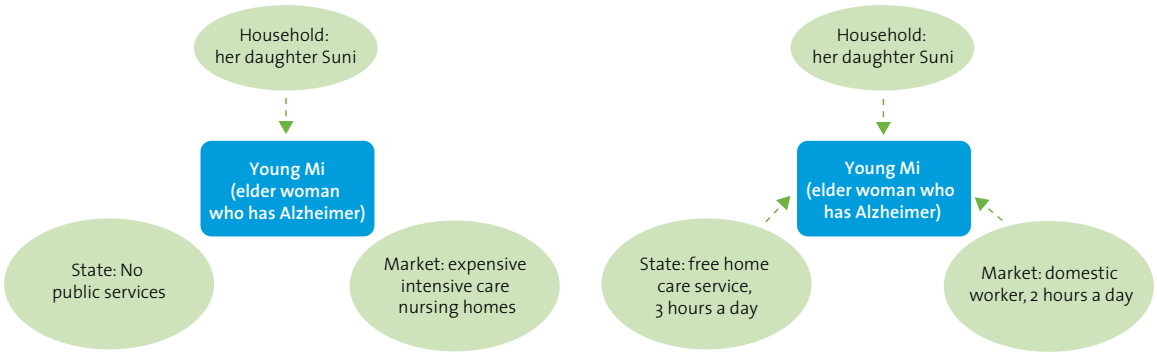
Zakat types (examples)	Value
Gold & Silver Zakat	2.5 per cent
Commercial & Trade Zakat	2.5 per cent
Cultivation Zakat	10 per cent if naturally irrigated 5 per cent if artificially irrigated

Fuentes: Brooks (2012) y Jarhum (2012)

We might therefore talk about a care map with networks and nodes of varying intensity, that can overlap each other and that also are not necessarily limited to a specific territory. (The transnational dimension of care is covered in Session 6.)

Dynamic care arrangements

Original situation	After the intervention of the State
Suni lives in Korea with her mother, Young Mi, an 83-year-old woman who has Alzheimer's disease. Due to the illness, she has lost urinary continence, meaning her diaper must be changed every so often, and she is barely able to eat alone and so must be fed. As the Alzheimer's has affected her orientation and memory, Young Mi cannot be left home alone. Before her mother got sick, Suni had a full-time job as a cook in a restaurant. When her mother fell ill she had to leave her job: the two intensive care nursing homes in her city were private and Suni could not afford them. With her cook's salary and her husband's wage as a caretaker, they also did not have enough to hire someone to care for her while Suni worked. And Young Mi did not receive a pension, as she had never had formal employment. As Suni is the only child, she does not have a brother or sister who could contribute money for hiring help. The only available solution was for her to leave her paid job.	A year later, the Korean government set up a free home care service to provide care for the highly disabled elderly, as was the case with Suni's mother. Through this service, someone comes to Suni's home every day for three hours. During this time the helper performs basic cleaning tasks, does the shopping, cooks lunch, washes Young Mi and feeds her a midday meal. In addition, Suni hired a domestic worker for the two hours after the home helper has left. This way, she has been able to return to work, if only part time.



In this example, we can see the dynamism of a network of care and the shift from a single node, which was the home (Suni), to the networking of various nodes: the State (home care service), the market (domestic employee for two hours a day) and the home (Suni again, who still has only been able to return to work part-time). It might also have a transnational dimension. That would be the case if the domestic worker that Suni hired was a Filipina woman who had migrated and entered the domestic employment market in South Korea.

The way in which these four actors - State, household, market and community - combine, and which one of them assumes greater prominence, gives rise to certain social organizations of care that relate in some way to the type of welfare regime operating in each country. Martínez Franzoni (2007) defines welfare regimes as "the constellation of practices, norms and discourses about what corresponds to whom in the generation of well-being - of which we know that care forms an essential part".

In market economies, the population's living conditions depend on three main forms of resource allocation:

- First, they depend upon how markets - especially labour markets - allocate income;
- Second, they depend on the amount of social income collectively assigned as cash transfers and services, to some extent independent of the people's income. Social income largely depends on the role the State has, and in particular, on its social policy vis-a-vis well-being, though local and international organizations also providing social income may intervene;
- Third, they depend on unpaid domestic and care work, mainly female.

As already introduced in Session 1, in the context of welfare regimes, States tend to promote:

- Some level of decommodification, e.g., a dissociation of well-being from the position that a person occupies in the labour market, or her purchasing power in the goods, services and insurance market;
- Some level of defamilization, e.g., a dissociation of well-being from the availability of unpaid female work, or from belonging to a family, or the norms of reciprocity and distribution operating within families.

In the case of the organization of care, which makes up part of welfare regimes, we can find two basic types of care - in generic but not exhaustive terms- according to the type of social organization. On the one hand, we find highly familist care systems, where:

- The provision of care largely depends on women's unremunerated work within households and within available family, social and community networks;
- The public provision of care services is extremely low or very lacking;
- The market supply tends to be much undeveloped beyond the supply of domestic employment except for the incipient supply of services such as child-care centres or privately-owned elderly residences; these services are affordable to a well-off minority and are often propped up by bad working conditions in the sector;
- There is an alternative to unpaid care work for the worse off.

Martínez-Franzoni (2007) defines these cases as "familist". In Latin America, these are Colombia, Ecuador, El Salvador, Guatemala, Peru, the Dominican Republic and Venezuela. And as "highly familist", Bolivia, Honduras, Nicaragua and Paraguay. Whatever the degree of commodification, these systems are only good for those homes with high levels of income; they meet their care needs at the expense of women's poorly-paid labour (lower classes have only the option of unpaid work within households).

On the other hand, we find care systems with some level of decommodification and defamilization too. In this case, the State plays a role by offering care services, cash transfers or the granting of time for care.

We can find different situations depending on what role the State plays according to Esping Andersen's classification for industrialized countries:

- Liberal: private market and families are the main providers of care services. The State intervenes, but only in those situations where the family fails, where market exchange is not enough, or in situations of poverty, as in the United Kingdom, the USA, Canada, Australia and New Zealand;
- Conservative: in which women's paid work is discouraged. There is limited support for families, limited public care services and marginal private-market supply. The provision of care offered by the State is conditioned upon a person's link to the labour market, for example, maternity services linked with formal employment and childcare centres only for the children of the formally employed, as in France, Germany and Italy;

- Social-democratic: private market supply is rare; there are generous public care services. The state intervenes in areas that could be the dominion of the market and does so for the general population, not just for the population in poverty or in extreme situations where family and market mechanisms have failed, nor just for the population attached to the labour market. Such as Denmark, Norway and Sweden.

Examples of these diverse care systems	
Familist care system	Fatou has a son with a mental disability. In her city there is only one private school for special education and it has a very high tuition. In the mornings, she takes her son to her mother's house while she works four hours in a hair salon, and in the afternoons, she cares for him herself.
	Duma has two children, 2 and 4 years old. In her city there is only private childcare. For almost the same cost she prefers to hire a domestic worker who, besides watching her children, can also perform cooking and cleaning tasks.
Decommodified and defamilized care system only in the case of poverty or in the failure of family mechanisms	Mariko is an older widow without children and cannot take care of herself. She lives in a home created exclusively for elderly dependents without living relatives.
	Yasaida is part of a state conditional cash transfer program to combat poverty. Through the program, she has the right to a spot for her 3-year-old son in a childcare centre, which forms part of a network of state centres only open to households that participate in the program.
Decommodified and defamilized care system only in the case of association with employment	Camille works as an official in the Ministry of Health. In her country, all companies and state agencies with more than 100 employees are required to have a child daycare centre in the building. Thanks to this, she can leave her 2-year-old daughter in the centre in while she works.
	Fiona has a 4-month-old baby. Thanks to parental leave regulations in her country, she or her husband can take care of him if they want, until he is 1 year old, for which either of them will receive 100 per cent of the salary corresponding to their current jobs.
Decommodified and defamilized care system	Agneta is an elderly woman with very advanced Alzheimer's disease. Though she has three daughters, she lives and is cared for in a special state residence for persons with serious disabilities. In her city there are two more public homes that welcome all seniors with disabilities that need it, regardless of their economic status and family situation.

The basic concept that allows us to define and assess the way in which these four actors are joined together in terms of development is the notion of co-responsibility or collective responsibility. In Session 1 we developed the theme of co-responsibility among people when addressing care provision. We will visit this concept in more depth in the next session to see how the distribution of care is affected within households.

But co-responsibility goes beyond people. It also implies shared responsibility between different social agents, between those actors in the public realm (the State, markets and the community) and in the private-domestic realm (households). If, as we mentioned in Session 1, care reproduces life and is at the core of development, then it can be understood as a social issue involving a collective responsibility and therefore, the creation of collective structures to cover the whole of society's care needs. Remember that we said that this way of approaching life in common is essential to a rights-based approach. Therefore, the notion of co-responsibility in care extends to all social agents, the State, the market, households and the community.

However, progress on co-responsibility in the provision of care inevitably means a change in the role the markets play in care provision. It is not that they should become more prominent in the offering of care services, because, as discussed in more detail in Session 7, the more privatized and commodified care services become, the more precarious employment there is and the more labour conditions worsen, while only low-quality services are offered to those who cannot pay very high prices. Thus, the logic of profit is at odds with the expansion of the right to care.

The responsibility of the market must be the product of two crucial steps:

- The transformation from the current ideal of the employee as self-sufficient subject with full availability for business needs or income-generation, to the idea of the worker as an interdependent person with care responsibilities. This implies introducing modifications into the working day, granting leave, etc., as well as extending these rights to atypical forms of employment; and
- The assumption by companies of some of the cost of the reproduction of the labour force through the payment of social security contributions that serve to establish care services.

In general, in the context of neoliberal globalization, one of the key strategies for increasing the competitiveness of countries has been the lowering of labour costs, and this has meant, among other things, reducing corporate contributions to social security (through bonuses for certain kinds of contracts, the reduction of quotas, free trade zones, among others) and increasing the flexibility of working time. These changes move in the opposite direction to the aforementioned co-responsibility of private companies.

The key questions that must be asked when examining a system of care are: do the four agents that should share the responsibility for guaranteeing care have the same presence and level of participation? Or do some of them assume a larger part while others hardly participate at all? Subsequently, we should be able to know how different citizens and social groups access the care they need. Do they access decent care or suffer from precarious care arrangements? Is the right to care guaranteed or violated to different extents and for different persons/social groups?

5. Conclusion

In this session we have examined analytical tools that we can now apply in a dynamic way to identify the social organization of care. We have used various examples in order to check their usefulness to understand how care is organized in diverse contexts.

We have also learned that the first step is to identify the care requirements of each society. These needs are profoundly linked to the age composition of the population. Age deeply affects a person's care requirements as well as her or his ability to take care of herself or himself and of others. Public policies are sharply and specifically challenged by global ageing and by the situations in which care needs are identified due to different reasons.

Then we have discussed who can assume the responsibility for coping with those care needs and in which spaces. We saw that the role played by four specific actors must be identified:

- The State can provide care services, establish income benefits for those persons in charge of caregiving or release time from employment so that workers can perform unpaid care;
- The market, where domestic employment is the main resource; other types of professional care work also exist;
- The community or the third sector, whose role is very relevant in certain regions; and
- Households, where the bulk of care responsibilities are assumed.

The way in which these four actors interact, as well as the role played by mixed actors, defines whether the caregiving network is more familized (households being the main or sole care providers), commodified (care functions as a commodity to be bought and sold), or defamilized and decommodified (whenever the State is the main care provider). Co-responsibility exists when caregiving is fairly distributed among all social actors. However, currently co-responsibility is a desirable direction to pursue. Care needs are overwhelmingly satisfied within households thanks to unpaid work or to domestic employment; care is highly familized.

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List of Terms included in the Glossary

- Care
- Care policies
- Co-responsibility
- Decommodification
- Defamilization
- Familism
- Gender
- Gender division of labour
- Gender role of women (in care)
- Interdependence
- Production/reproduction
- Public/private-domestic domains
- Remunerated/unremunerated work (paid and unpaid work)
- Right to care
- Rights-based approach
- Self-sufficiency (self-sufficient citizen/worker)
- Social organization of care
- Total workload

CHAPTER 3

FEATURES AND TRENDS OF THE CURRENT SOCIAL ORGANIZATION OF CARE

SESSION 3

FEATURES AND TRENDS OF THE CURRENT SOCIAL ORGANIZATION OF CARE

TAKE AWAY POINTS

Overall, care systems in most contexts are "familist". The degree of social co-responsibility is low, therefore care is mostly assumed by households thanks to unpaid care work and/or the hiring of domestic employment.

1. The first pillar of the provision of care: women's unpaid work

There are two main tools that shed light on the performance of unpaid work within households and on its unfair distribution between women and men:

- Time use surveys: they provide crucial information about the time that each family member dedicates to different activities- personal needs, leisure, employment and unpaid work. The results show that:
  - Households dedicate an impressive amount of time to unpaid carework, greater than the time devoted to paid work;
  - Care is primarily a female task: there are more women undertaking unremunerated care work than men, and they dedicate much more time to it;
  - Women's total workload - which includes remunerated and unremunerated work - is higher than men's;
  - While men dedicate the largest amount of their time to employment, women's total workload is mostly composed of non-remunerated work;
  - The total workload and its distribution vary depending on variables such as ethnicity and social class or whether it is in a rural or urban area; and
  - Women's dedication to care work varies depending on age, changes in the life-cycle, the household composition, available income and other inequality factors, such as ethnicity, residential area or housing conditions. Men's dedication tends to draw out a constant line, regardless of these variables.
- Satellite Accounts of Household Production: these measure the monetary value of the unpaid work performed in households and compare it to other components of National Accounts. They are a convenient tool to acknowledge the economic magnitude of unpaid (care) work. These Satellite Accounts allow us to reach the following conclusions:
  - The monetary value of the unpaid services provided in households represents very high percentages of countries' GDP;

- This value is notably greater than the value of related sectors in the market (paid domestic work, cleaning services, other care services), and of public spending in social services; and
- This value is obtained principally through the work of women.

The use of Satellite Accounts of Household Production responds to a broader notion of the economy that encompasses all tasks required to fulfil the population's needs, regardless of whether they are performed within markets or not. Macroeconomic indicators are socially constructed, therefore they reflect social conceptions about development and well-being. According to a notion of human development, care must be placed in the visible development agenda and the availability of adequate information is a necessary condition in order to achieve this. These Satellite Accounts can play a critical role in so doing.

2. The second pillar of the provision of care: women's domestic employment

- The reasons for hiring domestic employment lie between two extremes:
  - It might be motivated by an ambition of social distinction or by pressing care needs. The volume and the conditions of domestic employment are very sensitive indicators of the degree of social inequality, whether hiring is a cheap way of heightening social status or improving quality of life for certain social groups;
  - It might be prompted by pressing care needs that cannot be met by any household member. The volume of domestic employment is therefore also a sensitive indicator of the degree to which co-responsibility in the provision of care is lacking (or, whether hiring is the sole way of solving care needs).
- Domestic employment inherits from unpaid domestic work its characteristics of undervaluing and lack of social prestige for the employee. It is also equally feminized.
- Its main defining features are its commodified character, the individualized relationship between employer and employee, and being located at the domestic sphere. It is a scenario in-between the market and the household.
- Against predictions that anticipated the gradual disappearance of domestic employment, from the second half of the 20th Century onwards various factors linked to the care crisis have actually contributed to the continuity and expansion of this kind of work.

3. The crisis of care

Care systems are being reconfigured worldwide and many countries are experiencing a care crisis, whether it is embedded within a wider crisis of social reproduction or not. A care crisis refers to a situation in which the ability of a given society to provide care is not in accordance with the care requirements of the population.

- There are diverse factors than can prompt a care crisis:
  - The aging of the population - which is a feminized phenomenon - when it is linked to a high incidence of poverty and/or when adequate care policies to deal with the new challenges are not implemented, e.g.,policies that assist the elderly and that assume the caregiving tasks that they can no longer provide;
  - The increase in the rate of women's activity in the market and the changes in their life expectations when these changes are not accompanied by other transformations, such as (1) a stronger co-responsibility for care of men and the State and (2) changes in the labour market in the sense of recognizing that workers do have care needs and responsibilities; and
  - Broadly speaking, development models do not take care into account. Grounded on the distributive conflict between production and reproduction, they rather assume that there is an infinitely elastic cushion of unpaid care work. For example, urban growth models that complicate care arrangements are prioritized.

In contexts in which the model of social organization of care based on the gender division of labour and

the classic family male breadwinner/female carer has broken down, there is an overriding need to reorganize and redistribute care:

- Social agents acting in the public realm (the State, the market and the community) do not alter the way they operate in order to fully respond to the necessary reorganization. This means that care then continues to be considered a domestic responsibility;
- Although some changes in men's attitude toward unpaid work are noticeable, men as a whole have not stepped into care in the same way that women have stepped into the labour market. Care is still understood to be a woman's responsibility;
- Women deploy various individual reconciliation strategies to combine employment, care and their own lives (variations in care work, in labour entry and other indirect or spatial strategies). The characteristics of these strategies are:
  - They are based in the transfer of care mainly between women: intergenerational transfer or transfer via the purchase of care services, mainly in the employment of domestic workers;
  - They are increasingly externalized and commodified;
  - Although the problems women experience vis-à-vis care are similar, their capacities to resolve them are not. Therefore, depending upon the resources to which one has access, the final result will be much more, or much less, rewarding.
- As a consequence we find:
  - Broad segments of society with precarious or vulnerable care situations and transfers of care in unequal circumstances;
  - Women have a double presence/absence in the economy: they work a double shift but the negative impacts of this in terms of women's rights are not a matter of public concern.

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1. Introduction

Overall, in most contexts, what we find are "familist" care systems. That is, the bulk of care provision that a given society requires falls on households. These have a leading role in generating well-being, while the rest of the agents play a secondary role. State participation can be non-existent or deficient with partial, targeted or low-coverage service. In contexts of high "familization" of care, only the upper classes can afford to delegate them. The principal mechanism that they use for this is the hiring of domestic employees.

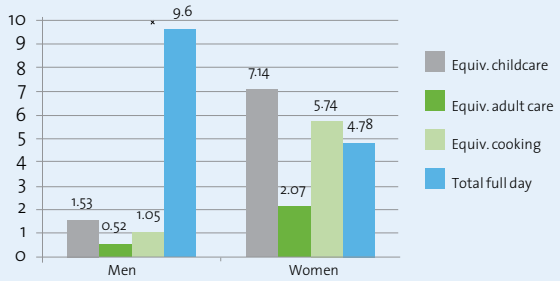
This unpaid care work by family members and domestic employment are the two regular pillars of care provision, as we shall see in this session. We will then go on to discuss the profound transformations that the social organization of care at the global level is undergoing and we will see how these transformations are linked to the care crisis.

2. The role of households and women in the provision of care

There is data that allows us to observe very clearly what proportion of total care needs in a given context are taken on within homes through the calculation of the number of jobs in the market that would be equivalent to all this unremunerated work. In other words, how many jobs would have to be created to substitute the care work done in the home assuming that these jobs were formal ones with regulated conditions, such as maximum daily working hours, breaks, vacations, etc.? The results speak for themselves. Figure 1 is the calculation made for Spain.

FIGURE 1

Full-time job equivalents to non-remunerated care work as compared to the total current working population, by sex (in millions)



Source: Durán (2009) and INE (2009)

As we can see, unpaid care work requires an impressive amount of time, which is not equally distributed between women and men. Childcare would amount to 8.77 million full-time jobs, of which 1.53 million would be care performed by men and 7.14 million by women. The care of adults would in turn be equivalent to 2.59 million jobs, of which 0.5 million would be performed by men and 2.07 by women. Just replacing the time that women dedicate to cooking for free would create 5,740,000 positions, which is more than the number of women that were full-time employed when these data were drawn up.

In the case of countries of the Global North, other approaches to the proportion of the total care needs of a given context taken on by the household are provided by two illuminating pieces of data from workforce surveys. First, the percentage of workers who work part-time because of care responsibilities and within this, the percentage of women:

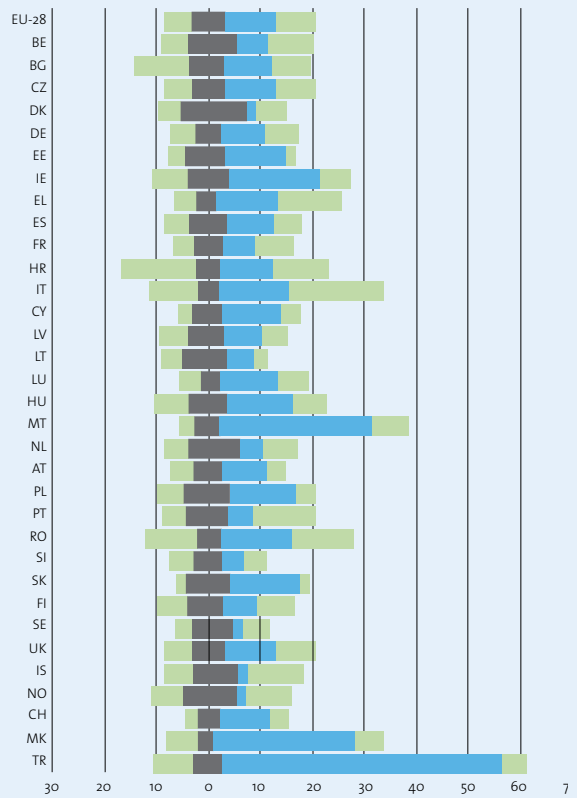
"The percentage of women employees working part-time was 31.2 per cent in 2007, four times higher than for men. Although part-time and other flexible working arrangements may reflect personal preferences, the unequal share of domestic and family responsibilities leads more women than men to opt for such arrangements. In the EU more than 6 million women in the 25-to-49 age group say they are obliged not to work or to work only part-time because of their family responsibilities." European Commission (2009)

Second is the percentage of people that are considered inactive, e.g., that are not in the labour market because of care work, and within this, the percentage of women (see Figure 2).

Therefore, in most developed countries, labour market inactivity and part-time work are accurate indicators that households have a high level of participation in covering care needs in society. In both cases, we also see that the percentage of women in these situations is overwhelming, indicating that, more than talking about how households are taking on the bulk of the responsibility for care, we should be talking about how it is women who are the ones doing it. When the informal economy is prevalent, as in many countries of the Global South, it is proven that care responsibilities are a crucial factor preventing women from entering the formal labour market.

FIGURE 2

Inactivity rates of prime-aged people (25 - 54) by sex and main reason for not looking for a job, 2013



Source: Statistics Explained (http://epp.eurostat.ec.europa.eu/statistics_explained/)

"Family responsibilities are one of the reasons women turn to vulnerable and informal employment. For example, 40 per cent of mothers working informally in the slums of Guatemala City were caring for their children themselves, with lack of childcare cited as a key reason for not taking formal economy jobs where children could not accompany them. Family responsibilities reportedly steer many women in Costa Rica to domestic work or other types of informal employment that provide a degree of flexibility in working hours. In the Philippines, where more than two-thirds of all women work in the informal economy, 20 percent of women cited family responsibilities as the reason they turned to informal rather than formal employment. In a study of small enterprises in Bangladesh, 13 per cent of women reported family responsibilities as a reason for turning to entrepreneurial activities, compared to less than one per cent of men. In Angola, women participating in the informal economy do so, in part, for the flexible work" hours that enable them to fulfil household and child care responsibilities." Addati and Cassirer (2008)

2.1. The intra-household distribution of care work: time-use surveys

Although households cover most care needs, tasks are not equally distributed between their members. Sex and age are two key variables when defining the distribution, and we will now focus on gender inequality.

The main source of data for understanding the distribution of unremunerated time dedicated to care within households is time use surveys. Although they are an essential tool, they are neither the perfect tool nor the only tool. They provide crucial information about the care work assumed by households, and who within the households takes on this work, how much time they dedicate to it and the differences between social groups. And not just between men and women, but also between ages and social classes; between rural and urban areas or between different ethnic groups. Knowing this is crucial in order to implement the mechanisms for defamilizing well-being. Above all, it allows public powers to understand which social groups are assuming the greater burden and unequal burdens of care provision, in order for them to design public policies based on this information.

In these surveys, people are asked how they distribute their time, usually over the 24 hours of the day or over the seven days of the week. From these data it is possible to understand what activities people are engaging in, the time they dedicate to them and which ones they are not doing. The activities registered in time use surveys include all those that require time throughout the day, such as remunerated work, household chores, the direct care of people, time dedicated to leisure and entertainment, volunteer work, transportation time, eating, etc.

In some countries, we find there are some independent and specific time use surveys that have been done with certain consistency over the years in order to see the variations; in others, there are modules within the multi-purpose household surveys, or a few questions about time dedicated to certain unremunerated activities in surveys done for other purposes, for example, surveys about child labour or labour market entry. The main problem with relying on data about the intra-household distribution of care, however, is that time use surveys are still not generalized enough. This is why many countries do not have these tools.

The main objective of these tools is to know how people's time is distributed between various activities:

<table>
<tr><th colspan="4">All Activities</th></tr>
<tr><th colspan="3">Productive</th><th>Non - productive</th></tr>
<tr><td>Activities within the System of National Accounts (SNA)</td><td colspan="2">Activities within the Extended System of National Accounts. Unpaid work.</td><td rowspan="2">Eating, sleeping, leisure and cultural activities, time for learning, etc.</td></tr>
<tr><td>Paid work and unpaid subsistence activities</td><td>Domestic work</td><td>Care for individuals</td><td>Volunteer and unpaid community service work</td></tr>
</table>

To understand the results, we must understand the basic categories of activities these surveys use to organize the presentation of results:

- Activities related to the System of National Accounts (SNA) include remunerated work, but also all self-sustaining unpaid work, such as subsistence agriculture, fishing and livestock breeding. Some activities, such as collecting firewood and fetching water, are also included in some surveys, although not as part of the System of National Accounts of a country.
- Activities pertaining to extended SNA include unpaid domestic work, unremunerated care work, voluntary activities and unremunerated services to the community.
- Non-productive activities are self-care activities, such as sleeping or eating, but also leisure, cultural activities, reading media, etc.

2.2. Results of the time use surveys

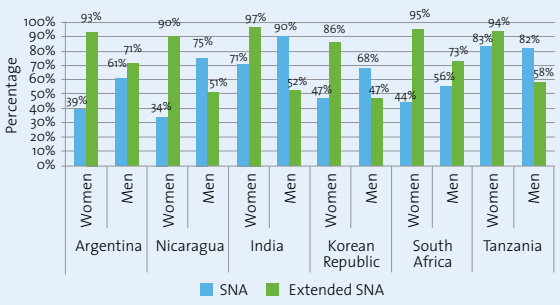
Independent of context, time use surveys consistently yield large differences between the amount of time that women dedicate to unremunerated care work within households and the amount of time dedicated by men, and in Session 1 we advanced some data about the gender division of labour. Now we will concentrate more on other data for investigating this issue.

The first piece of data to note is that domestic chores and care are primarily female tasks, as revealed by a comparative study between six countries around the world. Figure 3 shows the percentages of men and women reporting their participation in each kind of activity, and we see that the difference between the two is great. When we look at the extended system of national accounts activities that include unpaid domestic work and unremunerated care work, we see that the participation rates are always higher in the case of women.

Let us also look at how participation in System of National Accounts (SNA) activities, e.g., employment and subsistence activities, is always much higher in the case of men, except for in Tanzania (see Figure 3). In the particular case of Tanzania, it must be taken into account that, beyond questions relative to how

FIGURE 3

Participation rate by SNA categories, by sex and country



Source: Budlender (2008)

the survey registers information, much of this work is unremunerated: 71.1 per cent of women work on their own land, or shamba, and what many of them do is subsistence agriculture.

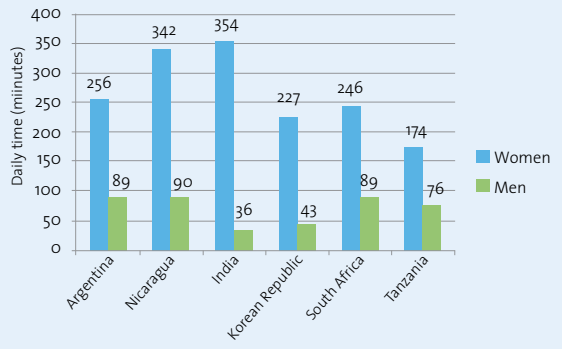
But not only is the percentage of women doing unremunerated care work much higher than the percentage of men. The second piece of data is that women also dedicate much more time than men to unremunerated care work.

Let us look at Figure 4. This graph shows the average daily time in minutes that men and women dedicate to extended SNA activities, including those that do not dedicate time to these activities at all. In all cases we see large differences between the average time that women dedicate and the amount of time men do. In most of these countries, women dedicate twice and sometimes three times the amount of time to domestic chores and care as men do.

We can also observe that the distribution of total work time is very different between women and men (Figure 5). Of total work time, women dedicate much more time to unremunerated domestic chores and care than to remunerated work. This relationship is inverted in men's case. This unequal distribution of total work time to different activities has important effects: the sphere that provides access to income and the associated rights occupies most of men's time while the sphere that produces neither income nor associated rights occupies most of women's time.

FIGURE 4

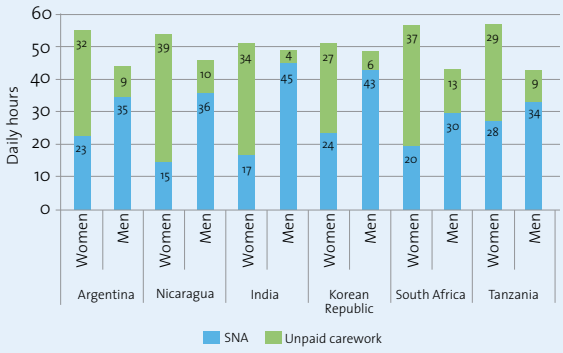
Average time spent on extended SNA activities by sex and country



Source: Budlender (2008)

FIGURE 5

Workload and composition of hours spent on SNA and unpaid care work, by sex

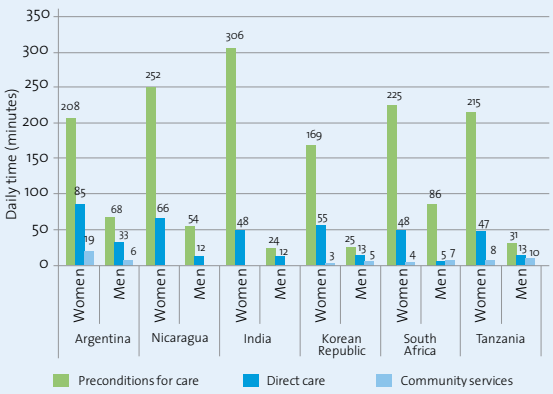


Source: Budlender (2008)

Time use surveys show us a third feature, how time is allocated between different activities in extended SNA (Figure 6). Recall that these include domestic chores - what we call in Session 1 "preconditions for care"-, caring for people and unremunerated community services. We can also see the breakdown of participation of men and women in each one of these activities, such as the average time that each dedicate to them.

FIGURE 6

Mean time in minutes spent per day on each type of unpaid care, by sex and country

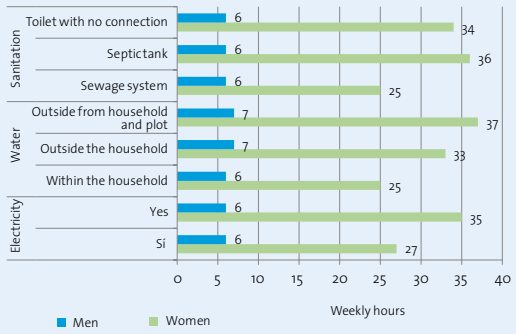


Source: Budlender (2008)

In some countries, domestic chores manage to consume much of women's working time. In the example of these six countries, we see that in countries such as India, Nicaragua or South Africa, time dedicated to domestic chores by women is much higher than in countries like Argentina or South Korea. This is because the care burden is directly related to housing conditions. The burden is much greater when there is no running water, when the house is of a build with a dirt floor, when there is no washing machine and one must wash the clothes by hand, etc. Populations that live in such conditions see their care burden intensified. We can also see that in Colombia (Figure 7), the number of hours that men and women dedicate to unremunerated housework varies depending on whether the household has electricity, water and a toilet.

FIGURE 7

Colombia housing facilities and hours per week spent on household work, by sex

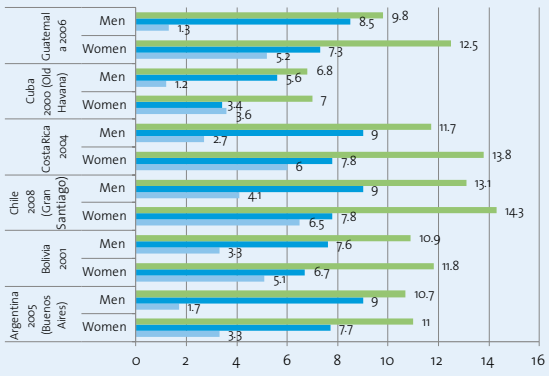


Source: Milosavljevic (2010)

A fourth and last essential finding revealed by these surveys is that women's total workload is higher than men's. Typically, women not only spend more time on housework than do men, but combined - if we include remunerated and unremunerated work - in all regions of the world women work more hours than men. We can see this difference in selected Latin American countries for which there are time use surveys (Figure 8), as well as in selected African countries (Figure 9).

FIGURE 8

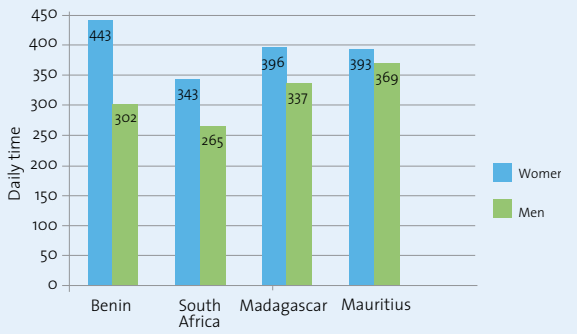
Total work time, by type, sex and country



Fuente: CEPAL, División de Asuntos de Género (2010)

FIGURE 9

Total workload by sex in four African countries

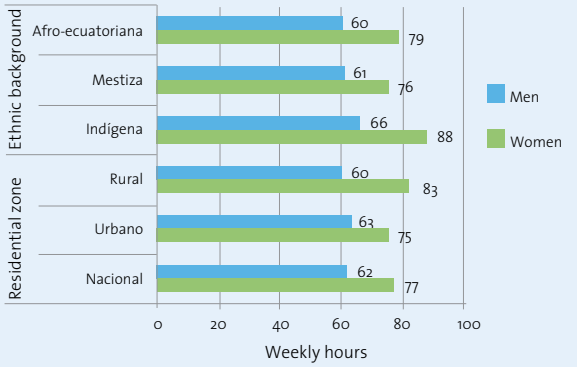


Fuente: Blackden y Wodon (2005)

This distribution of the workload between men and women varies depending on variables such as ethnicity or whether it is in a rural or urban area, as generally there is a higher workload for women of discriminated ethnicities and for those in rural areas. Let's observe this difference in the case of Ecuador (Figure 10).

FIGURE 10

Total workload by sex, residential zone and ethnic background, in Ecuador



Fuente: Pérez (2008)

The four results demonstrated by the time use surveys make clearly visible how care falls to women. The lack of shared responsibility between different agents in care provision has various effects:

- The unremunerated care burden borne by women is a factor that significantly hinders their access to the sphere of remunerated work and other spheres of public life, including politics;
- The increased dedication to unremunerated care tasks does not bring along with it the increased enjoyment of rights such as a pension in old age or access to healthcare, such as those associated with remunerated workers in the formal sector;
- Taking responsibility for care means more total work hours. This implies that women enjoy less leisure time and less time to take care of themselves, which can have effects on their health.

2.3. Variables affecting time spent on care and domestic chores

In the case of men, the main variable determining the time spent is their sex. In other words, their involvement in unpaid chores does not depend on the conditions of the home or on such other variables as their marital status, children or the income quintile to which they belong. There is a common understanding that their primary responsibility is to be the breadwinners. The quality of their position in the labour market depends on a number of factors related to their own position (education, social class...). But this position is not affected by unremunerated work or by its combination with paid employment (for example, they do not withdraw from the labour market because of paternity).

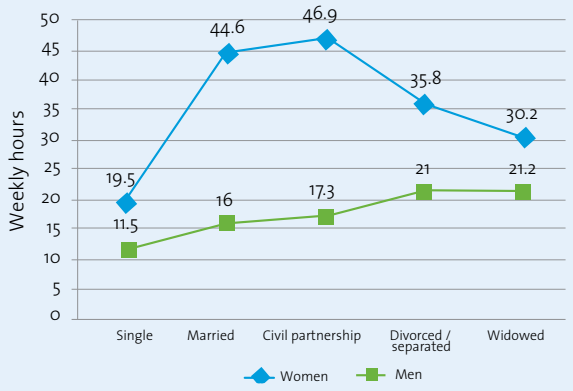
It is important to relate this to something we will see in more detail in Session 4: women are ultimately more responsible for well-being; they are the "life jugglers" who change their occupation and their activities as necessary.

We could compare this situation to an electrocardiogram. In men's case, their dedication to care work would draw out a constant line, regardless of other variables. But in women's case, time dedicated varies depending on several variables. Among those that stand out we find:

- The number of children: the more children there are in a household, the more time women dedicate to unremunerated work, although child age has a decisive influence, especially if they are under 3 years old;
- Marital status: going from being single to being in a couple does not mean that the work is distributed better, but rather that it increases, as demonstrated in Figure 11.

FIGURE 11

Mean time spent per week on unpaid work, by sex and marital status, Uruguay



Source: Faculty of Social Sciences and National Statistics Institute (2008)

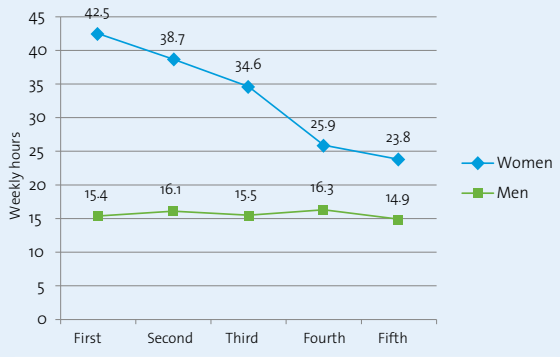
- Age: with age at first, work increases, then tends to decrease. This varies greatly according to social class. For example, in some countries or sectors, from a very young age girls and adolescents dedicate a lot of time to these jobs - sometimes children do, too. And something similar happens with the participation of elderly people: there are contexts in which the grandparents play a very relevant role in the care of children while in others we see a progressive reduction of time dedicated by the elderly to the care of others.

- Income: the relationship here is complex because the more income there is, the more work in the home can be replaced by work bought in the market. But at the same time, the less income there is, the more there is a necessity to go out into the market to obtain monetary resources. What is clear is that unremunerated care time is organized in conjunction with the rest of work; it is an overall strategy to support the home, an integral economic strategy. In the case of Uruguay, we can see however that time dedicated to unremunerated work varies depending on the income quintile (see Figure 12) while for men it is not a very significant variable - they dedicate a very similar average amount of weekly time independent of the income quintile to which they belong - for women, it is, as those belonging to the highest quintile dedicate many fewer hours.

We can also observe that, while women continue to register more than double the amount of unremunerated work hours in all income quintiles, the difference is more notable in the first quintile, in which women dedicate almost triple the amount of weekly hours than their male partners.

FIGURE 12

Mean time spent per week on unpaid work by sex and household income quintiles, Uruguay



Source: Faculty of Social Sciences and National Statistics Institute (2008)

- Ethnicity: as we saw in the data related to the total workload, women in discriminated ethnic or indigenous groups have a higher total workload (see Figure 10);
- Area of residence (urban or rural): as we saw earlier, women living in rural areas spend more hours on unpaid care work than women residing in urban ones. (see Figure 10)

3. Measuring unpaid (care) work

There is one principal instrument for measuring work in the market: household surveys or labour force surveys (which understand labour as work within the market). To measure the work done outside the market we have another key instrument, which we have just seen: time use surveys. Once we know the amount of time dedicated to work inside and outside of the labour market, we can calculate the monetary value of what is produced.

To calculate the value of what is produced in the market, there is a whole system of measurements that are brought together in Systems of National Accounting (SNA); one of the essential concepts is Gross Domestic Product (GDP). And to calculate the value of unpaid work in households, the Household Satellite Accounts (HHSA) have been developed.

3.1. Extended Systems of National Accounting

Systems of National Accounting (aggregate demand, investment, foreign investment, balance of payments, etc.) provide norms regarding what should and should not be included in calculations. This standardization is important in order to be able to compare the economic productivity of different countries. One of these systems is globally standardized, the SNA 2008, and upon this basis all countries calculate their GDP. The increase or decrease of the GDP and of the per capita income are generally considered the principal indicators of how well or how poorly any given economy is functioning.

The concepts of GDP and SNA are the result of a social construction and have about a century of history. And they have been universally accepted as

an economic point of reference for a much shorter time: since the Second World War. The fact that GDP calculations focus on markets is the result of a process of debate. For example, there are studies from 1913 in Norway and from 1921 in the United States that include the value of unpaid domestic work (on the basis of the number of housewives and adult daughters multiplied by the salary of a domestic servant). In general, we might say that there are two traditions: the Scandinavian one, which tends to include non-commodified production, and the Anglo-American, which tends to exclude it. Ultimately the Anglo-American tradition prevailed, this being the one that underlies the worldwide use of SNA. Today, a global coordinated system is used, and it can be consulted here: http://unstats.un.org/unsd/nationalaccount/.

GDP measures all transactions that take place in commodity production and also some others that occur outside of the market, principally production in households for their own use (subsistence production of livestock and building, housing rental and domestic employment). These data are included only if the total sum of production for household consumption is relevant compared to the commercial availability of the same goods in the country in question. But production of unpaid services within households is not included, services such as cleaning, preparing food, the care of children or the care of ailing or elderly people.

Why are these activities not included? Some of the arguments that have been used to exclude them are:

- They are services, not goods (like the production of subsistence);
- The production of services in the household is relatively separate and independent of the activities of the market; and
- Data are lacking and it is difficult to make measurements; the ability to make historical comparisons is lacking, as these services were not included before.

Some authors also maintain that the exclusion of unpaid domestic work from national accounting is actually an ideological and conceptual matter, not a problem of measurements. The fact that subsistence work is included (although it is not paid, nor does it enter into the market), and domestic and care work are not included, permits us to draw two conclusions:

- The exclusion of domestic and care work is not a question of methodological difficulty but rather one of political will;
- What is really excluded is not the unpaid work carried out in households in general but rather those activities that in Western societies are not commodified; they are done in the domestic sphere in a non-monetized manner. Subsistence activities are included (although they are not in the market in a given country) because it is assumed that, if the country were sufficiently developed (in capitalist terms), these activities would be included in the market. The very distinction between subsistence production and domestic services and care is drawn on the basis of what is commodified in developed countries and what is not. The SNA not only has a powerful gender bias, it is also created in reference to what occurs in wealthy countries, which are taken as the norm.

Included	Not included
Producing eggs, milk or foodstuffs. Threshing and milling grain. Making butter.	Preparing and serving food.
Sewing clothing.	Cleaning and repairing imperishable products in the household.
Carrying water. Cutting and gathering firewood.	Housekeeping.

In order to understand the biases that exist in the calculations that we habitually use to measure well-being, it is important to understand that the division between what is measured and what is not measured is a bit different than the distinction between what enters into the market and what doesn't. There are also activities that, in this course, we take to form part of care work and which are measured; in accounting terms they are not referred to as care or as domestic services but rather as subsistence production.

If we take the markets out of the centre, this is no longer an adequate form of measuring economic activity and the challenge becomes clear: how to measure all that which doesn't move money, which lacks the blessing of a natural unit of measure, a currency, which allows for apparently neutral and exact measurements? Although this is a challenge with difficulties, it is important to measure care work and to understand its dimensions relative to the total economic activity of a country for various reasons:

- First, we need to measure the economy as a whole: given that the economy is the result of the combination of work in the labour market and unpaid work, only measuring one of these two parts gives us an incomplete and distorted image of how a given context is really functioning economically. For this reason it is necessary to make clear the importance of non-commodified production in relation to the wealth that is generated in a given territory;
- We need to make the contribution of women to economic development visible. Inasmuch as unpaid activities are carried out principally by women, their contribution to well-being and economic development is rendered invisible. This invisibility perpetuates the economic and power relations that underlie gender inequalities;
- It is important to recognize the changes in the distribution of paid and unpaid work, between market production of goods and services and domestic production of goods and services over time in any given context. The economy is constantly changing. The way in which work is combined experiences variations over time: there are moments in which households externalize more of the work that is done, and others in which the inverse occurs, that is, work that was obtained in the market returns to the household. This latter phenomenon tends to occur in moments of economic crisis, in which the reduction of income obliges many households to forego care services they formerly purchased or received from the State (food preparation, care of children or the elderly, among others). It is therefore important to have a clear vision of the degree to which these various services, such as healthcare services, are covered by unpaid work;
- It is important to take into account unpaid care work in political decision-making and the design of policies. These data are key to any adequate evaluation of the impact of policies in general and policies regarding inequalities in particular.

Since 1993, the United Nations has recommended that countries compile statistics that take into account this work through the inclusion of satellite accounts. That is, the SNA continue to have a core content, the market. But then it is recommended that other collateral calculations be made which may serve to delve more deeply into specific aspects of social and economic life (but which do not confront the core, as they constitute a periphery). The recommended satellite accounts look at:

- Culture;
- Environment;
- Health;
- Tourism;
- Petroleum; and
- Unpaid domestic services in the household (HHSA).

The two satellite accounts that most closely relate to matters of care are the health and unpaid domestic services accounts. In this session we focus on the latter.

Satellite Health Accounts

Diverse satellite health accounts do not include unpaid health services, but there are others that do, such as Mexico 2008. Here, the monetary value of unpaid health care work performed within households is 0.9 per cent of the GDP and the following figure shows the percentage of the health sector in the national economy:

Source: Gómez Luna (2012)

3.2. Household Satellite Accounts

To measure the production of goods and services in households, we must first know how much time is dedicated to them. This is achieved through time use surveys, as mentioned earlier in this session. Then it is necessary to attribute a monetary value to this work time. This can be done using different methods, the two regular ones are those included in table 1.

Depending on the method in use, the results vary widely (there are as many as 12 different methods!). In order to get a sense of these dissimilar results, we may look at Table 2, which shows some methods and the results they arrive at. In any case, the important thing is to be aware that there are different methods and that it is complicated... but it can be done if there is the political will to do it!

Household satellite accounts (HHSA) allow us to reach the following conclusions:

1. The monetary value of the unpaid services provided in households represents very high percentages of countries' GDP, percentages that are often much higher than those corresponding to the aggregate values of large sections of the

TABLE 1

Methods to assign a monetary value to unpaid work

Method	What this means	Value of the food function in Spain*
Opportunity Costs	Hours of unpaid domestic work are valued in terms of wages that are not earned (that is, for the time that this person cannot dedicate to obtaining monetary compensation in the market). Various values may be used: the average wage in that country, the mean wage of similar persons (according to sex, educational level and age), or others.	11.8 per cent of the GDP (basis: minimum wage) 36.2 per cent of GDP (basis: average wage in Spain)
Replacement Costs	Calculates what it would cost to acquire this work in the labour market. Here there are two basic options: **The generalist method:** calculated according to what it would cost to have one person working fulltime to take care of domestic tasks, that is, the cost of hiring someone as a domestic employee. **The specialized method:** calculated according to what it would cost to pay specialized personnel in each one of the functions that unpaid domestic work fulfils.	22.3 per cent of GDP (basis: average wage in hotel industry)

* Source: Durán(2000)

TABLE 2

Unpaid domestic and care work as part of the GDP.

Country	Opportunity cost method	Replacement cost method (generalist)
Argentina (2005)	12%	10%
India (1998/1999)	63%	39%
Korean Republic (2004)	29%	18%
South Africa (2000)	28%	15%
Nicaragua (1998)	54%	31%
Tanzania(2006)	63%	35%

Source: Budlender (2008)

SNA, areas with great influence in the countries, such as construction, transport, financial services or manufacturing. In the case of Mexico, the monetary value of the HHSA that was obtained in the calculations came to 23.7 per cent of GDP. This value is greater than what is generated by commerce, restaurants and hotels (21 per cent) and manufacturing industry (18.5 per cent) and is only exceeded by communal, social and personal services, which generated 27 per cent of GDP;

2. The level of the product of the HHSA is notably greater than the value of related sectors in the market (paid domestic work, cleaning services, other care services). For example, Budlender (2008) calculated the total value of unpaid care work compared to the care sector, which is included in the SNA. The results, depending upon the method used and the country in question, varied between a minimum in South Africa of 155 per cent and a maximum in Korea of 712 per cent;
3. It is much greater than public spending in social services. According to Budlender (2008), the value of the HHSA fluctuates between a minimum of 4 times the public expenditure in social services in Argentina and a maximum of 110 times in India;
4. The GDP of the HHSA is obtained principally through the work of women. In the case of Mexico, women provided 76.9 per cent of the value of HHSA. This role is even greater if we calculate according to the hours of work, as women dedicate nearly five times more time to attending to their households than men do (82 per cent of the total time dedicated to activities related to social reproduction). The participation of women measured in quantity of time is greater than in monetary terms, as the latter reflect the situation of their wages on the labour market: lower than those received by men.

Some analysts hold that unpaid care work functions as a reproductive tax as, in various ways, it is a transfer from some social groups to others; it is as well a payment that women must fulfil before entering the labour market.

So if we compare the value of the production of care within households to the values citizens pay as personal taxes, we discover that what is being paid in this hidden manner is an enormous sum (see table 3).

TABLE 3

Value of unpaid domestic and care work in percentage of individual taxation

	In percentages of individual taxation
India	688%
Korean Republic	91%
Nicaragua	277%
South Africa	19%
Tanzania	248%

Source: Budlender (2008)

4. Domestic employment

The lack of social responsibility for care implies that this falls within households. Therefore care is provided thanks to unpaid - mostly family - care work, and to domestic employment in the case of the households that can afford it. Domestic employment is the second pillar of the social organization of care (the other one is unpaid work done by women). It shows up when families decide to hire someone to perform the tasks of attending the household and its members, tasks that otherwise will be undertaken for free by some family member.

The reasons for hiring domestic employment lie between two extremes. At one extreme, hiring might be motivated by an ambition for social distinction. It occurs when being served is considered a distinctive symbol of a higher socioeconomic status (employees might be hired with specific and different responsibilities). At the other extreme, hiring might be prompted by pressing care needs that cannot be met by a household member, for example, domestic employment might be the sole solution when a person is in a situation of high dependency and all the family members are bound to paid work.

The volume and the conditions of domestic employment are very sensitive indicators of:

- The degree of social inequality: the greater the difference between wages in a given context (polarization between rich and poor in a given society), the greater the volume of domestic employment. Income inequalities deeply condition this labour sector. It is based on the fact that some persons transfer the responsibility of the work that must be done in every household to others. Therefore, those who work as domestic employees assume the caregiving of an employer's household while at the same time someone (often themselves) does the care work in their own home;
- The degree to which co-responsibility in the provision of care is lacking: the fewer the public services providing care, the greater the difficulties in reconciling work and family life and therefore the greater the volume of domestic employment.

As we saw in Session 1, when care work is unpaid, it is not considered a job. Rather, it is considered an extension of the natural and proper role of women. For this reason it is not attributed value and women who do exclusively this work (housewives) do not count as an economically active part of the population. What happens when this care work, performed free of charge in the bosom of the family, is instead performed by a person who substitutes the housewife in exchange for a salary? We will discuss this in Session 5. Broadly speaking we can say that domestic employment has inherited from unpaid domestic work its characteristics of undervaluing and lack of social prestige. This in turn impacts the working conditions of domestic employees.

In general, the distinctive characteristics of domestic employment are:

- It is commodified: it is paid care work. Even so we find figures within domestic employment that are on the fence between commodified and free-of-charge labour, such as criadazgo in Paraguay, which takes children who are relatives belonging to poorer households and provides them with sustenance and education in exchange for domestic work. Or figures such as that of the neighbour who gets paid a little compensation for taking the children to school, for example.
- Its individualized character: it is a contractual relationship between the domestic employee and the employer, there are no companies mediating the relationship.
- It takes place in the household: although, for example, a domestic employee might be asked to spend nights in the hospital to take care of an ill member of the household.

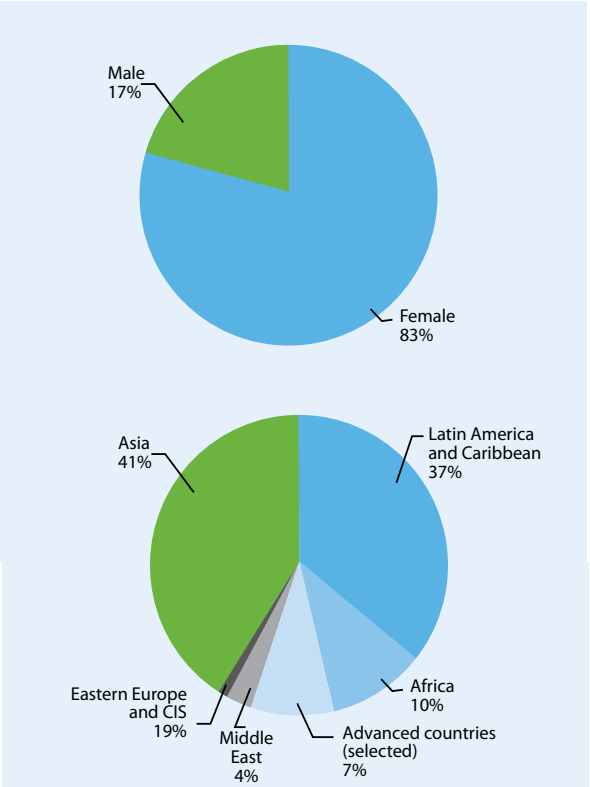
According to the ILO, for 2010 there were a minimum of 52.6 million domestic employees in the world. If all these people were to work in just one country, this country would be the tenth highest employer in the world. However the ILO itself points out that the sources from which the data are drawn tend to underestimate the number of domestic employees, and the real number may be more like 100 million.

Wealthy families and the upper class have always had domestic employees both as a way of freeing themselves from care work and as a mark of their social

status. These upper class households often have various employees with specialized tasks: cook, laundress, nanny, driver, gardener...

FIGURE 13

Distribution of domestic employees by sex and region, 2010



Source: ILO (2013)

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Going against predictions that anticipated the gradual disappearance of domestic employment due to its archaic and pre-modern character, from the second half of the 20th Century onwards, new households, including middle class and lower-middle class households - have joined in the purchase of care services on the market and have begun to hire domestic employees. Thus it appears that various factors linked to the care crisis, which we shall see in the next section, have contributed to the continuity and even expansion of domestic employment:

- The growing participation of middle- and upper-class women in the workforce: the transition to a family model with two adult providers of monetary income opens up a void with respect to the need for someone to take charge of the care work previously performed free of charge by women. The insufficient support provided by the State together with the insufficient involvement of men in caregiving and changes in family structure (an increase in the number of female-headed households and a reduction in the number of extended families) has also made externalization unavoidable in order to meet care needs;
- The increase in life expectancy, which has increased the need for care to attend to the elderly part of the population; and
- The expansion of lifestyles in which leisure and recreation are given great importance: middle-class households turn to domestic employment as a way of freeing time for other activities, such as sport, culture and entertainment.

Generally, these new households that purchase care work employ just one person who performs the majority of domestic tasks (cooking, cleaning, washing and ironing clothes, taking care of children and the elderly) or else these households purchase a certain number of hours per week from freelance care workers.

Worldwide, the labour force in this sector is characterized by being highly feminized and marked by other inequality axes. Child labour is also common. This labour sector presents some particularities (it is performed within the domestic realm and involves a highly individualized relationship) that favour the violation of labour rights as well as diverse forms of exploitation and situations of forced labour and serious sexual abuse are not rare. (We will deepen this discussion in Session 5.)

The presence of migrant women in the domestic employment sector is also increasing and this leads to

the formation of networks of interconnected households, the so-called "global care chains" that we will discuss in Session 6 as part of a broader process of globalization of care.

Let us now look at the "crisis of care".

5. Crisis of care

In many parts of the world, care arrangements are largely unsatisfactory, insufficient or not freely chosen. We come across a host of precarious care situations (as stated in Session 1), both in the way they are given and are received. In this sense we can say there is a crisis of care. Some problems, such as the reconciliation of work with family and personal life, the difficulties of caring for the elderly and the daily tensions involved in taking care of children, among others, are symptoms of this crisis. These are problematic situations in and of themselves, but the conflict does not end there. Rather, these situations bring to light deeper problems related to the secondary importance given to care at a social and economic level.

This crisis may be understood in different ways, or may be linked with various socio-economic processes depending on the context in which one finds oneself. In a large number of countries in the global South, the crisis of care is embedded within a wider crisis of social reproduction, in which the majority of the population does not have access to adequate living standards. There are high poverty rates and social inequality, there are no decent employment opportunities and the State has little role in ensuring well-being. In other words, the level of defamilization and decommodification is very low. Additionally, in these contexts of crisis of social reproduction, women are on many occasions the ones who tend to respond to household needs, combining their roles as providers in the market with that of caregivers.

In other contexts - especially in the countries of the global North, but also, increasingly, in a significant number of countries in the global South, especially the emerging countries - we find an increase in purchasing power and better levels of material well-being coexisting with a situation in which the care dimension not only does not improve, but suffers increasing precariousness. In other words, processes of commercial expansion do not appear to be accompanied by an improvement in the distribution of care work between different social agents or households. Rather, in these contexts, we see a crisis of care related to the breakdown of a particular mode of organization of care based on the classic gender division of labour.

This rupture calls for a reaction from society as a whole, but that reaction is not forthcoming or is insufficient, triggering a care crisis, the solution to which, as we shall see, has grave effects on gender equality and on development.

Here we will stop to analyse the case of such contexts, in which the model of social organization of care based on the gender division of labour has broken down, so we can see the effects of this breakdown. We will also analyse the solutions that are emerging to address these contexts.

To speak of crisis does not mean idealizing the previous model of care, which, among other things, was based on an unjust division of labour and which situated women in a category of second-class citizenship. But it does mean recognizing that this model supported a certain social peace, because it served to contain the distributive conflict between production and reproduction.(We will talk about this in more detail in Session 4.)We can exploit this moment of crisis in order to open up debate about how to approach this conflict, and about who should be responsible for the sustainability of life and its daily care.

5.1. Rupture of the previous model of organization of care

What was this previous model of care that broke down and triggered the crisis? Throughout the course we have already mentioned key elements, which we will now recapitulate. The organization of care was based on two interrelated pillars:

First, there was the classic gender division of labour, which ascribed to women unremunerated care work in the private - domestic sphere, and remunerated work to men in the public sphere. Here the gender discourse, which made care into a woman's issue, converged with familism, which made care into a private, family issue. In the macro sense, the spheres of production and reproduction were split and the latter was situated as the invisible base of the social whole. That is why we stated that women were not absent from the economy - as is often thought if only paid work is taken into account, and as we will see in Session 4 - but rather that they had an "absent presence". "Presence" because they worked even though their work was not paid, and "absent" because their activity was invisible.

Second, on the micro level, this gender division of labour crystallized in the imposition of a normative model of the family: man as provider/woman as caregiver. This type of family was not necessarily the actual form of organization of life in many social sectors but it was the standard to which to aspire, the form that was taken for granted and the basis for socioeconomic institutions. Mainly:

- The labour market, which urged workers to act as though they did not have any care responsibilities and needs (the self-sufficient worker). At its best, this model leads to the idea of a family wage: having to pay the worker enough so that he can maintain himself... and his family;
- The welfare state, which, at its best, structured rights around such a family: direct rights for the provider, derived rights for his dependents.

This model was deeply influenced by social class: to become the lady of the house, to maintain the family, were class expectations for women and men, respectively. "Problematic" social groups deviated from this model: single mothers, working-class women who could not dedicate themselves to their duties, unemployed men, for example. That is in fact why it has been said that women workers experience a double invisibility: in the factory they must act according to the standard of the unencumbered worker and in the family as the selfless caregiver not compromised by outside commitments.

Why does this form of organizing care break down? There are many reasons, among them, the changes in women's socio-economic position, which is normally understood as women's entry into the labour market. Indeed, many countries have experienced a steady increase in the rate of women's activity in the market. In part, this change has to do with the continued reduction of real wages and the erosion of the family wage figure: now, one pay check is not enough. This is an important quantitative change that reduces availability for care in the home: there are fewer women who can fully dedicate themselves to these tasks, or there are more and more women who must combine two types of jobs, those in the market and those related to providing family care. But the biggest change is qualitative; the way women understand themselves and their position in the world has transformed.

There have been changes in women's subjectivities and in their life expectations. The role of housewife is ever less an ideal to aspire to. The majority of women aspire to also have a profession, to come out into the public sphere, have their own life - not necessarily sacrificed for the well-being of others-and to have independent incomes. In other words, the crisis of care, at least in part, is due to women's empowerment.

Finally, the difficulties of combining work and care have always been a reality for working-class women. The point is that these difficulties are now affecting middle- and upper-class women more capable of making their voices heard. The crisis of care is not so new, but it is true that now we see it more clearly.

Another factor destabilizing care systems is the process of the aging of the population, which we have already spoken about in this session. Care demands changes

- the needs of children are not the same as those of the elderly for example - and the requirements are very different. This means reorganizing attention.

But there are other destabilizing factors about which we tend to talk less. They are not so directly linked to the changes in care needs or in care work, but are rather intertwined with the organization of life in a wider sense. That is why it is sometimes harder to see their relation with care. Let us take a moment to dwell on some of these factors:

- One of these is the model of urban growth. Big cities and the explosion of motorized transportation, e.g., cities built for cars, make it difficult to establish care arrangements: time dedicated to transport, that is, time in one's life that is not used for other personal, work, or care activities, multiplies. And different aspects of daily life - the office, the health clinic, school, the home - are spatially separated too, complicating the link between all of them; and public areas where one can care in a less intensified way are disappearing (for example, the fear that children go out into the street and are alone);
- "Precarization" of the labour market, with the resulting "flexibilization" of schedules and even of locations also greatly complicates the management of care;
- Finally, there is the process of the loss of neighbourhood and community networks; the management of daily life tends toward the nuclear, which means less ability to share care responsibilities and puts a greater burden on individual households.

All of these factors, with a different relative weight in each context, imply an overriding need to reorganize and redistribute care, look for new ways to guarantee them and integrate them into daily life. The question is, how can such a change come about?

5.2. Reorganization of care provision

Despite the large differences in context, in general it can be said that there are social agents that do not alter the way they operate in order to fully respond to the necessary reorganization. In many contexts, care public policies have been implemented, but they do not still add up to a full co-responsibility of the State. Neither do companies assume that responsibility. The growth model has been largely based on a deterioration of labour conditions, meanwhile. There are also no social or community networks with any significant presence. This means that care continues to be considered a domestic responsibility, in the home, despite the fact that the situation has changed. Now, there is also no substantial modification in the home in the distribution of tasks according to sex.

In some contexts, changes in men's attitude toward unpaid work are noticeable, but, men as a whole still have not stepped into care in the same way that women have stepped into the labour market. There is a tendency toward change in the composition of the total workload of women and men: men have increased the time spent in unpaid work and decreased the time spent in paid work. And women have done the opposite, increasing paid work and decreasing unpaid work. A certain transformation of male subjectivities has also been perceived, as we will see in the case of global care chains in Session 6. And these tendencies do add up to positive scenarios that should be reinforced through public policy. But these changes are still not relevant enough to speak of male co-responsibility. The time devoted to unpaid care by women is still much greater than the time devoted by men, broadly speaking. Additionally, while women may delegate some tasks - mainly to domestic employees - they are still in charge of mental management (supervising, planning and organizing the work). Following are some telling findings:

- women represent the overwhelming majority of those taking care leave associated with their jobs;
- maternity leave, a key right in care, remains associated with sex, that is, there is almost no country in the world where there is an equivalent right for men.

In the cases where the crisis of care is embedded in a more general crisis of social reproduction, and also in the cases where the crisis of care derives from a breakdown in the classic gender division of labour, we see common elements: the endurance of the gender division of labour and the public/private split as basis for the development models; and the consequent conditions of inequality in accessing decent care.

The model of development is still designed for a standard family model male breadwinner/female carer that maintains a split between the sphere of the paid work and the sphere of unremunerated care work, and attributes these to men and women respectively. In other words, the unjust care systems we saw in Session 1 are sustained by such a division of spheres. When this model disappears - because women's expectations change, because it becomes imperative to enter the labour market or for other reasons - and it becomes necessary to simultaneously respond to both responsibilities, e.g., of market work and care work at the same time, tensions that are very difficult to resolve begin to appear. These problems are partially common to all women, but different women have different capacities to solve them, especially depending on their social class.

So care continues to be the responsibility of women in the home. They can assume either the bulk of the responsibility or the total responsibility depending on the State and on men's presence. But theirs is the final responsibility. This conflicts with dedication to employment and other aspects of public life. How then do women provide care? They deploy various individual reconciliation strategies to combine employment, care and their own lives. Moreover, these strategies are combined with the use of various resources, e.g., public services and rights when they exist, the purchase of private services when one can afford them, free help from relatives, neighbours, etc. Here are some of the strategies deployed and the effects they have on women:

Individual reconciliation strategies		
Content	Impacts	Examples of different results in terms of decent/precarious care arrangements
Variations in care work		
Change in content or intensity of care work - reduction of tasks, simultaneous tasks, work intensification. Reduction of leisure time or time devoted to personal well-being.	Stress Less free time Loss of quality of life	Kim works as a domestic employee in Italy, in the home of a couple that has two daughters. She starts work at 8 a.m. and is responsible for taking the girls to school. She is done at 5 p.m. To arrive on time, she leaves her home at 7 a.m. in the morning and leaves her three children of 11, 8 and 6 alone. The children go to, and return from, school alone and the oldest is responsible for heating up the breakfast that Kim prepares for them before she goes. When Kim comes back at 6 p.m., she handles things in the house, helps the children with their homework and does the shopping. Aminata has four children who she maintains on her own since her husband left. She works as a sexual and reproductive health advocate in various communities far from her home, and in the afternoons she supplements her small salary by teaching literacy at a neighbourhood association. Before she goes in the morning she leaves a prepared breakfast for four children and does some basic cleaning. She gets up for this at 5:30 a.m. When she returns home at 8 p.m., she is very tired with little energy to help her children with their homework.

Variations in labour entry		
Part-time employment Search for less demanding jobs Renunciation of career advancement	Employment discrimination Unfavourable entry Less salary and poorer access to social rights	Sarah has been working for seven years in the sales department of an important mobile telecommunications company. Last year she was offered promotion to the head of the department, which meant increasing her hours and, above all, having to be available for trips and important meetings. Despite the recognition and the professional possibilities the promotion implied, Sarah refused. Her husband is a nurse and works the evening and night shifts and she is in charge of picking up their children and spending the afternoon with them. Milena has two children, two and four years old. When they were born, she left her position in a sewing factory where her mother also worked and began to work in a restaurant that served dinners at night. Her mother takes care of the children after 3 p.m., when she returns from the factory. In a nearby town, there is a new paper mill offering jobs to many women; a friend encouraged her to submit an application. She would like to work there, but there is no kindergarten service in the town and she has no one to leave them with in the mornings.
Other strategies		
Indirect: Giving up one of two responsibilities, e.g., exiting the labour market, sending children back to the country of origin, renouncing motherhood Spatial: • Bring the two together • Less mobility for seeking employment, taking the children to the workplace, bringing work home	Loss of quality of life and freedom to choose one's own life Less favourable labour entry	Elizabeth has an 8-month-old baby. Her husband works for 10 hours a day as a construction worker earning minimum wage. She has a small stall selling grilled corn at the market. They migrated a few months ago from their small town looking for job opportunities in the city. She does not have anywhere to leave their baby and works with him on her back for six hours a day. In Imelda's neighbourhood, a non-profit has launched a microcredit program for women. She would put up a food stand with a friend at the central market, but that would force her to spend the whole day away and she cannot. Her father is sick in bed and needs to be attended to every few minutes: he must be fed; his position changed; he must be accompanied to the toilet. So she continues work at a grocery store run by her neighbour on the corner. It's a job that does not pay much but it allows her to care for her father. Solange works as a live-in domestic employee in the home of a well-to-do family. She has two daughters and a son that she has left in the care of an aunt in her town. She would like to bring them to live with her but it is incompatible with her work.

Overall, multiform and dynamic care arrangements are established, the unchanging characteristic of which is that women in their homes are ultimately the managers of all arrangements. They are the ones who fill in the gaps and who guarantee that the whole process ultimately comes together. Depending upon the resources to which one has access, the final result will be much more, or much less, rewarding. That is, the problems women experience vis-à-vis care are similar, while their capacities to resolve them are not.

We therefore find broad segments of society with precarious or vulnerable care situations and transfers of care in unequal circumstances. Women have a double presence/absence in the economy. They have to work a double shift, because they continue to take charge of care responsibilities while also increasing their dedication to their employment. But also, these different economic spheres - market and care - operate according to different logics. The distributive conflict between production and social reproduction is manifest in the daily life of women and the difficulties of reconciling work and family life: human resources and time allocation can be aimed either at market production or at non-market care work. The diverse resources for addressing this issue - above all, money to buy services and rights associated with formal employment - show in turn the distributive conflict in production itself, the differences in social class.

Reconciliation strategies are characterized by the way they take the form of networks, that is, they are based in the transfer of care mainly between women. And they are increasingly externalized and commodified:

- On the one hand, there is an intergenerational transfer: the role of grandmothers, of women socialized in the classic model of care management, is currently a central pillar. Grandmothers who stay in the country of origin taking care of their grandchildren when their daughters migrate; grandparents, and especially grandmothers, who pick up their grandchildren from school and spend the afternoon with them until their parents come home from work.
- On the other hand, the other major path of transfer is via the purchase of care services, mainly in the employment of domestic workers, as we will see in Session 5: relatively inexpensive and affordable care services based on the precarious work of other women. There is then a redistribution based on axes of power: social class; ethnicity and immigration status. The increased recourse to the use of domestic employees and the growing presence of international migrant women in this sector leads to the appearance of so-called "global care chains", a subject that will be addressed in Session 6.

6. Conclusion

The insufficient role played by the State and other actors in the public domain implies that the ultimate responsibility falls on households, which deal with it through their privately available resources: time and money. According to socioeconomic status, households arrange a certain combination of unpaid care work and domestic employment. These are the two regular pillars of the social organization of care. Intra-household power dynamics linked to gender roles assign the responsibility for defining care arrangements to women both to perform care-giving themselves or hire domestic employment.

Adequate tools have been developed to understand intra-household allocation of tasks and responsibilities and the importance of unpaid work in society and the economy as a whole. On the one hand, time use surveys provide detailed evidence on both the relevance of households as care providers and the gender division of labour. Once the time devoted to different types of work is identified, the monetary value of unremunerated work can be calculated. Therefore, the relevance of the domestic sphere as a critical locus of economic activity is demonstrated.

The classic gender division of labour and the related family model male breadwinner/female carer are usually at the basis of labour market performance and of the articulation of the welfare state, wherever it is significantly developed. Nevertheless, this classic care arrangement is undergoing deep transformation due to factors such as changes in women's roles and life expectations, and other elements linked to the development model. This urges a reorganization of care toward greater co-responsibility of the four actors: the

State, the market and the community, lightening the overload that households - and women within them - assume. As long as the idea of co-responsibility is just a "desirable objective" rather than a realistic goal, we will continue to see a widespread situation in which care arrangements are unsatisfactory, insufficient and not freely chosen.

This situation can be described as a care crisis. In some countries, it is embedded within a wider crisis of social reproduction and in other countries it is a contrasting phenomenon opposed to a satisfactory performance of the market dimensions of the economy. Broadly speaking, it can be said that this crisis is caused by the undervaluation of care (which does not receive proper social and economic attention) and to the unequal distribution of care work (e.g., co-responsibility is lacking). This crisis is the more critical when situations of urgent or intensified care needs occur, such as the ones that were explained in Session 2.

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List of Terms included in the Glossary

- Care
- Care policies
- Co-responsibility
- Crisis of care
- Crisis of social reproduction
- Decommodification
- Defamilization
- Familism
- Gender
- Gender division of labour
- Gender role of women (in care)
- Household Satellite Accounts
- Human development
- Interdependence
- Production/reproduction
- Public/private - domestic domains
- Remunerated/unremunerated work (paid and unpaid work)
- Rights-based approach
- Self-sufficiency (self-sufficient citizen/worker)
- Social organization of care
- Time-Use Surveys
- Total workload

CHAPTER 4

CARE AS PART OF THE ECONOMY

CHAPTER 4

CARE AS PART OF THE ECONOMY

TAKE AWAY POINTS

1. Care is part of the economic system:

- Care is the base of the market economy and persons who produce in the market must be first reproduced;
- Care is itself an economic activity, understanding that the economy is defined as the whole set of processes that satisfy human needs, whether they occur within the market or not. Care is a critical dimension of well-being and to cover it, resources are required. Care is also a job that must be performed.

To fully understand the care economy, we need to introduce changes in the usual approach to economics:

- Economics is not what happens in markets, but the whole set of processes that sustain life. It is the processes of generating, distributing and consuming resources that allow for those goals considered worthy of pursuit to be pursued;
- Workers are not self-sufficient. They have responsibilities for the welfare of others, which might interfere with, or condition, their participation in the work force. They do not access everything they need with their wages. An enormous amount of work is done besides that which the market pays for; and
- The work of the economy of care begins with unveiling the economic processes that are behind these apparently self-sufficient workers. The key to the question is seeing that the commodified parts of the economy are only possible because of the existence of the economy of care.

Unpaid work serves three functions:

- Broadening well-being: purchase; transformation; adaptation and maintenance of market goods and services plus production of additional goods and services;
- Expansion of well-being: covering the affective and relational aspect of persons' well-being; and guaranteeing that all goods and services that come from the market and those that are provided by it fit together so as to reproduce life;
- Interaction with the labour market to make sure that workers are available and ready to produce.

Once we have visualized the total workload and the gender division of labour, we must ask ourselves two questions:

- How should paid and unpaid work be redistributed in a just way between men and women? That is, how to achieve co-responsibility?
- How could we render visible the spheres in which life is cared for?

2. The (macro, meso and micro) economy seen from the perspective of care

Looking into economics as a whole from the perspective of care implies placing the processes of sustaining daily life in the centre and asking how gender inequalities are reproduced through economic performance. This raises diverse questions:

- "Macroeconomic" level:
  - The economic system is comprised of diverse spheres: market production and care/social reproduction; markets and households; paid work and unpaid work...
  - There is a conflict between production and social reproduction regarding distribution: are living conditions the ultimate purpose of the economy (is production just a means to it)? Or are living conditions an adjustment variable that facilitates a profitable productive system?
  - When care acts as an adjustment variable, the consequent economic system is in the shape of an iceberg: reproduction is concealed and becomes the invisible base on which development is grounded.
- "Mesoeconomic" level:
  - Both the "Welfare State" and the labour market tend to assume that there is an infinitely elastic cushion of unpaid carework.
  - The numerous forms of labour discrimination on the basis of sex are deeply linked to the unfair distribution of care tasks.
  - Households are those economic units in charge of closing the economic cycle.
- "Microeconomic" level:
  - Households are not a harmonious unit but an arena for cooperative conflict.
  - According to gender roles, men are expected to be the family breadwinners and women the ones in charge of family well-being. This is why women's economic lives tend to be much more flexible than men's lives.

3. Impacts of economic policy upon care

All economic policies have a gender impact and an impact on the care economy. The most commonly identified impacts on care are the following:

- Recessive bias: policies that keep the activity of the markets below their full potential. Women usually are the first ones to be expelled from the labour market at the same time as they become overburdened with carework;
- Privatizing/commodification bias: policies that prioritized the private sector at the expense of the public sector; they increase the unpaid care burden of households; and
- Male breadwinner bias: policies that reinforce traditional gender roles - male breadwinner/female care-giver.

Possible impacts on care of the different levels of economic policy:

- Fiscal policy:
  - Through fiscal policy, the deflationary bias (which slows job creation), the commodification bias (which privatizes services), or the breadwinner bias (which foments the nuclear family model) may be put into place;
  - Additionally, it has an effect in a more direct manner through public spending (spending dedicated to the public provision of care services; policies of public employment in the care sector; and public care services frequently use unpaid work or poorly-paid work) and through fiscal revenue (can foment/discourage the private purchase of care services; defining fiscal treatment of care services);
- Monetary policy: regulates the care economy, especially through its effects upon fiscal policy;
- Labour policy: deeply impacts the care economy given the close relationship between it and the labour market:

- Any changes in access to employment bring along changes in the care economy and vice-versa;
- Labour policies regulate the conditions of work; the poorer the labour conditions, the greater the pressures upon the care economy; and
- Labour policies may be influenced by the male breadwinner bias;

- Trade policy: it has been observed that trade liberalization and the policies to promote direct foreign investment have negative effects upon care:
  - Making employment more flexible and more precarious;
  - Increasing women's employment without increasing the responsibilities of men and of public institutions;
  - Liberalizing the service sector, thus generating a privatizing bias; and
  - Trade and financial liberalization means there are intense pressures for them to impose deflationary and privatizing macroeconomic policies.
- Social protection policy: diverse components of the social protection systems impact care
  - Social security systems: Is employment the sole way to contribute to social insurance systems? Are mechanisms to contribute through unpaid carework established? Is the male breadwinner/female carer family the right-holder? How is regulation of domestic employment?
  - Social promotion policies: Are non-contributive or focalized benefits established in order to cover those in charge of unpaid carework?
  - Sectoral policies: Are the gaps in health care and education provision compensated through unpaid/poorly paid carework? Is assistance in situations of dependency an additional sectoral policy?

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1. The care economy

In recent years, the notion of an economics of care - or care economy - has become widespread. Use of this term brings into focus two issues:

- It attempts to take into account the interrelation between the way in which societies organize care and the functioning of markets: care is the base of the market economy because it feeds the markets both with labour force and with consumers;
- Further, it highlights the fact that care is itself an economic activity, although for the most part one that takes place outside the markets. Care is a necessity for all persons, and to cover this need, resources are required. Care is also work: it requires time, energy and knowledge, and providing care has "opportunity costs", as it takes time away from other activities. Moreover, care contributes to generating economic value in the markets. For all these reasons, care itself is an economic activity.

1.1. Rethinking economics to understand care

When we speak about an economics of care, we may use two different concepts of economics. The stricter one limits the notion of economics to market processes and the notion of work to paid labour (figures 1 and 2). This narrow definition is the most habitual one; it is so habitual that we seldom ask ourselves, "What is economics?" We will refer to this definition as the "economicist" definition. From the "economicist" perspective there are key questions about care that are not taken into account:

- If we think economics is what happens in markets, in the public sphere, then we don't see most care activities, as they occur outside the market sphere and do not involve the exchange of money;
- If we think that the economic behaviour of people is based on calculations of cost/benefit in which they seek to optimize their situations (that they are dictated by self-interest), then we will not understand care. People who perform care activities may do so out of their own self-interest or for other reasons, because they feel responsible for the well-being of others, because they expect a deferred compensation, because they feel obliged or because of affective bonds, among other reasons. Neither is it enough to think in terms of self-interest nor is it a matter of contrasting egoism with altruism. In care activities we find in play responsibility, commitment, the fulfilment of norms and social expectations and coercion, etc.;
- If we consider that money tends to work in a similar way for all people (the more we have, the more we consume; this is what provides us well-being), we understand little about care. In care activities, money doesn't function in a normal way. Sometimes people have buying power but do not demand care services. In other situations, there is a demand but there is no supply. For example, a middle-class family might not even think of delegating the care of an elderly person to a residence home even though they could pay for it. Or they may wish to do so but can't find a residence home. Such phenomena are usually explained by the existence of a social norm that dictates that the best and the only place in which care can and should be provided is the family. This social discourse, which we can call "familism", means that both the demand and the supply of commodified care services are quite underdeveloped, except in the case of domestic employment, precisely because this is just like part of the family;
- If we consider development to be a process in which the market increasingly meets the needs of different aspects of life, we distance ourselves from any notion of human development (introduced in Session 1) that takes into account well-being as a complex process going beyond market consumption to include emotional and relational dimensions. Being able to establish adequate ways of meeting care needs is a key dimension in development, but the way to a satisfactory organization of care is not necessarily through the market.

Faced with this "economicist" approach, there is a broader vision that would include within economics all of those processes that sustain life. That is, the processes of generating, distributing and consuming resources that allow that those goals considered worthy be pursued. From this broader perspective, care is

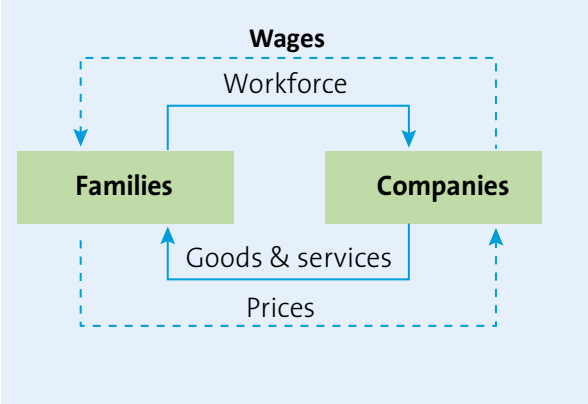
considered part of the economy because care forms the foundation of life itself. It requires resources and it represents work that must be done. This perspective is the one we will use in this session.

We will move step by step from the more habitual notion of economics (centred on markets and inattentive to questions of care), toward this perspective, which takes into account all the processes of sustainability of life and incorporates the economics of care.

We may use what is called the "diagram of the circular flow of income" (Figure 1) in order to sketch out the vision centred upon markets; this is the vision that, whether consciously or not, most people share. According to this diagram, two agents interact in the economy in two distinct spaces: companies in markets and families in households. Between the two there are real flows (goods and services, labour force) and monetary flows (wages and prices). There is economic exchange: companies produce goods and services that they sell to families in exchange for a price that families pay with the wages they earn by selling their time working.

FIGURE 1

Diagram of the circular flow of income



According to this vision, families depend on companies both to produce goods and to hire them for work. The initiative is first and foremost with the companies. They are the ones who put the economic process in motion and their activity begins these flows. According to this vision, well-being is a social consequence of good business activity.

In this diagram, the only population that is economically relevant is the business world and that part of households that participates in the labour market (the workforce); the rest is the dependent population. Workers are considered to be self-sufficient. They are economically important to the extent that they are part of the productive process. When not in the company, they are only relevant when consuming. It is assumed that they will access everything they need with their wages and that no work is done besides that which the market pays for. Workers are assumed to have no responsibility for the welfare of others that might interfere with, or condition, their participation in the work force.

From an "economicist" perspective, the whole part of the economy that is related to the reproduction of persons (of the self-sufficient worker, but also of the rest of society) lacks any explanation. The work of the economy of care begins with unveiling the economic processes that are behind these apparently self-sufficient workers: what flows of resources permit them to live; what labours sustain them; who does all this work and takes care of the responsibilities for the daily physical and emotional well-being of others that these workers do not take on. In other words, the key to the question is seeing that the commodified parts of the economy are only possible because of the existence of the economy of care.

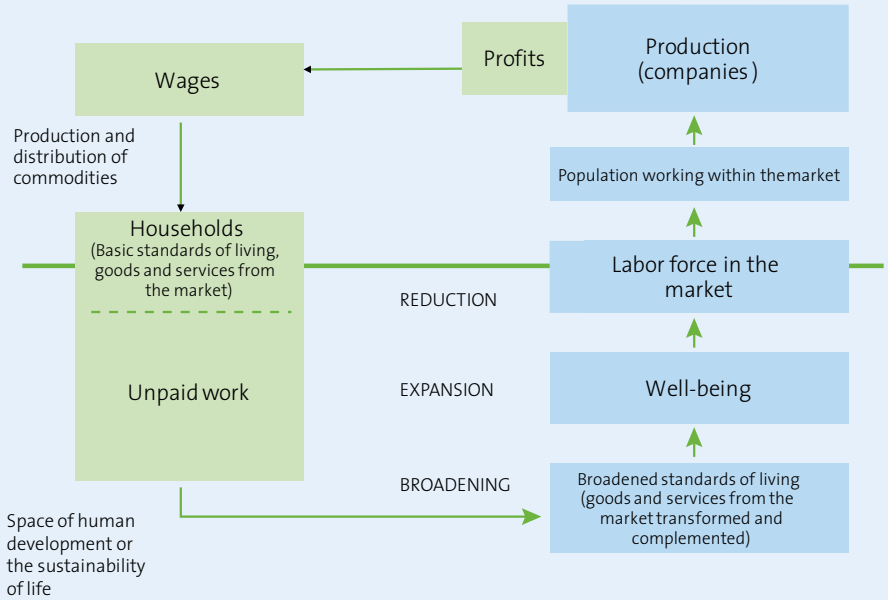
1.2. The economy as the processes that sustain life

We therefore broaden our scope in order to take into account the vast phenomenon of the sustainability of life. We will use an alternative diagram (Figure 2), which provides us with a broader alternative vision of the economy. In this diagram two different spheres are shown. From the horizontal line upward is the space of market production and distribution, in which capitalist companies operate using a work force that arrives from the households. But this work force is not just there waiting to be called upon. Rather, its presence implies a whole process of creation and sustenance. This sustenance is what occurs from the horizontal line downward, in what we might call the "space of human development" or the "space of social reproduction".

The production process we already know about in detail because it is what we tend to look at. Let us look now at the other process, the social reproduction. What happens once goods and services have been produced on the market? These commodities enter into the households, where they are combined with unpaid work. There are three functions of unpaid work (the three of them can be contained by a single activity, such as cooking):

- Broadening well-being: The goods and services purchased on the market that a household accesses generate certain basic standards of living. But the greater majority of these require an intense process of transformation, adaptation and/or maintenance in order to satisfy necessities, e.g., cooking the food products, washing the clothing, etc. Moreover, in households, many additional goods and services are produced, e.g., weaving clothes, growing vegetables, grain milling, raising small animals, caring for health or attending to children, among others. The goods and services that come from the market, once transformed and adapted, together with the goods and services produced in non-market spaces define certain broadened standards of living. This is the

FIGURE 2
Expanded circular flow of income



Source: based on Picchio (2001)

first function of unpaid work that we can identify: the broadening of well-being through the transformation and maintenance of those resources that come from the market and through the generation of additional resources.

- Expansion of well-being: This function includes two processes. First, it guarantees that the economic system serves its final aim of sustaining life. The goods and services that come from the market and the goods and services that are provided "out from it" (through unpaid work) are combined in a jigsaw puzzle manner. They fit together so as to reproduce life. The vegetables (some of them obtained in the supermarket and others grown at home) are cooked thanks to the previously fetched wood. The cooking appliances are clean and the child has been picked up from the school. Thanks to all that, the child can eat her or his meal. Second, unpaid work has a distinctive feature. The market produces for an abstract consumer, but households take on the role of assuring that well-being is generated specifically for those precise and unique persons. If someone has high blood pressure, we cook without salt. If someone else detests lentils, we try to avoid them. For some persons it is very important to share dinner with their partners; in that case they try to get together at dinner time. Well-being is expanded thanks to the generation of an enormous bulk of personal services. They cover the affective and relational aspect of persons' needs, taking into account that each person is different.
- Reduction of the workforce: In the space of the social reproduction the needs of all persons are responded to. Yet only some of these persons participate in the space of production. The last function of unpaid work is mediating the interaction with the labour market. This means selecting the persons who will participate in the market and making sure that they appear there with their care needs resolved and without responsibilities for the care of anyone. For example, cooking allows workers to enter into the labour market properly fed and with sufficient energies to accomplish their tasks. This is the function called "reduction". It is a matter of reducing the entirety of the population to those who participate in the market and reducing these persons to only their facet as a work force, completely flexible and available, such as the self-sufficient worker who is demanded by the labour market.

Broadening and expanding well-being, and reducing the workforce: These are socio-economic processes that must not be left out of any serious effort to comprehend how the economy functions, and which are revealed when we ask ourselves about care. If we keep them in mind, we will have a much more complete idea of how the economy works, that is, of how the needs of all people are satisfied - through the functions of broadening and expanding that use what is produced in the markets - and how the labour force is supplied - through the function of reduction.

Let us think in a visual way about the broadening of the notion of the economy. This figure below appears on the cover of the Human Development Report for 1995 (Figure 3) and refers to the total amount of work done in the world. In red we see the work done by women and in green the work done by men. From the horizontal line upwards we see that work that is done within the market and from the horizontal line down we see the work done outside the market. If

FIGURE 3
Cover of HDR 1995

we were only to see the portion that is in the market (Figure 4), we would have to conclude that the greatest part of the economy is in male hands and that most women are economic dependents. But if we pay attention to the total workload (Figure 5), that is, to all the work that is done, whether within the market and remunerated or outside the market and unpaid, the situation changes.

Although in each place and each historical moment the proportion between paid and unpaid work varies, we can still observe the enormous quantity of unpaid work that is required to keep society functioning, as we saw in Session3. However this work is not equally distributed. The majority of paid work is done by men and the majority of unpaid work is done by women.

FIGURE 4

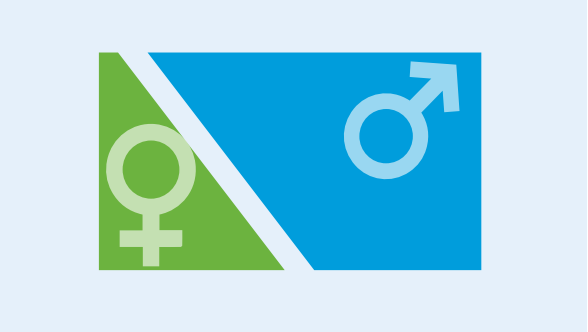
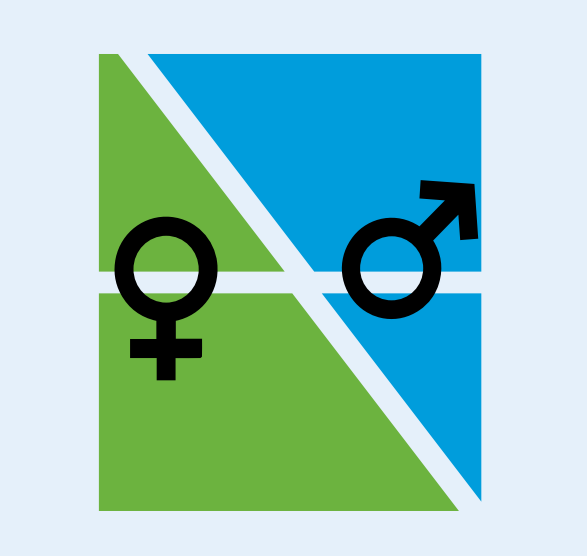


FIGURE 5



In broad strokes, this is what we refer to as the gender division of labour in capitalist economies, as explained in previous sessions.

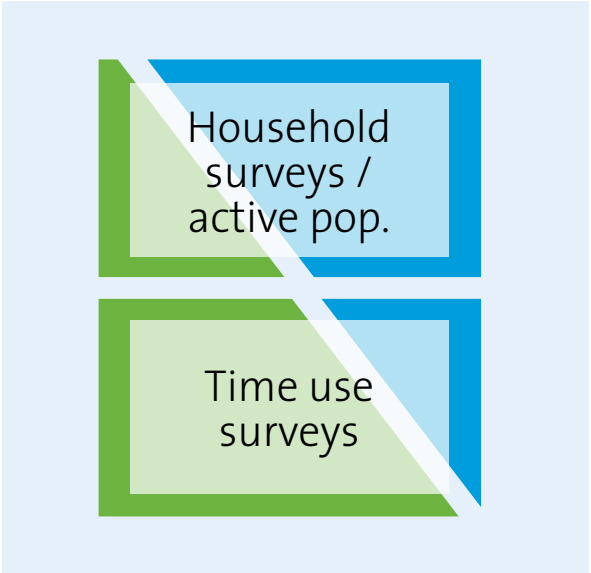
As explained in Session 3, the main instruments for measuring work in the market are household surveys or labour force surveys. And the main tools for calculating the monetary value of market production are SNA, with GDP as the cornerstone. To measure the work done outside the market we have another key instrument: time use surveys. And to calculate the value of unpaid work in households, the Household Satellite Accounts have been developed. See Figures 5 and 6.

Once we have visualized the gender division of labour, we must ask ourselves two questions:

- How should paid and unpaid work be redistributed in a just way between men and women (how to change that diagonal line to a vertical one)? (Figure 7) This question is directly related to the question of how to make men co-responsible for care work and also to what extent we want care work to occur outside of households. That is, if we want the co-responsibility of the State to entail supporting care within households or externalizing care.

FIGURE 6

Medir el tiempo de trabajo



• How can we render visible the spheres in which life is cared for? (Figure 8) As we will see further along, hiding the non-market spheres means that care for life is not considered a collective responsibility, and that this is related to the conflict regarding distribution that exists between commodity production and the reproduction of life. Thus rendering those spheres would require dealing with such a conflict, building co-responsibility in care and making care the top socio-economic priority.

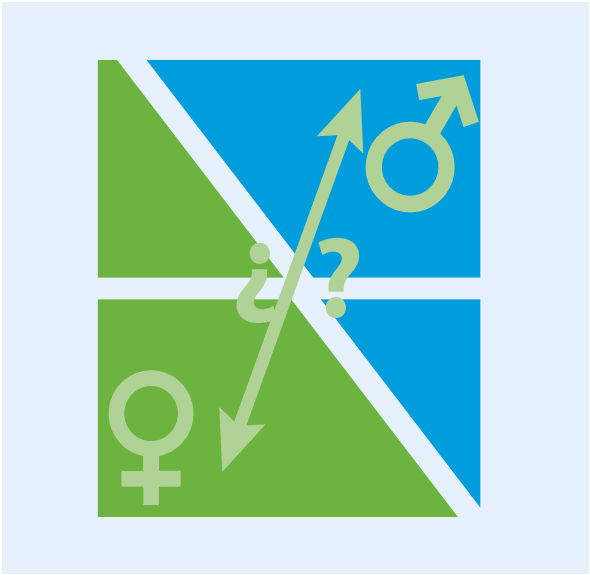
FIGURE 7

FIGURE 8

2. The macro, meso and micro economy seen from the perspective of care

We can now affirm that taking into account the economics of care means two things. First, that we look into the economics of care in itself, asking who are the agents, what are the spheres and in exchange for what are care needs being covered. These questions situate us in the social organization of care addressed in Session 2. Second, that we look into economics as a whole from the perspective of care. That is, that we place the processes of sustaining daily life in the centre rather than placing the processes of commodity exchange in the centre. From a market-focused perspective, the most we can hope for is to include care as a necessary input for the reproduction of the labour force. From the perspective of the

FIGURE 9



sustainability of life, we can go further, we can ask how the economy responds (or doesn't respond) to people's life goals, their needs and desires and their need for care. We will now focus on this question.

Looking at economics from the perspective of care implies causing ruptures in the various levels of economic analysis. The economy is organized in three levels and we must change our way of looking at each of them:

Macroeconomic level: macro aggregates

The monetized economy (production, markets) and the non-monetized economy (reproduction)
How is this measured: National Accounts System + Household Satellite Accounts
Gender division of paid and unpaid work

Mesoeconomic level: norms and institutions

Economic institutions:
- Companies (markets)
- State (at various levels: nation-state, sub-national and super-national)
- Households
- Other

Laws, norms, rules and systems with gender biases

Microeconomic level: Agents

- Men and women, boys and girls in households and companies
- Intra-household processes of distribution of work and resources

Source: Table based on Salvador and Pedetti (colab.) (2012)

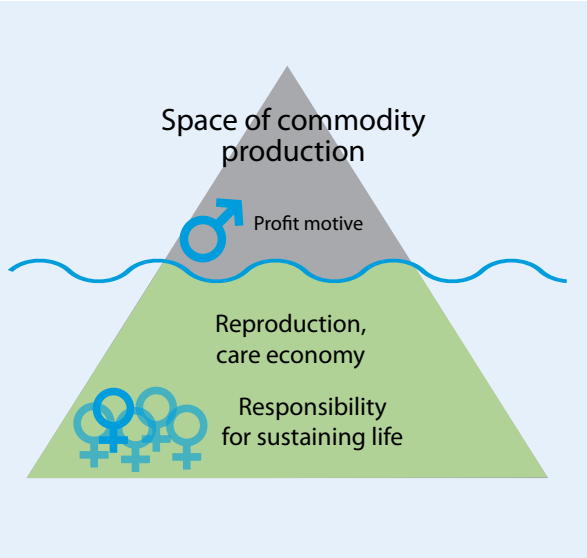
2.1. Macroeconomics: the economic system as an iceberg

Looking at economics from the perspective of care means trying to comprehend how the two spaces interact, the sphere of markets and the sphere of carework, also referred to as the space of human development or social reproduction. In other terms, we try to understand how production and social reproduction interact, assuming that:

- these are interrelated spheres;
- the functioning of the former affects the latter; and
- the ability to sustain a life worth-living (the capacity to provide the resources required to achieve human development) must be the ultimate criteria to value whether the economy is performing adequately or not.

We might use the metaphor of an iceberg to describe the economic system as a whole (Figure 9). An iceberg is characterized by two principal features. It has two clearly differentiated parts; one of these is visible and the other is not. The two parts that make up the iceberg are precisely the sphere of the markets and the sphere of social reproduction.

FIGURE 10
The iceberg metaphor



What is the difference between the two parts? Above all, the objectives they pursue:

- The main aim of market production is the "valorization" of capital. A certain capital is invested in order to produce goods and services and benefits are made by selling them. Diverse inputs are needed in this production process: natural resources; capital; labour. In this sense, reproducing the workforce is a cost for the production process. Human needs can be satisfied through this process. But this is not the objective in itself. Therefore, living conditions are a derivative effect. Indeed, they are an adjustment variable too, as long as benefit rates can be increased thanks to the reduction of wages and/or the raising of prices on goods and services. All the goods and services that are not affordable are obtained thanks to unpaid work. Thus, unpaid work functions as a saving mechanism for companies and for the whole of the monetized economy.
- For social reproduction, the conditions of life are the sole objective. Markets serve as one way to access resources and reproduce persons, both those who enter into the market as workforce and all the others. Living conditions are not a cost, but the ultimate goal. Yet producing and selling market goods and services is not a goal either, but a means to be used together with other non-market resources. Unpaid work is a cost because it requires time and energy, and because it reduces the ability to perform paid work.

Production and reproduction are the two parts of the economic system, understanding that it is defined as the whole set of processes that sustain life. Nevertheless, there is a conflict between them regarding distribution. Are energy, resources and time all for producing and generating profit (social reproduction being a means) or are they for reproducing and caring for people (production being a means)?

So we ask ourselves how this conflict between market production and the care of life is to be resolved: which of these processes is to be given priority? This brings us to the second part of the iceberg metaphor: in market economies, where development is equated to market expansion, life is cared for in order to assure that the monetized economy can work. In other words, social

reproduction is made to serve production. Social reproduction does not enjoy social priority, nor is there any collective responsibility to guarantee this process. The conflict of distribution is resolved in favour of the market sphere, where the process that dominates the whole of the economy is profit-seeking or the obtaining of private gain. Care is taken for granted and "instrumentalized". In this sense, care is an indispensable requisite. Without it there is no life, no workforce; there are no consumers and no investors. But it is also not considered a priority or a collective responsibility.

All these processes are related to the gender division of labour and to gender roles: the markets require self-sufficient workers. Men are expected to assume this breadwinner role. It is in the non-market spheres where the care needs of these workers are covered and all the responsibilities that these workers do not assume are taken up. This is done through networks that sustain the economy of care in the invisible economic spheres. The presence of women in these networks is overwhelming.

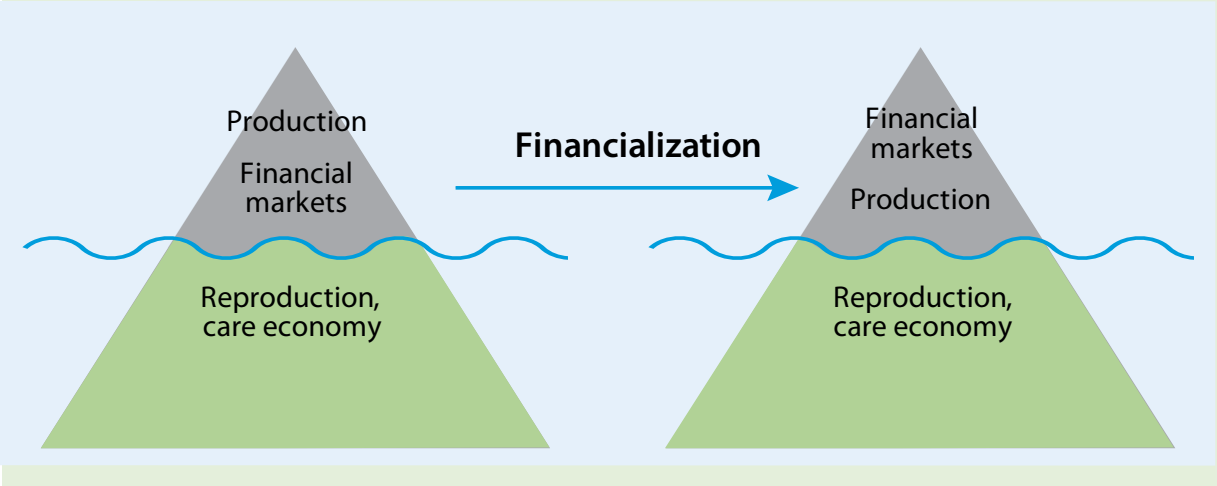
That the economy of care is invisible means that the place in which the conditions of life are sustained day in and day out remains hidden. This is the space where the economic system is ultimately adjusted; that sphere where all the (market and not-market) goods and services that are produced and distributed are finally translated into embodied material and emotional well-being for specific persons. This is why we use the metaphor of the iceberg to explain how the economy works. At the end of the day, the invisibility of the sphere of care has to do with the disempowerment of the subjects responsible for care, who are not allowed to define how they want the whole to function. It also has to do with the secondary citizenship of carers and with the link between care and exclusion, vulnerability and poverty that was introduced in Session 1.

Voice is denied to those who assume the responsibility for care and they therefore have to absorb the structural tension between production and reproduction. Thanks to this, the conflict seems to disappear because it is not seen and because the capacity to bring it to light is lacking. Market economies are based on unjust care systems, which were explained in Session 1. In this sense, it can be said that these productive models are socially unsustainable. Care is the invisible base that is taken for granted and that is publicly discussed solely when it is absent, when it fails. The concern is that there is not enough discussion about structural tensions that have to do with a system that gives priority to markets while undervaluing care.

Going into a bit more detail, we can affirm that this metaphor of the iceberg works to explain both

FIGURE 11

Social reproduction remains hidden



Keynesian and neoliberal, or "financialized" models of development (Figure 10).

Those models can be differentiated according to the pre-eminence they grant to the financial system. While in the former the purpose of this is to endow production with financial resources (as accumulation and "valorization" of capital principally arise from production), in the latter finance becomes independent and dominates or determines the functioning of the productive sphere (as accumulation principally arises from financial markets). Even with this key difference, however, they share an important element: in both development models the responsibility for sustaining life is relegated to households and is associated with women's gender roles. Also, the places in which it occurs are "invisibilized". That is, they are not named, not regulated, not measured and not negotiated in an open and political manner.

2.2. Mesoeconomics: economic gendered institutions

The second level that we must look at is mesoeconomics, and looking at economic institutions from the perspective of care permits us to see two key questions:

- Aspects of these institutions that were heretofore invisible: we can inquire to what extent both the markets and the State are configured according to how care is socially organized;
- There are economic institutions that tend not to be perceived. The most relevant of these are households, but there are others that fall outside the triad of companies-state-households: forms of subsistence economy; the third sector; community networks, etc.

This is a matter of discovering the real, existing diversity of the economy and of understanding how it holds together and what life conditions it makes possible.

2.2.1. The labour market and the and gender division of labour

The functioning of the labour market is profoundly conditioned by the organization of care: it is based upon the figure of the self-sufficient worker and reproduces the gender division of labour that exists in non-commodified spheres. The labour market is built upon the figure of a standard worker who does not have responsibilities or needs in terms of care, but rather is fully prepared, flexible and available to do whatever the production process requires. The principle ways of breaking with this standard figure are:

- Making companies responsible for social security payments, which then pay for services within a welfare state that takes responsibility for the reproduction of the labour force. Some of these services are directly related to care, specifically the right to work-family balance (maternity/paternity leave, breastfeeding hours, leave for at-risk pregnancy). That is, many of the measures that allow time for care are paid for thanks to social security systems.
- Regulating work time and of workplaces in a way that responds to workers' care needs and responsibilities.

There are many forms of workplace discrimination on the basis of sex too. And although this is not the place to go into them in depth, we should mention their relationship to care.

Work-place discrimination	Content of the discrimination	Examples of how this is linked to care
In access to work:	Women participate less in the labour market (they have lower rates of market activity).	The care responsibilities that women bear, or the cultural construction that associates women with the domestic sphere, may prevent women from seeking employment.
	Women have a greater presence in the informal economy (and particularly in the most vulnerable sectors of the informal economy).	Being the only ones or the principal ones responsible for care may mean that women seek jobs that are compatible with these responsibilities, even though these jobs may have worse labour conditions.
	Women have greater difficulty finding work with greater rates of unemployment and under-employment.	Often companies are reluctant to hire women because they think that women will not be as fully available as required, although this is usually not true.
In keeping jobs:	Women have greater rates of part-time employment and of informal employment.	They may seek part-time work or informal jobs because they tend to be more compatible with care; or this kind of precarious employment may be directed to women with this excuse. Therefore the kind of employment and labour conditions that women find tend to be worse.
	Horizontal segregation.	Women find more employment in sectors related to care, with poorer labour conditions.
	Difficulties for career promotion. Vertical segregation	The responsibilities for care may inhibit their professional promotion. The requirements in terms of time availability and space mobility tend to be incompatible with care. Withdrawing from the labour market because of family responsibilities hinders re-insertion into working life.
	The aforementioned factors provoke two simultaneous processes commonly called the "glass ceiling", where invisible barriers prevent women from reaching top labour positions, and the "sticky floor", where women are trapped in blue collar jobs.	
	Pay gap	Pure wage discrimination is identified whenever the principle of equal pay for equal work is violated (undervaluation of care related jobs, such as domestic employment). This, together with wage differences due to horizontal and vertical segregation, and the scant time devoted to employment (because of inactivity, unemployment or under-employment), adds up to an important gender pay gap.

Work-place discrimination	Content of the discrimination	Examples of how this is linked to care
In job loss:	Dismissals based on sex	Pregnancy is often a cause for dismissal and frequently there is no legal protection, or this protection is not upheld.
	Worse access to unemployment or retirement payments	Unpaid care work does not contribute to Social Security. The employment histories of women are often more conditioned by their life-cycles and are often less stable. Payments reflect this inequality. The discrimination suffered while one is in the labour market is then extended to social security payments.

World data on gender inequality in the labour market

There are useful databanks that we can consult to know more on gender and the labour market:

There are countries in which women are not allowed to work in the same industries as men, or in which women are restricted from certain shifts. You can look into whether this is the case in countries that concern you (check working hours and industry restrictions): http://wbl.worldbank.org/data/exploretopics/getting-a-job#working-hours-and-industry-restrictions

Here you can learn about the situation in each country with respect to the laws that protect against discrimination (check work place protections): http://wbl.worldbank.org/data/exploretopics/getting-a-job#workplace-protections

The following links contain information about the situation of women and men in the labour market in various countries and about how this has evolved over time:

- International Labour Organization: thorough information on labour market, disaggregated by sex (you can go to "browse by breakdown" and then go to "sex"):http://www.ilo.org/ilostat
- World Bank: In the section Recommended Core List of Gender Indicators you will find indicators in the economic structure of various countries): http://datatopics.worldbank.org/gender/monitoring-progress
- The World Bank also presents this information in graphs (go to Themes/"Economy"): http://www.app.collinsindicate.com/worldbankatlas-gender/en-us

The gender division of labour is reflected in the market. But in addition, being responsible for care work in the household means that one cannot behave like the self-sufficient worker thatis the market standard. This leads to discrimination in the world of employment. The ILO and UNDP indicate that in the labour market the following myths exist in relation to women's employment:

- The principle role of women is to take care of their family and their children;
- Women constitute a secondary work force and their wages are only a help to the family economy.

These myths socially legitimize the inequality and discrimination that lead to women not being considered the principle objectives in job-creation projects, the objectives being male heads-of-household. They also socially legitimize the inequality and discrimination that lead to part-time employment being directed to women, among other phenomena. These myths also explain the social tolerance of female unemployment, which is much higher than the tolerance of male unemployment, as well as tolerance of wage discrimination and dismissals due to pregnancy. While being responsible for fulfilling care needs may limit women's entry in the labour market, we shouldn't imagine that women are the ones who must resolve this problem, rather that:

- When men's participation is not limited it is because this responsibility is not assigned to them socially. Economic normalcy should be the shared responsibility for care, not its abandonment;
- The labour market does not consider this shared responsibility as normal because this would mean modifying the workday, providing leave for work-family balance and covering social security payments for those who provide care services, etc. That is, it would mean that companies would also share the responsibility;
- For society as a whole the fact that care work is done free of charge saves money or, better put, is a cost which only one part of the population has to confront, the part that assumes the responsibility for providing free care in households, poorly paid care in domestic employment or other precarious forms of care work.

Moreover, this question doesn't limit the labour market participation of all women in the same way. The key here is that there are some households that can afford to commodify this work by hiring a domestic employee, sending children to preschool, or purchasing ready-made food, and other households that cannot.

The non-existence of social responsibility for care is one of the key factors in the feminization of poverty. The obligation to participate in housework is one of the reasons why girls and young women leave school or why poor women frequently have few employment options besides domestic work, which provides no opportunities to better their situation. This is an example of the sticky floor; there is no possibility of professional promotion in this sector. Poor women are overloaded with care work because worse socio-economic conditions imply greater care needs, their work is not valued and they face impediments to full participation in the labour market. Thus we return to the vicious cycle of care-inequality described in Session 1.

2.2.2. Welfare States and the gender division of labour

Regarding the role of states in welfare systems, it is essential to introduce a gender analysis that pays close attention to issues of care. A welfare system is defined by the interaction between three principal spheres: the market, the State and households. Let us come back to some questions that we have already discussed in previous sessions.

The degree of welfare that a State provides tends to be measured by the degree of decommodification that it permits. That is, if we look at the extent to which the risk of losing a paid job (because of illness, a crisis, aging) is covered and an adequate standard of living guaranteed, are there services and public programs to protect us from this risk? But this question is still insufficient because it leaves out the economics of care. It should be complemented with a question about the degree of de-familization: how are risks related to unpaid care work covered? That is, are there

possibilities to cease to do this unpaid work without the well-being of those who require care suffering because of it? Is there public coverage that protects us from this loss?

Frequently, when the State does not assume responsibility for welfare, what happens is that the well-being of the upper social classes is heavily commodified and that of the lower classes is shifted to the family. For example, if there is no public and universal health care system, there are those who will be able to pay for private health care and those who will not (and will have to take care of health issues in the home). This places great pressure upon care work.

Despite the very diverse welfare systems that exist, in general they share one characteristic: the take for granted the gender division of labour. This can be observed in various features:

- Only paid work is considered a contribution to the system (and not unpaid care work);
- Coverage tends to exclude the care of dependent persons;
- Systems frequently regard the nuclear family as the subject of rights, direct rights for the employed head of household, that is, the provider, and derived rights for that person's dependents, that is, spouse and offspring);
- Systems rely on unpaid care work for the educational and healthcare systems to function;
- And, in general, they guarantee very low levels of defamilization, especially among the working classes who have less access to the market, that is, who must do through unpaid work what the State doesn't provide and what their income doesn't allow them to purchase.

2.2.3. Households as economic institutions

The final aspect we will look at on the meso- level is the importance of households as an economic institution. Households are the basic economic unit, not only as consumers but also as producers. It is in households that the tripartite responsibility of broadening and expanding well-being and reducing the working population tends to be carried out. Households assume the responsibility for "making it all fit together" because it is in households that the various resources and economic processes are ultimately transformed into the specific well-being of persons. Through unpaid work, households function as the final element of readjustment in the economic system. In Session 3 we discussed in detail the broad trends in the intra-household distribution or work. We now must understand them as critical features of the economic system, not just of care systems.

When we speak about households we are referring to the institution that articulates the economic life of persons, but we in no way mean for this to be reduced to the idea of family, much less of the nuclear family. That is, households are very diverse. They are strung together by threads of affinity and kinship and it is vital to understand their changing forms. Households are not formed according to criteria of efficiency but rather, in large part, according to social norms, particularly gender norms. It is also important to understand that households do not act in an isolated manner, one by one, but rather in networks. The economy is based on interdependence, as we also described care to be in Session 1.

2.3. Microeconomics: opening the black box of the household

Looking at micro-economy from the perspective of care means, first and foremost, opening the black box of the household. We have to ask ourselves a number of questions. What happens to the resources that enter? How are they distributed and controlled? Who has access to them in order to achieve well-being? Who does what and in exchange for what? How is work distributed? This means asking what the intra-household processes of negotiation are, because we know that economic life is not organized by each individual person in isolation but rather in households. That is to say, we should avoid falling into the assumptions, shown below, that often underlie public policy:

- Thinking that the agents acting in the economy are rational, self-interested, self-sufficient and separate from others. That is, that each person acts on his or her own, in isolation.
- The flipside of imagining that in the market we behave as rational individuals is imagining that in households decisions are made in a harmonious and unified manner.

The process of decision-making in households is seldom given proper attention and there are some approaches that attempt to explain this by applying the theory of comparative advantage, which assures that each person will do those activities in which he or she has an advantage relative to others, and the theory of investment in human capital, where each person will invest in their own training according to the profits he or she expects from that investment. These approaches also assume that that the household behaves as a unit in deciding who does what in order to maximize the total well-being of the whole family. Figure 11 summarizes their argument.

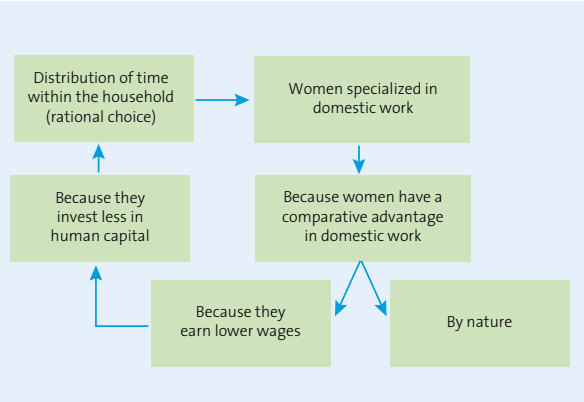
In deciding which member of the household will participate in the labour market, the wages of each member are considered, and this is a rational choice based on comparative advantage. As women's wages are lower, they usually are to specialize in domestic work, and men are to be employed. Why are women's wages lower? Because they have invested less in human capital, they are less prepared. And why are they less prepared? Because they are specialized in domestic work... and so goes the circular explanation, which doesn't actually explain anything.

In order to break this cycle, there are some who say that women are specialized in domestic work because they are more biologically prepared for it, as if their comparative advantage is not based on unequal investment but on nature. In this case, one comes to an explanation that not only justifies the gender division of labour, but which describes it as the most efficient way to organize the economy. Ultimately, this legitimizes and reinforces inequality.

To confront this vision, it is important then to understand how the negotiation of care shows that in households, decision-making processes occur in cooperative conflict. This is based on two ideas:

- On the one hand, a certain degree of cooperation does exist in households, and decisions are made more or less in common. This does not mean that the process is just or symmetrical, but that it is shared, whether by choice (the members decide to be together) or because there is no other alternative (the members have to be together, and have to make decisions that affect all);
- On the other hand, these decisions are not made harmoniously, nor do they benefit all members of the household equally. Rather, there is negotiation

FIGURE 12
Explanations that justify inequality



between people who may sometimes have common interests and sometimes have opposing interests. The question then is how decisions are made and what factors affect the bargaining power of each member of the household.

The organization of care is frequently rife with co-operation and conflict; both may be present at once. For example, in the decision to care for someone there may be both concern for the well-being of others alongside a feeling of obligation or imposition.

The responsibility for guaranteeing well-being and therefore closing the economic cycle is assumed by households. Within them, the actors are not self-interested, individual and isolated beings but rather subjects in relation who are, and this is key, marked by gender identity. The gender roles assign to women the ultimate responsibility for the well-being of households, even when this is at the expense of their own well-being.

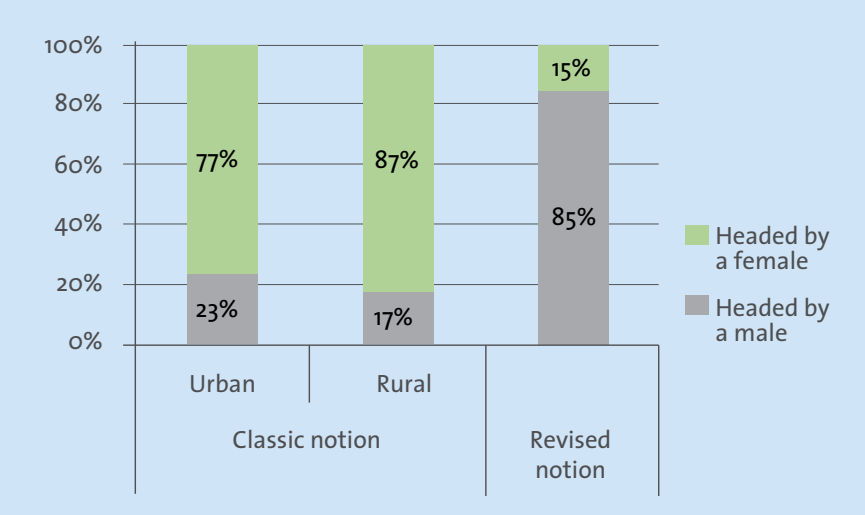
We see that the role of women in households often turns them into "sponge women", that is, they become the ones who ultimately absorb all the consequences of change. They are the ones who, if there

Heads of households?

From the data provided by time use surveys we can rethink the term head of household. The classic notion just asks respondents who is the head of the household. These answers are deeply marked by social conceptions on who leads the family, linked to the breadwinner role that men are supposed to fulfil - although women are also frequently income earners, whether in the formal or informal economy.

According to this gender-biased and market-biased notion, most households are headed by men.

Interestingly enough, if we consider the main figure in the household as he or she who assumes most of the daily tasks of maintaining the household through paid and unpaid work, the majority of households are headed by women.



Source: ECLAC and Armas et al. (2009)

is less money, will buy un-milled grain because it is cheaper and then grind it at home, the ones who - if they do not find a paying job - will do a thousand and one things to make a few pennies, the ones who move from one sphere of the economy to another. Like the Andean woman who goes from the vegetable garden to the house, then from the house to the neighbour's, and from there to the health clinic, and from there to the market to find the best deal, and then to prepare meat and hominy to sell on the corner, and from there to somewhere else, etc. Or the European woman who prepares her son's breakfast, takes him to school while leaving the baby with the grandmother, and then from the office, calls the gas company to resolve a service problem, then leaves the office and picks up the baby and takes the other daughter to the eye doctor while calling a friend who is ill to ask if she needs her to buy medicine, and then... etc. Women take responsibility, in the end, for the network that makes the world turn, as we said in the previous session.

For this reason, the economic life of women tends to be very mobile and flexible, moving between different economic spheres, because this mobility is necessary in order for the economy - understood as the sustainability of life - to actually function. They are sponge women, called by others "jugglers of life". The gender roles, in economic terms, attribute the responsibility for absorbing the distributive conflict between commodified production and the social reproduction of life to women. In the realm of care this is a constant question, as care requires coping with these tensions on a daily basis.

3. Interactions between economic policy and the care economy

Let us now look now at how all economic policies have a gender impact and an impact on care.[1] What do we mean by this? Although it might seem that economic policy doesn't have anything to do with inequality between women and men, on the contrary we can observe that no policy is neutral in terms of gender. All interventions have a gendered impact, which can be negative if it reinforces existing inequalities, or, if we do our work well, can be positive and reduce inequality. We may also see this in the opposite sense: economic policies act upon terrain that is already marked by gender, which imposes limits on what is economically possible. What do exist are policies that are gender-blind, because they don't make an effort to see gender, and for this reason bring with them gender biases, elements that tend to deepen inequalities.

Likewise we should say that there are no economic policies that are neutral in terms of care: all policies are going to have an effect upon how care is organized. Gender impacts and other impacts on care are deeply interwoven, given the close relationship between the social organization of care and gender roles. Here we will present some of the types of policies and the impact that they may have.

3.1. Gender biases and impacts on care

Three main gender biases of economic policy have been identified: recessive bias, privatizing bias and male provider bias (Elson, 2002; Çağatay and Ertürk, 2004). Let's discuss their meaning and their impact upon care.

A recessive bias is found whenever policies keep the activity of the markets below their full potential. They therefore also maintain the level of employment under the maximum possible. In general this occurs when the principal objective is to guarantee fiscal balance so that there is no public deficit, and to keep inflation levels low in order to attract foreign investment. This recessive bias ties the hands of institutions,

1 This section is largely based on Rodríguez (2005).

which then cannot attempt to reactivate the economy in times of crisis through public spending and investment. For example, a policy of this type would be the Stability and Growth Pact signed by the countries of the European Union.

How does this impact men and women differently? Generally, and this may vary depending on the characteristics of specific economic crises, women are the first ones to be expelled from the labour market or pushed into the informal economy. If there is little employment to be had, women's access to employment diminishes or the quality of the employment they find diminishes. At the same time, as the State does not have the capacity to intervene, the negative consequences of the crisis upon the standards of living are prolonged, increasing the risk of feminization of poverty. Moreover, greater pressure is placed upon homes to absorb the effects of this, substituting with unpaid work those services that cannot be purchased on the market or that public services cease providing.

And how does this affect care? In general, it becomes more difficult to balance paid work and care in the household, because when formal employment is lost, the rights associated with work-family balance are lost; and also because the informal economy, which is much more precarious, expands to compensate the lack of formal employment. Lastly, when there are no other alternatives, the domestic employment sector swells because it is an emergency employment niche that women turn to when no other paid work is available.

Often not only is balancing the budget given priority, but it is achieved by reducing public spending and public income. This goes together with a policy of privatizing services like health, education or pension systems. This is what is called a privatizing, or commodification, bias.

What gender impact do these privatizing policies have? The narrowing of the State affects women in three ways:

1. As public employees: in the public sector there tends to be a concentration of women, because it is an employment niche less subject to discrimination than the private sector;
2. As beneficiaries of services: women use public services more than men, largely as a function of their responsibilities as the guarantors of family well-being;
3. As the ones charged with substituting, through unpaid work, the State when the State ceases to provide services. For example, it would not be possible to cut spending in health care if there were not family members, mostly women, willing to substitute for the reduction in days of hospitalization, or to take food to the hospitalized.

This last point is linked to the key fact that the degree of de-commodification is reduced; one depends more on wages in order to access the resources necessary for living. The level of well-being depends more and more upon position in the market. For example, access to pensions and the amount depends upon how much was paid into social security, or when protections like minimum pension rates are eliminated. This has two consequences:

- Households that cannot afford to buy on the market those services formerly provided by the State will substitute them with unpaid work, usually by women;
- Women have a more vulnerable position in the market and therefore suffer the consequences more acutely and this depends on social class. The risk of poverty then increases, in general, and poverty is feminized.

And how do they affect the organization of care? Cuts in public care services due to cuts in public spending mean that the care services formerly provided by the State become the responsibility of households. This has an unequal effect upon households:

- For households in a better socio-economic position: the purchase of private services increases. This in turn has two effects:
  - An increase in the possibilities of finding work as a domestic employee;
  - An increase in the precariousness of the care sector because the working conditions in the private sector tend to be worse than in the public.

- For households in a worse socio-economic position: an increase in the quantity of care that must be resolved through unpaid work in the household or other informal networks.

Often recessive and privatizing policies drag along an additional bias: they take for granted that people live in traditional nuclear families (mother, father, daughters and sons), that in these families it is the man who participates in the labour market and that the rest depend upon his wages to live. In other words, it is assumed that women have time to dedicate to unpaid work. We have already spoken about the gendered impact of these policies, but let us go over it again. When this model of family is taken for granted, male employment tends to be given priority over female employment, for example, leading to job-creation policies oriented only toward men, or to the encouragement of different and more precarious forms of employment for women, like part-time work. This bias is also present when social services take this kind of family for granted: direct rights are established for male providers and derivative rights for his dependents. Women then access second-class social rights and households that do not follow this model suffer penalties.

And what is the impact upon care?

- Above all, care is not understood to be a public responsibility but rather a domestic one. The gender division of labour is reinforced;
- It is taken for granted that there is an infinitely elastic cushion of unpaid work that can compensate for anything that wages won't cover. Care in the household becomes the adjustable variable for the whole system; and
- Women in households are overloaded with work. They are often not only charged with unpaid care work, they also participate in the labour market. Phenomena such as the double and triple shift then appear.

3.2. Impacts of specific economic policies

In addition to looking at the general biases that it is usual to find in policies, we can see the possible impacts upon care of the different levels of economic policy. We will now take a quick look at fiscal, monetary, labour, trade and social protection policies.

3.2.1. Fiscal and monetary policy

Fiscal policy regulates public spending, such as how much is spent and on what, and the State revenue, principally the taxation system. It also regulates the balance between the two: whether there is a deficit (spending is greater than income) or surplus (spending is less) or a balance between them. Fiscal policy may affect the care economy indirectly because, ultimately, it determines the level of activity in the markets and whether private initiative or State presence is fomented in the economy. That is, through fiscal policy the deflationary bias, which slows job creation, the commodification bias, which privatizes services, or the breadwinner bias, which foments the nuclear family model, may be put into place. But policies may also have an effect in a more direct manner:

- Through public spending:
  - Spending dedicated to the public provision of care services: the most obvious form of impact. This affects the degree of de-familization of care. The greater this expenditure is, the greater will be the whole population's access to care services. This means the pressure upon households and informal networks will be lessened and the inequalities between different social sectors will be reduced, as public services are a way of compensating for existing inequalities.
  - The policies of public employment in the care sector: if the labour conditions of the personnel in public care services are degraded, the quality of these services is also degraded (and the better the labour conditions, the better the quality).

- Public care services frequently use unpaid work or poorly paid work. For example, hospitals wouldn't function if family members of the hospitalized persons weren't available to do a multitude of tasks. Many care services use the semi-voluntary work of women. For example, the communal mothers who take care of minors in working-class sectors. The State saves enormous quantities thanks to this work.

- Through fiscal revenue:

  - Fiscal measures may be established that foment the private purchase of care services. For example, vouchers for the hiring of domestic employees for large families, tax deductions for companies that offer daycare;

  - How private care services are categorized (whether they are considered primary necessities or not) determines the fiscal treatment they receive and the fiscal obligation that is applied to them. That is, whether greater or lesser taxation is applied to their consumption. This influences their price and their affordability; and

  - Quite often, tax systems favour the traditional family unit male breadwinner/ female carer. The do so mostly through the mechanisms to calculate personal income taxes (whether separate or joint income taxation exists, through the systems of tax deductions and exemptions, etc.).

Monetary policy regulates the money market, intervening in the quantity of money circulating in the economy and in the price of money (that is, the types of interest that apply, how much a person pays to borrow money). It also regulates the care economy, especially through its effects upon fiscal policy. When the priority is to control inflation, a deflationary fiscal policy is required, which often leads to privatization.

3.2.2. Labour policy

Labour policy regulates the labour market, establishing the norms by which it is governed. It may also attempt to control the amount of employment available, encouraging job-creation. It has deep impacts upon the care economy too. To understand these, we should take into account the following three matters:

- The gender division of work in households is reproduced in the labour market and is intimately connected to diverse forms of labour discrimination;

- Households combine paid and unpaid work to access the resources they require to live;

- In addition to the importance of having or not having employment, the conditions of that employment matter, such as the level of income and whether or not the employment generates social rights.

Any changes in access to employment bring along changes in unpaid work, which adapts to the ultimate purpose of the economic process. That is, accessing the resources necessary to live. And changes in unpaid work (for example, the birth of a third child) also have repercussions on the possibility and the necessity of entering the world of employment: on one hand there may be greater need to be employed (there are more mouths to feed); on the other there is less time (more time is needed for care).

Additionally, labour policies regulate the conditions of work. The more precarious employment is (e.g., the poorer are its conditions), the greater the pressure on the household:

- There is less income, so purchasing on the market is increasingly substituted with unpaid work. Example: a reduction in wages may mean preschool is an unaffordable luxury;

- Access to social rights is reduced, and again everything that is not accessed is compensated with unpaid work. Example: street vendors don't pay social security so they cannot access the healthcare system. Who takes care of them when they are ill? Probably a female family member; and

- The more flexible employment is (in terms of the workday and the workplace) the more difficult it becomes to make arrangements for care. For example, in a sweatshop, shifts are doubled to meet a production deadline; some workers have to take their children to sleep at the factory because they don't have anyone with whom to leave them.

Labour policy also has to do with the general level of employment (whether or not it is kept below its full potential and, therefore, whether the deflationary bias appears). Often labour policies may be influenced by the male breadwinner bias as well. Lastly, labour policies determine to what extent companies are required to pay the costs of reproducing the work force, above all through contributions to social security.

3.2.3. Trade policy

One of the realms of economic policy in which the impact upon care has been most analysed is the realm of trade policy. It has been observed that trade liberalization and the policies to promote direct foreign investment have the following effects:

- Making employment more flexible and more precarious: above all when labour costs are reduced in order to attract investment. This means, on the one hand, that funding for public care services is reduced (less is paid into social security, making it difficult to cover the costs of these services). On the other, it means that companies are often freed of the obligations they had to provide care services to their employees (especially day-care centres in work places).
- These policies very often go hand-in-hand with the increase of female employment in export sectors (manufacturing, agro-exportation, etc.). Women's entry into the labour market has a powerful impact on how care is organized in households. The problem is that if there is no increase in the responsibilities of men and of public institutions, what occurs is that women are overloaded, as we saw when we addressed this in Session 3;
- Sometimes the service sector is liberalized (especially the sectors of health-care and education), generating the effects associated with the commodifying or privatizing bias.
- In general, trade and financial liberalization mean that countries or territories that are subject to external economic policy decisions lose their ability to decide their own fiscal policies. In the context of neoliberal globalization, this means there are intense pressures for them to impose deflationary and privatizing macroeconomic policies.

3.2.4. Social protection policy

Finally, the role played by the social protection systems must be highlighted. Let us briefly review this issue, which connects two topics that we already saw and/or that we shall later explain in deeper detail:

- The type of welfare regime: the degree to which well-being is decommodified and defamilized is determined by the role of the State on the social protection of life risks. Caring is part of that level of social protection;
- The Social Protection Floor initiative that will be introduced in Session 7 is a proposal to work toward the universalization of social protection. We shall see how care is included within this initiative.

Additionally, we can think about the implications that the diverse components of the social protection systems have on care.

Components	Implications for care
Social security systems	Frequently, employment is the sole way to contribute to social insurance systems. Mechanisms to contribute through unpaid carework can be established: • Developing specific contributive systems for those in charge of unpaid carework; • Maintaining the contribution to employment-based social insurance during periods when a person is absent from the labour market due to care responsibilities (maternity and paternity leaves, unpaid leaves to take care of relatives...). The family (thus reproducing the male breadwinner bias) or the individual citizen is then identified as a right-holder by a certain social security system. The regulation of domestic employment must be attended to. Sometimes, domestic employees are not entitled to social security benefits. In other occasions, they are entitled to poorer benefits than other workers. We shall discuss this in Session 5.
Social promotion policies (targeted to those who are not included within social protection systems)	Specific non-contributive or focalized benefits can be established in order to cover the persons in charge of unpaid carework.
Sectoral policies (mainly, health and education)	• The gaps in health care and education provision are usually compensated either through unpaid carework within households or by hiring domestic employees; • The assistance in situations of dependency can be considered an additional sectoral policy (what we named as the fourth pillar of the welfare state in Session 1).

4. Conclusion

In this session we have seen how to talk about the economics of care is to highlight that care is a dimension of life that requires resources and which, at the same time, requires work to satisfy necessities. Moreover, care is the base that sustains all other monetized economic processes: thanks to care there are subjects who act in the markets, who work and consume.

In order to better understand their economic role, we need to think from an economic perspective, which differs from the usual perspective. We need to look not only at the markets but at all the processes that generate resources for sustaining life (and here unpaid work appears, with its triple character of broadening and expanding well-being and reducing the population) and pay attention to the unequal gender relations that extend throughout the economy.

We have looked at the economy anew, at each of its levels, from this perspective: at the macro level, asking ourselves about whether the sustainability of life is considered a priority or not; at the meso level, looking at households as economic institutions and indicating the gendered dimensions of the markets and the State; and at the micro level, asking ourselves how decisions are made within each household.

On that basis, we have analysed the interactions between economic policies and the care economy, with the goal of understanding the many ways in which they are related and affirming the idea that care is not a social question outside the purview of economics. In order to have a care economy that functions well, we should intercede through macro (fiscal and monetary) economics, as well as labour and trade policies and social protections.

It is especially important to finish this session identifying the tensions in the socio-economic system. On the one hand, families are not a harmonious unit but an arena for cooperative conflict. On the other hand, it is clear that in the monetized spheres of the economy, the creation of well-being is not a direct objective; the direct objective is the individual obtaining of monetary profit. All the well-being that is not generated in the market must be generated within households through care work. Thus we say that households (and in them, women) are the "last-instance adjustment factor" in the system, the place in which the economy is resolved if we consider that this means sustaining life.

Care is always present in any development model and in any economic system. The question is, what priority it is granted? In the current models, which we might call mis-development, they are the foundation that remains hidden. The key to good development would be to advance toward systems that place care in the centre, which recognize care as the primordial element in life processes and therefore take it upon themselves to make care a public responsibility, and then redistribute it.

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List of Terms included in the glossary

- Care
- Care policies
- Cooperative conflict
- Co-responsibility
- Crisis of care
- Economy of care
- Decommodification
- Defamilization
- Familism
- Gender
- Gender division of labour
- Gender role of women (in care)
- Household Satellite Accounts
- Interdependence
- Production/reproduction
- Public/private-domestic domains
- Remunerated/unremunerated work (paid and unpaid work)
- Self-sufficiency (self-sufficient citizen/worker)
- Social organization of care
- TimeUse Surveys
- Total (global) workload

CHAPTER 5

A SPECIAL CASE OF PAID CARE WORK: DOMESTIC EMPLOYMENT

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CHAPTER 5
A SPECIAL CASE OF PAID CARE WORK: DOMESTIC EMPLOYMENT

UN WOMEN TRAINING CENTRE
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A SPECIAL CASE OF PAID CARE WORK: DOMESTIC EMPLOYMENT

TAKE AWAY POINTS

1. Domestic employment is the second pillar of care systems:

- Domestic employment is linked to "the world history of slavery, colonialism and other forms of servitude" (ILO 2009). Therefore, dignifying this sector is a critical task;
- Both the care crisis that is propelling its expansion and the coming into force of ILO Convention 189 on decent work for domestic workers urge us to focus on this sector; and
- There are diverse modalities of domestic employment: live-in, daily employment, full time by day or by hour, and mixed models.

2. The care workforce presents the following characteristics:

- Care is a highly feminized sector (83 per cent women) and it is one of the most important labour sectors for women;
- It intersects other inequality axes: persons belonging to the working classes; migrants (either internal or, increasingly, international) and ethnic groups that experience discrimination; and
- The presence of children and adolescents is significant in some countries. According to ILO estimates there were 15.5 million children between the ages of 5 and 17 working as domestic employees in 2008.

3. There are two features that distinguish domestic employment for other types of paid work, and they entail specific vulnerabilities:

- Domestic employment is a labour relationship that is established individually and takes place in the household. These distinguishing features complicate the protection (or even the recognition) of labour rights in the sector. These rights are often violated and situations of serious exploitation are not rare.
- It is a job associated with women and the unpaid care performed by them. Therefore:
  - The mechanisms aimed at controlling and subjecting women's bodies and lives that affect society as a whole are reproduced. This gives room for verbal or physical punishment, controlling the freedom of movement, controlling personal decisions, limiting the worker's personal relationships, etc. It also gives room for a serious prevalence of sexual abuse;
  - It inherits the characteristics of undervaluing and invisibility allotted to unpaid care work. This translates to low wages; the undervaluation of it as an unskilled job; and the lack of definition, elasticity and simultaneity of tasks.

- The frequent violation of rights in the sector is also linked to legal norms, cultural discrimination, the problematic behaviour of private recruitment agencies and diplomatic immunity in the case of domestic work in diplomat households.

4. Working rights and regulations

Regulations applying to the sector are usually poor, ranging from no regulation at all to poorer labour conditions relative to other occupations and/or to the systematic failure to observe the norms. The following labour rights, which constitute a decent job as conceptualized by the International Labour Organization (ILO), are usually violated, although to varying degrees:

- The right to fair, equitable and satisfactory working conditions, including:
  - The obligation to hire through a written contract. This makes any demand for labour rights more complicated and obstructs control by administrative authorities;
  - Right to a minimum remuneration (non-deductible minimum wage, bonus pay, overtime pay). This implies that domestic employees are overrepresented among indigent and poor women and creates a deep pay gap with respect to other labour sectors;
  - Reasonable working hours, rest and free time (maximum work-day, vacations, daily and weekly rest). Protection against dismissal on the basis of pregnancy is also a matter of serious concern.
  - Protection against unjustified dismissal (reasons for dismissal, advance notice, severance pay); and
  - The right to Social Security, including access and coverage regarding short-term contingencies (illness, labour accident, pregnancy), and old-age and disability coverage;
- Compliance with labour legislation and the right to legal aid: the possibility of labour inspection is limited by the right to the inviolability of the dwelling;
- The right of workers to organize collectively: In some countries domestic employees have been organizing themselves for decades in order to demand their rights. However various factors make it especially difficult for them to organize, and make it difficult for existing organizations to function.
- This situation is exacerbated in the case of migrant domestic employees, who are subjected to immigration laws and who live in greater isolation than native-born workers. In some countries they also suffer discrimination, which is often enshrined in the legislation of the country. Forced labour of migrant domestic employees can by prevented and ILO points out significant ways to do so.

5. Protecting domestic workers' rights: Convention 189

On June 16th, 2011 a great step forward was made on the path to protecting the rights of domestic employees on a global level with the adoption of the Convention on Decent Work for Domestic Workers. Called Convention 189, it establishes minimum standards that all countries should uphold, and which relate to the aforementioned rights. It is a binding convention that has been ratified by 14 countries to date.

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1. Domestic employment: definitions

When we speak of "domestic employment" we are referring to what is often called "domestic service", "housekeeping", or "private home service". There have been extensive debates over how best to refer to paid care work privately hired by individual households, but no consensus has been reached.

Why do we prefer to call it "domestic employment"? As we will see farther along, domestic employment inherits the characteristics of undervaluing and invisibility allotted to unpaid care work. By calling it "domestic employment" we:

- Attempt to highlight that it is a form of work mediated by a labour relationship in which wages are earned. That is, it is employment. Nevertheless, as "domestic work" is the most commonly used term, we will alternately refer to domestic employment or domestic work (domestic employees/domestic workers) whenever there is no risk of confusing paid and unpaid work;
- Attempt to free it of the servile connotations implied by the word "service" in the term "domestic service". Although many other occupations exist that are referred to as services, in the case of domestic employment the noun is irredeemably tainted with a servile connotation inasmuch as it is linked, in the words of the ILO, to "the world history of slavery, colonialism and other forms of servitude" (ILO 2009).

Although today there is still a symbolic domination between the employer and the employee that recalls this history of servitude, one important step toward dignifying this form of work and turning it into a job with full rights has been to refer to it in a way that eliminates connotations of domination and servility. Nevertheless, it should be stressed that the ILO names it as domestic work. Therefore, mentions of domestic work by labour rules or labour institutions are not referring to unpaid domestic work, but to these tasks when they are done for a salary.

In previous sessions we have discussed domestic employment as one of the two pillars of the social organization of care. Two events now compel us to devote a whole session to this labour sector:

- The care crisis is propelling the expansion of paid domestic work, which is increasingly linked to international migration. This leads to the constitution of global care chains, as we shall see in Session 6; and
- Countries are obliged to establish mechanisms to guarantee labour rights for domestic workers due to Convention 189, which came into force on 5th September 2013.

But first we should clarify and carefully limit what we are calling "domestic employment" and what other occupations we are not including in this category. As stated in Session 3, the distinctive characteristics of domestic employment are that it takes place in the household, it is a commodified exchange (paid labour) and it implies an individualized contractual relationship.

Domestic employment refers to a labour relationship that is established individually and directly between the owner of a household and a worker who offers paid services in that household. The worker performs care tasks such as house cleaning and maintenance, gives attention to members of the family, provides childcare, performs gardening and drives vehicles, among others. Domestic employment does not, therefore, include work done on the basis of friendship, kinship or neighbourly relations (as these are not paid and are generally classified as reproductive work), nor does it include work through companies that offer household services (as there is no direct and individual work relationship between the employer and the employee), nor household assistance offered by public entities or through volunteer work.

Although domestic employment is often thought to focus on the tasks that we define as preconditions for care (principally cleaning and cooking), the fact is that in practice the category often includes everything, mixing simultaneously these tasks of housekeeping with the direct care of children, the elderly or persons with disabilities. This may also include management tasks.

Within the category of domestic employment we can distinguish various modalities:

- Live-in domestic employment (also called "in-house"), where the employee lives in the household that employs her/him, and in addition to wages s/he receives room and board. As we will see later in the section on regulations that apply to domestic employment, this modality is the one that most easily lends itself to abuse;
- Daily domestic employment(also called "live-out"), which in turn can be divided into two types:
  - Full time: the employee goes to the employer's household for the whole work day;
  - By day or by the hour: the employee goes to the employer's household one day or various days per week, usually just for a few hours at a time. In this modality many employees combine work in different households.
- Mixed models: in which the function of the domestic employee is solely to spend the night in the employer's household. This model is frequent in the case of care for the aged.

2. Characteristics of the workforce in domestic employment

The workforce in domestic employment shares a number of characteristics around the world, which we may find to a greater or lesser extent depending on each national context.[1]

2.1. A highly feminized sector

Domestic employment is a highly feminized sector. Within the socio-professional category of domestic employment we find an overwhelming majority of women in all countries, although the percentages may vary from 58.8 per cent in India to 95.5 per cent in Peru. Globally, 83 per cent of domestic workers are women. Men in this workforce are a minority, and in most cases are chauffeurs, watchmen or maintenance personnel who work in private homes. According to ILO estimates in 2013, 8.9 million men work in this labour sector.

Therefore, domestic employment is one of the most important sectors for women. Although its specific weight in generating employment for the whole of the female work force varies greatly between countries, what is clear is that it generally constitutes a very important source of employment for women. According to ILO estimates, nearly 7.5 per cent of all the paid women workers in the world are domestic employees (compared to 1 per cent of all paid male workers), which reflects the importance of domestic employment as a source of work for women around the world. For example, domestic employment is the occupation of 50.7 per cent of the working women in Lesotho, of 34.9 per cent of working women in Namibia, of 17.8 per cent of working women in Nicaragua, of 10.7 per cent of working women in Peru, of 19.1 per cent of working women in the Philippines and of 6.5 per cent of working women in India.[2] This fact is especially accentuated in Latin America and the Caribbean, where paid domestic work represents over a quarter (26.6 per cent) of female paid employment, and in the Middle East where nearly a third (31.8 per cent) of paid female workers are domestic employees.

In some countries, especially in some countries of Latin America like Argentina and Chile, it would seem that domestic employment is losing importance as an employment sector relative to other sectors in which women are employed. There are well-founded doubts about this, however, and it may be that the apparent reduction has to do with the increase in the modality of daily work by hours and the decrease of live-in work, as hourly work tends to be statistically underestimated. In other contexts, however, it has expanded. This is the case in India, where the number of domestic employees doubled between 1995 and 2005 (ILO 2011).

The expansion of domestic employment is intimately linked to the degree of inequality that reigns in a given society. Its expansion or contraction also has to do with fluctuations in the economy. In times of economic crisis, the demand for domestic employees declines (households, in order to adapt, tend to

1 If not otherwise stated, the source of the data is ILO (2013).

2 Source: LABORSTA database of the ILO, Women and men in the informal economy: http://laborsta.ilo.org/informal_economy_E.html.

substitute the purchase of goods and services in the market for goods and services produced within the household), while the supply of domestic employees increases (more women from poor households seek to enter the labour market, albeit in poorly paid jobs such as domestic employment). But economic crisis might also lead to deteriorating working conditions - lower hourly wages; decrease in total contracted hours to do the same tasks; increase of informal hiring - rather than to a decrease in the volume of employer households.

2.2. Intersecting inequality axes

The bulk of the workers in this sector tend to be women. Additionally:

- They tend to belong to the working classes, with little formal education, whose employment opportunities are therefore very limited. For many women this is the first employment they hold and they hope to progress towards a more favourable situation, such as forming a family or learning a trade. Therefore many domestic employees are young. However the very conditions of domestic employment, which we will look at in more detail later, make it an occupation from which it is often difficult to move on.
- They tend to come from a migrant background. The majority of domestic employment tends to be concentrated in major cities, and therefore in many countries the ranks are fed by young women and girls arriving from rural areas. These migrations may be autonomous (rural women who move to major cities in their own countries seeking work opportunities) or else they may be mediated by recruitment agencies (frequent in Asia). In other countries the cycle of migration from the countryside to the city may not be as relevant, and domestic employment therefore feeds upon lower class women from the peripheries and outlying areas. Lastly, in various countries of the world we encounter the growing phenomenon of domestic employees who are international migrants, whether from within the same region (as in the case of Latin America or Asia) or from other regions of the world (as in the United States and much of Europe). For example, of all the domestic employees in the world in 2010, 12.6 per cent in Argentina and 14.7 per cent in Costa Rica were migrants, as were 53.1 per cent of those in the special Social Security regime for domestic employment in Spain in 2008 (Molano et al., 2012). In 2005, around 6.3 million Asian women migrants worked legally in the more developed Asian countries. Coming principally from Indonesia, the Philippines and Sri Lanka, they represent between 60 per cent and 80 per cent of the migrants throughout the region, and the majority of them work as domestic employees (UNFPA, 2005). The Arab countries employ millions of migrant domestic workers too. In Saudi Arabia there are approximately 1.5 million migrant domestic workers, principally from Indonesia, the Philippines and Sri Lanka (Human Rights Watch, 2008).And in the case of migrant domestic employees working in the Arab countries, there are many abuses. Generally, they are excluded from systems of social protection, their mobility is limited and employers frequently take their passports. To learn more, see Harroff-Tavel and Nasri, 2013.
- They tend to come from ethnic groups that experience discrimination. Domestic employees not only belong to the most underprivileged economic sectors, but in countries with ethnic diversity, an ethnic-racial dimension is important in shaping the mass of domestic employees, as women belonging to discriminated ethnic groups or lower-status groups (indigenous groups, groups of African descent and minority ethnic groups) are overrepresented
- Children and adolescents are usually among these workers. Significant numbers of children and adolescents between 5 and 17 years of age form part of the workforce in the sector of domestic employment. According to ILO data, in 2008, 15.5 million children between the ages of 5 and 17 worked as domestic employees: there were 3.5 million in the 5-to-11 group, 3.9 million in the 12-to-14 group and 8.1 million in the 15- to-17 group. The regions

most affected by this problem are Asia, Africa and Latin America. In Asia we find this phenomenon in significant numbers in the Philippines, Nepal, Cambodia and Thailand. In most of these countries the workers are girls, although in Mongolia boys are the majority. In Africa, meanwhile, we also find child labour in Tanzania, Senegal, Kenya, South Africa and Togo. And in Latin America we find it in significant numbers in Central America, Paraguay, Haiti and Peru. Overall, there are 175,000 children under 18 years of age working as domestic labourers in Central America, more than 688,000 in Indonesia, 53,942 children under 15 in South Africa and 38,000 between the ages of 5 and 7 in Guatemala (Source: ILO-IPEC, 2013).

It must also be kept in mind that the data from ILO that we are using in this session do not include child domestic labour. ILO uses data from national surveys, which are focused on the working age population. Thus, children and adolescents under legal working age (usually 15 or 17) are excluded from national calculations and therefore from ILO data.

Child Domestic Labour: A Longstanding Tradition

Often the work of children in domestic labour has a strong historic tradition in the culture, such as the criadazgo in Paraguay, the restavek in Haiti or the petites bonnes in Morocco. Children are sent to live with relatives in the city in order to do care work in exchange for better housing and food with the understanding that the relatives will pay their schooling. The problem is that frequently these conditions are not fulfilled, leading in many cases to near slavery.

You can watch this piece about restavek in Haiti: Modern slavery: a video interview with a former Restavek (ILO). "The term 'restavek' in Haitian Creole means literally 'to stay with'. Today it is one of the worst names to be called in Haitian society. Originally conceived as a system to send children to live with wealthier relatives in the city so they could receive an education and enjoy a better life, the restavek system has deteriorated in recent years. It has become a form of domestic trafficking and modern-day slavery, particularly in the face of increased economic pressures following the January 2010 earthquake. Middlemen recruiters, known in Creole as koutchye, are sometimes paid to find a restavek for host families."

http://www.youtube.com/watch?v=gkHMxWWjztw

3. Distinctive features of domestic employment as a form of work

There are two features that distinguish domestic employment from other types of paid work, and that entail specific vulnerabilities: its location in-between the market and the family and its association with women and the unpaid carework performed by them.

3.1. A labour relationship within the private-domestic realm

One of the distinctive features of domestic employment is that it is right on the line between the market sphere (it is paid) and the private sphere. It takes place in a family home, that of the employer, where it is mediated by a highly personalized relationship that goes beyond the mere provision of services. Domestic employment is closer to the home (the sphere of non-commodified relations) than it is to the market. This particular characteristic of being a form of employment carried out within a home brings along various problems that have direct repercussions on the living and working conditions of domestic employees.

First, as it takes place in a private home and requires daily or periodic cohabitation between employer and employee, a personalized and individualized relationship is established. The relationship between employee and employer is therefore not limited to the mere provision of services, rather, personal bonds tend to be formed that greatly condition circumstances. These personal bonds often constitute a certain affective relationship, a familiar treatment, which makes the labour relation ambiguous. There is a conceit that the domestic employee is like family. While in some cases this is in fact true (domestic employees who are distant relatives, as often occurs with children who are sent to live with relatives in the city), this conceit shifts attention away from the existence of an employment relationship, replacing this with a form of affected familiarity that might justify, for example, requiring the domestic worker to work harder or for more hours without receiving any compensation. Or it permits controlling the employee's life "for her own sake".

Second, the fact that the work takes place within a home means that the labour context is reduced to the four walls of the employer's home. The work is therefore done in isolation from other domestic employees and from the rest of the working class. This isolation makes the work invisible to society and even to the workers themselves. It also makes unionization difficult and at the same time it means that domestic workers are more susceptible to sexual harassment and assault.

Third, the fact that domestic employment takes place within private homes means that many countries consider that labour laws do not apply to this sphere; they hold that a home cannot be compared to a workplace like a factory or an office, for example. This means that in many countries domestic employment is not regulated, or it is regulated by special norms in many other countries. This fact also makes labour inspections very difficult, as the inviolability of the private household is given greater priority than the labour rights of workers. We will look at this aspect in greater detail further along.

The intersection of all the aforementioned elements provokes the appearance of serious forms of exploitation in the domestic employment sector: physical and sexual violence, ranging from unwanted touch to rape; psychological abuse; non-payment of wages; and abusive labour and living conditions ranging from isolation and confinement to forced labour. Forced labour is more common in domestic work in general and international migrant domestic workers are peculiarly vulnerable. Forced labour in this sector is linked to diverse elements:

- Legal norms: such as the individualized sponsorship system (kafala) for overseas workers in many Arab Gulf Countries. Under this system, visas depend on individual employers, which creates a structural dependency relationship for the employee;
- Cultural discrimination: for example, in Latin America discrimination against indigenous groups exacerbates labour exploitation;
- The problematic behaviour of private recruitment agencies in search of profit, which is especially remarkable in Southeast Asia; and

- The diplomatic immunity that too often prevents domestic workers in diplomat households from denouncing abusive labour conditions.

3.2. A job associated with women and with the unpaid care performed by them

The fact that domestic work is overwhelmingly performed by women is an additional factor that must be mentioned. Domestic workers frequently are treated in a way that reproduces the mechanisms aimed at controlling and subjecting women's bodies and lives, and which affect society as a whole. It allows for verbal or physical punishment whenever the performance of care work is considered to be unsatisfactory, controlling the freedom of movement, controlling personal decisions and limiting the worker's personal relationships, etc.

Sexual abuse, which is one of the most serious forms of violence against women, is also very common. However, obtaining comparable data on this reality is extremely difficult. A study by Kalayan in the UK found that a minimum of 10 per cent of migrant domestic employees were sexually abused by their employers (Wittenburg, 2008).[3] Another study in Peru found that 28 per cent of respondent domestic workers were victims of harassment and sexual abuse, and 13.8 per cent had been raped (Viviano Llave, 2007). In a sample of 145 domestic workers from Sri Lanka working in the Arab countries, 17 per cent had suffered sexual harassment and 5 per cent had been raped (Source: UNDP/IOM et al. 2008). The great majority of victims are women and girls, although there are also men and boys who are subject to harassment. Male members of the employer household are usually the aggressors, and in the case of Peru, 62 per cent of the victims report the "señor de la casa" (lord of the house) as the aggressor while 31 per cent report the employer's son.

Sexual abuse even functions as a mechanism to control the worker. It might even be considered a service to be provided by the worker, as ultimately some employers consider that paying a salary implies buying the employee's body, "justifying" rape in their minds. And there are peculiar conditions of domestic employment that favour this situation:

- The isolation that tends to characterize the workers' living arrangements;
- The worker's dependency on the employer: this might consist of very constrained relations, for example, when the employer retains the worker's passport; or the aforementioned situation when the work permit depends on a specific employer. Or the usual dependency characteristic of live-in domestic work that implies that being fired means being simultaneously left without home and sustenance;
- The different socioeconomic status (greater in the case of children and adolescents) that creates a sense of impunity for employers;
- The worker lacking a room of her or his own; no door to close for privacy; and
- Weak State prosecution and punishment of violent acts.

Those questions are frequently a taboo, however, which prevents action. Therefore, data tend to reflect solely the tip of the iceberg (Amnesty International, 2007). Quitting uses to be the main strategy to stop the abuse, but then this leaves workers in a vulnerable position, especially in the case of migrant workers.

There is also another series of elements, inherited from the gender roles and stereotypes around care, that contribute to making domestic employment informal, precarious and very poorly paid:

- The undervaluing of domestic employment as work and low wages: the mentality that frames free-of-charge care work is transferred to paid care work. Since women perform care work free of charge, it is thought to have no value. So why would the same task, performed outside of the home or by someone else, have much value? The negation of the value of care work is transmitted to the labour market and is perpetuated through very low wages, which leave domestic employment

3 "Sexual abuse is consistently underreported by MDWs [migrant domestic workers], so the real percentage may be much higher" (Wittenburg, 2008: 13).

in the lowest levels of the wage structure. If, as we said in Session 4, the idea of the economy and of work is based on the movement of money and the functioning of markets (and the rest is considered non-economic), then domestic employment is situated in a confusing in-between space. It is economic because it is paid, but it is also not, because it takes place in private homes. The tools of mediation and collective bargaining of labour conditions, among other things, are designed for paid work in public spaces, and are therefore only applied with great difficulty in this sector. The low value attributed to this work is also manifest in the widespread practice of paying in kind. In the case of live-in domestic employees who reside in the same household in which they work, food and lodging is always considered a form of payment in kind. Lastly, domestic employment is undervalued and poorly paid not only because it is done by women but also because it is done by women pertaining to underprivileged groups (poor, discriminated ethnic groups, migrants).

- The idea that it is a job that does not require qualifications: as domestic employment is considered an extension of the natural role of women, it is taken for granted that women will have the innate capacity to carry out the tasks required. Therefore, these tasks are considered easy by those who do not do them, and it is inferred that neither a high level of education nor specific training is required for their performance.
- The difficulty of defining or limiting the tasks it includes: cooking, cleaning, washing, ironing, caring for children, caring for the aged or those with disabilities. Domestic employees, especially women, may perform one of these tasks, some of them or all of them. Frequently their tasks are not precisely defined from the outset, and they vary over time as the needs of the household change. The terms themselves are imprecise: caring for a child may mean anything from keeping an eye on the child for a short time while his or her parents are away to being the principal person responsible for the child's education. Tasks may become, in some cases, unlimited, and may therefore require that the employee be available an unlimited amount of time in order to perform them.
- The elasticity and simultaneity of tasks: although there are some determined sequences and schedules that have to do with the routines and preferences of the household in which the domestic employee works, the degree of freedom is greater because the products of this kind of work are many and their production may be combined. In domestic employment several different tasks are often performed simultaneously, or with interruptions such that the employee can advance some tasks while others wait. This way of organizing work is what gives this job its artisan character, even when it makes use of advanced technology (household appliances, cleaning products, semi-prepared foods, etc.). But this artisan character often means that time is not limited. Just as it is taken for granted that a mother is available 24 hours a day in order to attend to any necessity that might arise, it is easy for employers to expect the same total availability of the domestic employee.

4. Regulations that apply to domestic employment

We may group the problematic aspects of the sector in three major categories:

- The question of its regulation: special legislation that puts domestic employment in a position of unequal conditions relative to other occupations;
- Difficulties related to monitoring the fulfilment of those rights that are recognized in the sector; and
- Difficulties related to collective bargaining and demanding rights within the sector.

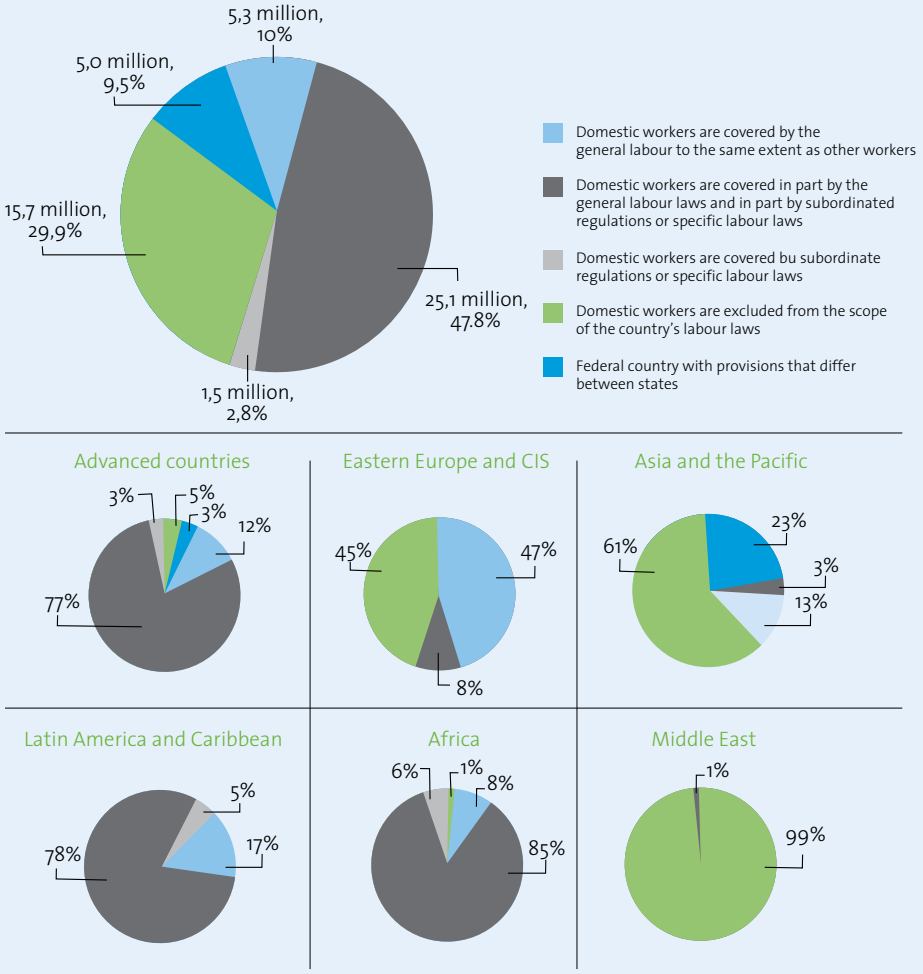
The distinctive characteristics of domestic employment that we have described (its position in the private sphere of households, the social conception that it doesn't constitute a real job, the affective relationship it establishes between employees and employers) all make it more difficult to regulate the labour rights that domestic employees should enjoy. While domestic employment as a form of work has

some distinctive characteristics, these have not been reflected in labour regulations specifically written to assure that workers' rights be protected in light of these particularities. Rather, as we will see, most of the time when regulations are established they generally leave domestic employees unprotected. At a global level we find five basic situations with regard to the regulation of this sector (see Figure 1).

- Countries in which domestic employment is governed by the same labour statutes or codes as other occupations, and therefore is entitled to the same rights. The problem in these cases is the low level of compliance with the legislation;
- Countries in which domestic employment is governed only partly by the same labour statutes or codes as other occupations;
- Countries that have specific chapters or sections of their general labour laws dedicated to domestic employment. In these cases the general labour law is applied to domestic employees and employers,

FIGURE 1

Coverage of domestic workers by national labour legislation across the world, 2010



Source: OIT (2013)

but not completely. Certain questions are made explicit in order to establish a lower level of protection than is enjoyed by other categories of work;

- Countries that treat domestic employment as a special labour situation that does not enter the general legal framework of labour relations, or countries that have made special laws or regulations to govern domestic employment; and
- Countries in which domestic employment is not regulated at all. That is, it is not governed by the labour statutes and codes that establish labour rights in other occupations, nor is it governed by any other regulations.

According to the ILO (2013:46-47):

"In Western Europe and Scandinavian countries, the working conditions of domestic workers tend to be regulated by special labour laws, with only a few countries, such as France and Italy, having collective agreements on domestic work. By contrast, the Eastern European labour law tradition has not favoured dedicated norms for domestic workers. In Latin America, domestic work regulation, where it exists, usually comes in the form of special laws or dedicated chapters on domestic work within labour codes, while African countries that regulate domestic work have used a variety of approaches based on their national legislative traditions. In Asia, where migrant domestic workers are particularly exposed to the lack of legal protection under the labour laws of host countries, sending coun¬tries have reacted by demanding better protection for their workers and have negotiated bilateral memoranda of understanding. Similarly, labour laws in Arab states largely exclude domestic workers, who, in this region, are to a very large extent women migrant workers from Asia and Africa."

Let us look for a moment at those cases in which domestic employment is governed by special codes or at those in which it forms part of specific chapters within the general labour code. These special labour codes (independent of general labour legislation or included in a special chapter within general legislation) establish inferior rights for domestic employees in aspects that vary greatly from one context to the next. Nonetheless, we can identify various areas in which, in general, the norms establish discriminatory conditions for domestic employees compared to employees in other sectors. We will conduct this review from the perspective of the rights that constitute a decent job, as conceptualized by the ILO, which include:

1. The right to fair, equitable and satisfactory working conditions;
2. The right to Social Security;
3. Compliance with labour legislation and the right to legal aid; and
4. The right of workers to organize collectively.

We shall compare these rights with the current conditions of domestic employment.

4.1. The right to fair, equitable and satisfactory working conditions

The following rights are included: the obligation to hire through a written contract; the right to a minimum wage; reasonable limits on working hours, rest and free time; and protection against unjustified dismissal.

4.1.1. The obligation to hire through a written contract

Often the regulations pertaining to domestic employment do not require a written contract or do not consider equally valid a written or oral contract (in this case, given the informal character of the sector, contracts tend to be oral). When no formal work contract exists, domestic employment forms part of the informal economy, which includes "all economic activities by workers and economic units that are - in law or in practice - not covered or insufficiently covered by formal arrangements" (ILO, 2002:5). In general, employer households do not see the need to formalize their relationship with domestic employees. They expect the exchange of services to transpire on the basis of respect, affection or sense of duty, and not on the basis of a contractual relationship. Thus, the private sphere habitually considers itself foreign to the logic of the commodification that characterizes the labour market, as well as to the supervision of the State.

Without a written contract:

- Access to the justice system is more difficult for workers;
- The authorities can't exercise more effective control;
- Any demand for labour rights (for example, the description and limitation of which tasks are included in the job and which are not, or the clear delimitation of working hours) is more complicated.

4.1.2. Right to a minimum remuneration

The most common situation in legislation on minimum wage tends to be (see Figure 2):

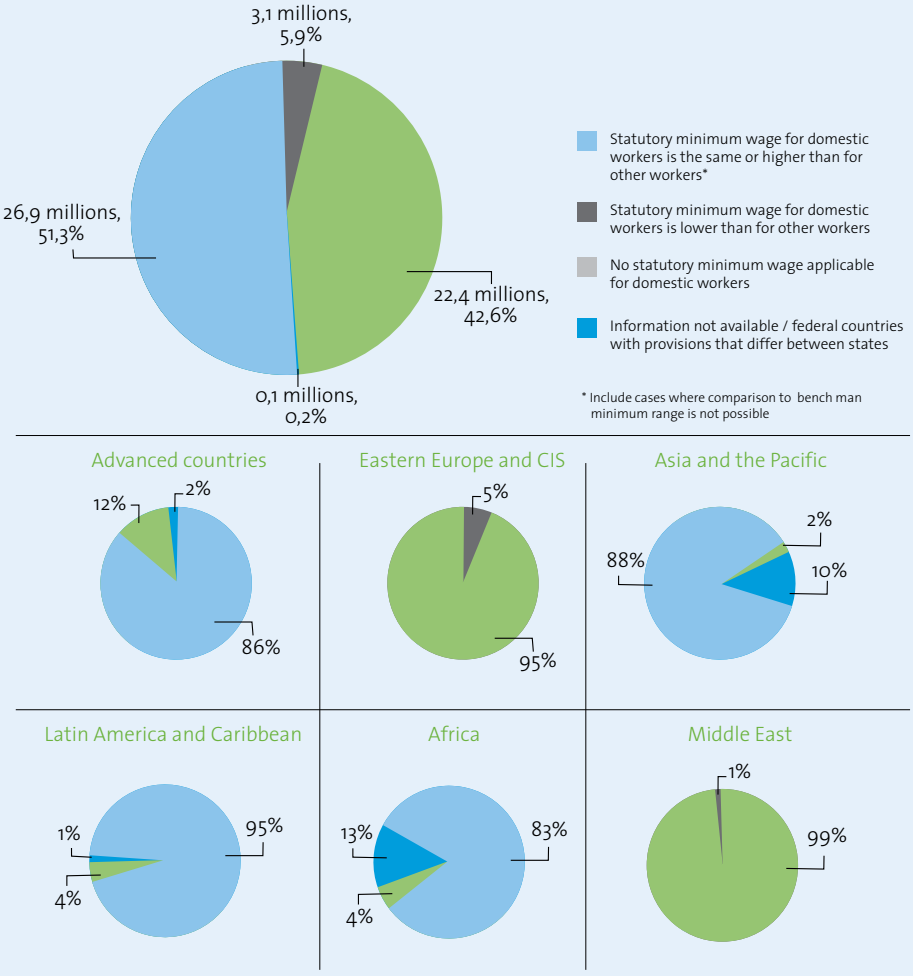
- Regulations that do not establish a minimum wage but which do leave wage negotiation to the parties involved;
- Regulations that establish a minimum wage for domestic employment below the minimum wage established for other sectors (often this is established as a percentage: for example, Brazilian legislation requires that domestic employees be paid 70 per cent of minimum wage); and
- Regulations that establish a minimum wage equal to that of other occupations.

Additionally:

- Non-deductibility of minimum wage: the paying of wages in kind in order to cover food and lodging is permitted, and this value is discounted from the minimum wage. The percentages that may be discounted are often very high. For example, until 2011, Spain allowed up to 40 per cent to be discounted.
- Bonus pay or tips: either this is not taken into account or, if it is, the sum is less than in other sectors.
- Overtime pay: either this right does not exist or, when it does exist, hours worked on holidays tend to count but not hours on workdays or at night. The percentage increase by which overtime pay is calculated varies greatly: very few countries pay double time or time-and-a-half.

FIGURE 2

Minimum wage coverage for domestic workers, 2010

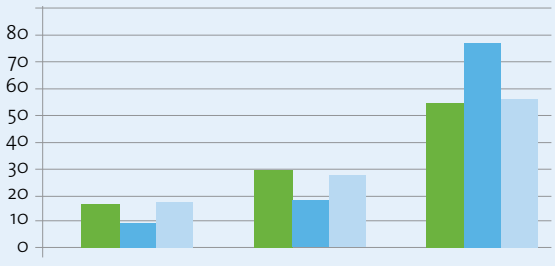


Source: ILO (2013)

Overall, the effects of the failure to fulfil the right to a minimum wage are that domestic employees are overrepresented among indigent and poor women (see Figure 3); and a deep pay gap with respect to other labour sectors exists (see Figure 4).

FIGURE 3

Overrepresentation of domestic employees in levels of poverty and indigence. Women, over age 15, Latin America, urban areas. By level of poverty and type of activity (2005)

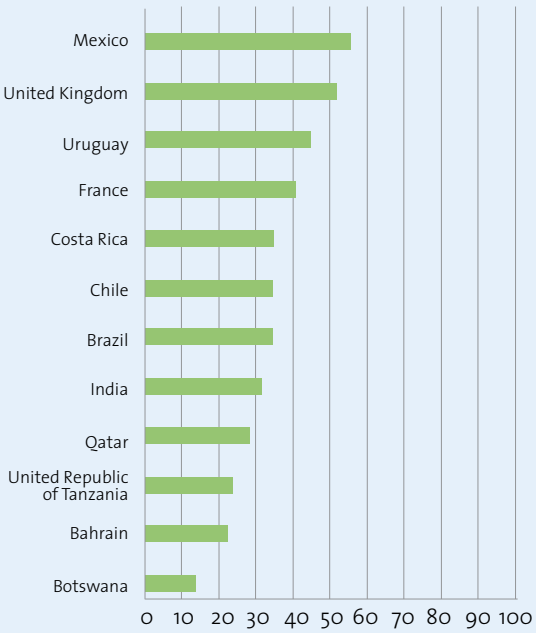


	Indigent	Poor	Not poor
Domestic employment	16	29	54
Other occupations	8	16	76
Housewives	17	27	56

Source: Montaño (coord.) (2007)

FIGURE 4

Domestic workers' wages (average wages=100)



Source: ILO (2011)

4.1.3. Reasonable limits to working hours; rest and free time

The key aspects concerning maximum workday: most general labour laws establish a maximum workday of eight hours. In contrast, workdays of 10 or 12 hours are enshrined in many laws, specifically on domestic employment, while in some legislation there is no established legal limit. Additionally, in much legislation, there are what are called "hours of availability", or the time during which the employee is in the employer's household without engaging in any work but is available to do tasks if requested. These hours of availability do not generally count as part of the agreed-upon workday. Rather, they are additional hours (for example, there might be up to 20 hours a week of this type), meaning that the workday ends up being all day except for the established minimum rest time (see Figure 5).

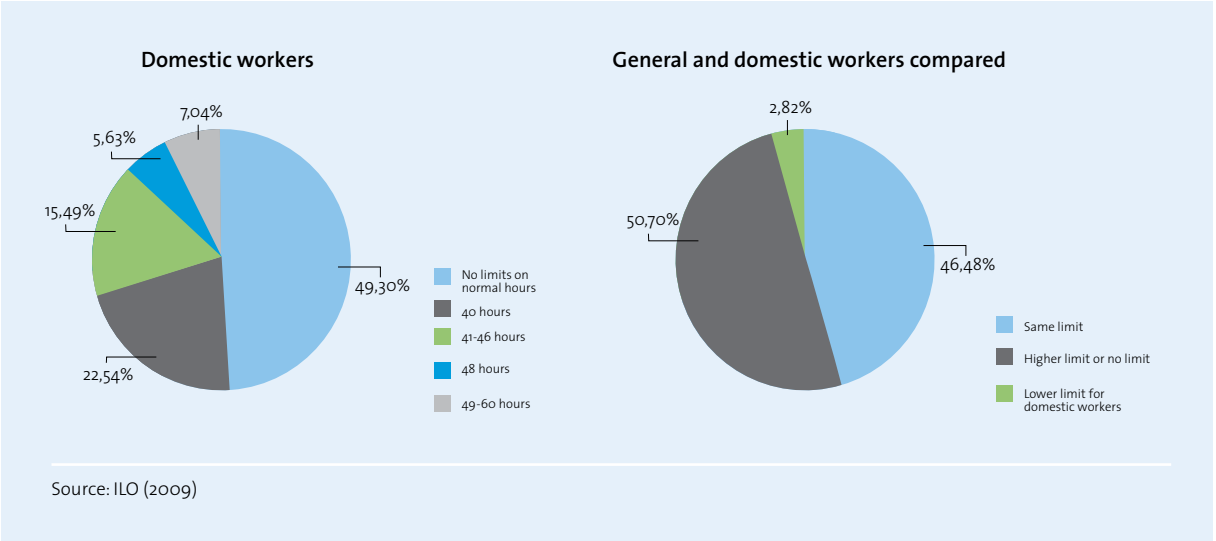
These problems with maximum workday impact workers by depriving them of the right to any overtime pay, which should be remunerated at a higher rate and considered as an exception to the normal regime. Instead, according to their stipulated salary, overtime is not paid and the wage always remains the same no matter how many hours the employer household requires in a given day.

Additionally:

- Vacations: domestic employees usually have shorter vacation time than in other sectors;
- Daily and weekly rest: often the daily rest time is not specified. In many cases it is reduced to nine hours. Or, in many cases, weekly rest time is not recognized by law. Another significant percentage only acknowledges a weekly rest period of 24 hours, when, in other sectors, this tends to be 36 hours. In those places in which 36 hours of rest are allowed, it is often the case that these hours are not necessarily consecutive (see Figure 6).

FIGURE 5

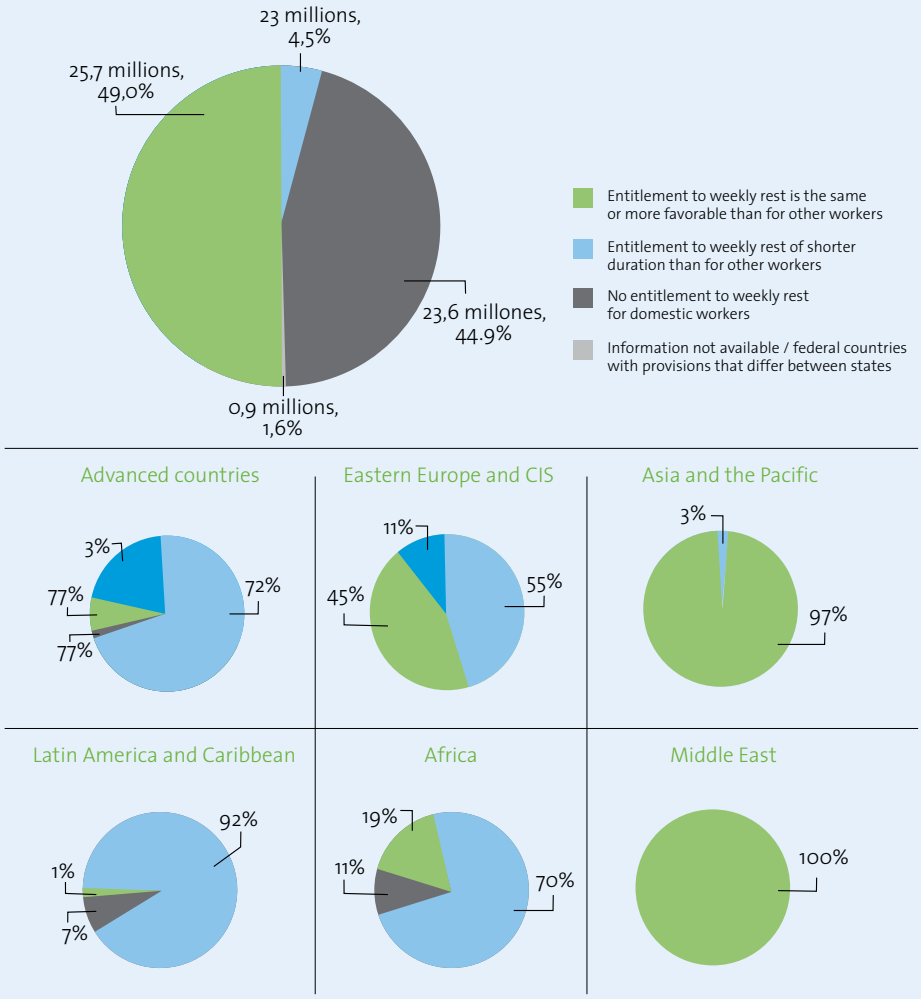
Maximum legal hours of work per week in the countries surveyed (percentages)



Source: ILO (2009)

FIGURE 6

Weekly rest (at least 24 consecutive hours) for domestic workers under national legislation, 2010



Source: ILO (2013)

4.1.4. Protection against unjustified dismissal

Regarding unjustified dismissal (see Table 1):

- Reasons for dismissal: while in special labour regimes there should be a fair or serious reason for firing, in the special labour regimes for domestic employment, ending a contract is often permitted even in the absence of a legitimate motive;
- Advance notice: there tends to be shorter notice time than in other labour regimes. That is, the number of days of notice of termination tends to be shorter. This short notice period (which in some legislation may be as few as seven days) has serious consequences for live-in domestic employees, as their access to housing depends on their employment. In a very short time the employee may find herself both without work and without housing.
- Severance pay: in the case of unfair dismissal, the severance pay dictated is less than in general labour regimes.

TABLE 1

Countries in which dismissal without legitimate motive is permitted

Country	Advance notice	Severance pay
Germany	x	
Argentina	x	x
Austria	x	x
Barbados	x	x
Belgium	x	
Bolivia		x
Brazil	x	
Colombia	x	
Costa Rica	x	x
United States	x	
Philippines	x	
Ireland	x	x
Italy	x	x
Kenya	x	x
Malaysia	x	x
Mali	x	x
Mexico	x	x
Nicaragua		
Niger	x	x
Panama	x	x
Peru	x	x
Senegal	x	x
South Africa	x	x
Uruguay		x
Zimbabwe		

The x indicates the rights applicable in each country.
Source: ILO (2009)

An additional concern is dismissal for pregnancy. The protection of workers under general labour laws against dismissal for pregnancy is a kind of protection against unfair dismissal specifically oriented to guarantee non-discrimination against women in the workplace on the basis of pregnancy. Many labour laws dictate a special compensation in the event of this kind of dismissal (in addition to normal compensation for unfair dismissal); many others establish that a dismissal for reasons of pregnancy is a null dismissal. When a dismissal is null, the employer is obliged to reinstate the worker and provide back pay. In the case of domestic employment:

- There are countries in which the protection against dismissal on the basis of pregnancy is not established for domestic employees;
- In others, it may be that this protection is recognized in the case of domestic employees but that this, as an exception to general legislation, does not constitute a null dismissal.

4.2. Right to social security

This includes access and coverage regarding short-term contingencies (illness, labour accident, pregnancy):

- In cases of illness, the entitlement to health care tends to be recognized. Nonetheless, the inclusion of domestic employees in social security insurance systems is very low, especially for women (see Table 2).
- Employment injury and occupational diseases: in the majority of countries, the legislation regarding

TABLE 2

Percentage of domestic workers included in social security insurance systems, in selected years, by sex

	1990			2003*		
	Total	**Women**	**Men**	**Total**	**Women**	**Men**
Latin America	17.6	16.6	35.5	23.3	22.8	33.6
Argentina	7.8	6.8	25.5	4	3.5	29.3
Bolivia	-	-	-	5.5	5.4	8.1
Brazil	24.9	24.1	44	29.7	29.1	40.4
Chile	51.7	51.4	66.7	53.8	57.4	52.1
Colombia	12.5	10.8	51.3	24	23.3	40.9
Costa Rica	40	39.3	59.5	35.7	35.2	41.8
Ecuador	17.8	17.5	20.8	11.3	11.5	8.3
Mexico	4.2	2.5	20.7	9.2	7.9	18.7
Nicaragua	-	-	-	3.8	2.9	9.5
Panama	-	-	-	3.5	30.6	38.9
Paraguay	-	-	-	20.5	21.2	6.8
Peru	17.3	16.3	31.3	20.5	21.2	6.8
Uruguay	44.8	44.8	42.1	97.9	97.8	99.4
Bolivarian Republic of Venezuela	-	-	-	23.4	22.4	49.3

* Bolivia - 2002, Chile - 2000
Source: ILO (2004)

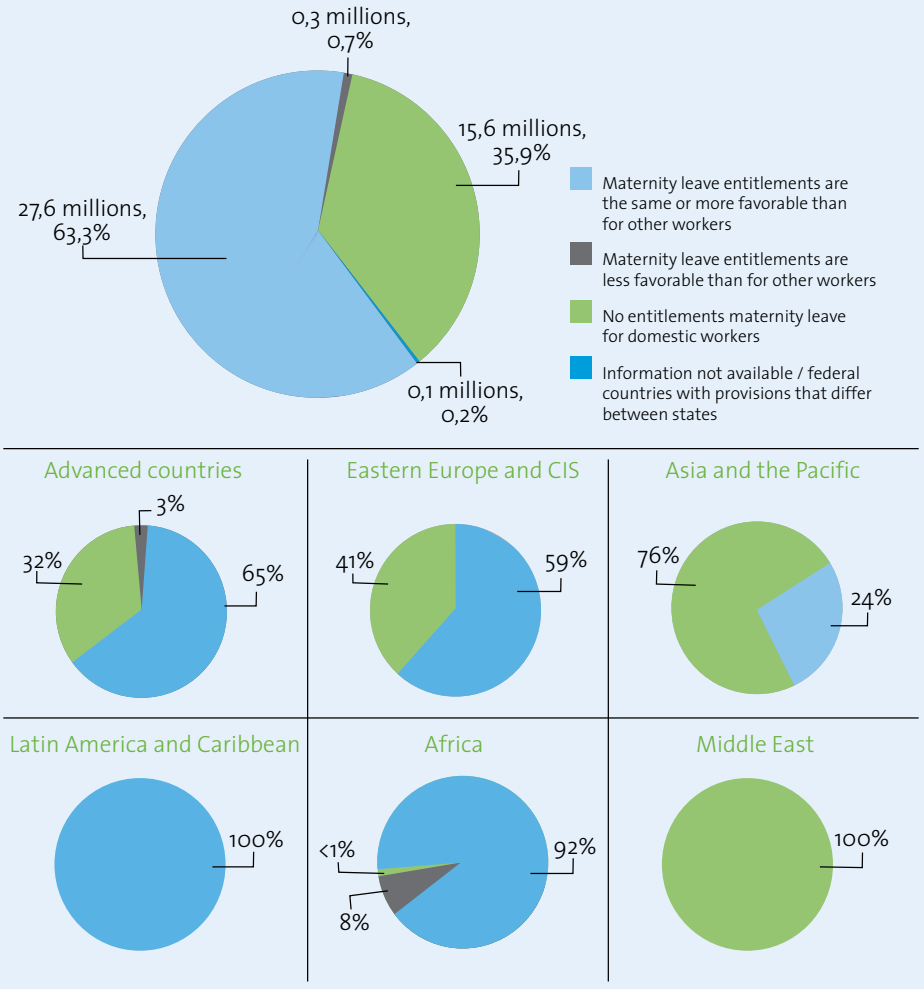
workplace health and safety does not offer protection to domestic employees. That is, care work is considered a risk-free job. However a study carried out in Brazil showed a rate of non-lethal labour-related accidents among domestic employees of 7.5 per cent per year in contrast to5 per cent for the rest of workers.

- Maternity leave (see Figure 7): although many countries recognize the same right to maternity leave for domestic employees, there are many other countries in which domestic employees are excluded from this right. In those countries in which it is recognized, the problem is that pregnancy often leads to dismissal.

Social security should also cover old age and disability (retirement and pensions) but in many legal codes regarding domestic employment these rights are excluded.

FIGURE 7

Entitlement to maternity leave for domestic workers under national legislation, 2010



Source: ILO (2013)

4.3. Enforcement of labour laws and access to justice

Workplace inspection services are essential in order to achieve compliance with labour legislation. In the case of domestic employment, the principal problem is that in many countries the possibility of labour inspection is limited by the right to the inviolability of the dwelling, or such an inspection requires the consent of the employer or else a warrant.

4.4. Collective organization of domestic employees

In some countries domestic employees have been organizing themselves for decades in order to demand their rights. However, various factors make it especially difficult for them to organize, and make it difficult for existing organizations to function. Among these:

- The isolation of domestic employees in private households;
- Precarious working conditions;
- Low wages and therefore limited resources available (problems in funding the activities of their organizations or unions);
- The character of the work itself, which often leads workers to not dare request time for union activities; and
- Although in some countries the major unions have supported the creation of specific domestic workers' unions and have stepped up their demand for labour rights, many other unions have shown

Good practices in labour inspection of domestic employment: the case of Uruguay

According to Article 11 of the Constitution of Uruguay, "The home is sacred and inviolable. It prohibits night-time visits without the consent of the head of the household and allows day-time visits only with written authorization by a competent judicial authority." Section 13 of Act No. 18.065 permits the Ministry of Labour and Social Security to undertake home inspections when there is a "presumed violation" of labour and social security norms. In the light of the new law, the labour and social security inspectorate has created a specialized section in charge of monitoring provisions on domestic work. The labour inspectorate has also coordinated with the judiciary to determine appropriate objective criteria upon which inspections are to be based. The Supreme Court of Justice has reportedly established that the decision to grant authority to carry out a home inspection visit must be established on a case-by-case basis by each labour judge using his or her technical expertise, following an independent evaluation. Labour inspection also entails preventative measures and collaboration with other entities. In effect, the inspection services have integrated into their work the recommendations of a Tripartite Commission on Equality of Opportunity and Treatment in Employment, which has supported a public awareness campaign to promote the law. One activity has been the preparation of a pamphlet for both employers and workers summarizing the rights of domestic workers. Specific mention has been made in equality plans of Uruguayan women of African descent, as many are domestic workers.

Source: ILO (2009).

Examples of a domestic employees' organization and its difficulties

In Namibia, domestic workers organized even during the colonial era, when trade union membership was illegal and the struggle against colonialism gave women the confidence to work with men on an equal footing in the union. A 1994 ILO study reported that the Namibian Domestic Workers' Union (NDWU) had recruited approximately one-third of the 12,000 domestic workers in the country, 70 per cent of whom were women. The Namibia Broadcasting Corporation played an important role in informing workers of the NDWU's existence. The biggest challenge facing the Union was funding, given that the domestic workers were poor. It was financed at the time by the Trade Union Solidarity Fund of Finland and international donors such as Oxfam, so that it could identify alternative organizational and employment options, notably cooperatives. A more recent publication, however, reports that many domestic workers today remain outside the realm of organized labour and that the NDWU is no longer in existence, low wages and job insecurity being the main causes of the Union's inability to recruit and retain members.

Source: ILO (2009).

You can watch this video by Domestic Workers Unite, which is an organization of Caribbean, Latina and African nannies, housekeepers, and elderly caregivers in New York. The video is about organizing domestic employees (4:28 minutes): http://www.youtube.com/watch?v=h6kIh2SdK-o&feature=plcp

Despite the difficulties, domestic employees have succeeded in creating regional organizations like the Latin American and Caribbean Confederation of Domestic Workers (CONLACTRAHO) and the Asian Domestic Workers' Network (ADWN); as well as global organizations: International Domestic Workers Federation (IDWFED)

little interest in incorporating their demands or in fomenting the organization of domestic employees.

Another major problem is that in many countries' domestic employees are denied the right to negotiate collectively. For example, a Brazilian court annulled the collective agreement arrived at by a domestic workers' union and an employer with the argument that "domestic work was non-commercial and non-productive, and that the employer could not therefore be classified as an 'enterprise' for the purposes of unionization." (ILO 2009:77). In Ontario, Canada, the Labour Relations Law of 1995 explicitly excludes domestic employees working in private homes from its sphere of application, meaning that these workers are denied the right to unionize and this is consecrated in the Constitution. The denial of the right to collective bargaining also means that domestic worker organizations are not present in the entities that debate and approve the regulations and the legislation that affect these workers.

4.5. Migrant domestic employees

Lastly, the special situation of migrant domestic employees. These workers suffer the convergent effects of the discriminatory regulations, which we have seen here, as well as the rules that regulate foreigners' residency and legality in their country of arrival. The confluence of these two sets of regulations leads to situations of greater vulnerability than that of native-born domestic employees. Let us look at some of these specific aspects:

- The greatest vulnerability of migrant employees arises in those cases in which their migratory status is irregular. In many countries there is a vicious circle between the informal character of domestic employment as a sector and the irregularity of migrant status. As it is an informal sector and it is one of the simplest ways to enter the labour market for those migrants who do not have their permits in order. But the very fact of not having permits in order worsens their working conditions and makes the migrants reluctant to report abuses for fear of being expelled from the country.
- The labour migration programs of many countries are conceived in such a way that, when a domestic employee loses her job, she also loses her status as a resident. This seriously limits the liberty of workers to terminate a labour relationship, which is one of the basic guarantees of free labour. Another frequent practice is linking the migrant with a specific employer (such that the migrant only has legal residence and work permit if working for that one employer), which also has serious effects on migrants' capacity to report abusive conditions.
- Often, migrant domestic employees are required to show a written contract in order to acquire residency and work permits. But in many countries, an oral contract is considered legal for domestic employment, or there simply is no obligation to provide a written contract. This aspect makes it difficult for migrants to normalize their situation.
- In the case of labour migration to and from Asia, agencies for recruiting domestic workers and mediating their hiring play an important role. However, there are many reports of fraudulent activities on the part of these employment agencies, who keep part of the workers' salaries as a commission for their mediation and do not guarantee that the agreed-upon conditions are fulfilled. Both receiving and sending countries should assume the responsibility to regulate and monitor the performance of these agencies.

Lastly, there is some discrimination actually enshrined in the legislation of some countries too, such as:

- A series of countries that authorize the dismissal or repatriation of migrant domestic workers in the case of pregnancy;
- In Thailand, Article 88 of the Labour Relations Law stipulates that, in order to unionize, all workers must hold Thai nationality.

The Story of Maya Gurung

I am Maya Gurung from Nepal, a woman migrant worker returning from Kuwait. Before taking on foreign employment, I was working in a day care centre in my village. But I was forced to seek foreign employment to pay off the debts from my husband's failed investments. I left a 17-month-old daughter and 5-year-old son behind with my husband and my in-laws and went to Kuwait as a maid. I paid US$ 500 to an agent for this. Due to restrictions, I went to Kuwait via New Delhi. I travelled without any paper, without any training and without even the address of the employer. When I reached the Kuwait Airport, the employer came and took me to the agency, gave me a contact number and told me that I would be paid 35 dinar per month. My passport and other documents were kept by the employer.

I took care of a three-storey house with five family members and eight children from two married daughters who used to visit - most of the time. My main duties were cleaning the house, washing the clothes, ironing the clothes, preparing food and taking care of children from 5:00 am to almost 1:00am!I was not allowed to rest and I could not eat the remaining food from family dinners. So I survived on bread and black tea for 15 days. I returned to the agent without any money for 15 days of work and I was then sent to another employer. There I received only 10 or 15 dinar per month instead of the 35 (which I had been spending to call my children).

After 11 months, I left that home with nothing, and then I found out that a relative of mine from the village was also in Kuwait. This relative was an agent too, so I began cooking, cleaning, and helping other Nepali women in Kuwait who were also working as maids. But my relative, the agent, never tried to find any work for me outside of this new work and he never gave me a penny.

I was fed up, helpless and unable to return to Nepal without my passport or papers. I was very desperate. I then met an Indian man who had a shop there. He promised to help me get my documents. It then turned out that the relatives, where I was staying, were leaving, so my only option was to live with the Indian man. After one year, my son was born, in a very vulnerable situation. Being undocumented, I couldn't get any medical help, from pregnancy to childbirth.

Then one day, the Indian man, my son's father, did not come back and would not respond to my calls when my son was sick. I then found out that he was already married and had one child. He and his family shunned me and the child that I bore him.

Then, with no other choice, I made a complaint to police because there was no Nepali embassy in Kuwait. But instead of receiving justice, I was sent to jail for two years with my 7-month-old son for being undocumented. And my "husband" was sentenced to five years in jail.

Next I found a Nepali, Mr. Mitra Sinjjali, who facilitated my deportation back to Nepal with the help of the Nepali Embassy in Saudi Arabia. After serving 14 months in jail I went back to Nepal. When I got back I had not a penny. I found a person who would let me stay in their motel, and I was at the point of desperation, with bills pilling up, when I was approached by Pourakhi, an organization for returnee WMWs. Pourakhi provided me with shelter and paralegal help but, again, because I had no papers, I couldn't file a case. I am now in touch with my daughter and son but not with my husband or in-laws. I have been told that my husband and in-laws still want me to re-join the family, but without my other son (from the Indian man in Kuwait)!

Source: Presentation by Maya Gurung in the Superior Consultation on migrant women and families, previous to the World Forum on Migration and Development, Mexico City, September 7-8, 2010.

The Story of Maya Gurung

I am Maya Gurung from Nepal, a returnee women migrant worker from Kuwait. Before going Foreign Employment, I was working in day care center in my village. I was forced to go for Foreign Employment to pay off the debts of my husband's unproductive investment. I left 17 months daughter and 5 years son behind my husband and in laws and went to Kuwait as housemaid paying US$ 500 to agent. Due to restriction, I went to Kuwait via New Delhi. Without any paper, training, and address of employer, I reached in Kuwait Airport. Employer came and took me to agency and given a contact number and informed that I will be given 35 dinar per month. My passports and other documents were kept by my employer.

I took care of 3 story big house with 5 family members and additional 8 children of 2 married daughters who used to visit most of the time. My main duty were cleaning house and cloths, ironing, preparing foods, taking care of children from early morning 5 am to late night 1 pm. Not allowed to take rest, could not eat with the remaining food that had been ate by all the family member from same big plate. So I survived on bread and black tea for 15 days. I returned to agent without any money for 15 days and sent to another employer. I used to receive only 10 or 15 dinar per month instead of 35 (which used to spend on phone to my children). After 11 month, I left the home with nothing and came to know that my native villagers/ relative are also there living in Kuwait. Relative was a agent, so I used to cook, clean and attend to other Nepali women those were brining as house maids. He never tried to find any work for me outside and never gave any penny.

I was fed up, helpless and unable to return without passport and papers, I was very desperate. I met an Indian who had a shop there. He promised me to help for getting my documents. The relatives, where I was staying were leaving, so my only option was to live with that Indian. After 1 year, my son was born in very vulnerable situation. Being undocumented I couldn't get any single medical help since pregnancy to childbirth. One day he did not come back and would not respond to my calls when my son was sick, later I found that he was already married and have one child. He and his family shunned me and the child I bore from him. After no choice, I made a complain to police for the help as there was no any Embassy of my country. Instead of justice I was convicted for 2 years jail with my 7 months son for being undocumented and my husband was sentenced for 5 years jail term.

I came to contact with Neppali worker Mr. Mitra Sinjjali, he facilitated my deportation with the help of Nepali Embassy in Saudi Arabia and send me back to Nepal after serving 14 months in jail. After returning to Nepal I had no single penny, requested to one person and came to a motel, I was at a point of desperation with bills pilling when I was approached by Pourakhi, organization of returnee WMWs. Pourakhi provided me with a shelter and paralegal help but again because I had no papers I couldn't file case. I am now in touch with my elder daughter and son but not with my husband and in laws. I came to know that my husband and in laws are still interested me to join family but without son.

Source: Presentation by Maya Gurung in the Superior Consultation on migrant women and families, previous to the World Forum on Migration and Development, Mexico City, September 7-8, 2010.

How to avoid the forced labour of migrant domestic employees?

According to ILO (2009):

"Migrant domestic workers' vulnerability to forced labour is not inherent but constructed; and certain practices associated with migrant domestic work can have a significant impact on whether forced labour conditions are cultivated or rooted out. Legislation can help to prevent forced domestic work and trafficking by:

- forbidding employers holding the passports of migrant workers;
- removing binding requirements and at least providing renewable extensions to prevent immediate expulsion on termination of the employment contract;
- removing the requirement to reside in the home of the employer;
- banning the payment of agency fees by workers and restricting similar deductions from their pay;
- strengthening MoUs to prevent abuse;
- requiring agencies to be accredited.

An international instrument that identifies and seeks to put an end to forced labour in domestic work would go a long way toward promoting decent work."

5. ILO Convention 189 on decent work for domestic workers

On June 16th, 2011 a great step forward was taken on the path to protecting the rights of domestic employees on a global level. The 100th International Labour Conference, hosted by the International Labour Organization (ILO), adopted Convention 189 on Decent Work for Domestic Workers and Recommendation201, of the same name. This was the first time that the ILO had drawn up international norms specifically regarding this group of workers. By adopting Convention 189 and Recommendation 201, the International Labour Conference sent a clear message, that domestic employees, like all other workers, have a right to decent living and working conditions. In accordance with the Constitution of the ILO, governments are now obliged to present the Convention and the Recommendation to their national legislative bodies in order to promote measures that ensure the application of these instruments. In the case of the Convention, the procedure of presenting it to legislative bodies also has the objective of ratifying the instrument.

The Convention establishes minimum standards that all countries should uphold. But it does not affect other, more favourable rulings that may be applicable to domestic workers on the basis of other international labour conventions. As a binding convention, it obliges the countries that ratify it to put into practice the regulations it contains through legislation, collective agreements or other additional measures, extending and adapting already-existing measures, or new measures, so that these will also be applied to domestic employees.

All of this should be done, according to the Convention, in consultation with the most representative organizations of both employer households and of workers. Recommendation 201 is a non-binding instrument that offers practical guidelines for strengthening the legislation and the policies of each country with respect to domestic work. The Recommendation is based upon the rulings of the Convention and should be read together with it. It also serves to orient Member States regarding measures they might take in applying the Convention.

But even before Convention 189 was approved, some countries had already made reforms in their legislation in order to improve the working conditions of domestic employees, or had taken action to ensure greater compliance with existing regulations.

Ratification of "C189"

Convention 189 is open to ratification by Member States of the ILO. It came into force 12 months after the second ratification was registered. Uruguay was the first country to ratify it, on June 14th, 2012. You might want to watch the video: Uruguay Takes the Lead to Protect Domestic Workers (in English, with subtitles in Spanish and French): http://wiego.org/resources/uruguay-takes-lead-protect-domestic-workers

The second country was the Philippines, on September 5th, 2012. Like other conventions of the ILO, the ratifying Members are obliged to present reports to the ILO on the measures they have adopted to apply the Convention.

In 2012,Campaign 12 for 12 was launched in order to get the Convention ratified by 12 countries during 2012. Nevertheless, just three countries had ratified the Convention by the end of 2012, Uruguay, the Philippines and Mauritius. Now, as of the beginning of this course, 14 countries have ratified the convention, Argentina, Bolivia, Colombia, Costa Rica, Ecuador, Germany, Guyana, Italy, Mauritius, Nicaragua, Paraguay, the Philippines, South Africa and Uruguay.

- Bahrain: In 2012, Bahrain announced a new law that endows domestic employees with rights, including the right to a written contract, a calculated weekly income, annual vacation time and conflict resolution.
- Zambia: In 2011, for the first time, Zambia approved legislation oriented specifically to regulate the conditions of domestic employees, setting a minimum wage, establishing the right to sick leave and maternity leave (though the latter is unpaid), and establishing a legal age limit for workers in this sector. Though this law is far from the rulings established by Convention 189, still it represents a step forward from the previous situation in which there was no regulation at all (Source: ILO, 2011).
- Ecuador: The Ministry of Labour Relations of Ecuador launched the campaign, Dignified Domestic Work, in March 2010 with the goal of raising awareness about labour rights and obligations, and to promote participation in the social security insurance system. The campaign, principally oriented at domestic employees and employers, began in the cities of Quito, Guayaquil, Cuenca and Ambato, where 148 mobile tents were set up in strategic areas, such as lower class neighbourhoods, commercial centres and parks. Each tent had two facilitators and an Internet connection in order to help submit forms and regularize the situation of employees who were not signed up for social security. During the first month, 19,967 persons participated and in the course of the year there was a significant increase in the number of domestic employees covered by the social security system (Source: Ministry of Labour Relations of Ecuador).

Finally, let us have a look at the countries that have made some progress toward decent work for domestic employees since the adoption of Convention 189, according to HRW (2013).

PROGRESS FOR DOMESTIC WORKERS

Since the Domestic Workers Convention was adopted in 2011, countries around the world have taken action to ratify the convention and to strengthen national laws and regulations to protect domestic workers. This map highlights this progress.

Now we invite you to do two practical exercises to check your understanding of "C189" and to know more about regulations in the country that concerns you most.

Practical exercise 1

Read the Convention here and the Recommendation here and respond to the following questions (see correct answers at the end of the exercises at footnote):

1. About paying wages in kind, the Convention establishes:

a. Wages may be paid in kind in a just and reasonable proportion.

b. Wages may be paid in kind up to a maximum of 20 per cent of the total wages.

c. Wages may not be paid in kind.

2. The rulings of the Convention and the corresponding legislative reforms will be in consultation with:

a. The members of the legislative body, as representatives of the citizenry.

b. Domestic employees' associations and employers' associations.

c. Major unions and business representatives.

3. About private agencies that work as intermediaries in hiring domestic employees:

a. Each agency will follow its own rules.

b. States should adopt measures to ensure that the commissions charged by the agencies are not discounted from the wages of the domestic employees.

c. Private agencies are not permitted to mediate; hiring should be done through state organs.

4. On weekly rest time:

a. It should be 24 hours a week.

b. It should be 36 hours a week.

c. It should be the same as that which other workers enjoy.

5. On maternity leave:

a. Workers are entitled to maternity leave at half wages.

b. Workers are entitled to maternity leave for at least two months.

c. Workers are entitled to maternity leave with the same conditions as other workers.

Practical exercise 2

1. Review the legislation on domestic employment for your country or for a country you are interested in.

2. Identify three points that are lacking and which you consider most important in relation to Convention 189:

Gap 1:
Gap 2:
Gap 3:

3. Fill in the following table:

	Regulated	Not regulated	The same conditions as other workers	Worse conditions than other workers
Daily and weekly work hours				
Hours of rest and whether these are paid				
Weekly rest time				
Minimum wage				
Minimum age for working				
Payment in kind				
Obligation to provide written contract				
Social Security (health-care and pension)				
Maternity leave				
Sick leave				
Existence of intermediary agencies				
Collective bargaining				
Regulations regarding migrant workers				
Labour inspections				

Correct answers: 1-a, 2-c, 3-b, 4-a 5-c

6. Conclusion

The volume of domestic employment is a sensitive indicator of the strength or weakness of the social and public co-responsibility in the provision of care (the greater this responsibility, the smaller presence of domestic work) and of social inequality (the greater the inequality, the greater the volume of domestic employment).

The labour force in this sector is characterized for being highly feminized and marked by other inequality axes. Child labour is also common. This labour sector presents some particularities (it is performed within the domestic realm and involves a highly individualized relationship) that favour the violation of labour rights as well as diverse forms of exploitation. Situations of forced labour and serious sexual abuse are not rare.

Often, labour laws applying to the sector are worse than the general labour laws. Additionally, infringement of them is frequent. Violation of the rights that constitute a decent job, as conceptualized by the ILO is frequent:

- The right to fair, equitable and satisfactory working conditions;
- The right to Social Security;
- Compliance with labour legislation and the right to legal aid; and
- The right of workers to organize collectively.

This phenomenon creates a situation of vulnerability, which is exacerbated in the case of migrant domestic employees. They are subject to immigration laws and live in greater isolation than native-born workers.

The ILO Convention on Decent Work for Domestic Workers was approved in 2011 to deal with this situation. It is a roadmap for Member States to protect labour rights in the sector. Additionally, the experiences of diverse countries provide good examples on how to improve the regulation of the sector, how to guarantee already recognized rights and how to empower domestic workers at both the individual and collective levels.

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List of terms included in the glossary

- Care
- Care policies
- Co-responsibility
- Crisis of care
- Gender
- Gender division of labour
- Gender role of women (in care)
- Public/private-domestic domains
- Remunerated/unremunerated work (paid and unpaid work)
- Social organization of care
- Total (global) workload

CHAPTER 6

GLOBAL CARE CHAINS: CARE BEYOND NATIONAL BORDERS

CHAPTER 6

GLOBAL CARE CHAINS: CARE BEYOND NATIONAL BORDERS

TAKE AWAY POINTS

1. The globalization of care

The globalization of care is a critical dimension of the globalization process, albeit one of the most invisible ones:

- Carework - mostly but not solely domestic employment - has been internationalized, leading to the formation of "global care chains".
- The provision of care is led more and more by supranational agents, although this aspect has not, as of yet, been sufficiently studied:
  - Private agents: A significant portion of care work may be dislocating itself in the context of the liberalization of the service sector. The influence of multinational corporations may be increasing in the context of the commercialization of many care services and the diversification of the menu of services offered by large companies.
  - Public agents: International multilateral organizations have a relevant impact in decision-making when it comes to public policies related to care and to economic policy predetermining the conditions in which these are designed. International cooperation (bilateral and multilateral) is increasingly present in the provision of care. Additionally, there is also the increasing importance of bilateral social security agreements.

2. Global care chains

The most discussed dimension of this globalization of care is the formation of global care chains:

- A large share of migrant women are employed in the care sector, mainly in domestic work, where job opportunities are created as a consequence of the care crisis;
- The migration of women provokes a reorganization of care in the origin household. Women tend to play the leading role in these new arrangements, mostly women from the extended family;
- Global care chains show the entanglement of households in different places around the world that transfer caregiving tasks from one household to another on the basis of power axes;
- Global care chains are formed according to power differences based on gender, ethnicity, social class and place of origin. This is the same dynamic as in other care arrangements, where care is deeply connected to inequality; and
- Global care chains connect gender inequalities in the home countries and in the destination countries. This connection is at the crux of the feminization of migration, which is mainly, but not always, caused by:
-

- The crisis of social reproduction that impels women to migrate to guarantee their families' well-being;
- The partial resolution of the crisis of care through the expansion of job opportunities in the care sector, which many native women have abandoned.

3. Impacts of the chains at the household level

Global care chains have impacts that differ for each one of the involved households:

- Impact on the household receiving care work from migrants: this is undoubtedly positive, as the recourse to domestic employment or the purchase of another type of service in the market is a response to particular needs. Nevertheless:
  - When domestic employment addresses urgent needs, receiving this work is not a cure-all for all care deficiencies, nor does it imply the end of unremunerated care;
  - In other cases, social differentiation processes are intensified; and
  - It prevents the questioning of gender roles and prevents advancement toward a fairer distribution of unpaid carework.
- Impact on migrant homes: here there are significant infringements in the right to care:
  - The violation of labour rights in the domestic employment sector is frequent and the poor labour conditions in this sector have a negative impact in the exercise of other rights. This also puts the domestic worker's own health and care situation at risk;
  - Public policy does not always take into account that migrant families have care needs that are frequently different to those of the native-born population; and
  - Migrant families face great difficulties in solving the care needs of their members; they tend to lack adequate resources to combine paid work and care responsibilities.
- Impacts on households in the home country: this is not as positive. We can say that women's migration brings with it an improvement in the preconditions of care while at the same time making direct care difficult:
  - Migration is a strategy, and receiving remittances helps cover the expectations - or imperative needs - of material well-being;
  - When women migrate, care is rearranged. Whether migration becomes an element of vulnerability or of empowerment depends on a variety of factors in the home country (strength of the bonds put in place, existence of a migration culture, support of public institutions) and destination country (job situation and immigration status); and
  - Migration is an additional risk factor added to previous deficiencies or vulnerabilities related to the fact that care is not a social priority.

4. Impacts of the chains on the care system

Beyond the involved households, it can be argued that global care chains provide private solutions to problems that should be collectively solved. Their functioning comes from the non-recognition of care. At the same time it feeds the undervaluing of care work. But what is new now is the global character of this phenomenon.

What global care chains show us is a worldwide reformulation of unjust care systems:

- A re-privatization of care: care is a private-domestic responsibility of the household and it is increasingly commodified, so those who can afford to buy care do so;
- Care continues to be a responsibility associated with women, although it is articulated in different ways depending on class and migration status. For a growing number of women this gender role consists of being managers of complex, global, commodified care networks; and

- The care/inequality nexus reconfigures itself and reaches a new global dimension. The inequality between women and men persists and even moves from the domestic sphere to the labour market. A key phenomenon here is that immigration status becomes an axis of strong social differentiation. Care becomes yet another element marked by unequal international relations.

Keep in mind also that care chains are not such a new phenomenon. They have always existed and have always been a testament to inequality and the lack of co-responsibility on a local or national scale. It is the global dimension that these processes have acquired that is new.

5. The urgency for global action on care

The global crisis of care has a component of empowerment, calling problems that once didn't seem to exist a "crisis". The problems of work-family reconciliation and the difficulty to readjust care arrangements when one migrates become a public affair. This all means that the problem, often lived in silence and hidden by the denial of women's voices, becomes an open letter.

The globalization of care urges countries to implement cross-border interventions in order to promote comprehensive co-responsibility for care, the exercise of the right to care and the observance of labour rights in the domestic work sector. Similarly, the question on what priority care receives in development models must be answered at the international level.

The diverse international instruments that countries are subject to provide an enriching entry point to deal with care issues in a coordinated way at the global level.

Among the most important are:

- The Beijing Platform for Action
- CEDAW
- The Covenant on Economic, Social and Cultural Rights
- The Convention on the Rights of the Child
- The Convention on the Rights of Persons with Disabilities
- The Convention on the Protection of the Rights of All Migrant Workers
- ILO Conventions
  - 189 on Decent Work for Domestic Workers
  - 156 Workers with Family Responsibilities Convention
  - 183 Maternity Protection Convention
  - 182 on the Worst Forms of Child Labour
- Regional instruments:
  - The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
  - The Quito Consensus (Xth Regional Conference on Women in LAC)

CONTENT

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GLOBAL CARE CHAINS: CARE BEYOND NATIONAL BORDERS

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1. Introduction

When speaking about care, we have been focusing largely on specific country contexts. We have assumed that the care-provision problems we encounter are problems that can be clearly delimited to a particular territory defined by borders - whether they be local or national - without being affected by what happens in other areas.

Yet now, in the context of globalization, there is no longer any dimension of the socioeconomic system that is so independent of the broader context; global interconnections are becoming deeper and care is no exception. We must therefore begin to introduce a perspective that allows us to understand the social organization of care within the context of globalization.

The "globalization of care" is a critical dimension of the globalization process, albeit one of the most invisible. Carework - mostly but not solely domestic employment - has been internationalized, leading to the formation of global care chains. But people who move internationally are not the only ones contributing to the globalization of care. Increasingly, public and private agents with a capacity for supranational influence are emerging. Therefore, the provision of care is led more and more by supranational agents, although this aspect has not, as of yet, been sufficiently studied.

A significant portion of care work may be dislocating itself in the context of the liberalization of the service sector. Among these figures are telephone assistance services for the elderly or for persons with disabilities. Similarly, the influence of multinational corporations may be increasing in the context of the commercialization of many care services, such as home care, homes for the elderly or long-term care insurance (which can include home care itself), as well as in the context of diversification of the menu of services offered by large companies.

In addition to the influence of the private sector it is also important to note the importance of public bodies in three ways:

- On one hand, we must consider the influence of international multilateral organizations in decision-making when it comes to public policies related to care or, more generally, to economic and social policy predetermining the conditions in which these are designed. This was discussed in Session 4;
- On the other hand, international cooperation (bilateral and multilateral) is increasingly present in the provision of care: it can be directly responsible for care services or it can finance their provision;
- There is also the increasing importance of bilateral social security agreements coordinating the provision of welfare benefits between the home and destination countries.

In this session we will address the globalization of care by focusing on two issues, (1) global care chains, which will help to understand the gender and development dimensions of that process, and (2) the international instruments that set the mandate for care at a transnational level.

2. Global care chains: definition and emergence

In Session 3 we saw that the (piecemeal and deficient) solutions for the crisis of care were often the outsourcing of a large part of the work that women had previously done in the home for free. At the same time, in many countries it is increasingly common for care work to be done by people from other countries. This represents the "internationalization" of the issue: both in institutions - homes for the aged, daytime care centres, preschools, homecare services, etc., whether managed by the public sector or by private companies- and in situations of domestic employment directly hired by families, as we saw in Session 5. The new international division of labour, often spoken of as characteristic of globalization, also encompasses care work. Yet instead of relocating production across borders - care work cannot be separated from the person who receives it - the ones moving are the workers themselves.

2.1. What are global care chains?

To discuss this we employ the concept of global care chains. But what are global care chains? Consider a simple example: Rosario is a Filipina woman who has migrated to Italy. In the Philippines, she has three children of 4, 6 and 9 that she has moved to her mother's home while Rosario's husband stays in the family home. In Italy, Rosario works as a live-in domestic employee six days a week caring for an elderly couple. The man has Alzheimer's and the woman cannot walk properly since she broke her hip.

Global care chains thus bring together homes from different parts of the world, providing the care needed by the members of those homes. In these chains, individuals and households transfer care work from one to another, not on an equal footing, but on the basis of power differences. Gender, ethnicity, social class and place of origin determine what care tasks are assumed by whom and in what conditions.

Women generally play the leading role in global care chains. They are the ones who actively undertake the bulk of carework and/or the ones who used to assume the responsibility for caregiving before delegating it. Nevertheless, keep in mind the role of:

- Men: they might be active caregivers, although they assume this role much less frequently than women, as we shall see. In any case, they are receiving the care that is provided along the chains;
- The State: these chains frequently replace the absence of care public services; and
- Companies: the availability of a workforce entering into the production sphere is due to the care that is provided along the chains.

Global care chains are not such a new phenomenon:

- There has always been domestic employment and it has always been undervalued, with poor labour conditions. The number of migrant women among domestic workers has always been high;
- Care needs have always been resolved by transferring the jobs that no one wants to do whenever possible to someone who cannot refuse to do them. This has always meant that some people can establish care arrangements that are more satisfactory than others. Care networks established between women have always been framed by the weak role of public institutions - and of men;
- Women have always migrated from the country to the city, from their home country to a neighbouring one or from their country to another one across the ocean. And migration from rural to urban zones has always involved a large component of women working as domestic employees. In turn, these women leave families behind in their communities, or cannot form their own families because their time is fully dedicated to the well-being of the family employing them;
- Internal care chains have always existed. They persist in countries where the urban growth process continues. Migration tends to render visible the socioeconomic problems that could otherwise go unnoticed. Care chains have always been a testament to inequality and the lack of co-responsibility on a local or national scale, and today they are this same testament.

What is new in all of this, then? The global dimension that these processes have acquired, as well as the increased interdependence between countries. The way care is organized in any part of the world increasingly depends on what is happening in other parts: job opportunities that open up in one or another place, immigration policies, availability of care services, among others. This is why intervention should not be limited to the nation-state. It should reach the transnational level.

Another important issue to consider is that global care chains do not only flow from the Global South to the Global North. Migration is a much more diverse phenomenon.

Data on migration and domestic work[1]

Asia

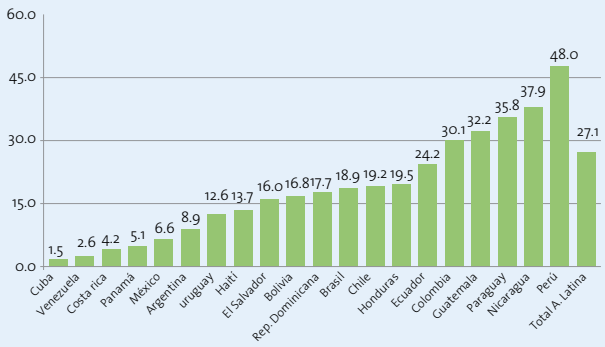
- Asian domestic workers mainly migrate to the Middle East, to North America, to Western Europe and to the richer countries in East Asia.
- Intra-regional migration: In 2005, 6.3 million Asian migrants worked legally in other, richer countries of the region and it was estimated that there could be up to 1.2 million more working without legal documentation.
- There are very feminized intra-regional flows, such as those from Indonesia, the Philippines, and Sri Lanka, where women comprise between 60 per cent and 80 per cent. The majority are domestic workers.
- In Thailand, female domestic workers made up 32 per cent of immigrants from Laos, counting both women and men.
- In the 1990s, 84 per cent of all migrants from Sri Lanka to the Middle East were women, mostly domestic workers.
- Indonesian women make up almost half of the 300,000 migrant domestic workers employed in Hong Kong (AI, 2013)
- More than half of the migrants in France work as domestic workers.
- In Spain, it is estimated that approximately 60 per cent of the people working in domestic service are immigrants; almost 60 per cent of them come from Latin America; 19 per cent also come from Romania. (Source: Orozco and Gil, 2011)

Europe

Intra-regional migration: 60 per cent of internal and cross-border migrants work as domestic workers. Of the total of intra-regional migrants they make up 27 per cent, but this varies widely by nationality, from a minimum of 1.5 per cent of Cubans to a maximum of 48 per cent of Peruvians, as can be seen in this figure:

FIGURE 1

Latin America, percentage of migrant women working as domestic employees in the countries of the region, by birth country. Circa 2000:



Source: Kösters (2008)

The tightening of immigration laws in the United States and the opening of job opportunities in Europe in the care sector have transformed many Latin American flows of migration, from the predominance of men migrating to their neighbour in the north in the 80s and 90s, to the more central role of women in European countries since the end of the 90s.

1 Unless otherwise indicated, all data comes from UNFPA (2006).

Data on migration and domestic work

Middle East and Gulf countries

- Arab countries employ millions of domestic workers. In Saudi Arabia alone there are about a million and a half of these workers, the majority from the Philippines and Sri Lanka. (Source: Human Rights Watch website)
- A survey carried out in 2011 found that out of 542 typical Qatari families, 478 employed women to work in their households, or a total of 885 women! Out of the 542 families, 71 employed men (the number of male domestic workers totalled 119). A "typical" family might then employ two women in the house, one primarily focused on childcare and the other focused on cleaning, with a man employed as the driver (AI, 2014).

Sub-Saharan Africa

- Domestic employment is a job niche for internal and cross-border migrants, though it varies by nationality: 44 per cent of migrants from Lesotho to South Africa work as domestics but only 6 per cent of Zimbabweans do. In Johannesburg, it was found that 86 per cent of domestic workers came from outside the city. (Source: Various studies by the Southern African Migration Project.)
- There is a "brain drain" of qualified healthcare personnel from Sub-Saharan Africa to richer countries, which makes dealing with the HIV/AIDS pandemic all the more difficult.

United States

- In 2000, the majority of female domestic workers were migrants from Mexico and other Latin American countries, and this group also represented 58 per cent of the workforce in home services.

The metaphor of the chain allows us to visualize a series of links, made up of people through whom care moves. This is a set of interlocking links through which care flows, with a woman who migrates and performs care work in the destination country - the migrant Rosario, for example - forming the first link in the chain. The chains are comprised of three basic links, to which others may be joined. Let's look again at the example from above:

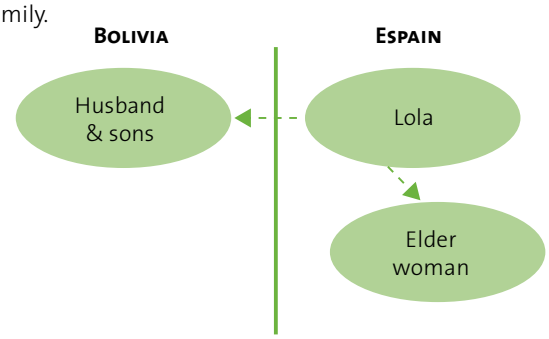
- The employer household, which is transferring care to a migrant. In the above case, it is the elderly couple that employs Rosario. If the couple could no longer care for themselves, we might wonder who would do the job if they could not hire a domestic employee. Probably some female family member such as a daughter or a daughter-in-law.
- The migrant household, which performs care in the destination country (the care needed by both the family members and by the employer's household) and in turn transfers on a series of care tasks that the migrant cannot perform in her home country. We speak of a migrant household even when it is a single person living in the employer's home, as is the case with Rosario, who works as a live-in domestic employee. But we will see other cases later, as the domestic worker may have a reunited or newly-formed family in the destination country.
- The home-country household: composed of people who depended upon the care work done by the migrant before s/he left. In Rosario's case, this is her three children and her husband, who must now re-organize all the care arrangements. In this example, the arrangement is to transfer the children to the maternal grandmother's house while the husband stays in the family home.

Let's now consider a slightly more complicated case:

Case study: Lola

1

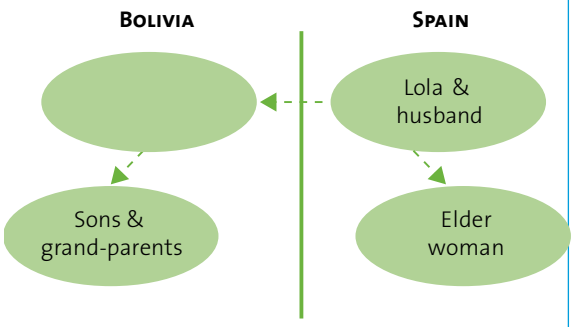
Lola arrived in Spain in 2005 and her children stayed with her husband in Bolivia. Thus they became a transnational family.



Transnational families are families that have a common life even though they are separated geographically. Remittances - money transferred from one place to another - and care flow between members of these families.

2

Lola's husband followed her some months later. He did not assume the role of primary caregiver, as his male identity linked him to the role of breadwinner. Both were able to get jobs in Spain, she as a domestic employee, he as a construction worker: preferred employment niche, markets segregated by sex.



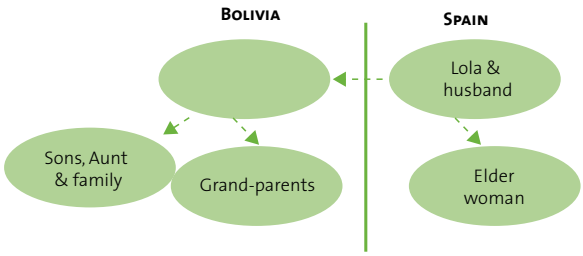
Case study: Lola

Male identity of breadwinner: As explained in Session 1, there are gender roles that operate in the distribution and value of care, and the tasks required to achieve family well-being. When women take on the role of breadwinner, men rarely take on the role of caring for the family.

Labour market segmented by sex and ethnicity: Labour markets do not offer the same opportunities to everyone, as they do not only take into account qualifications and experience. And in this environment, sex and place of origin are grounds for discrimination. Domestic employment is overwhelmingly performed by migrant women and/or women belonging to working classes or discriminated ethnic groups.

3

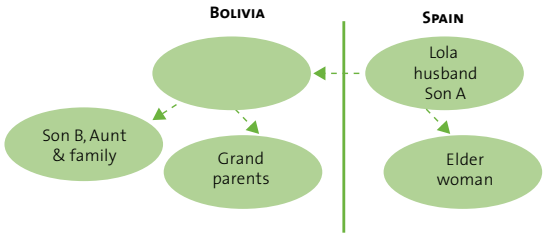
Their children were first with their maternal grandparents, but Lola was not happy with this arrangement (long-distance home management) and agreed with her sister-in-law that they move to her house (reorganization of family strategies).



Long-distance home management: Migrants, when they are far away, cannot take on care tasks directly or establish preconditions for care. But they can play an important role in organization, decision-making and supervision. And they often do. In general, when they leave, they are still responsible and do not lose contact with those staying behind in the home country. The responsibility to take care of the family from a distance is much more frequently assumed by women than by men.

4

When they had achieved some job security, they wanted to bring their children before a visa might become necessary (family strategies affected by immigration policy). But they were denied entry at the airport twice. Only the eldest was able to enter the country (family reunification).



Immigration policy and labour and family strategies: One of the aspects that has the most impact on the articulation of transnational families is migration policy, because it define members' legal status and, consequently, the possibility of access to social and economic rights (such as health, education, social protection), job opportunities, and the ability to reunite families. Just as there are different labour policies for domestic employment, there can also be different immigration policies, or ones that are especially harmful to domestic workers.

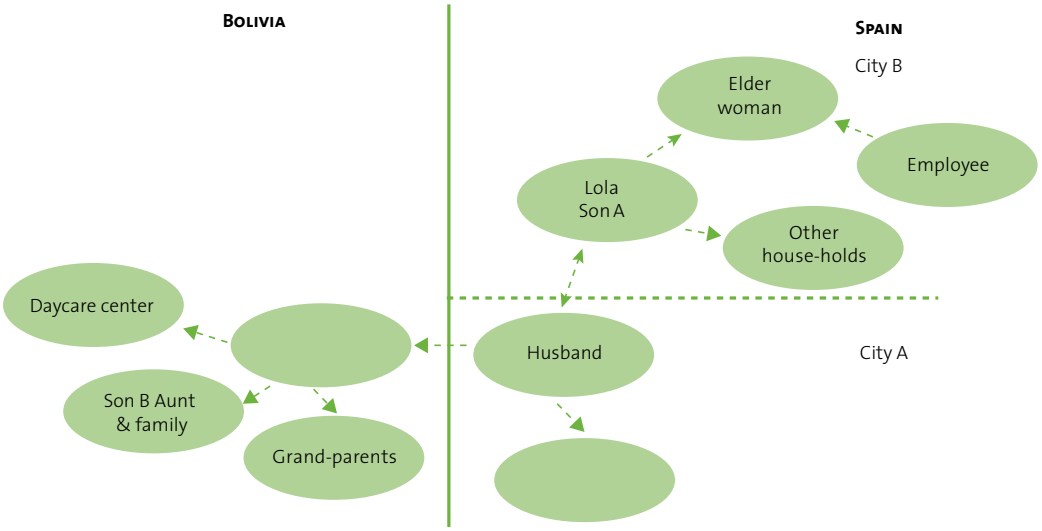
Case study: Lola

Reorganization of family strategies: Transnational families are dynamic; how they work changes according to changing circumstances and expectations. The home is managed from a distance and decisions are made to adapt to new circumstances or so that it will function better.

Family reunification: Often migrants would like to reunite their family members, including sons and daughters. But this is not always possible. Sometimes, labour conditions make it difficult or impossible to bring family, as for example in the case of live-in domestic employees. Staying separated is an extreme reconciliation strategy (as explained in Session 3) that implies the total denial of the right to care.

5

Lola needs her "papers" and she has found an opportunity by moving to another city where she is able to get a work contract that will give her the status she needs. This is an example of work strategy affected by immigration policy. She has taken her son with her. Lola now attends to an elderly woman at night and her older son stays at home alone napping. Lola faces a great difficulty achieving home-work balance (reconciliation difficulties). Her son has also been diagnosed with autism and has started to attend a daycare centre. But Lola still feels as though this is an untenable situation. Her care arrangements are extremely vulnerable and seriously risk collapse.



Reconciliation difficulties: While domestic employment helps to reconcile professional and family obligations for the employer's household, it sometimes imposes difficult conditions on the employees themselves, because it is a job that is done precisely in the areas in which it is hardest to combine care with other facets of life. This can lead to intensely precarious situations.

2.2. Gender and intersecting power differences

Global care chains are based on power differences, which are themselves based on gender, ethnicity, social class and place of origin. Let's dissect these power relations further. First, women generally play the leading active roles in each link of global care chains due to the gender roles operating in care:

- In the homes of the employers, women continue to be the backbone of arranging care. It is they who most often make the arrangements for hiring a domestic employee and who then supervise them (the component of mentally managing care that we saw in Session 1). Similarly, it is women who take on care if they cannot hire others to do it, and it is they who cover most of the gaps that cannot be taken care of by domestic employees. That is, they still assume the main responsibility for unremunerated care work and for coordinating the transfer of care.
- For migrant homes, the phenomenon of global chains is closely linked to job opportunities in the care sector opened up by the crisis of care in many developed countries, as explained in Session 3. As we saw in Session 5, the care sector is highly feminized globally. There are men working as paid domestic workers, and their presence is increasing in some contexts, such as in caregiving for elderly men. But their migration does not usually involve a reorganization of care work in the home country, e.g., their absence does not impel the formation of chains. Men tend to assume the ultimate and main responsibility for care neither before nor after migration.
- In the home country household, jobs performed by women before migrating are in most cases transferred to other women, or to several women according to the complexity of the case. This could take the form of women extending their pre-existing care responsibilities (for example aunts taking charge of nieces and nephews) or assuming new ones when their own reproductive cycles are through (grandmothers) or when it has not yet begun (adolescents in charge of their brothers and sisters). There are also men who perform care tasks in the country of origin when their wives migrate, either because they are left in charge of the children or because their participation in unremunerated care tasks increases after the migration of their wives or sisters. But these tend to be transient situations - the desire is to return to the previous situation and the intention is to restore it - that are broadly supported by the women surrounding them: care is dispersed. Where it seems there are indeed quite relevant changes in the case of men is when brothers are left in charge of their younger siblings.

Highlighting the active role of women should not imply losing sight of the changes in men's gender roles whenever they occur. Neither should it obscure the question on who is passively benefiting from this carework: the State might benefit if this work makes up for the deficiency of public services; or companies may benefit from it, given that this work reproduces the workforce; and men benefit from it whenever they are passive recipients.

Second, the transfer of care occurs, as we saw in Session 1 when discussing unjust care systems, from social groups with a better position to those with a worse one on the basis of ethnicity, social class and migration status. From upper- and middle-class households to lower-class ones; from native households to migrant households. Ethnicity and caste also play an important role where ethnic and race categories are relevant. Therefore, domestic employment is carried out by immigrant women and those from the lower classes and marginalized ethnicities.

Although worldwide a large portion of female migration is constituted by poor women from the Global South with low levels of education, there is also a significant presence of women with average or even high education levels that are only able to enter the labour market in the destination countries via care work, as immigration laws "stratify" jobs available to natives and foreigners. It is in these cases that we see how the place of origin variable operates above and beyond social class when placing migrant women in labour niches segmented by gender and place of origin.

Ethnicity also "stratifies" the migrant population within the same country. For example, Latin American women whose appearances are similar to those of the native population of the country to which they migrate achieve a better position than those whose phenotypes place them in categories such as mestizo, indigenous or Afro-descendent.

2.3. Why do global care chains emerge?

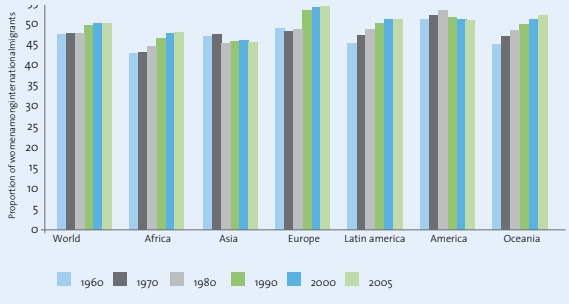
Global care chains connect gender inequalities in the home countries and in the destination countries and this connection is at the crux of the feminization of migration. The proportion of women in global migratory flows has remained stable, though, with significant differences according to region.

By the "feminization of migration" we understand not so much the increase in that proportion, as the changing role of women in migratory flows (see Figure 2). Ever more women migrate as the principle breadwinners for their household in the home country; as pioneers of family migratory projects; or as women with their own migratory projects - not as daughters or wives of a male immigrant, who was the prototypical figure of the migrations of the 1970s.

What has caused the increasing feminization of migration? On one hand it's the crisis of social reproduction that many home countries are increasingly experiencing and which prevents the satisfactory completion of people's material and emotional living aspirations.

FIGURE 2

Female migration, trends 1960-2005, by continent/region



Source: Population Division, DESA (2006)

Many of these crises have been the direct consequence of structural adjustment policies that were imposed upon these countries, and as we saw in Session 4 about care and the economy, macroeconomic policies have effects on women.

And women are the final, if not the only, guarantors of family well-being. When all else fails, in the face of men's unemployment, cuts in governmental assistance and increases in the prices of basic goods, women have to deploy multiple strategies to guarantee the well-being in their household. To this we must add the fact that their job opportunities are more reduced and that they suffer higher unemployment rates than men. But not all migration comes out of economic necessity and of inequality. It also comes from empowerment processes:

- Women's educational levels have significantly increased. But there are not always labour opportunities in accordance to their expectations. Migration might be a way to achieve them;
- Among the significant motivations for women's migration are also the desire for more freedom or autonomy in their lives and in their sexuality, as well as the desire to distance themselves from situations of domestic violence.

Simultaneous with the crisis of social reproduction in the home countries, the partial resolution of the crisis of care in many other countries has meant the expansion of job opportunities in the care sector, as we saw in Session 3. The low status and low pay of care work have meant that the native-born population has been abandoning such jobs bit by bit only to offer them to other populations that they fit better. Also, another element stimulating the increased entry of migrant women into the care sector is the time-availability that this sort of work demands, for example in the case of live-in domestic employees. The figure of the migrant woman whose family responsibilities are thousands of miles away fits particularly well with the type of permanent, full-time care that certain households in destination countries demand. But this is not always true, or not only so:

- The crisis of care does not always open up job opportunities. So, although one can speak of a crisis in

Japan, for example, up until very recently the country has not resorted to hiring migrant women. Indeed, immigration policy in Japan has historically been very restrictive. In 2008, Japan ratified the Japan - Philippines Economic Partnership Agreement, a bilateral agreement for commercial liberalization that included the opening of the professional care labour market to professionals from the Philippines. However, between 2009 and 2011 only 209 nurses have been able to access this market;

- The crisis of care is not only triggered by the high rates of commercial activity of native-born women, though. There are more elements in play, crucially, the model of urban growth that is also at the centre of the energy and environmental crisis. Ecological crises are also often behind the decision to migrate - the so-called environmental migrations - in the case of famine or loss of agricultural jobs, among others. The various elements of the global crisis feed off one another (crisis of social reproduction, care crisis, ecological crisis). For example, in Ethiopia, the degradation of the environment has increased forced migration and the International Organization for Migration (IOM) reports that many young Ethiopian women employed as domestics in the Gulf States are victims of human trafficking or have been trafficked and are facing situations of servitude;
- The demand for migrant caregivers is not always related to a case of native-born women lacking the time to do these tasks because they are employed in other labour sectors. There are contexts, such as in the Gulf countries, where there are very high rates of employment of foreign domestic workers and a low rate of native-born women in the labour market. For example, in Kuwait, an estimated 660,000 Asian and African migrants work as domestic employees, one for every two Kuwaiti citizens! Yet the participation of women in the labour market is not only low but it has remained unchanged over the past decade - 44 per cent in 2000 and 43 per cent in 2010. (Sources: Human Rights Watch and World Bank)

3. Impact of global care chains on the households that make them up

The formation of global care chains has an impact on development and we can evaluate these impacts at two levels:

- on households directly included in the chains; and
- on the whole socioeconomic structure.

In looking at the impact on the households participating in these chains we should look at least at three basic links, to which others can be added: (1) the employer household that hires a migrant in the destination country; (2) the household of the migrant herself or himself in the destination country; and (3) the transnational household remaining in the home country.

3.1. Impact on the household receiving care work from migrants

The impact for these households is undoubtedly positive, as the recourse to domestic employment or the purchase of another type of service in the market is a response to particular needs. These needs could be the urgency of additional care sources (filling in gaps in the case of caring for minors or adults in situation of dependency), the search for a better quality of life (liberating time for leisure or more dedication to one's professional career) or the satisfaction of social expectations associated with socioeconomic status. Nevertheless, depending on what need it is addressing, the impact should be assessed differently.

When domestic employment addresses urgent needs, receiving this work is not a cure-all for all care deficiencies, nor does it imply the end of unremunerated care. This is still essential, both to harmonize the different sources of care and to address the gaps that paid work does not cover. And it continues to be mostly a female responsibility.

In other cases, social differentiation processes are intensified: employing a domestic worker implies social status and allows one to have more time, whether for buying leisure and rest time or for one's job (professional advancement). This coincides with a process in which the satisfaction of very intimate dimensions of

well-being is increasingly sought via market consumption – the "commodification of intimate life".

Finally, there is an additional negative consequence of hiring a domestic worker: it frequently is one of the main strategies for avoiding arguments with men over how their presence in care tasks is not increasing in the same way women's presence at employment is. Therefore, one of the impacts is that it helps to avoid the conflict. It also prevents questioning of gender roles and prevents advancement toward a fairer distribution of unpaid carework.

3.2. Impact on migrant homes

The frequent violation of labour rights in the domestic employment sector was discussed in the previous session. Poor labour conditions have a negative impact in the exercise of other rights, because they have a negative impact on the living conditions of domestic workers and their families. Nevertheless, analysing the labour conditions of domestic employment is not sufficient. It would imply addressing the workers solely as paid caregivers and disregarding the care networks in which they are involved. Their own and their families' quality of life should be taken into account.

Too frequently we think about an always-available domestic worker without any family in the destination country when discussing migrant domestic employment. But that is not the reality. Migrant women who have left behind sons, daughters and a partner in their home country often aspire to bring them to the destination country and may have more children there. Those who, at the time of migration, did not have their own family may start their own family projects. And the aging of parents in the home country may also impel them to try to bring them to the destination country.

Because of their particular demographic structure, migrant families have certain care needs. So for the migrant population, dependence and the demand for care is generated principally by children - in fact, it is thanks to the migrant population that fertility rates in many destination countries are recovering. Meanwhile, for the native-born population, the increase in pressure comes principally from the needs of the elderly.

Public policy does not always take this situation into account. For example, there is a tendency to make the reunification of older relatives more difficult for the migrant population. This hinders what is for many migrant households the only way to reconcile work and family life, by bringing grandmothers to take care of their grandchildren. At the same time, no additional resources are allocated so that children can be taken care of in public care networks.

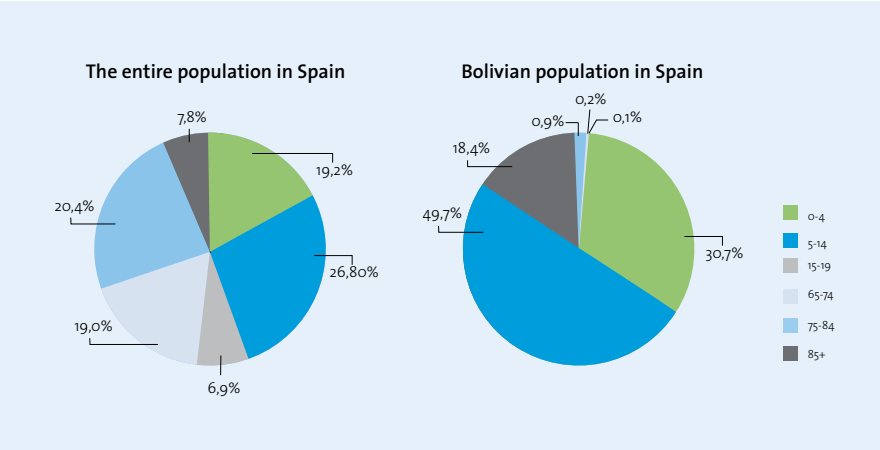
As stated in Session 3, we should also keep in mind that the factors that usually contribute to the difficulties in reconciling work and family life intensify in the experience of migrant families, especially in the case of migrant domestic employees. Among them:

- the precariousness of employment and its effects (instability, undesired flexibility of time and space, limited access to benefits and labour rights to reconciliation and care) generally affect all migrants, but especially domestic employees;
- scarce financial resources that do not permit one to purchase care services; and
- the lack of social networks; this is especially serious in the case of live-in domestic employees.

Also, much of the care that migrants are responsible for is in another country, not in the one they are in. Public policy quite often does not take this into account. For example, work-family reconciliation policies recognizing working people's care responsibilities do not take into consideration that these responsibilities might be in another country. Many labour laws give leave in the case of illness of a family member, and these can be longer if travel is necessary, for example if the family member lives far away. But this is in the case of internal travel, never transnational.

The domestic worker's own health and care situation may be at risk due to the very conditions of migration or work in the domestic sector, e.g., labour risks because of the physical and psychological difficulty of the work, or because the domestic worker does not have access to the healthcare system in the destination country. For example, according to SAMP/IOM (2005), domestic employees in South Africa are especially vulnerable to HIV/AIDS for a variety of reasons, including social isolation, low education levels, lack of access to

Women facing different care needs in native and migrant households



The demand for unremunerated care of third parties covered by all women in Spain comes from the population under 18 (52.8 per cent) and over 65 (47.2 per cent) with more difficulties coming from the latter. Bolivian women are one of the main migrant groups working as domestic workers taking care of the elderly. Therefore, their work is a key solution for covering the needs of the ageing Spanish population. This contrasts with the demand for care that migrant women cover in their own families thanks to their unpaid work. 98.8 per cent of this time is devoted to taking care of children under 19, 30.7 per cent to children under 4 years old, 49.7 per cent to children from 5 to 14 and 18.4 per cent to adolescents between 15 and 19.

Source: Orozco and Gil (2011)

health care, lack of information about HIV/AIDS and the frequent necessity to supplement income with sex work due to low wages. There is also the difficulty of accessing health benefits through work when they are HIV-positive.

Overall, we can say that migrant families face great difficulties in solving the care needs of their members - intensified in the case of domestic workers - and that this does not usually receive an adequate response from public institutions. We can observe significant infringements in the right to care, and this constitutes a serious development problem for immigration destination countries.

3.3. Impacts on households in the home country

Now consider the impact upon family units reshaped following women's departure. As we already saw, there are no relevant changes in the organization of the origin household when it is men who migrate, as long as they keep on assuming their breadwinner role. However, households are re-arranged when women migrate because care arrangements are reorganized.

The impact for them is not as clearly positive. We can say that women's migration brings with it an

improvement in the preconditions of care while at the same time making direct care difficult. Migration is a strategy, and receiving remittances helps cover expectations - or imperative needs - of material well-being. Remittances are used for expenses directly related to everyday well-being and care, education, health, supplementing the lack of pensions for the elderly or the sick, food and shelter, etc. However the impact on the provision of care is unclear. An alarmist attitude often prevails, claiming that the migration of women - especially mothers - leads to a process of family breakdown, placing much emphasis on the effects for daughters and sons.

But what really happens as a result of migration? Women, when they migrate, if they were in charge of the household, generally look for someone to replace them. In this search, they follow a "classificatory" sequence that often prioritizes blood ties. So it is normally a woman from the extended family left in charge of children. Care is often dispersed - more often a network led by a female figure in the family than a single person taking responsibility - and it is frequent that the borders between who cares and who is being cared for are blurred, e.g., grandmothers take care of grandchildren who in turn take care of them as they age. These arrangements are dynamic and are adjusted as new conditions and needs arise, such as an illness or a new pregnancy, for example. And they tend to be supervised by the migrant from a distance. It is true that these arrangements are often precarious or vulnerable:

- There is frequently a strain placed on the woman responsible for the care of the dependents that the migrant has left behind; her time can be stretched very thin. She may encounter difficulties combining these tasks with that of caring for her own family and work. This extra workload can lead to less possibility of being able to provide the required care, so we therefore come across cases in which not enough care is provided.
- The most negative impacts occur in households in which a grandmother has been left in charge but who also has care needs of her own due to her advanced age. Or there are cases in which an adolescent is left in charge - usually an adolescent girl - as a consequence of the collapse of previous care arrangements. Imagine, for example, a case in which an adolescent is left in charge of various younger siblings when a grandmother dies or the father leaves.

There are also households that are able to successfully reorganize themselves: they reorganize care and can take advantage of new opportunities that migration opens up–to study, for example. Whether migration becomes an element of vulnerability or of

Back in the origin country, Rafaelina, an unpaid care worker, is in need for care

Rafelina is 65 years old. Twenty years ago her oldest daughter migrated to Chile and made arrangements to bring a sister, and later another, and then another, until she had reunited her four sisters. The only family member that Rafaelina has remaining in the country is a son who lives with her along with his children from a previous marriage and his current girlfriend. Seven years ago, Rafaelina had a thrombosis that left half of her body paralyzed. Although she has recuperated some of her mobility, she needs help every day to wash and dress, as well as to cook and take care of household chores. In the past month they also had to operate on her knee, so her mobility is once again limited. To take care of Rafaelina after her operation, one of the daughters came back from Chile for two months. When she leaves, she will be replaced for two more months by one of her sisters, who will also travel specifically to attend to their convalescing mother. Rafaelina's daughters are concerned about who will take care of their mother once the second daughter's stay is up. Although the son lives in the house, they are certain that at any time he will leave to live his own life. They are considering hiring a live-in employee, but Rafaelina resists this solution. As can be seen, the possibility that there might be some sort of public service is not even considered.

empowerment depends a lot on a variety of factors, as well as on the context in the home and destination countries:

- In the destination country: this depends on the job situation and immigration status affected by labour or immigration policies, e.g., whether one is legal or not, if one can reunite with family members or visit periodically, etc.;
- In the home country: depends on the strength of the bonds put in place, on the availability of a support network and of the existence of a migration culture, e.g., previous migration experiences in the surroundings or in the community - as well as on the support of public institutions; and
- In all cases, migration is an additional risk factor added to previous deficiencies or vulnerabilities related to the fact that care is not a social priority.

In cases registering increased household vulnerability, what can be observed are actually two underlying problems:

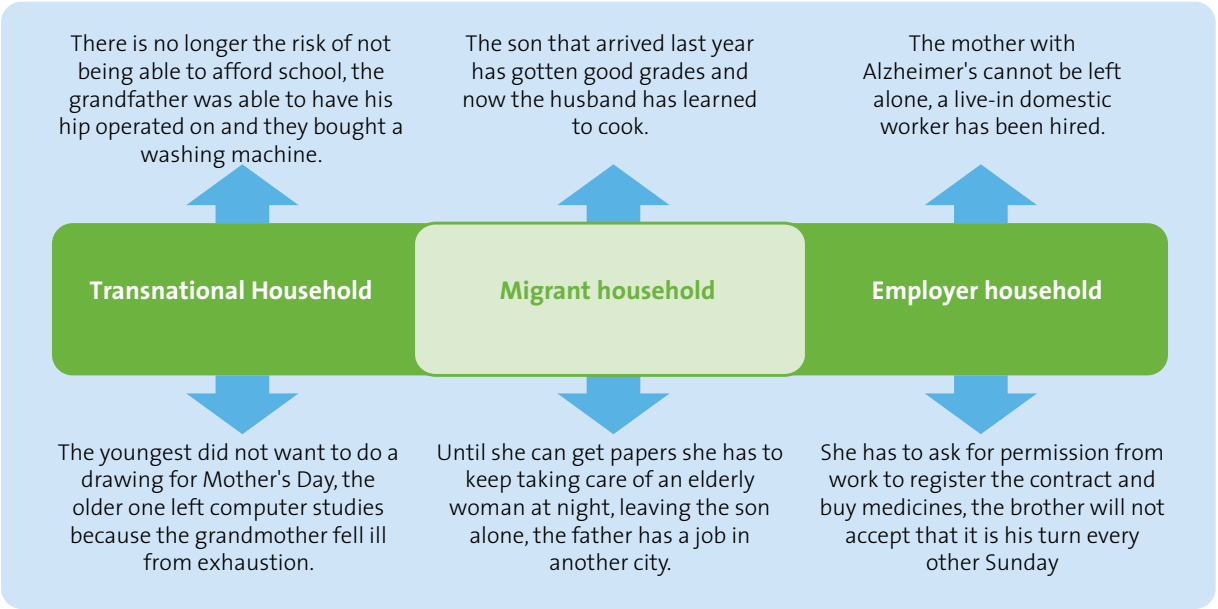
- Care was concentrated in the woman who migrated, and combined with the lack of accountability of other actors - men, the state - their absence creates great imbalances; and
- Migrant women are faced with an impossible-to-solve dilemma: they either fulfil their role as caregiver or fulfil their role as breadwinner. But to do both is impossible, despite inventing forms of long-distance care. This reflects the distributive conflict between production and reproduction explained in Session 4.

Finally, there is also the potential problem of attending to the elderly, which may arise in countries with net emigration and which, as a consequence, are experiencing a rapid aging of the population. This is occurring, for example, in certain Latin American countries.

3.4. Overall impacts

In conclusion, we can say that within any of the links, the impact on care chain households is not completely positive or negative, though the benefits for the better-positioned households in the chain (employer households) are clear.

An additional question is what happens with the other households not participating in the chains? They do not hire domestic workers and they do not migrate. They do not have access to services hired in the private sector so they must engage in unpaid work for all their care needs. And they do not have access to remittances to cover public services that do not exist or are of dubious quality - to pay for school, the hospital, to cover the wages that a sick person cannot earn, to dedicate more



time to washing because there is no washing machine, etc. By observing what happens in global care chains, issues affecting all of society, not just the households directly involved, come to light.

4. Impact on care systems

From a macro perspective, if we ask ourselves what this all means on the level of development models, what global care chains show us is that the multidimensional crisis, with its various forms and dimensions at both ends of the chain, is not receiving an appropriate answer. It is important not to lose sight of the fact that care has always been organized on the basis of inequitable transfers. As we saw earlier, there have always been care chains based on inequality. Their functioning comes from the non-recognition of care. At the same time it feeds the undervaluing of care work. What is new now is the global character of this phenomenon: we see, on a transnational level, the reformulation of elements that formerly characterized unjust care systems as the basis of unsustainable development models. What do we mean by this? Let's consider each of the defining elements of injustice in care systems:

First, a collective responsibility for care is still lacking. The public or collective responsibility for care is still insufficient. Global care chains demonstrate a re-privatization of care. Care is private in two different senses of the word:

- It is a private-domestic responsibility of the household: in the destination country, households that can afford to do so purchase domestic services while those that cannot afford to do so replace it with free labour. In home countries, recomposed or extended households deal with the necessary reorganization following migration.
- It is commodified: increasingly, those who can afford to, resort to buying care - hiring domestic employment. In the home country, the monetization of care relationships via remittances occurs.

In a broader sense, it is the sustaining of life that is being re-privatized. In the home countries, it is clear that the lack of collective solutions for life needs - education, health, social protection systems - is at the crux of migration. In the destination country, the privatization of care is a prelude to a wider process of introducing severe cuts in public services and benefits associated with the welfare state. This process has now been exacerbated by the crisis that has affected Europe and the USA since 2008.

By focusing on migration and on the conformation of global care chains we can identify the tendency to provide doubly private solution to the lack of public services: each family manages as best it can to pay for access to schools, universities, medicine, etc., and this search for privatized and commodified solutions is sometimes encouraged by public policies. For example, in Sweden, the introduction in 2007 of a system of fiscal deductions for hiring domestic workers was one of the fundamental causes of growth in this sector along with other causes, such as cuts in social services, which transferred responsibility to households. There are yet more factors: the increasing number of hours demanded by work on the labour market; the growth in wage differentials, making hiring more affordable; and rising unemployment, making those who had left the sector return to it. The problem is that labour statistics do not include a domestic employment category, so it is difficult to know precisely how the situation has evolved. To use terms from previous sessions, the level of defamilization of well-being is low and the level of commodification is high, so only groups with a good position in the market - with assets, good job opportunities, etc. - have good access to care and well-being in general. The search for private and commercial solutions is often promoted by public policy.

Second, care continues to be a responsibility associated with women, although it is articulated in different ways depending on class. So for a growing number of women this gender role consists of being managers of complex and commodified care networks: managing the hiring of domestic employees; combining this with the scheduling of extra-domestic services; covering all the gaps. In addition, hiring domestic employees is a mechanism for avoiding the conflicts that arise when men are required to shoulder their responsibilities. For example, Kerstin, who hires a Ukrainian woman to attend to the house and children, is very explicit on the subject: "At the beginning, my husband said he was going to help with cleaning the house. After a while I saw this wasn't really working and, instead of fighting

with my husband, I hired Iryna to help us". In the case of migrant women, this management occurs remotely: being responsible for care does not so much mean physically performing activities, but rather ensuring that they are performed by supervising and organizing from afar. But in addition to the role of cybercafé caregiver the migrant also takes on the role of breadwinner, which she may have had since the outset.

Breaking with the mandate to carry this burden in silence, turning the problems of work-family reconciliation into a public affair, positioning the debate around what happens when one migrates - this all means that the problem, often lived in silence and hidden behind the denial of women's voices, becomes an open letter. This is why the crisis of care has a component of empowerment, calling problems that once seemed not to exist a crisis.

Third, inequalities between women increase because the inequitable transfers between them intensify. For example, differences in wages between migrants and native-born may be enhanced by the increased presence of migrants working as domestic employees, the sector with lowest wages. Or, the axes of inequality are transformed. For example, rural-urban migration loses ground to the international migration.

The inequality between women and men persists too, and moves from the domestic sphere to the labour market. The gender division of labour then becomes international and care is unfairly distributed by social class, generation, ethnicity and migrant status. A key phenomenon is that immigration status becomes an axis of strong social differentiation. The care situation of the migrant in the destination country is especially vulnerable, and although migration is often an inter-generational social mobility project, in many cases the success of that project is questionable. In the home countries, remittance flows may enhance local inequalities, for example, by provoking inflationary processes in the real estate market or the concentration of land ownership. In the destination countries, the differences between those who can afford to hire domestic workers and those that cannot then tend to increase.

The restrictive and non-rights-based dynamics in immigration policy are the cause of the vulnerability that migration generates, both for the people who migrate and for their households in the home country. This vulnerability can be extreme, as in the countries of the Gulf Cooperation Council, where the kafala system is at work, as seen in Session 4.[2] The gravity of the abusive situations arising in such a system can be seen in the title of the Human Rights Watch (2010) report, Walls at Every Turn: Abuse of Migrant Domestic Workers through Kuwait's Sponsorship System.

In a broader sense, global inequalities become more profound. Care becomes yet another element marked by unequal international relations. In the context of the lack of public mechanisms to make up for inequalities and redistribution, inequality tends to increase. Also, once these chains are set into motion, it is difficult to put a brake on them:

- Those who become accustomed to delegating care will not give up this extra comfort as long as they are able to maintain it and the arrival of new migrant women assures that there will always be someone who has no other alternative.
- Those working in the domestic employment sector will probably keep on doing it. It is easy to get into domestic employment but hard to get out of it. In fact, it is easy for domestic employees to persuade other women nearby - sisters, nieces, daughters - to migrate and undertake this job.

2 Remember that this is a sponsorship system through which employers hold on to migrants' passports and all official documents until their departure.

Relationship and Pending Dialogue between Migration and Care Stakeholders

Why should stakeholders working on MIGRATION consider the issue of care?

- The most common sector of labor insertion for migrant women is care work.
- Due to the care crisis in destination countries, there is likely to be growing demand for female immigrant labor.
- However, care is barely on the policy agenda, and so migration policies do not usually take into account this demand, meaning that few formal channels of labor migration have been established for women to work in the care sector.
- Care work tends to be informal or very poorly regulated, making migrant women caregivers vulnerable to exploitation.
- Unregulated migrant labor may be a temporary solution to the care crisis, but it is not sustainable.
- Migrants' families' right to care is often left out of the picture, leaving them to negotiate major difficulties in terms of reconciling work and care responsibilities, family reunification, etc.
- Women's migration exposes gaps and deficiencies in the social provision of care, both in origin and destination.

Why should stakeholders working on MIGRATION consider the issue of care?

¿Por qué es necesario que los actores que trabajan temas de CUIDADOS consideren las migraciones?

- A large proportion of care workers are migrant women.
- In addition to difficulties associated with the informality of the sector (low pay, little free time, isolation, and vulnerability to abuse), migrant women have specific needs in terms of their:
  - Access to documentation
  - Ability to validate their degrees/exercise their profession
  - Access to health and care services for themselves and their families
  - Participation in spaces and social organizations that could defend their rights (labor unions, migrant associations)
- In origin, it is common to blame migrant women for social problems facing youth, instead of recognizing that their migration is often caused by difficulties providing care for their family in the first place.
- In this way, women's migration points to deficiencies in the care system in origin, and to possible points of intervention: lack of paternal responsibility; lack of social protection policies for the aging, sick or disabled; lack of investment in primary education, health, child care centers, or other services.

Source: Petrozziello (2012)

5. International instruments

There are diverse international instruments and agreements that reflect the need to articulate policies on care. They address issues that are directly related to care, although they may not use this specific nomenclature. These are instruments that we can use as references in making proposals to articulate a right to care. Among the most prominent are:

- The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW): Most specifically, in Article 2, where it obliges the State to "condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women" and Article 11, "In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Party shall take appropriate measures to prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave." Also, "To encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities."
- The Beijing Platform for Action: The agreements written into this document widely embrace several issues related to care, in particular, Action F, "Women and the Economy", that states the need to:
  - "Adjust employment policies to facilitate the restructuring of work patterns in order to make it possible for family responsibilities to be shared"; and
  - "Promote harmonization of work and family responsibilities for women and men." Actions to be taken: "Adopt policies to ensure the appropriate protection of labour laws and social security benefits for part-time, temporary, seasonal and home-based workers"; "ensure that full and part-time work can be freely chosen by women and men on an equal basis"; "ensure, through legislation, incentives and/or encouragement, opportunities for women and men to take job-protected parental leave and to have parental benefits";and "promote the equal sharing of responsibilities for the family by men and women".

It also includes agreements on a series of measures for making visible women's contributions to the economy, e.g.:

- "Devise suitable statistical means to recognize and make visible the full extent of the work of women and all their contributions to the national economy, including their contribution in the unremunerated and domestic sectors";
- "Develop an international classification of activities for time-use statistics that is sensitive to the differences between women and men in remunerated and unremunerated work, and also collect data, disaggregated by sex. At the national level, subject to national constraints:

i. Conduct regular time-use studies to measure, in quantitative terms, unremunerated work, including a record of those activities that are performed simultaneously with remunerated or other unremunerated activities;

ii. Measure, in quantitative terms, unremunerated work that is outside national accounts and work to improve methods to accurately reflect its value in satellite or other official accounts that are separate from but consistent with core national accounts";

- In the African context, of exceptional importance is the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, (known as the Maputo Protocol), adopted in 2003 and entered into force in 2005.Article 13 states that women have the right to equal access to employment, calls for acknowledgement of the value that women's work at home has and their right to have maternity leave. Also, the Declaration on Gender Equality in Africa, drawn up by the African Union in Addis Ababa in July 2004, under which member governments agreed to take measures to reduce the workload of women and expand their employment opportunities.

- In Latin America and the Caribbean, the 10th Regional Conference on Women in Latin America and the Caribbean set out an agreement on the need to progress toward establishing a right to care and the "visibilization" of unpaid care work. The Quito Consensus, adopted at this 10th Conference, establishes several agreements directly related to this issue:
  - "To formulate and apply State policies conducive to the equitable sharing of responsibilities by women and men in the family, overcoming gender stereotypes and recognizing the importance of caregiving and domestic work for economic reproduction and the well-being of society as one of the ways of overcoming the sexual division of labour";
  - "To equalize the labour conditions and rights of domestic work with those of other types of paid work in accordance with ratified International Labour Organization conventions and international standards of women's rights, and to eradicate all forms of exploitation of domestic work by girl and boy children";
  - "To adopt measures in all spheres of institutional democratic affairs and, in particular, in economic and social areas, including legislative measures and institutional reforms, to ensure recognition of unpaid work and its contribution to families' well-being and to countries' economic development, and to promote its inclusion in national accounts"; and
  - "To develop instruments, especially time-use surveys, for periodically measuring unpaid work performed by women and men in order to make such work visible and recognize its value, to incorporate their results into the System of National Accounts and to design economic and social policies accordingly."
- The International Covenant on Economic, Social and Cultural Rights, adopted in 1966, entered into force on 3 January 1976. Many of its articles deal with issues directly related to the social organization of care, mainly: Article 9 on the right to social security; Article 10, protection and assistance to families, protection for mothers and protection of children and adolescents; Article 11, right to an adequate standard of living; article 12, physical and mental health; and Article 13, right to education.
- Convention on the Rights of the Child: Articles 18, 20 and 23 specifically state the common obligations of parents (father and mother) regarding the raising of children. Regarding the role of states, it sets out the obligation they have to create institutions, facilities and services for childcare; to take appropriate measures to ensure that children of working parents have the right to benefit from childcare services and facilities; guarantee the provision of care for children who are temporarily or permanently deprived of their family environment; the right for mentally or physically impaired children to receive special care, and the obligation of states to promote and guarantee the required assistance to do so.
- Convention on the Rights of Persons with Disabilities: This recognizes "that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others". The following Articles are especially important: 19 (living independently and being included in the community), 20 (personal mobility), 23 (respect for home and the family), 25 (health) and 28 (adequate standard of living and social protection).
- ILO conventions: in addition to Convention 189, there are three other relevant conventions from the perspective of care:
  - Workers with Family Responsibilities (Convention 156): This convention seeks to guarantee that "persons with family responsibilities who are engaged or wish to engage in employment to exercise their right to do so without being subject to discrimination and, to the extent possible, without conflict between their employment and family responsibilities." Article 5-b is particularly important, as it requires the development or promotion of "community services, public or private, such as childcare and family services and facilities".

- Maternity Protection (Convention 183): This establishes the right to maternity leave with cash benefits, prohibits termination of employment due to pregnancy and protects the nursing period by establishing the right to breaks during the day, or to a reduced workday. This convention covers atypical forms of dependent employment.
- Convention 182 on the Worst Forms of Child Labour: This establishes the obligation of states to put into practice action programs to eliminate these forms of labour. This includes boys and girls in domestic service.

- International Convention on the Protection of the Rights of All Migrant Workers and their Families: After its approval in 1990, 13 years passed before it was ratified by the required minimum of 20 countries needed for it to enter into force. The greatest problem with this convention was its ratification. Until October 2010, there were only 43 States party to the convention, most of them being countries of origin for migration. This convention does not set forth new rights, but rather enumerates those already existing and extends them to migrant persons on the basis of equality among all individuals. A key aspect that could explain the reticence to ratify is that it recognizes the rights of irregular migrants by stating that they are all entitled to the basic principle of legal equality. Among the key protections related to care, which are applicable to both regular and irregular migrants, is the right to equal pay and working conditions, which is especially important in the case of migrant domestic workers. Also notable is the right to the education of children of migrants, which is especially important so that these children can have access to preschool education services before the age of compulsory schooling. The recognition of the right to family reunification is only applicable for migrant persons with legal status. This recognition is problematic because of its ambiguous wording: "States Parties shall take measures that they deem appropriate" to facilitate the reunification of migrant workers with their families and only considers spouse and children under the age of 18, omitting, for example, the regrouping of older generations that are especially important to migrant women.

Ratification status of international instruments

- Ratification status of CESCR: http://treaties.un.org/pages/Treaties.aspx?id=4&subid=A&lang=en (In case the link does not work, you can go to http://treaties.un.org, then Status of Treaties, Chapter IV, number 3)
- Ratification status of CEDAW: http://treaties.un.org/pages/Treaties.aspx?id=4&subid=A&lang=en (In case the link does not work, you can go to http://treaties.un.org, then Status of Treaties, Chapter IV, number 8)
- Ratification status of the Convention on the Rights of the Child: http://treaties.un.org/pages/Treaties.aspx?id=4&subid=A&lang=en (In case the link does not work, you can go to http://treaties.un.org, then Status of Treaties, Chapter IV, number 11)
- Ratification status of the Convention on the Protection of the Rights of All Migrant Workers and Their Families: http://treaties.un.org/pages/Treaties.aspx?id=4&subid=A&lang=en (In case the link does not work, you can go to http://treaties.un.org, then Status of Treaties, Chapter IV, number 13)
- Ratification status of the Convention on the Rights of Persons with Disabilities: http://treaties.un.org/pages/Treaties.aspx?id=4&subid=A&lang=en (In case the link does not work, you can go to http://treaties.un.org, then Status of Treaties, Chapter IV, number 15)
- Ratification status of the diverse ILO Conventions, searching by Convention or by country: http://www.ilo.org/dyn/normlex/es/f?p=NORMLEXPUB:11300:0::NO::P11300_INSTRUMENT_ID:312260

As already stated in Session 1, care should also be addressed in the context of the debate on the Post-2015 Development Agenda and on the definition of Sustainable Development Goals. In order to do so, a reference can be found in the linkages between Care and the Millennium Development Goals (MDGs):

Millennium Development Goals	Examples of their link to care
MDG 1: Eradicate extreme poverty and hunger	Women are widely responsible for producing and processing family food crops, particularly in sub-Saharan Africa. When the workload of unpaid care is extreme, women have less time and energy to devote to productive agricultural work, threatening household food security and nutrition. They also have less time to invest in the unpaid preparation of food in the home. Providing unpaid care also has very immediate financial ramifications for the career and the family, and affects people's rights and well-being.
MDG 2: Universal education	In many developing countries, children - particularly girls - provide many of the care activities described in this report. As a result, they may be withdrawn from school to care for younger siblings while their parents are out working, or to care for parents or other family members who are ill or have a disability. Even when girls do attend school, they often have to combine their education with heavy care workloads. This reduces the time they have to study and can leave them too exhausted to learn.
MDG 3: Promote gender equality and empower women	**Economic empowerment:** • Care responsibilities also inhibit women's involvement in participatory development processes [...] The result is that women's specific priorities are often overlooked. • Restrictions on the type of work available to women arise both because of the time absorbed by care and because the carer has to remain near to the person requiring care • The fact that women's working lives are often interrupted to care for dependents also limits opportunities for career advancement **Political participation** But care obligations continue to limit women's access to the public sphere, making it difficult for them to enter debates about social policy, stand as representatives for local, national and international decision-making bodies or even exercise their right to vote. For the minority who do enter political life, the strain of trying to reconcile domestic and care demands with their political roles has been shown to lead to their resignation from government posts in some cases. **Freedom from violence** Responsibilities for care and domestic work can also put women and girls at greater risk of gender-based violence. For example, the fact that men tend to do more and better-paid work while women do more unpaid work makes it difficult for women to leave abusive men on whom they and their children depend financially.

Millennium Development Goals	Examples of their link to care
MDG 4: Reduce infant mortality	An estimated 40 per cent of child deaths could be prevented with improved family and community care¬: not high-tech health equipment, but access to solid knowledge on infant feeding and breastfeeding, as well as support and basic supplies.
MDG 5: Improve maternal health	Women usually continue to shoulder heavy care workloads throughout pregnancy, putting their health at risk before childbirth. Assuming care responsibilities soon after giving birth is also likely to impede women's recovery, especially for those who already have several young children.
MDG 6: Combat HIV/AIDS	The HIV/AIDS epidemic has resulted in increased reliance on underpaid or unpaid home-based care by family and community caregivers - mainly women and girls - as already inadequate public health services struggle to cope with this added burden of care. Care for orphans and other vulnerable children for whom the ill, dying or deceased would normally have provided care has also largely fallen upon girls and women, many of whom are themselves elderly and in need of care.
MDG 7: Environmental sustainability	Depletion of natural resources, water scarcity, lack of energy sources and decreasing agricultural productivity increase the demands on women's and girls' time and health, as they have to walk greater distances, often carrying heavy loads, to fetch the water and fuel needed to feed and care for their families. This reduces the time and energy they have available for income-generating activities, education, and participation in decision-making processes. Women also have distinct and valuable knowledge about the environment, which is lost in cases where care obligations constrain them from participating in decision-making processes relating to the environment or climate change This could jeopardize larger processes of reducing environmental degradation and its impacts and undermine the effectiveness of projects at the local level.
MDG 8: Develop a Global Partnership for Development	Care is increasingly globalized. This is due to the growing role of international institutions, and to international migration that leads to the constitution of global care chains. This is why care systems cannot be addressed solely at the nation-state level. Additionally, trade and financial regulations deeply affect care systems (Session 4). And so do macroeconomic policies, which are often designed under the pressure of debt obligations.

Source: MDGs 1 to 7: Esplen (2009). MDG 8: own elaboration

6. Conclusion

Migration rarely implies the rise of totally new socioeconomic phenomena. It usually renders visible processes that are already occurring. This is the case of global care chains. Gender dimensions of globalization that frequently go unnoticed can be identified through the functioning of these chains. Globalization implies the conformation of new transnational value chains and the establishment of a new international division of labour. Global care chains show a similar pattern for the economy of care, which is an often disregarded or hidden dimension of development models.

Women play a leading role in global care chains. However, some positive changes in men's roles are perceived. These changes should be firmly encouraged. We should identify the implications of global care chains in terms of development models, going beyond the observation of their effects for the households that experience such phenomenon. These chains show at the global level the same patterns that were noticeable at the internal level of diverse countries:

- Care arrangements are based on care unequal transfers; and
- And they are framed by the lacking or weak public responsibility for care.

Their performance entails the global reformulation of unfair care systems, thanks to which people's lives are sustained and the workforce is reproduced. We see that invisible carework is the basis for unsustainable productive development models at a transnational level.

The main problem is that the chains bring all of this to light, but at the same time offer private solutions. They resolve the care crisis individually and in the short term for those social sectors with a better socioeconomic position and more resources. These sectors are also the ones that are better able to influence the public debate. Therefore, the risk is that now, the functioning of the global care chains inhibits the appearance of collective claims and facilitates the legitimization of global inequality. The most urgent need, then, is including both the organization of care and the inequality between women and men on the public development agenda.

The policy implications of the globalization of care are serious: the social organization of care cannot be affected solely by acting at the nation-state level. Cross-border interventions are needed in order to promote full co-responsibility for care, the exercise of the right to care and the observance of labour rights in the domestic work sector. Care policies must be addressed from a global approach. The question of what priority care receives by development models must be answered at the international level. At the same time, the very functioning of global care chains is a consequence of a stake for a "productivist" model of development. This happens both in the destination countries - where the massive entering into the labour market leaves a vacuum in the sphere of care - and in the countries of origin, when exporting the workforce is an explicit strategy to obtain remittances (while a vacuum in care is also reproduced). Questioning the global expansion of the unfair dimension of care systems entails questioning the global development strategies. The diverse international instruments to which countries are subject provide an enriching entry point to deal with care issues in a coordinated way at the global level.

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List of Terms included in the Glossary

- Care
- Care policies
- Co-responsibility
- Crisis of care
- Crisis of social reproduction
- Decommodification
- Defamilization
- Economy of care
- Gender
- Gender division of labour
- Gender role of women (in care)
- Production/reproduction
- Public/private-domestic domains
- Remunerated/unremunerated work (paid and unpaid work)
- Right to care
- Self-sufficiency (self-sufficient citizen/worker)
- Social organization of care

CHAPTER 7

POLICY INTERVENTIONS: TOWARD A RIGHT TO CARE AND CO-RESPONSIBILITY

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TAKE AWAY POINTS

1. Advancing toward fair care systems

From a human development and rights-based approach to care, the following measures are urgent:

- A shift from the current lacking or weak social responsibility for care toward co-responsibility between women and men, within households and between all socioeconomic actors in the public sphere (the State, private companies and the community);
- To shift from care as a woman's responsibility, toward gender equality; and
- To shift from the care-inequality nexus toward the recognition and full enjoyment of:
  - Labour rights in the care sector;
  - A universal and multidimensional right to care that guarantees access to decent care for all the citizenry.

Rights to be promoted

A universal and multidimensional right to care is comprised of:

- The right to receive the care needed in different circumstances of the life-cycle, including the fostering of autonomy;
- The right to decide if one wants to provide care or not - not being obliged to provide care because of a gender role - with the option to give care in decent conditions and assuring that caregiving does not conflict with the enjoyment of other rights.

The right to care entails a duty to care for the whole society. Therefore, advancement toward the right to care goes hand-in-hand with the construction of comprehensive social co-responsibility.

The recognition of labour rights requires:

- Adherence to ILO Convention 189 on decent work for domestic workers, which came into force in 2012,as well as the establishment and fulfilment of labour rights in compliance with this convention, as a minimum benchmark;
- The establishment of mechanisms to guarantee that migrant domestic workers enjoy all the labour rights applying to domestic employment; and
- The professionalization of the sector, linked to the establishment of public care services.

2. Guideline criteria for the progressive crafting of a right to care

In order to translate the right to care into concrete policy, we must make decisions based on a democratic debate that is lead by voices of the main players in care relations and informed by the following criteria:

- In cases where care is part of targeted policies it must be progressively articulated as a universal right. The right to care should be part of the "Social Protection Floor";
- The right to care must be an objective unto itself, not a means to achieve other aims;
- The right to care must be progressively differentiated from other rights that constitute the Welfare State, such as health, education and social security; and
- Positive feedback should be encouraged between the different dimensions of the right to care, and between this right and labour rights in the care sector.

There are best practices in advocacy for the right to care that demonstrate the need for:

- Availability of data on the social organization of care (including data on unpaid carework) on the interaction between unpaid care and employment, and on care needs;
- Availability of conceptual frameworks and methodological tools that incorporate a gender perspective, understanding that this implies taking into account the social organization of care and the care economy; and
- Cooperation between diverse actors on co-responsibility, going beyond a situation in which each of them separately assumes their share of responsibility.

3. Care policies

The establishment of a right to care requires the implementation of care policies at three levels:

- Policy that improves the conditions of unpaid care provision within the domestic realm:
  - Measures to advance toward a fairer distribution of care responsibilities between women and men; encouraging men's involvement in carework and introducing legal changes to assure equal rights and duties within families for women and men;
  - Providing monetary compensation for supplying unpaid care (money for care). This would provide financial autonomy to the persons who assume the responsibility for unpaid care. However, a critical problem is that it can have a perpetuating effect on inequality;
- Policy that facilitates interaction between the public sphere and the private-domestic realm (reconciliation measures):
  - Policies that allow for free time away from employment (time for care). Most of these measures are recognized equally for women and men, although there are major differences between maternity and paternity leave. And these are rights that are almost entirely exercised by women. And one serious limitation is that they are usually configured around remunerated work in the formal sector;
  - Promotion of flexible working arrangements;
- The establishment of care public services that take care responsibilities out of households and advance toward the professionalization of carework. Guaranteeing egalitarian access to care without compromising workers' rights seems to require imposing serious limitations on profit-making, instead focusing on public services, whether publicly funded or directly provided by public entities.

4. Mainstreaming care into policies and into the development model

Beyond these care policies, a three-fold objective with regard to care must be mainstreamed into the whole set of public policies, including health, education, housing, urban planning and transport, sexual and reproductive health and social protection:

- R1: Redistribute both care-giving tasks and the resources required to satisfy care needs among all citizens and the society as a whole;
- R2: Reduce the most precarious care arrangements;
  - Reduce the most arduous forms of carework with respect to both unpaid carework and to domestic employment, improving labour conditions;
  - Reduce dependency and promote persons' autonomy;
- R3: Recognition of care:
  - As a job: recognize unpaid carework as a job that should be compensated and fully value domestic employment;
  - As a need: recognize interdependency and avoid the idea of the self-sufficient worker/citizen;
  - View care as a critical dimension of everyone's life and not as just a woman's activity or attribute.

The current global transformation of care systems is a window of opportunity for promoting development models that are no longer grounded on precarious care, but where universal access to decent care is guaranteed. The departure point is a system in which the care economy remains "invisibilized", where the conflict between market production and social reproduction is resolved in favour of the former and social reproduction is not seen as a priority of socioeconomic organization. Unfair care systems are thus the basis for unsustainable development models, which prioritize production.

It is also critical to avoid making economic policy that has a negative impact on care and instead use economic policy as a tool that can help us to advance toward development models that prioritize well-being and assure that markets serve it. Economic policy should encourage a structural transformation aimed at creating a sustainable system, which prioritizes social reproduction. And, going beyond debate on the efficiency, efficacy and equity of concrete measures, we must also ask, "How could we advance toward a model where the production process serves the daily regeneration of well-being?"

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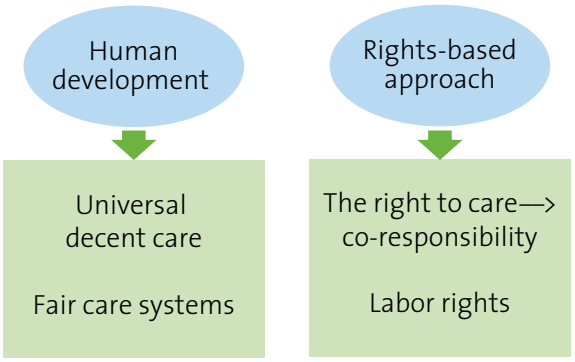
1. Social transformations necessary to achieve universal decent care

Access to decent care is a critical dimension of human development, as we saw in Session 1. When we speak of decent care we refer to situations in which individuals access care that is sufficient (satisfies needs), is freely chosen (individuals have decision-making power) and is satisfactory (fulfils what the individual considers important). How can we move, then, from a situation in which many social groups suffer from precarious care to a situation in which all individuals can access decent care? To do so, we must advance toward fair care systems.

From a rights-based approach, we may ask, "What are the rights that should be guaranteed by the social organization of care?" They are:

- The right to care: understood as a universal and multidimensional right. The right to care entails a duty to care for the whole society. In other words, it can exist solely on the basis of the existence of full social co-responsibility; and
- The labour rights in the care sector, including domestic employment as well as other professional care work.



In Session 5 we saw in detail the labour rights applied to paid domestic work, so discussion on labour rights in this session will be brief. The focus will instead be on the right to care and co-responsibility, which are two sides of the same coin. In Section 2 we will discuss some guidelines to establish the right to care. Then, in Section 3, we will explore some best practices in advocacy for the right to care. In Section 4, we will reflect on the care policies that can materialize this right to achieve full social co-responsibility for care.

The establishment and fulfilment of the right to care requires the implementation of specific care policies. Beyond that, it requires mainstreaming care-related objectives that have to inform the whole public policy (as we shall see in Section 5), as well as positioning care as a top priority of development models, as we shall discuss in Section 6.

1.1. Labour rights in the care sector

Since domestic employment is a fundamental sector allowing for a segment of households to cover their care needs in many countries, priority must be given to improving on it and matching the rights of domestic employment with those of other labour sectors. In Session 5 we saw in detail the violations of rights suffered by domestic employment as a labour sector and in this regard it is extremely important for all countries to adhere to Convention 189 of the ILO on decent jobs for domestic workers.

The connection between domestic employment and international migration is becoming narrower and this phenomenon has various policy implications:

- A need to establish mechanisms to guarantee that migrant domestic workers enjoy all the labour rights applying to the domestic employment sector;
- A need to join the Convention on the Rights of All Migrant Workers and Members of their Families; and
- A need to review all migration policies while taking into account that migrants, as with any other person, have care needs, and that they assume care responsibilities for others. This should be done by both home and destination countries.

Moreover, two debates must take place regarding domestic employment:

- The professionalization of the sector: This entails demarcation of the tasks included, distinguishing it from other professional categories where overlap currently occurs, like the nurse's aide and a domestic worker who both care for the aging with chronic or severe illness, or like the nursery school

teacher and a domestic employee who both care for the children as well; and

- Related to the former is the debate on the role that domestic employment should have within the social organization of care. Until now, domestic employment has operated as an escape route, both "commodified" and "familized". It continues to be a private solution in a private household framework that allows upper-and middle- class households to cover the gaps that are produced by a lack of co-responsibility and collective social responsibility for care. So if we aim to evolve toward co-responsibility between the actors in care provision to construct just care systems, several questions then arise that must be addressed through democratic debate on what role domestic employment would play in a social setup responsible for care provision and in what types of situations would it make sense and in what working conditions?

1.2. The right to care: concept

As discussed in previous sessions, care systems are usually unfair, which means that:

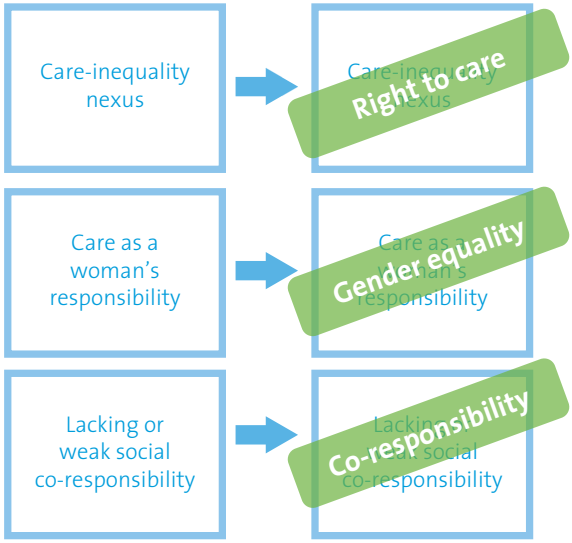
- The care-inequality-exclusion nexus forms part of various care systems that we find throughout the world;
- It is systematically connected to gender inequality and to the assignment of the responsibility of care to women; and
- Those characteristics are directly linked to lacking or weak social co-responsibility for care.

The link between care and inequality means that different social groups benefit distinctively from development processes depending on whether they access decent care or suffer from precarious care arrangements. Gender is a critical dimension in shaping such a link, but it crosscuts other inequality axes too, mainly ethnicity, social class, age and migration status. This nexus is taking on new and dire transnational dimensions too, albeit with grand and irrefutable differences according to temporal and territorial contexts. Yet such diversification does help us to identify the change patterns that must be encouraged.

Care systems are being reformed on a global scale. The care crisis originates global care chains that impact care arrangements in the home countries. Many countries are undergoing significant demographic changes and the global trend toward population ageing is opening challenges and opportunities. So how can we take advantage of this situation to achieve development processes that promote decent care instead of being grounded on precarious care?

Currently, the following patterns are identified: the intensified privatization of social reproduction; the "redimensioning" of the gender division of labour; and the increased relevance of migration status as a critical axis of the care-inequality-exclusion connection, joining the historical connections between gender and social class. Dealing with the dimensions that define the diverse care systems is therefore urgent in order to reverse those patterns:

- Achieving universal decent care;
- Establishing full co-responsibility; and
- Doing this in a way that is inclusive for women and is part of the broader achievement of gender equality.



2. Establishing the right to care as a public responsibility

The care-inequality-exclusion nexus comes about due to the absence of a right to care and also due to the absence of social co-responsibility. How do we break this vicious cycle, then? The only way is to achieve the configuration of a right to care that is placed at the very core of citizenship and consequently at the core of development processes, if we understand development from a human development and rights-based approach as "the comprehensive right to fully enjoy all rights".

To speak of a right to care means to understand care as an individual and universal right of the citizenry as a whole, from the two-way perspective of citizens who both need care (and therefore must be entitled to receive care), and who provide care (and therefore must be entitled to do so with decent conditions and in a way that assures that caregiving does not conflict with the enjoyment of other rights).

This holistic perspective, which must inspire development processes, has two dimensions, receiving care and providing care. This right - though still yet to be established - is multidimensional and would encompass:

1. The right to receive the care needed in different circumstances and moments of the life-cycle, where the fulfilment of this need does not hinge on having enough income or family or affective ties. The right to receive care not only involves assistance in cases of dependency but also the fostering of autonomy that we mentioned in Session 1; and
2. Regarding non-remunerated care, the right to choose whether one wants to provide care or not, with the following options:
   a. Having chosen to provide care, the right to do so in decent conditions; and
   b. The right to redirect care and not be obliged to provide care because of a gender role. This means that providing care, oftentimes full-time care, is not the only alternative, and that the negative impacts explained in Session 1 of caregiving on empowerment and on other rights (such as the access to education, employment, political participation, etc.) are deactivated. This involves revising the protection measures that the Welfare State must provide. The idea of "decommodification" (the possibility of being removed from the remunerated labour market while still maintaining an acceptable quality of life) must go hand-in-hand with the idea of "defamilization" (the option to not provide care in the family because formulas exist that guarantee the care needed will be fulfilled, or, the right to redirect care, meaning that providing care is not the only option available).

It is important to point out here that all people can be the subject of this right in different dimensions at the same time, for example the person with a disability who must receive care but who also has the right to be able to assist a parent who is hospitalized. Or when an elderly woman who provides non-remunerated

State intervention: Improving "Suni's" right to care

Let's remember the case of Suni, introduced in Session 1. Before the intervention of the State, the only option available to her was to leave her paying job to take care of her mother, who has Alzheimer's disease. Guaranteeing the right to chose means that Suni would have other alternatives available to her. She can leave her paying job to care for her mother if she so desires (the right to provide care) and do this in decent conditions, for example. It also means that there would be alternatives available to her should she decide not to provide this care, such as homes for the disabled elderly or home care services, which guarantee both her right to choose and her mother's right to receive care. Usually, though, we find a lack of alternatives, making care provision for many women like Suni an obligation imposed on them within the gender roles framework.

care for her elderly husband should have the right to not provide care (availability of care homes and respite housing). A domestic employee should also have the right to continue receiving a salary if she is ill, or should have the right to reunite her family if she is a migrant.

- The right to care goes hand-in-hand with the notion of the duty to care too. A collective responsibility for care should be constructed in such a way as to be synonymous with comprehensive co-responsibility. This means that responsibility in the provision of care must be shared between the public and private-domestic spheres, and it should be assumed by all actors and subjects within each sphere. And here there are more questions to keep in mind:
  - The public sphere includes the State, and the State should not just play a substitute role with respect to the family, becoming involved in caregiving solely when the family is lacking. As we shall see, this requires progressively shifting care provision from a targeted to a universal policy;
  - The public sphere includes other agents beyond the State. It includes the market (private companies) and other civil society and community agents, and all of them should share the responsibility for recognizing and guaranteeing the enjoyment of the right to care. In the context of the care that companies cover, responsibility also means that they should be responsible for part of the reproduction costs of the work force they use. In Session 2 we saw some of the key mechanisms for this: social security payments made by companies; the adaptation of timetables and labour space to caregiving needs; and the establishment of care facilities in their buildings, such as child daycare centres; and
  - In the private/domestic sphere, a redistribution between all the members of the household, especially between women and men, must take place.

2.1. How does targeted policy work regarding care?

When the right to care is not recognized as a right of citizenship, the State tends to act only as a substitute for the family. It neither supports families nor complements families in the provision of care. It appears only in those cases in which social safety nets fail and when there is no income, such as when the individual cannot guarantee access by her or his own means and within the framework of her or his family. This is what has happened historically with regard to questions such as education and health care in many countries. They were first part of targeted policies, and then became citizenship rights, while in other countries they remain part of targeted policy.

In many contexts today, care has become part of targeted policy aimed at preventing or mitigating situations of social exclusion and poverty. In cases in where "universal rights" still have not been achieved and vast layers of society live in exclusion, we can frequently see a proliferation of scattered and fragmented measures and services. In order for the right to care to be a right that is recognized and exercised under conditions of equality, it must be established as a universal right. This means that target policies should progressively include more and more social groups along a process where steps are taken to achieve universality. Granted, each country's point of departure is very different:

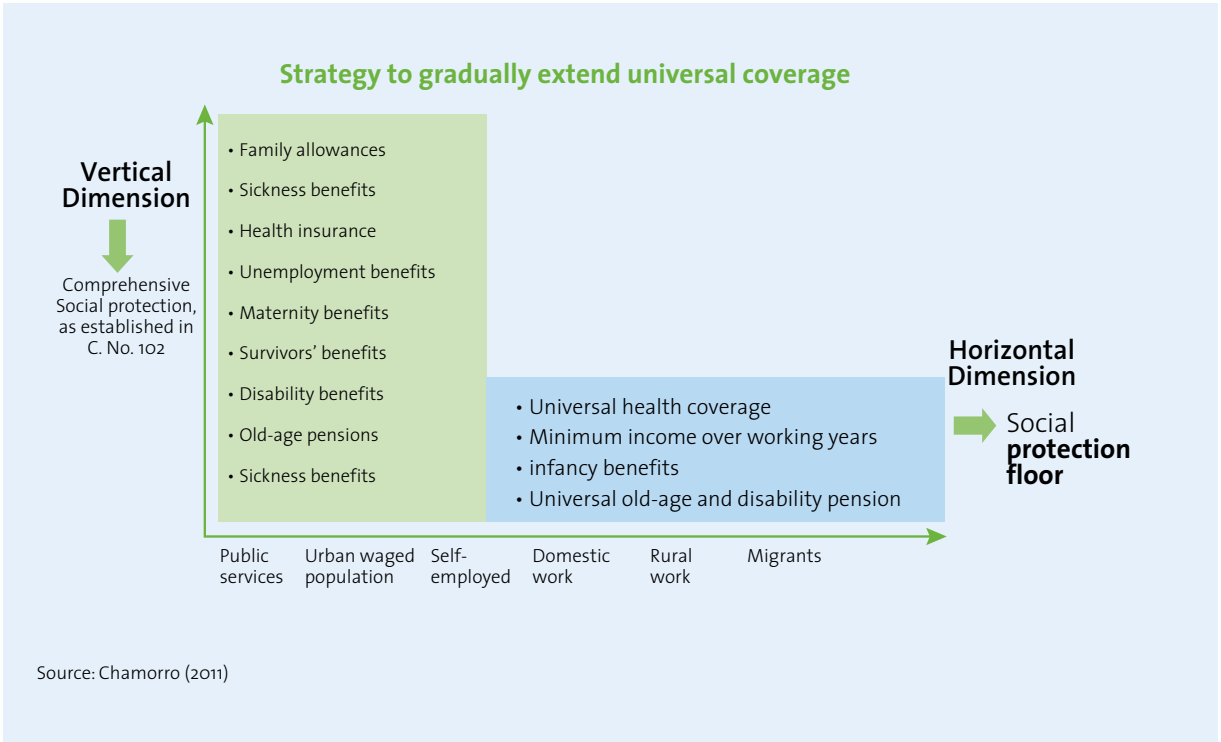
- In longer-standing welfare states, the three classic pillars, health, education and social protection, are joined by a fourth pillar that recognizes the right to receive assistance in situations of dependency. This dimension of welfare is closely linked to an aging population and means the beginning of the recognition of the right to receive care. This care is limited to what are deemed situations of dependency, a term that normally includes persons with disabilities, whether or not this is due to age. Additionally, work-life balance policies are also being crafted, which we will refer to as "time for care" and "flexible working arrangements".

- In some countries, consolidation of these three pillars still has not been attained. It is, however, important to envisage the right to care as an element that must be present at the start of any roadmap toward attaining a welfare state. In other words, from a development perspective with a rights-based, gender-equitable approach, the right to care cannot be considered the last step in the process, once the other three pillars are in place (and only when there are available resources remaining). Rather, right to care must occupy a central place with the same weight as the other three pillars. Planning and public policy systems must approach the pillar of the right to care in the same way as the other pillars of welfare. This means progressively building it up beyond the intermediary stage. And although implementing the right to care will require that the gradual introduction of quality services - with decisions to be made about which social groups are priority - the final aim should be to cover the entire population as a way of guaranteeing its rights.

2.2. From targeting to universality: the Social Protection Floor Initiative

The ILO's Social Protection Floor Initiative is a good example of how to progress from targeting to universality and especially how care must be integrated as a basic cog in the social protection machinery. On 5 April 2009, the UN System Chief Executives Board for Coordination took multilateral and urgent action "to tackle the crisis, to accelerate recuperation and pave the way for a more just and sustainable globalization". An agreement was reached on nine joint initiatives and the sixth of those initiatives was the Social Protection Floor Initiative. It calls for the administration of essential services and transfers to all individuals needing protection to prevent them from falling into abject poverty. The ILO approach to extending effective social security coverage is comprised of the following features:

- The horizontal dimension, which consists of a rapid implementation of national social protection floors, meaning a minimum package of transfers, rights and services aimed at providing access to



Source: Chamorro (2011)

essential medical assistance and sufficient income to all those in need of this protection; and

- The vertical dimension, which consists of providing greater levels of social security, complying at least at the minimum with the coverage and benefits envisaged in the ILO Convention 102 on Social Security (minimum standards), 1952, as well as other more recent standards.

Globally, the workers with the best protections are typically those within the public administration system and, in general, those working in cities. Workers who don't fit those two criteria generally suffer an acute lack of decent work and in general are unprotected. But the "Basic Floor" attempts to come to their aid, while conditions improve, so that they can access the protection that a decent job provides. The aim is to bring protection levels above the "ground floor" (in a metaphor that views social security as a stairway). While economies grow and a fiscal space is created, social protection systems can and should "rise up" the stairway, extending the scope, level and quality of the benefits and services they offer.

But in order for the Social Protection Floor to respond to social inequalities regarding social protection and access to resources, it is also necessary to bridge the gender gaps derived from women's overall lack of protection (due to lesser access to the social protection of formal remunerated jobs), women's greater vulnerability (due to bearing nearly the entire brunt of care work) and women's social exclusion (due to lesser access to resources and power). Thus, to identify the gender gaps that the Social Protection Floor must respond to, we must:

- Challenge the gender division of labour;
- Estimate and account for the economic and social costs of reproduction and care of persons in situations of dependency;
- Question the fact that access to social protection is provided only through the formal job market in contrast to social protection as a human right (exercise of citizenship); and
- Question the mechanisms of targeting due to limited resources, based on a particular model of family as compared to a universal model of social protection.

2.3. Guideline criteria to identify public policy measures

In order to translate this generic right to care into concrete policy, we must first define the sort of care we are talking about: what needs must be fulfilled and what degree of public responsibility we think should exist. For example, the same measures cannot be designed for assisting infancy as for the population of aged persons that cannot take care of themselves. Or, in the case of working adults, the public responsibility could be to guarantee quality time to organize one's personal life and be able to care for others, instead of always being available for the changing needs of companies.

We must also encourage democratic debate on the subject. The decisions regarding concrete policies on right to care have to come about through this process and the voices of the main players in care relations have to lead this discussion, putting an end to the historical negation of their voice (in the sense of political influence) and putting an end to the recognition of only those social agents working within the wage labour system. No debate on care provision can consider unions or employer representatives the only legitimate voices.

A series of guidelines should thus be followed to promote discussion, and there are three basic criteria in identifying the public policy measures to adopt. Let's look at them in detail:

2.3.1. The right to care must be an objective unto itself

Establishing the right to care focuses on the recognition of this vital dimension as a fundamental aspect of welfare and citizenship. It is an end unto itself and the measures adopted to achieve it cannot be defined as instruments seeking other ends. For example, the establishment of a network of preschools must not be obliged to prove that it will bring advantages for productivity in the future.

And at any rate, we cannot overlook the fact that guaranteeing sufficient and decent care is a way of investing in human capital that results in

productivity. The results in this sense are enormous; care is an instrument that permits the expansion of human capital reserves for the future. And the current failure to maximize women's capacities simply because they are relegated to care work is a weakness that prevents countries from progressing.

But this argument cannot stand on its own either, as it excludes from the start the allocation of public resources to people who it does not consider to be potentially productive in a market sense. In other words, if the right to care does not become an objective with its own value, there is a risk of excluding policies aimed at the elderly and at persons with disabilities, among others, from care policies.

2.3.2. Differentiating the right to care from other rights

As a guiding principle, the right to care crosscuts many other social rights. But the concrete measures that configure this right must differentiate it from others, such as the right to education or the right to health. In the countries that have progressed most in the construction of what we referred to earlier as the fourth pillar of the Welfare State, this differentiation is still underway. The interactions of this fourth pillar with the health system are blurry, and at the same time there is debate on whether care for children under 3 years of age is part of the educational system. This unclear demarcation shows how recent this attempt at incorporating care into public policy really is. And, as this incorporation takes shape, greater clarity will come with it.

In order to outline the differences between rights, then, we must be able to distinguish care work from other professional competences, and this entails the professionalization of care. This brings us to two unresolved issues:

- That professionalization, understood as the clear identification of tasks, working conditions, and required training, tends to shift the idea of the activity from the generic form of care to more qualified professions. For example, in the contexts of more developed welfare states, it is understood that the educational system performs an educational function and not one of care, and the debate then shifts to pre-compulsory schooling, where differentiation between education and childcare is clear; and
- The risk of this tendency toward professionalization is that, by default, care can end up being identified with multifaceted jobs that do not require qualifications, as we see in the case of domestic employment. The other risk is of limiting the concept of care to just assisting individuals in a situation of dependency, forgetting that all people need care always, as we saw in Session 1.

2.3.3. Positive feedback from different dimensions of the right to care

The right to care is multidimensional and the different facets of it are not independent of one another. If somebody receives care, somebody else administers it, then the person who provides the care needs care as well, and different conditions for domestic employment mean different capacities for caring for a family. In other words, the main objective is to understand the irremediable interconnection and to then seek a mutual strengthening process rather than a downward spiralling negation.

This forces us to see that there is no clear-cut division between who gives care and who receives it, that care occurs within a framework of social relations of interdependency, and that nobody can enjoy this right in only one of its two aspects but rather in both simultaneously.

This interrelation can easily take on contradictory traits. Among the most common is the clash between the right to receive care and the right to not provide care and/or labour rights in the care sector. Let's look at some examples:

- Entitlements to time or money for providing care that do not come with alternative services outside the domestic domain only serve to guarantee care at the expense of imposing it on the family. This is what happens, for example, with instruments such as leave or time off to take care of a family member, in contexts where there are no homes for the elderly. If one does not opt to take time off, what alternatives are there?

- Programs called "conditional cash transfers", prototypes of new social policy, seek the well-being of impoverished minors. However, they do so by monitoring the role of mothers, and so reinforce their role as non-remunerated caregivers. The right to choose is denied in a differential manner according to sex, either indirectly (those who get cash transfers are usually women, although men have the right to do so), or directly (conditional cash transfer programs are expressly directed at mothers, not fathers);
- The contradiction between receiving and providing care can also appear in paid jobs. For example, the more privatized and commodified the services are (e.g., at-home care, preschools, care homes), the more they tend to rely on precarious employment. This then creates problems for workers in these sectors regarding possibilities for caring for themselves and their families;
- In the same fashion, when care services are extended to the poorest quintile, it is often done so by taking advantage of work done in the volunteer-informal framework; and
- Another frequent contradiction is that of the age-old question, "Who cares for the caregivers?" Slipping into this pattern, of the woman as caregiver who ignores her own care needs, is even easier in the case of immigrant women who, as we saw earlier, are usually only recognized as caregiving agents and never as persons who need care.

The interrelation between the different facets of the multidimensional right to care, and of this right with labour rights in the care sector, can transform into a positive feedback pattern. The more preschool facilities that exist, the more opportunities there are to not care for toddlers for free at home. If these services are provided through public systems with decent employment contracts, this employment improvement will result in greater quality of the care provided. Recognizing labour rights in the care sector and guaranteeing decent conditions for family care are in then themselves ways of ensuring the care of working people.

3. Advocacy for the right to care: best practices

The progressive crafting of a right to care requires a combination of multiple efforts and the availability of appropriate tools. The following ones can be mentioned among the most relevant: data availability; the accessibility of gender and care sensitive conceptual frameworks and methodologies; and cooperation toward co-responsibility. Let's briefly discuss them by introducing examples of best practices of each one of them.

3.1. Availability of data

The availability of data on the social organization of care is the first and most essential condition in order to materialize a right to care, and these data are useful in a variety of ways. They provide a better understanding of reality, and thus more effective interventions. They allow us to elaborate more appropriate models that can be the basis for public policy decisions. Finally, they are very helpful for awareness-raising purposes because they render visible care as a job and as a dimension of well-being that has been historically neglected. Some useful types of data are:

- Data on unpaid care work: can be obtained through time use surveys and/or satellite accounts - explained in Session 3. Also, original indexes that shed light on largely invisible socioeconomic spheres can be obtained thanks to these data (see Best Practice 1: LIMTIP);
- Data on the interaction between unpaid care and employment: care arrangements are complicated when one must devote time to paid work; undertaking unpaid care responsibilities tends to limit one's labour participation (see Best Practice 2: Finland and working life survey);
- Data on care needs, taking into account the changing age structure of the population as well as the potential impact of situations that require specific policy responses, such as in Session (see Best Practice 3: Manuela Espejo Mission); and
- Data on domestic employment: this is still a poorly understood labour sector, especially with regard

TABLE 1

Official, LIMTIP, and "Hidden" Poverty Rate and Number of Poor (thousands)

	Official income poverty		LIMTIP income poverty		"Hidden poor"	
	Number	Per cent	Number	Percent	Number	Percent
Argentina	60	6,2	107	11,1	47	4,9
Chile	165	10,9	271	17,8	106	6,9
Mexico	10.718	41,0	13.059	50,0	2.341	9,0

Source: Zacharias et al. (2013)

to the situation of migrant domestic workers (see Best Practice 4: Migrant domestic work).

Best Practice 1: LIMTIP

The UNDP Regional Office for Latin America and the Caribbean (LACRO) was supported the Levy Economics Institute in the elaboration of an innovative index that connects time and income poverty. This produced the Levy Institute Measure of Time and Income Poverty (LIMTIP). This index broadens the notion of poverty, from the understanding that this can be due to lack of income as well as lack of time, because time itself is a dimension of well-being. It also looks at the way goods and services can be accessed thanks to time devoted to unpaid work. The index thus brings hidden poverty situations to light, as shown in Table 1.

Best practice 2: The Finland Work Life Surveys

Finland began a series of Quality of Work Life Surveys in 1977 aimed at monitoring the work conditions of the wage and salary earning population. Data and reports are available for 1977, 1984, 1990, 1997, 2003, 2008 and 2013 on:

- Paid work and family
- Absences from paid work life to care for children
- Reconciling work and family life
- Unpaid domestic work
- Care responsibilities

The surveys revealed many trends:

- Positive trends: greater involvement of men in care responsibilities, which can be perceived in the greater share of men who are taking family leave and the greater amount of time that they devote to domestic tasks;
- Challenges: family leave taken by men is much shorter than that taken by women; women are in charge of the heaviest domestic tasks;
- The relative position of the country: there are more opportunities to reconcile work and family life in Finland than in the rest of Europe;
- Halts that urge policy intervention: one in four employees feel like they neglect home matters because of their job. This proportion has remained stable since 1990.

Lehto and Sutela (2009) provide a detailed analysis of all the surveys (except 2013), and further information is available at Statistics Finland.

Best Practice 3: Manuela Espejo Mission

Ecuador joined the Convention on the Rights of Persons with Disabilities in March 2007 and the Manuela Espejo Mission was launched in 2009. This was an inter-institutional cooperation programme aimed at identifying and geo-indexing all persons with disabilities in the country. The in-depth study provided data on their real needs, taking into account their family and social context and the connections between poverty and disability. Data was obtained for 294,000 persons. Afterward, a new set of programmes was implemented to guarantee the disabled their right to receive care. More information can be found at http://www.setedis.gob.ec/?cat=7&scat=6&desc=misi%C3%B3n-solidaria-manuela-espejo- and http://manuelaespejo.tumblr.com/(in Spanish).

Best Practice 4: Migrant domestic work

This project by Human Rights Watch covered labour trends, immigration and criminal justice reforms in Saudi Arabia, Kuwait, United Arab Emirates, Bahrain, Lebanon, Jordan, Singapore and Malaysia over six years and produced recommendations to be made to:

- Labour Ministries and Parliaments
- Ministries of Interior
- Foreign Ministries
- Ministries of Justice and Social Affairs

These recommendations dealt with the necessary labour reforms, immigration policies, criminal justice and the role of labour and civil society organizations in the defence of migrant domestic workers' rights. They can be consulted at: Human Rights Watch (2010).

3.2. Conceptual frameworks and methodologies

Another essential element is the availability of conceptual frameworks and methodological tools that incorporate a gender perspective, understanding that this implies taking into account the social organization of care and the care economy.

Best Practice 5: Social Protection Floor and gender gaps

Joint work by international agencies, combining their complementary expertise on different dimensions of the development processes, is a critical step as well and the combined efforts of ILO, UN Women and UNDP in various Central American and Caribbean countries stands as an example. The joint work by these agencies provided a conceptual framework and a methodological proposal to be used in the definition of a "Social Protection Floor" from a gender perspective. The following table shows the implications of applying a gender perspective throughout all the stages that add up to the definition of a social protection floor:

The first three stages of the methodological tool designed by ILO, UNDP and UN Women to assess the cost of implementing a Social Protection Floor in Panama, Costa Rica, El Salvador, Nicaragua, Honduras, Guatemala and the Dominican Republic serve as a good example. This best practice illustrates what it means to obtain a gender sensitive and care sensitive methodology. The tool can be consulted in Torada et al. (2013) if you wish to learn more on this initiative.

Aim: to promote a social dialogue to assess the national situation		What should be done in order to correct gender gaps
1	Taking into account the fiscal capacity and the on-going programmes	Analysing the role that is assigned to women and men in access to and management of resources and services
2	Identifying gaps in social security	Analysing whether gender inequalities are reinforced or eroded
3	Assessing the cost and the sustainability of diverse possible options	Estimating the economic and social cost of social reproduction and of taking care of persons in situation of dependency
4	Designing specific measures to set up the social protection floor	Guaranteeing that the concept of basic services is in accordance with the social mandate of providing care for elderly persons in a situation of dependency due to age, disability or health condition

Stage: Assessment	
Content	**Gender inputs**

The completion of a country profile, identifying the population that is excluded from social security systems and defining the situation of public health, education, care-services and other services.	1. Proposals based on an initial template for information gathering:
	• In those realms that are already considered:
	  • Indicators that must be sex disaggregated
	  • New indicators
	• Additional realms that should be analysed and the pertinent indicators
	
	Example for the data on the national situation:
	
	• Already considered: macroeconomic data and labour market data:
	  • Indicator to be sex-disaggregated: employment and unemployment by sex and age
	  • New indicator: mean hourly and monthly wage gap between women and men
	• New dimension and proposed indicator: time use and unpaid work/ estimated value of women's and men's unpaid work
	
	Example for basic services of the Social Protection Floor:
	
	• Already included: access to health.
	  • Indicator to disaggregate by sex: gaps in legal/formal coverage; share over total population by sex
	  • New indicator: access to sexual and reproductive health promotion and prevention
	• New dimension and proposed indicator: care social services/coverage of services attending elderly persons
	
	2.Guidelines for the assessment–> proposal: including questions such as:
	• How do the challenges that the State faces in guaranteeing a rights-based approach depend on the sphere of care and well-being provision?

Stage: Roster of programmes	
Content	**Gender inputs**
Already designed or implemented: • Which programmes • Contribution to the objectives • Need of funds • Defining which one should be first and more carefully evaluated	Proposal–>including a question on the assumptions on which the programme is based: conditionality, assuming that any specific member of the family provides welfare and attributing responsibilities to that person, gender division of labour, etc.
Stage: In-depth description of programmes	
Content	**Gender inputs**
Objetivos, servicios y cobertura	1. Proposal–>including questions such as: • Does it guarantee the equal participation of women and men? • Does it reproduce or modify the gender division of labour? 2.A template that includes sex disaggregation of data is provided. It gathers information on (among others): • Populations not covered • Covered households, by head of household • Persons who finalize the programme

Source: Torada et al. (2013)

3.3. Cooperation on co-responsibility

Advancement toward the right to care requires the progressive establishment of a full co-responsibility between all actors. This co-responsibility can be reinforced through the cooperation between many different actors, going beyond a situation in which each of them separately assumes their share of responsibility. Examples are:

- Cooperation between multilateral agencies and civil society organizations (see Best Practice 6 on maternity protection resource packages);
- Cooperation between companies and public institutions (see Best Practice 7 on local social economy and reconciliation); and
- Cooperation among citizens, whether in terms of organized civil society or not (see Best Practice 8 on "grandmothers to grandmothers").

Best Practice 6: Maternity protection resource package

This resource package is the result of a collaboration between ILO and UNICEF, UN Women, the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the International Baby Food Action Network (IBFAN) and the Geneva Infant Feeding Association (GIFA). It is aimed at maternity protection at work and is designed for a broad audience, including decision-makers and staff from government ministries, representatives of workers' and employers' organizations, ILO staff, staff of the UN system and non-governmental organizations. It includes:

- An overview of the key issues, actors and frameworks around maternity protection at work, including its in-depth meaning and key global frameworks and instruments;
- Core elements of maternity protection at work (maternity leave, cash and medical benefits, health protection at work, employment protection and protection against discrimination, breastfeeding) and measures to balance work and family responsibilities; and
- Guidance and tools to assess national legislation and to assess maternity protection in action.

Best Practice 7: Local social economy and reconciliation

The Community Actions for the Reconciliation of Family and Working Life Enhancing the Role of Local authorities and Social Economy Programme (CARE) was implemented by the European Network of Cities and Regions for Social Economy (REVES). This programme identified and developed best practices of local authorities and social economy actors that promoted shared care for family members and new childcare/elderly care models for the local community. Information can be found at REVES and REVES (2007).

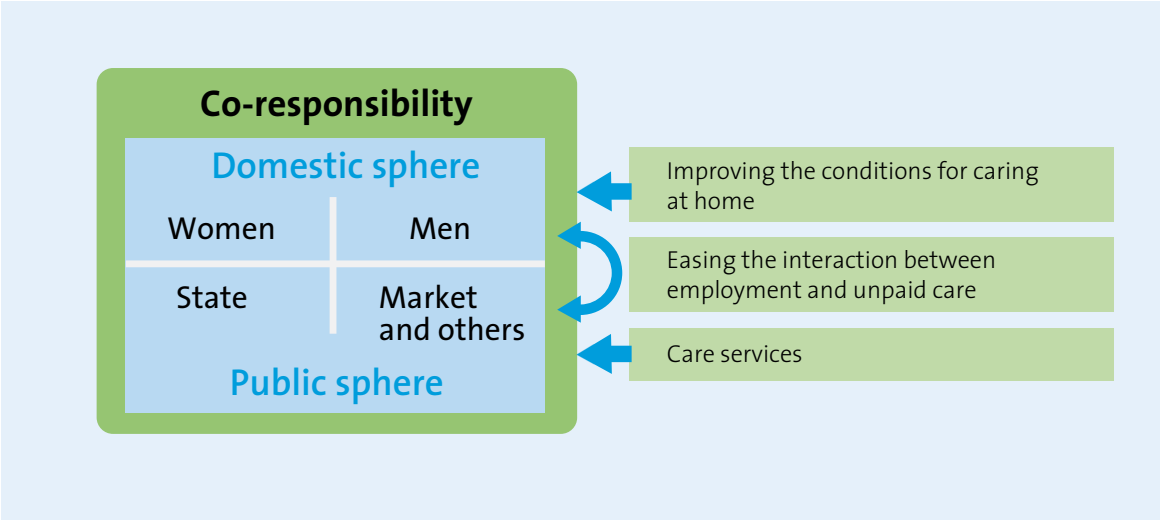
Best Practice 8: Grandmothers to grandmothers

This campaign was launched by the Stephen Lewis Foundation in 2006. It was aimed at raising awareness on the hard work of African grandmothers who take care of children orphaned by HIV/AIDS. Its main goal was to get Canadian citizens acting on the issue. From there on, an international network bringing together African and Canadian grandmothers was created, while Canadian groups organize fundraising activities. These funds then go to African organizations that support grandmothers.

- Here you can see a video on the African Grandmothers' Gathering, Swaziland, 2010 http://youtu.be/02czzNn3ixs
- To learn more on this initiative, visit: http://www.grandmotherscampaign.org/

4. Transforming the right to care into concrete care policies

How do we approach the right to care? When examining our specific contexts, what types of measures can be taken to guarantee the right to care from a public policy standpoint? Care is something that is woven into the social system, and therefore intervention can come from spheres other than public policy. Communities, cooperating agencies and other agents can intervene, as can the State. These interventions are based on the idea that, although there is still a wide expanse of terrain where policies are inadequate, especially in contexts where public



policy is greatly debilitated, focusing on those actions in public policy is also critical.

Public policy for care can be classified in different ways. One way is to differentiate according to the diverse spheres that should be involved in the constitution of co-responsibility between all social and economic actors:

1. Measures that improve the conditions of unpaid care provision within the domestic realm:
   - Measures to advance toward a fairer distribution of care responsibilities between women and men;
   - Measures that provide compensation for supplying unpaid care at home;
2. Measures that ease the interaction between employment in the public sphere and unpaid care in the domestic realm, also called work-life balance or reconciliation policies:
   - Time for care;
   - Flexible working arrangements;
3. Measures that take care responsibilities out of the domestic sphere and position them in the public sphere: care services.

Let's now examine each of these types of measures, which, as we shall see, are not exclusive. They must be formulated in such a way that they complement each other. Thus, in general terms, progress in this multidimensional right to care means:el desarrollo de sistemas de atención a la dependencia (para personas ancianas o con discapacidad);

- A network of facilities to care for children below compulsory education age;
- The development of systems to care for persons with some degree of dependency (elderly or persons with disabilities);
- A set of rights for balancing employment and unpaid care responsibilities aimed at enabling free choice; and
- The debate on the professionalization and "dignification" of domestic employment.

4.1. Improving the conditions of unpaid care provision within the domestic realm

As we just saw, there are two different types of policy relating to care measures (1) that aim at reinforcing the redistribution of domestic care work between women and men, and (2) policy that provides compensation for supplying unpaid care at home. This policy can be labelled "money for care".

4.1.1. Encouraging the redistribution of care work between men and women

Guaranteeing equal rights and duties for women and men within the family is the first step. This might require modifying family laws and personal status laws, such as in the following best practice:

Best Practice 9: Modifying family law

- On December 2003, the Mozambican Parliament passed its new Family Law, legally recognizing both customary marriages and informal unions, therefore protecting women who were previously in unrecognized unions. The law also asserts that both spouses have responsibility over the family and eliminates the requirement of the husband's consent before taking a paid job. Source: United Nations, Economic Commission for Africa and African Development Bank (2008).
- In 2004, Morocco reformed the personal status law (or family law, moudawanah) to establish equal rights and mutual duties for both spouses. It incorporates a new philosophy, not "maintenance in exchange for obedience" but "shared responsibility for both spouses". This positive change came about as a result of pressure from civil society, in particular from women's organizations, which approached the reforms from both an Islamic and a human rights framework. Nevertheless, there are still unaccomplished demands. Source: ESCWA (2011).
- In 2008, a new personal status code was approved in Bahrain. Positive results include: putting an end to uncertainty regarding spouses' rights and duties, as well as their mutual obligations

TABLE 4

Co-responsibility, help or participation?

Take responsibility FOR a task	Taking responsibility, guaranteeing and fulfilling the completion of the task. The party undertaking the task is accountable for the completion of the task, however thorough. Undertaking the task depends on the needs to be covered and not the desires of the undertaking party. This is what women most frequently do in the home.
Help a person WITH a task	Assistance or supporting the party responsible for the task. Involves being free of final responsibility. Requires supervision of the responsible party. Participation depends on the fulfilment of the desires of the party engaged and not the needs to be covered. This is what men most frequently do in the home.
Participate IN responsibility	Engaging more or less fully ("percentage-wise") in carrying out these tasks. Men generally engage only partially while women participate fully, therefore assuming full responsibility, which is often exhausting.
Share responsibility WITH somebody	Taking joint responsibility for a task (co-responsibility). Requires agreement and negotiation on what aspects of this task are shared between the parties for best results. This requires cooperation, collaboration and a commitment to full participation.

Source: Bonino (2003)

TABLE 5

Gender stereotypes and resistances

South Africa: Assuming care responsibilities calls masculinity into question	Nicaragua: Women are reluctant to allow men to be involved in domestic chores
In a study on care providers for people living with HIV/AIDS in South Africa, two male caregivers spoke about how the men in the community saw them as deviants for carrying out tasks that weren't men's work and about how they were sometimes made fun of because of this. Other studies show similar findings, indicating that a great deal of men's reluctance to involve themselves in care provision is due to the fear of being cast out by their peers for doing what is conventionally considered to be women's work. Source: Esplen (2009) **Interviews with children in the Nkandla and Mhlontlo districts of South Africa:** • Researcher: What do you kids think about this man who is bathing a baby? • Children (both girls and boys): People would say that he's crazy, bathing a baby when there's a woman around? Some would say his wife controls him. • Researcher: Do fathers cook here? • Child: No, they don't cook. • Researcher: Why not? • Child: They would lose their dignity, so the women do it. Source: Clacherty (2008) in Esplen (2009).	The complexities involved in challenging the norms and strict gender roles are crudely visible in the testimony of the work done by the Nicaraguan NGO, CANTERA. CANTERA offers a course on Masculinity and Popular Education, which includes reflections on paternity and the responsibility for domestic work. A challenge they discovered was women's resistance to the sudden efforts made by men to take on more household/housekeeping responsibilities. Many men, when they try to introduce small changes, do so from a position of power, e.g., lending a hand in the kitchen without consulting or saying anything previously. Women frequently feel a sense of invasion of their space and loss of power over a sphere of daily life that has been their domain, their source of identity and purpose. This can create conflict since the men feel that their efforts are not appreciated. To try to prevent these tensions, CANTERA works with women's organizations committed to processes for achieving feminine empowerment. This prepares the way for greater dialogue and reduces the risk of men imposing changes from a position of power, even when they do so with good intentions. Source: Esplen (2009)

and obligations to their children. Approval of the reform was encouraged by the Bahrain Women's Union through the establishment of a coalition of civil society organizations and the formation of a religious committee. Source: ESCWA (2011).

Beyond formal equality, the State can, and should, play a leading role in taking action targeted at increasing men's participation in care work. Until now, in numerous contexts, actions have been mainly directed at lessening women's personal conflicts in their work and professional lives with measures designed exclusively for women, such as flex time, workday reduction and financial aid for women. This leaves the issue of men's scant participation in caregiving largely untouched, and as we saw in Session 3, means an increase of the burden of care on women who care for autonomous men who could care for themselves as well as provide care for others.

Fostering co-responsibility in the household thus goes beyond promoting help or simple participation and more toward achieving a more just distribution of caregiving between men and women.

There still tends to be general resistance by men to engage actively in care tasks that goes beyond legal changes, however. This resistance is governed by deeply rooted gender norms that create social barriers for men, preventing them from taking on caregiving roles. The problem also emanates from women, who may resist the greater participation of men in care provision. This is partly due to fear of loss of value and social status linked to their role as caregivers, since in many societies, femininity is associated with motherhood. There is also a fear of social criticism for having failed as a wife or mother, or because a man helping may suggest that a woman doesn't have a "real man".

The most basic public policies for promoting the participation of men in care work are:

- Campaigns that stimulate critical debate on norms and traditional gender roles. This can include broader actions where, beyond TV and radio ads and posters, workshops and group actions on a community level are launched. One example of advertising campaigns focused exclusively on the topic of participation in caregiving comes from Moldova, "Reconciliation of public & private life and equal sharing of family responsibilities". Other campaigns try to approach a broader notion of masculinity in general and the negative effects that certain rigid stereotypes have on men and their families. In these campaigns, through the promotion of men's engagement with, their affection for, and care of their children, the aim is also to prevent other consequences of the stereotypical masculine role, such as violence against women. We can see an example of this type of campaign in "The Men Care Campaign".
- The second action falls within the realm of educational policy, not care policy. It has to do with educational curriculum design and mainstreaming of gender equality education on all educational levels, from preschool to university.

4.1.2. Money for care

Money for care falls in the realm of benefits granted as a compensation for devoting time to caring for somebody in the family circle. These benefits bear witness to the fact that there are people outside the labour market who are dedicated to caregiving and that this should give them access to pay and social rights. Some examples of these types of provisions:

- In Spain, the Dependency Law recognizes the non-professional caretaker within a family setting. A salary is not recognized for that caregiver, since the financial benefit granted by law (and that is below the minimum wage) goes to those needing care. However, the caregivers are offered the option to sign up for a Social Security scheme. Until 2012 the State paid the Social Security quota, but from 2012 it is the caregiver who must assume this cost. In any case, this quota was - and still is - less advantageous than that for other occupations. Even though the non-professional caregiver was conceived in the law to be something exceptional, with the hope of shifting the burden to public services created to this end, in practice it has become the pillar of the law and hence it is poorly paid women who provide the bulk of care. A System for Autonomy and for Dependent Persons has been created;

- In Latin America, several constitutions recognize the productive role of unpaid domestic work, for example Venezuela and Ecuador; this feeds into the recognition of the active role women play in low-income sectors, as the backbone of households and communities. Within this context, there are temporary financial allocations, for example, the Mission Madres del Barrio "Josefa Joaquina Sánchez" in Venezuela, where a monthly stipend of 80 per cent of the minimum wage is paid out to caregivers as an "economic compensation for the provision of care and an acknowledgement of its economic value and social contribution".

The main advantage of this policy is that of providing financial autonomy to the persons who assume the responsibility for unpaid care. Therefore it partially compensates for the difficulties in entering the labour market that grow out of those responsibilities, as we saw in Session 4. Additionally, this is a way of placing value on the work that women already do in their homes and it does give them a certain economic independence. Given that these situations apply mostly to women, this policy does contribute to closing the gender pay gap, but only slightly. And there are still serious problems associated with these measures:

- They perpetuate inequality to the extent that the benefits are usually very low; they take advantage of care that is not totally free of charge but is poorly paid. They also perpetuate the gender division of labour in that they confine women to the care sphere;
- They are frequently merged and confused with policies to combat poverty; and
- The greatest challenge is to acknowledge and value these jobs that already exist, granting economic and social rights to those who carry them out without reinforcing a situation in which most care is still provided in this manner.

4.2. Measures for combining paid work and unpaid caregiving

These policies help to ease the interaction between the public sphere and the private sphere. With respect to the public sphere they mainly refer to the integration into the workforce, although they may also apply to the capacity to study, to become involved in politics, etc. With respect to the private-domestic realm, they mostly refer to unpaid caregiving, but they can also apply to the availability of personal time for any other purpose - free time, rest, or affective relationships. They are also known as reconciliation policies or work-life balance policies and there are diverse types:

- A set of policies that recognize temporary leave of absence to undertake unpaid carework. This can be called "time for care", but only as long as it creates free time from paid work;
- A set of policies that make work arrangements more flexible, thus facilitating integration with care responsibilities. These are flexible working arrangements; and
- Employers might provide care facilities for their employees, and so make it easier for them to work (for example, childcare facilities in the work place). These care services will be discussed in the next section.

These measures guarantee that individuals can be simultaneously present in the labour market and present in the household and it is no longer assumed that the male is the breadwinner and the one in charge of the labour sphere while the female carer is in charge of the care sphere. Thus, they can be understood as an antidote to the male breadwinner bias explained in Session 4. They are also an antidote for the self-sufficient worker image, as long as they recognize that workers have care responsibilities.

4.2.1. Time for care

These are entitlements that free up time so it can be devoted to unpaid care, such as maternity and paternity leave, break time for nursing mothers, time off to care for family members and reduced work day, among others. This time can be paid or unpaid, just as time off from work can be calculated as time paid into the social security system or not.

Most of these measures are recognized equally for women and men, but they are rights that are almost entirely exercised by women. The exception is when paternity leave is not recognized, or, if it is recognised, the time allotted greatly differs from that allotted to maternity leave.

Problems associated with these types of measures:

TABLE 6

The case of paternity leave

- The duration and compensation of paternity leave varies considerably. For example, in Tunisia and Saudi Arabia, fathers are entitled to one day of paternity leave; while this type of leave is three days in Algeria and Uruguay, and three months in Iceland and Slovenia. In a number of other countries, there is no specific paternity leave, but there is a more general, short-term emergency leave or family leave that can be used by new fathers. This is the case in Cambodia, where fathers can take up to 10 days of special leave for family events, and in the Bahamas, where fathers can take up to one week of family-related leave. Paternity leave is often paid, as well, either by the employer, the social security system or a combination of both. In other cases, national legislation does not provide for paid paternity leave. Source: ILO (2009)
- Scandinavian countries are particularly advanced in this. In Iceland there is no distinction between maternity and paternity leave (parental leaves); nine months of leave with 80 per cent pay are granted after the birth of the child. This benefit is divided equally in three parts, among the mother (this is non-transferrable), the father (this is non transferrable) and the couple (mother or father). Parental rights are also the same for same-sex couples. And overall, encouraging changes have occurred as a result. In three years, the mean number of days that a father in Iceland takes after the birth of his child has increased from 39 to 83 days, while in Sweden a couple with a baby has the right to a total of 480 days paid leave, the cost of which is split between the employer and the State. If the father does not take leave, 60 of the 480 days are lost. In 2002, men made up 15 per cent of paternity leave applications, which was a 12 per cent increase from the previous year. However, the figures also indicate that in Scandinavia, paternal leave policy, designed to increase men's involvement in family life, is affected if men fear that their professional life would be compromised by taking paternity leave. Hence, it is necessary to exercise greater influence on the executive levels of companies. Source: Esplen (2009)
- While this type of government support is not always possible in low-income countries with limited State resources, some positive examples in Latin America indicate otherwise. In Colombia, a mother can transfer one of her twelve weeks of maternity leave to the father. Elsewhere, 13 countries have already implemented paternity licenses in the case of a newborn or adopted babies as well. These benefits, however, range from 2 days in Argentina and Paraguay, to 15 days in Costa Rica. In the case of Ecuador, family responsibilities are supported with an eight-day entitlement to leave for civil servants for "domestic calamity", understood as, among other scenarios, a serious illness befalling a spouse, live-in partner or blood relative up to the second degree of consanguinity. In the Caribbean, Bahamas, Belize, Dominican Republic and Cayman Islands, some type of family permits for leave are given to the parents. In Cuba, the law allows the father to share the mother's maternity leave until up to six months without losing his job, and still receive his salary. Source: CEPAL (2010).

Source: CEPAL (2010).

- All of these benefits are configured around remunerated work in the formal sector and they generally hinge on salaried employment, although some of them are slowly being introduced into self-employment schemes. For this reason, their relevance and the possibility of implementing them in contexts where much activity is informal is very limited.
- Some experts deem it more relevant to think of care services organized around the household and/or the neighbourhood, since, in the absence of a formal work environment, these are usually the first reference point for people in general, and women in particular.
- This problem is relevant not only in developing countries but also in those with supposedly structured labour markets such as developed countries, where job insecurity is increasingly becoming a reality, blurring the borders between the formal and informal job markets and multiplying the number of self-employed workers.
- When free time is not remunerated and/or it is not calculated as time paid into the social security system, this reinforces women's role as givers of free care and accentuates their present and/or future situation of greater vulnerability in work and in life.

4.2.2. Flexible working arrangements

Flex work is a broad concept that includes a variety of questions. First, an organizational culture of flexibility:

- "Culture of flexibility includes not having to choose between advancement and devoting attention to family life, not having advancement jeopardized by asking for flexibility and overall supervisor support when work-life issues arise" (Source: www.whenworkworks.org);
- "A culture of flexibility is characterized by widespread use of flexibility, absence of perceived penalties for using flexibility and an emphasis on results rather than 'face time'" (Source: OFPW, 2010);
- "How and when work gets done and how careers are organized so that work 'works' for both the employer and employee" (Source: OFPW, 2010).

Second, it also includes flexible working hours and work location. These are measures that introduce flexibility in the establishment of the working time (work hours, working day) as well as in the physical location of the worker. The main types of measures are:

- Flexitime: The employee chooses when to start and end work (within agreed limits) but works certain 'core hours';
- Staggered working hours: The employee has different start, finish and break times from other workers;
- Working hours bank: Working extra hours. The hours accumulated in the working hours bank can be taken out later as time off, or can be exchanged for modifications in working day;
- Scheduled break for external learning activities;
- Compressed hours: Working full-time hours over fewer days;
- Work away from the office (telecommuting): It might be possible to do some or all of the work from home or anywhere else other than the normal place of work;
- Short-time changes due to family emergencies.

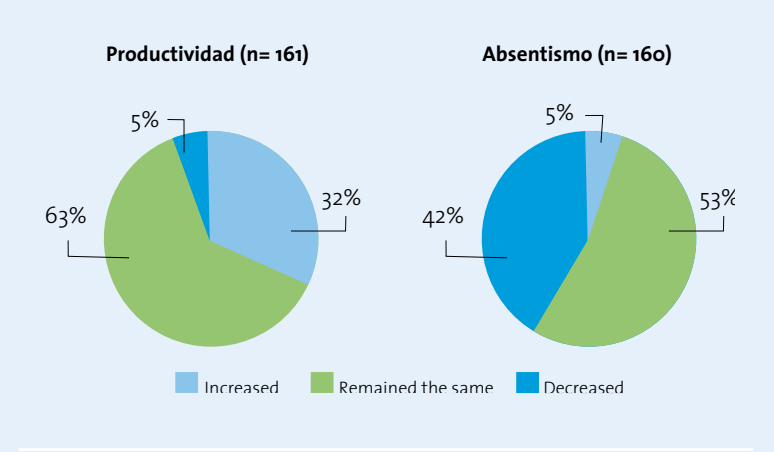
Third, it includes flexible career paths. Flexibility can be applied either in a static or dynamic way. Professional careers can be approached from a long-term perspective, alternating diverse forms of combining job and care responsibilities that respond to the changing requirements over the life-cycle. This dynamic flexibility may include diverse arrangements at organizational unit level, as well as changing tasks, locations and working hours along the career path. This concept is comprised of phased retirement, sabbaticals and extended leaves of absence so that the employee can take time off when needed for care reasons.

Myths about flexible working arrangements

A series of myths on the introduction of flexible working arrangements (FWAs) might hinder their implementation. These myths should be refuted in order to fully benefit from flex work measures in terms of paid work-family reconciliation, increased organizational effectiveness and improved employees' quality of life.

Myth 1: Productivity decreases with FWAs.
Reality: Many studies have proven that flexible work arrangements can be a win-win situation for both organizations and staff members.

FIGURE 1
Productivity and absenteeism rates of telecommuters



Source: Workplace Flexibility in the 21st Century, Society for Human Resource Management (2010), tomado de OFPW (2010).

Myth 2: Flexible work arrangements only benefit female staff.
Reality: These practices are of particular benefit to those with care responsibilities (not only staff with young children) and staff with study commitments. There are men among the staff in both situations. Indeed, they allow for the enhancement of all the staff's work-life fit and well-being.

Source: OFPW (2008)

4.3. Care services

As an alternative to policies that set the conditions for providing care at home and/or for reconciling paid work and care responsibilities, care services can be put in place. These services take caregiving tasks out of the household and insert them into the public sphere. This type of care service can be:

- Services provided in institutional spaces, for example, homes for the elderly, nursery schools, day and night care centres, respite care homes and after-school programmes for children;
- Services provided at the work place: private businesses can provide these types of services such as compulsory preschool facilities in companies with a certain number of employees. In those centres that do exist, the services are usually linked to the employment of the mother and are non-existent for males, and they only cover childcare. The service is offered more as a way of guaranteeing women's right to employment than as a way of guaranteeing the right to care; and
- Services provided in the home, for example, home assistance. Although located within the domestic sphere, care is the State's responsibility.

The basic issues around state-provided services are:

- Universal or targeted: keep in mind that when we talk of the right to care, we talk about the need for "universality";
- Different degrees of privatization:
  - Public care services managed by public administration;
  - Public funding for private centres (managed by companies or NGOs);
  - Monetary aid given by the State to households to finance the free purchase of services on the market.

The degree of privatization desirable in these services, and whether they should require users to make co-payments, is a key debate. Also in the care sector, using technology to increase productivity or to increase the quantity of care provided per work unit is quite complicated. Ultimately, there are two main ways to increase business profitability in the care sector: the gradual decline of working conditions and the segmentation of the market, where the quality of the services received varies greatly depending on the purchasing power of the care users. Also, guaranteeing egalitarian access to the care needed without compromising workers' rights seems to require imposing serious limitations on the functioning of the profit motive and making a clear stake for public services - both publicly funded and directly provided by public entities.

State action to provide care services

Aging Care Insurance in South Korea

An important example of innovation in care provision comes from the Republic of Korea (South Korea). In the past, South Korea depended heavily on the family to cover the needs of members' well-being. This started to change in the face of the Asian economic crisis of the 1990's. Within this context of poverty and the increase of single-parent families, women searched for new employment opportunities created by the lack of labour market regulation and the increasing presence of atypical types of work (half-day and temporary). Nevertheless, many women could not engage in this due to the lack of public childcare systems. In the meantime, the fertility indexes lowered and the forecasts for Korea's aging population caused alarm about the growing needs for care and the long-term reduction of work opportunities and economic growth.

In response to these challenges, and as a result of feminist activism, from 2001 onward important social policy initiatives were adopted that focused on employment and work-family balance for single and other working mothers. These measures include the National Childcare Plan, which requires the government to substantially increase the facilities and subsidies for childcare over a period of 10years in addition to an Aging Care Insurance scheme that was introduced in 2008.

The Aging Care Insurance scheme grants citizens over 65 the right to access public care services according to their needs. It covers a wide range of care services for the elderly, including help with domestic chores and delivery of prepared meals, as well as comprehensive institutional care in homes for the aged if necessary.

There was an intense debate over whether the recipients of benefits should have the right to receive it in cash or via public services. The consensus was to follow Japan's example and limit the Aging Care Insurance to the provision of services. This was partially due to feminist activists' concern that elderly people, instead of using this money to pay for caregiving, would continue to depend on their wives, daughters or daughters-in-law to cover their care needs, as occurred in Germany. The new childcare policies came about to meet both the need to increase the total birth rate and promote economic growth and gender equality by reducing the burden of care on women. Just as for childcare, care for the aging is seen as a new source of economic growth and creation of jobs for the care sector, including the training necessary for new workers in the care sector. Moreover, it is seen as an initiative that is both socially and politically acceptable.

Source: Esplen (2009).

Building a care system in Uruguay

Uruguay began a process in 2011 to create it's Comprehensive National Care System, the aims of which were to deepen the new universal social protection net as part of social reform. The care system is aimed at three sectors of the population:

- Children ages 0 to 3
- Dependent persons with disabilities
- Dependent elderly

In compliance with the criteria of universality, the system ultimately seeks to reach all persons belonging to these demographic groups. Criteria are being studied, however, for the first steps of the system to focus efforts on the most vulnerable sectors. The aim of the system is to socialize the costs related to care work through the creation of public services or by stimulating and regulating private sector care. Among the goals of the program are improving the existing range of care available both in terms of quality and in terms of access, extending and creating care systems and professionalizing and training people working in the care sector or who are planning to work in it.

To create this care system, a preliminary phase of debate was established in which task forces were created. The participants were those who would be the end users of the programs throughout the entire country, such as children, the elderly and persons with disabilities. At the same time, television and radio campaigns were launched to engage citizens in the problem and broadcast the measures up for debate. You can see the campaigns (in Spanish only) here.

The participatory and consultative process followed by the Government succeeded in giving a voice to a very diverse set of actors, including the university community. Some of the activities in which scholars participated were radio and television programs aimed at informing and explaining the importance and significance of care, the right to care and other issues. Videos of these interventions can be viewed here and here (available only in Spanish).

Source: based on information available at http://www.sistemadecuidados.gub.uy/ and www.sendasal.org.

5. Linking care policy to other policies

Care policies are separate and distinguishable from other policies such as health and education. They are, however directly connected to other policies, and in order to be implemented they must acknowledge that care goes both ways: it must be received and it must be given. The objectives are three-fold and they should cut across the entire set of policies:

- R1: Redistribute care - redistribute caregiving tasks and the resources required to satisfy care needs among all citizens, in order to construct collective responsibility for care and achieve equal access to decent care;
- R2: Reduce the most precarious care arrangements:
  - Reduce the most arduous forms of carework with respect to both unpaid carework (for example, by providing basic infrastructure that facilitates the establishment of the preconditions for care) and to domestic employment (improving its labour conditions);
  - Reduce situations of dependency and promote persons' autonomy (for example, by providing the technical means that a person with limited mobility needs in order to freely move around the city);
- R3: Recognition of care:
  - As a job: both unpaid carework (which must be recognized as an activity that requires skills, expertise, efforts and should therefore be compensated) and domestic employment (fully valuing it as a job that is performed in the domestic realm);
  - As a need: recognize that all individuals are interdependent and that acting as a self-sufficient person with neither care needs nor care

responsibilities is feasible solely at the expense of delegating care to someone else; and

- As a critical dimension of everyone's life and not as a solely a woman's activity or a woman's attribute.

The needed transformations must therefore take place at the material level (redistribution and reduction) and at the cultural level (recognition). Both types of changes are mutually reinforcing. Thus, a policy aimed at recognizing care will also help to redistribute it. For example, if carework is properly recognized and valued, it will not be relegated to those who have fewer options to choose from. Similarly, if carework is not an arduous task, it will be much easier to redistribute it. At the same time, the very fact of undertaking carework is the best way to revalue and recognize it.

It is crucial to keep in mind that specific interventions related to care are extremely important, but these are insufficient on their own. If the goal of development is the daily regeneration of wellbeing (care), then all public policies must be targeted at favouring care. Among the most relevant policies that have consequences on, and affect, care, we find:

Mainstreaming Care into Infrastructure policies

SAFE is an initiative that promotes safe access to firewood and alternative energy in situations of humanitarian crises. It makes a distinction between diverse phases and issue areas. The following objective is one of those recognized for "Livelihoods, Development & Food Security" in Phase II, "Acute emergency":

"Support development/use of alternative fuels/energy technologies as a means of decreasing time spent collecting firewood/cooking and increasing time available to women to participate in productive activities/non-wood, fuel-intensive income-generation activities".

FAO and UNDP were largely responsible for these provisions. UNHCR, WFP and NGOs (including Action Aid, Mercy Corps) also contributed.

Source: IASC (2009)

Type of policy / Main impact	R1 (redistribute)	R2 (reduce)	R3 (recognize)
Social policies: In Session 4 we discussed the importance of this policy and in this session we've just explained the ILO's Social Protection Floor Initiative, which clearly demonstrates the interrelation between social protection and care policies. Especially pensions, disability compensation and basic social services.	X	X	
Educational policy: The distinction between care and education in infancy is very blurry. The educational system can establish measures that have a positive impact on care while still being within the educational realm, an example being the promotion of extra-curricular programs. Similarly, a balance should be reached between school and work schedules without excessive school hours: the trend would preferably go toward reducing workdays and synchronizing the starting and finishing hours of schools with parents' jobs. At the same time, the school system can play a central role in breaking with gender stereotypes in the delegation of care work, through teaching children to value care and the need for all of us to take responsibility for it.	X	X	X
Health policy: A pivotal dimension of daily care is health and disease prevention. In fact, it has been widely recognized that health systems could not function without the unpaid work done by family members - in general, women - both in hospitals as well as in the home. For this reason, all decisions taken regarding health policy have an impact on care. For example, in some countries, feeding hospitalized patients is the responsibility of the patient's family. This means that this person (generally a woman) must be available to carry out this task	X	X	
Housing, urban planning and transport policy: These policies have a great deal of bearing on care arrangements. Housing and urban planning policies have an impact to the extent that they either facilitate collective care management or they don't, e.g., availability of public recreational spaces where children can play safely or ample walking space versus motor vehicle space. Transport policies in themselves influence the amount of time people spend on moving from one place to another and hence, time available for care.	X	X	

Type of policy / Main impact	R1 (redistribute)	R2 (reduce)	R3 (recognize)
Infrastructure policy: These policies have a direct impact on the burden of care and the how hard it is to provide that care. Access to adequate infrastructure - running water, electricity, drainage, etc.- drastically reduces the level of difficulty involved in providing care.		X	
Sexual and reproductive health policy: These guarantee that women can choose how many children they have and how births are spaced, thus reducing the burden of care.		X	X
Labour market regulation: In Session 4 we focused closely on the interrelation between labour policy and care. We should add here that this also has a direct impact on the availability of the reconciliation measures recently mentioned. It defines the degree of co-responsibility for which companies are accountable and is especially important to avoid the male breadwinner bias.	X	X	X
Trade policy: In Session 4 we focused on the interrelation between trade policy and care, mainly by focusing on its impact on labour conditions.	X	X	
Immigration policy: These policies configure migrants' right to care and they can make family reunification difficult or impossible. Also, by hindering or impeding administrative processes regulating migrants' legal status, these policies can have an impact on the conditions in which domestic employment is performed. Domestic employees with irregular migration status suffer greater vulnerability.	X	X	

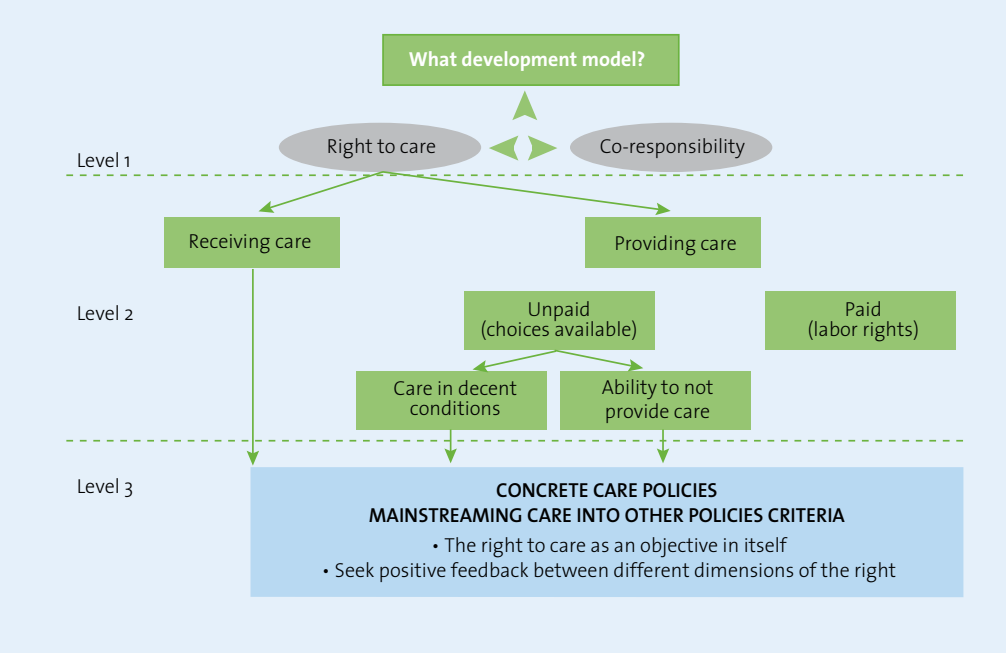
6. Which development model allows for the right to care?

The two-fold human development and rights-based approach places the right to care at the core of the development process. And consequently, it also places social co-responsibility and labour rights in the care sector at the core of the development process.

- It is a universal right - although targeted policies might be the departure point to progressively achieve universality; and
- It is a citizenship right, and therefore entails both formal recognition as well as the capacity for the effective exertion of that right. There is no clear division between inclusion and exclusion, only a line connecting the negation, formal recognition and full exercise of rights, a configuration in which multiple economic, social, political and cultural factors come into play. The final aim is its full exertion.

Having said that, to what extent does the effective exercise of a universal right to care require sweeping transformation of the socioeconomic structure? The right to care acts as a guiding principle of the social structure rather than as an additional dimension of well-being that can be fulfilled through concrete policies, which are nevertheless necessary.

The Right to Care: From guiding principle to concrete policies



In this figure, the right to care can be seen as a guiding principle of social structure. Working from this level upward, we must identify what specific rights are included in receiving care, providing non-remunerated care and working in the care sector (second level); finally, we debate the measures through which these can come about (third level).

As we saw in Session 4, the departure point is a system in which the care economy remains "invisibilized". The structural conflict between market production and social reproduction is presently resolved in favour of the former process: social reproduction is understood as a cost for the production process and not as its final purpose; neither is it seen as the priority axis of the socioeconomic organization. This is especially clear in terms of the social organization of time. A prerequisite to the right to care is the availability of time: time to care; to receive care; to care for oneself; time to engage in reciprocal care relationships. This means that care is cross-cutting - permeating all of life's facets - and this is irreconcilable with the fact that living time is informed by logics that are far from care itself. At the same time, the labour market requires that workers act like self-sufficient subjects, fully available for employment needs and with neither care needs nor care responsibilities. This ideal worker reflects a conflict between:

- Companies' need for employees to be available and ready to move at their behest and, in deeply informal markets, workers' need to put in long days and carry out several jobs to make sufficient income;
- The care needs and responsibilities of people that work or are engaged in some type of job in the market.

This figure is a fiction that only one part of the population can simulate, provided that there is an entire, nearly invisible sphere of caring going on to fulfil these needs and responsibilities. The so-called conflicts in work-life balance are really just the structural impossibility of expanding this standard model worker.

This micro perspective on citizens' position as workers and carers explains wider macroeconomic phenomena, where unfair care systems are the basis for unsustainable productive development models. Neglecting the right to care is an essential factor retaining the structural tensions that characterize a socioeconomic system that gives priority to the logic of accumulation and therefore prevents the existence of social responsibility for taking care of life. There are two relevant limits inherent in those types of unsustainable productive development models, then:

- The logic of accumulation, according to which care is a cost, and the right to care then appear difficult to reconcile. At the same time, such logic of accumulation acts as an organizational axis for the socioeconomic system; and
- Though investing in care might be seen as investing in human capital, and therefore lucrative from a market perspective, it becomes evident that the distributive conflict between production and social reproduction reappears. For example, reconciliation policies are frequently aimed at making it possible for women to enter and remain in the labour market, rather than guaranteeing the right to choose whether workers want to provide care or not.

In Session 4 we argued that economic policy, especially fiscal and monetary policy, should avoid reproducing the male breadwinner bias. In other words, the assumption that workers are always fully available should be prevented, because the hidden side is the need for individuals who undertake invisible care tasks in the household. Moreover, the deflationary and commodification biases should also be avoided. This means that the State should play a leading role in the economy, both in the direct provision of care services and in the establishment of a framework that makes possible a fair social organization of care.

Two essential points might then be concluded. First, economic policy plays a critical role in the definition of the priority that care receives in any given development model. Second, making care a priority in development models requires putting limitations on the functioning of the profit motive as the driving force of the economic system.

In effect, the conflict between production and social reproduction implies that there is an inherent contradiction not only in striving to guarantee a right to care through market expansion, but in the will to do so within a system in which the logic of accumulation is the priority axis of socio-economic organization. Therefore, beyond the debate on the efficiency, efficacy or equity of concrete measures, we must place the discussion on a structural plane: How can we advance towards a sustainable (re)productive model, grounded on two pillars - the right to care, and co-responsibility - and in which the production process serves the daily regeneration of well-being?

7. Closure of the session

So how do we picture a scenario in which the right to care is recognized? How do we picture a society that has successfully given care a priority role in its development model? Juliana Martínez Franzoni, co-coordinator of the report, Work and Family: Toward New Forms of Reconciliation with Social Co-responsibility, by the United Nations Development Program in Latin America and the Caribbean (LACRO) and the ILO, describes it like this:

"The ideal situation would be one in which, firstly, people would have decent paid employment, meaning jobs that provide decent wages and possibilities for the collective bargaining of working conditions, as well as social security, maternity and paternity leave, not only for birth but for illnesses and situations demanding special care provision. In productive worlds, where formal enterprise with high productivity coexists with informal enterprise with extremely low productivity, the formalization of labour relations requires the active participation of the State to transform production costs into investment, amongst other things.

Secondly, quality public services must exist, emphasizing care and education systems, as well as schedules that facilitate covering the needs of children, elderly, the sick, and others, while participating in the working world.

Thirdly, care and work-life balance must stop being an issue concerning only women and become one of people, meaning both men and women.

Effectively, the ideal situation would be one where both labour markets and public policy place at the centre of their concerns persons with rights and responsibilities to give and receive care.

We mustn't get side-tracked. In the words of Rebeca Grynspan, appointed UN Undersecretary and Associate Administrator of UNDP, at the public launch of this report in Geneva, in the context of the Annual ILO Assembly: "All living beings need care: from feeding and cleaning, to affection and emotional support. Care encompasses a wide spectrum of human needs without which we could not grow nor function in society. Without care there are no institutions, there is no economy, no State, no family; there is no society. Furthermore, from a rights-based approach, without care there are no capabilities and without capabilities there is no freedom. Public policy must recognize this and act accordingly."[1]

1 Interviewed by America Latina Genera, http://www.americalatinagenera.org/es/index.php?option=com_content&view=article&id=1197&Itemid=364.

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List of terms included in the glossary

- Care
- Care policies
- Co-responsibility
- Crisis of care
- Decommodification
- Defamilization
- Economy of care
- Gender
- Gender division of labour
- Gender role of women (in care)
- Household Satellite Accounts
- Human development
- Interdependence
- Production/reproduction
- Public/private-domestic domains
- Remunerated/unremunerated work (paid and unpaid work)
- Rights-based approach
- Right to care
- Self-sufficiency (self-sufficient citizen/worker)
- Social organization of care
- Time-Use Surveys
- Total workload

CHAPTER 8

PERSONAL REFLECTION: CARING ABOUT CARE

CHAPTER 8

PERSONAL REFLECTION: CARING ABOUT CARE

We have reached the last week of the course and now it's time to write the assignment. Session 8 includes no additional content, we're simply going to wrap up the main ideas of the course (take away points) and establish how everything we have learned here can make a difference in our personal lives (personal reflection). Hopefully you're all now better prepared to incorporate a critical issue for gender equality and development into your day-to-day work with a solid foundation.

1. Care and women's economic empowerment

There are six changes related to care that must take place in order to achieve women's economic empowerment:

- Reduce the barriers that women face in gaining access to employment: these barriers are numerous, but are especially related to the work performed almost exclusively by women (non-remunerated carework);
- Identify and erode intra-household power dynamics: the unbalanced bargaining power of men and women affects the unequal distribution of care responsibilities; at the same time, the unfair share of care-giving tasks that are undertaken by women reduces their bargaining-power;
- Engage men in all types of carework, increasing their involvement in non-remunerated work and encouraging their presence in the care sector;
- Shift the place that care occupies in the development agenda: care should be granted top priority in development and should not be misused as a tool for development. This requires redistributing and recognizing care;
- "Dignification" of working conditions in domestic employment and professionalization of the care sector; and
- Make visible the effects that economic policies have on the care economy: one of the hidden consequences that should be avoided is to overburden women with carework.

2. All of us need care; but is it a shared responsibility?

Care is comprised of all those activities necessary to recreate, day after day, the physical and emotional well-being of people. It embraces:

- Tasks that involve direct interaction between people in the interest of physical and emotional health (direct care);
- Tasks that lay out the material conditions that then allow for direct care to take place (preconditions for care); and
- Coordination, planning and supervision (mental management).

Approaching care from a life-cycle perspective allows us to recognize that care is an ever-present reality in our lives, although the conditions under which we provide and/or receive it change. We must deal with

the crosscutting character of care as well as with its changing concrete manifestations.

Discussing care implies focusing on daily well-being. There are specific care policies targeted at certain population groups, such as children or the elderly. Beyond that, care crosscuts the entire set of public policy and the broad priorities of any given development model can be identified by asking about the priority that care is granted.

Care illustrates how life is a relationship of interdependence, but that this interdependency has now been sorted out in unequal terms:

- Every one of us needs some form of care at all moments of the life-cycle, but the resources available to cover this need are very unfairly distributed. Social groups are differentiated in terms of their ability to access decent care; and
- During the majority of our lifetime, most of us are able to assume our share of co-responsibility for care. However, because care is undervalued, we usually delegate it if possible. Carework is then distributed around relationships of inequality based on gender, social class, migration status and race-ethnic differences.

Care is a question of the utmost importance when considering gender inequalities:

- Women perform the majority of care tasks, most of which are not paid. When care enters the labour market it is characterized by poor conditions. Carework also does not usually provide access to economic and social citizenship; and
- Unequal distribution of care has a negative effect on other aspects of life: taking on a large number of non-remunerated tasks means that women have less time and fewer opportunities to get involved in other activities. It also undermines their intra-household bargaining power.

There are several international instruments that establish the mandate for building social co-responsibility for care, therefore assuring that all persons can access decent care. The following are among the most relevant:

- CEDAW
- The Beijing Platform for Action
- The MDGs (and most probably SDGs)
- Regional norms such as the "Maputo Protocol" and the "Quito Consensus"
- The Convention on the Rights of the Child
- The Convention on the Rights of Persons with Disabilities
- The Convention on the Rights of Migrant Workers and their Families
- ILO conventions156, 182, 183 and 189.

3. Identifying the social organization of care: what are the needs and who are the care providers?

In order to comprehend the social organization of care in a specific context, we must look at two crucial issues:

- The care requirements:
  - Zooming out to take into account the entire population: There are three critical questions. Does society distribute caregiving tasks among all those potentially autonomous persons, or does it only assign these tasks to one segment of society? Does the labour market require workers to act as persons with neither care needs nor responsibilities? Do collective structures to guarantee care exist or is the provision of care considered the private responsibility of each household?
  - Zooming in on diverse age groups: What is the age composition of the population? How does it evolve? What weight do care needs related to childhood and old age have? Do they receive specific attention?
  - Zooming in on specific groups: Are there urgent or peculiar care needs such as those related to a high incidence of disability, a care emergency (for example, due to HIV/AIDS), large age imbalances, large sex imbalances, etc.?
- The different scenarios in which care needs are (or could be) met.

- What is the role played by the State, private companies, domestic employment, the third sector and households?
- What are the articulations between the different actors? Is the whole society co-responsible for care, e.g., is a sufficient level of "decommodification" and "defamilization" promoted? Or are households taking on the bulk of the responsibility for care by using resources privately available - either using monetary resources to purchase care services (high commodification of care) or drawing upon the unpaid labour of family members (high "familization" of care)?

4. Care is part of the economy. The economic system can be revisited by approaching it from the perspective of care.

Care is part of the economic system in a double sense:

- Care is the base of the market economy and persons who produce in the market must first be reproduced; and
- Care is itself an economic activity, where "economy" is defined as the whole set of processes that satisfy human needs, whether they occur within the market or not. Care is a critical dimension of well-being and to cover it, resources are required. Care is also a job that must be performed.

Focusing on care implies paying attention to those non-market spheres of the economic system that are frequently disregarded when making decisions on economic policy. Unpaid work thus serves three functions:

- Broadening well-being: purchase, transformation, adaptation and maintenance of market goods and services; plus production of additional goods and services;
- Expansion of well-being: covering the affective and relational aspect of persons' well-being; and
- Interaction with the labour market to make sure that workers are available and ready to produce.

Looking into economics as a whole from the perspective of care implies placing the processes of sustaining daily life in the centre and asking how gender inequalities are reproduced through economic performance. This raises several questions:

- "Macroeconomic" level: The economic system is comprised of many different spheres including market production and care/social reproduction; markets and households; paid work and unpaid work. There is a conflict between production and social reproduction regarding distribution: are living conditions the ultimate purpose of the economy (is production just a means to it)? Or are living conditions an adjustment variable that facilitates a profitable productive system? When care acts as an adjustment variable, the consequent economic system is in the shape of an iceberg: reproduction is concealed and becomes the invisible base on which development is grounded.
- "Mesoeconomic" level: Both the Welfare State and the labour market tend to assume that there is an infinitely elastic cushion of unpaid carework. The numerous forms of labour discrimination on the basis of sex are deeply linked to the unfair distribution of care tasks. Households are those economic units in charge of closing the economic cycle.
- "Microeconomic" level: Households are not a harmonious unit but an arena for cooperative conflict. According to gender roles, men are expected to be the family breadwinners and women the ones in charge of family well-being. This is why women's economic lives tend to be much more flexible than men's lives.

All economic policies have a gender impact and an impact upon the care economy. The most commonly identified impacts upon care are the following:

- Recessive bias: These are policies that keep the activity of the markets below their full potential. Women usually are the first ones to be expelled from the labour market at the same time as they become overburdened with carework;
- Commodification bias: These are policies that prioritize the private sector at the expense of the

public sector. They increase the unpaid care burden of households; and

- Male breadwinner bias: Policies that reinforce traditional gender roles - male breadwinner/female caregiver.

Fiscal, monetary, labour, trade and social protection policies have specific impacts upon care as well.

5. The present social organization of care is unjust

The way care is organized varies widely in different societies and contexts. While in some we find that the State participates significantly, in others the State is hardly present at all and the burden falls almost entirely on more or less extended households. The presence of the community and the third sector also varies greatly.

Despite large geographic and historical differences, there is one factor that most care systems share: they are unjust, although this unfair character varies widely.

- Social responsibility in the provision of care is lacking or weak: The State sometimes takes on responsibility for the provision of care. Nevertheless, often the bulk of care requirements is delegated to households, to the domestic-private sphere. Citizens are asked to act as self-sufficient subjects, especially when entering the labour market. Interdependence, which urges social co-responsibility between all citizens, public and private actors, is suppressed.
- Women are assumed to hold the responsibility for care: While care-giving is not conceived as a man's responsibility, women are considered to be born willing and skilled care-givers. These gender stereotypes are the basis for the gender division of labour, for women assuming the bulk of unpaid carework and for the devaluation and feminization of the domestic employment sector.
- There is a systemic nexus between care and inequality: A vicious cycle is created between care and exclusion; vulnerability or poverty. The existence of asymmetrical flows of care from those who are in a lower socio-economic position toward those who are in a higher one - from women to men, from lower to upper classes, from some countries to others - is a common pattern.

Building care as a collective responsibility assumed by all citizens and institutions is urgent in order to reverse this unequal access to care and to advance toward gender equality. Care must be considered a right, which facilitates the further exercise of other rights.

6. The two pillars of the provision of care: unpaid work and domestic employment

Overall, care systems in most contexts are "familist". The degree of social co-responsibility is low, therefore care is mostly assumed by households thanks to unpaid carework and/or the hiring of domestic employment.

There are two main tools that shed light on the performance of unpaid work within households:

- Time use surveys provide crucial information about the time that each family member dedicates to different activities - personal needs, leisure, employment and unpaid work. The results show that:
  - Care is primarily a female task and there are more women undertaking unremunerated carework than men, and they dedicate much more time to it;
  - Women's total workload - which includes remunerated and unremunerated work - is higher than men's;
  - While men dedicate the largest amount of time to employment, women's total workload is mostly composed by non-remunerated work;
  - The total workload and its distribution vary depending on ethnicity and social class, or whether it is in a rural or urban area; and
  - Women's dedication to carework varies depending on changes in the life- cycle, household composition and available income. Men's dedication tends to draw out a constant line regardless of these variables.
- Satellite Accounts of Household Production measure the monetary value of the unpaid work

performed in households and compare it to other components of National Accounts. They allow us to reach the following conclusions:

- The monetary value of the unpaid services provided in households represents very high percentages of countries' GDP;
- This value is notably greater than the value of related sectors in the market (paid domestic work, cleaning services, other care services), and of public spending in social services; and
- This value is obtained principally through the work of women.

Domestic employment is the second pillar of care systems

- The reasons for hiring domestic employment lie between two extremes: hiring might be motivated by an ambition of social distinction or by pressing care needs. The volume and the conditions of domestic employment are very sensitive indicators of the degree of social inequality (whether hiring is a cheap way of improving the social status or quality of life for certain social groups) and of the degree to which co-responsibility in the provision of care is lacking (whether hiring is the sole way of solving care needs).
- Domestic employment is a labour relationship that is established individually and takes place in the household. These distinguishing features complicate the protection (or even the recognition) of labour rights in the sector. These rights are often violated and situations of serious exploitation are not rare.
- It is a highly feminized sector that constitutes a very important source of employment for women in most countries. The women workers in this sector tend to belong to the working classes and/or to be migrants - either international or internal migrants - and/or to belong to discriminated ethnic groups. The presence of children and adolescents is also very significant.
- Regulations applying to the sector are usually poor, ranging from total lack of any regulation at all, to poorer labour conditions relative to other occupations and/or to the systematic failure to observe the norms. The following labour rights are usually violated to varying degrees:
  - The right to fair, equitable and satisfactory working conditions;
  - The right to Social Security;
  - Compliance with labour legislation and the right to legal aid; and
  - The right of workers to organize collectively.
- This vulnerable situation is exacerbated in the case of migrant domestic employees, who are subjected to immigration laws and live in greater isolation than native-born workers.

7. Care is being globally reorganized: The care crisis and global care chains

Care systems are being reconfigured worldwide. Many countries are experiencing a care crisis, whether it is embedded within a wider crisis of social reproduction or not. A care crisis refers to a situation in which the ability of a given society to provide care is not in accordance with the care requirements of the population. There are diverse factors than can prompt it:

- The aging of the population - which is a feminized phenomenon - when it is linked to a high incidence of poverty and/or when adequate care policies to deal with the new challenges are not implemented, such as policies that assist the elderly and that assume the caregiving tasks that they can no longer provide;
- The increase in the rate of women's activity in the market and the changes in their life expectations when these changes are not accompanied by other transformations: (1) a stronger co-responsibility for care of men and the State; and (2) changes in the labour market in the sense of recognizing that workers do have care needs and responsibilities.
- Broadly speaking, development models do not take care into account. Grounded on the distributive conflict between production and reproduction, they rather assume that there is an infinitely elastic cushion of unpaid carework. For example, urban

growth models that complicate care arrangements are prioritized.

The social organization of care is reaching a global dimension due to international migration and to the formation of global care chains:

- A large share of migrant women are employed in the care sector - mainly in domestic work - where job opportunities are created as a consequence of the care crisis;
- The migration of women provokes a reorganization of care in the origin household. Women tend to play the leading role in these new arrangements, mostly women from the extended family; and
- Global care chains have ambivalent impacts that differ for each one of the involved households. They provide private solutions to problems that should be collectively solved. Migrant households in the host countries suffer from peculiarly vulnerable care arrangements; and
- From a broader perspective, what global care chains show us is a worldwide reformulation of unjust care systems: they demonstrate a re-privatization of care; care continues to be a responsibility associated with women; and the care/inequality nexus reconfigures itself and reaches a new global dimension.

Keep in mind that care chains are not such a new phenomenon. Care chains have always existed and have always been testament to inequality and the lack of co-responsibility on a local or national scale. It is the global dimension that these processes have acquired that is new. The globalization of care urges countries to implement cross-border interventions in order to promote comprehensive co-responsibility for care, the exercise of the right to care and the observance of labour rights in the domestic work sector. Similarly, the question on what priority care receives by development models must be answered at the international level..

8. Policy interventions toward the right to care and co-responsibility

United Nations Agencies are subject to a mandate for action on care that is grounded on:

- The human development approach: Care is made up of a set of activities that allows life to exist, life being at the heart of human development. Therefore, assuring universal access to decent care must be a critical component of development;
- The rights-based approach: There are many different recognized labour rights that are often violated in the domestic employment sector. At the same time, many human rights intersect with what we could recognize as a right to care (both to receive and provide care).

Advancing toward fair care systems requires a three-fold transformation:

- From the current lacking or weak social responsibility for care toward co-responsibility: between women and men within households and between all socioeconomic actors in the public sphere (the State, private companies and the third sector);
- From care as a woman's responsibility toward gender equality; and
- From the care-inequality nexus toward the recognition and full enjoyment of:
  - Labour rights in the care sector; and
  - A universal and multidimensional right to care, including (1) the right to receive the care needed in different circumstances of the life-cycle, and (2) the right to decide if one wants to provide care or not, with the possibility of caring in decent conditions.

The recognition of labour rights requires:

- Adherence to ILO Convention 189 on decent work for domestic workers, which came into force in 2012. As well as the establishment and fulfilment of labour rights in compliance with this convention, as a minimum benchmark. The experiences of certain countries provide good examples of how to improve regulation of the sector, how to guarantee

already-recognized rights and how to empower domestic workers at both the individual and collective levels;

- The establishment of mechanisms to guarantee that migrant domestic workers enjoy all the labour rights applying to domestic employment; and
- The professionalization of the sector, linked to the establishment of public care services.

Advancement toward the right to care goes hand-in-hand with the construction of comprehensive social co-responsibility. What policies are needed in order to achieve it?

- Guideline criteria for decision-making:
  - In cases where care is part of targeted policy, it must be progressively articulated as a universal right. The right to care should be part of the Social Protection Floor;
  - The right to care must be an objective unto itself, not a means to achieve other aims;
  - The right to care must be progressively differentiated from other rights that constitute the Welfare State - health, education and social security; and
  - Positive feedback from different dimensions of the right to care, and of this right with labour rights in the care sector, must be encouraged.
- There are best practices in the advocacy for the right to care that demonstrate the need for:
  - More data;
  - The accessibility of conceptual frameworks and methodologies; and
  - Cooperation among diverse actors on co-responsibility.
- The establishment of a right to care requires the implementation of care policies at three levels:
  - Policy that improves the conditions of unpaid care provision within the domestic realm: encouraging men's involvement in carework and providing monetary compensation for supplying unpaid care;
  - Policy that facilitates interaction between the public sphere and the private-domestic realm (reconciliation measures): policies that free time from employment (time for care) and promotion of flexible working arrangements; and
  - The establishment of care public services that take care responsibilities out of households and advance toward the professionalization of carework.
- Beyond these care policies, a three-fold objective with regard to care must be mainstreamed into the whole set of public policies (health, educational, housing, urban planning and transport, sexual and reproductive health, social protection).
  - Redistribute care between all citizens and the society as a whole;
  - Reduce the most arduous and precarious care arrangements; and
  - Recognize care as a work to be done and a dimension of well-being to be met.

The current global transformation of care systems is a window of opportunity for promoting development models that are no longer grounded on precarious care, but where universal access to decent care is guaranteed. Avoiding negative impacts of economic policies upon care is critical for advancing toward development models that prioritize well-being and that assure that markets serve it. Economic policy should indeed encourage a structural transformation aimed at creating a sustainable re-productive system.

And at the most personal level, we must all us ask ourselves, "What can I do?"

- In our personal life within the private-domestic sphere, are we assuming our share of co-responsibility? When we hire domestic employment, is the contract in compliance with labour rights?
- In our professional life, do we deal with care by directly introducing it among the objectives of our work or by mainstreaming it? If staff is at our orders, do we implement reconciliation measures?

Care is always present; let's not lose sight of that. Care regenerates life and it should be a top priority of development, recognizing interdependence as the most basic factor that constitutes society.

PERSONAL REFLECTION: CARING ABOUT CARE

What can we do at the most personal level? Doing a simple exercise might help us to reflect on this. We can start by recovering the double dimension of our lives that we have discussed throughout the course: how we behave in the private-domestic realm and how we deal with our responsibilities in the public domain.

1. The private-domestic realm I: care arrangements

We need to ask ourselves whether we are undertaking the carework for which we should be responsible depending on the circumstances of our intimate relationships, covering our own care needs and those of the persons in situations of dependency for whom we have responsibility.

Completing the following table provides you a simple and practical exercise that might help you to reflect on that.

Once you have completed the table, reflect on your answer. Do you think that it is a situation of co-responsibility? Asking the rest of the people with whom you are living to fill in this same table might be a good idea. Do your perceptions on the sharing of responsibilities differ?

This is just one way to view the issue, and we have not discussed the responsibilities that may arise with respect to other households, as in the case of close friends or relatives who cannot take care of themselves. The crucial issue is the willingness to reflect on our involvement and to modify it, if necessary.

Paying attention to our own care needs is also very important. We must avoid being so committed to other persons' care or to employment that we put our care needs at risk.

Within your household, who is in charge of the following tasks?					
	Me	Mainly me	Another person(s)	Mainly another person(s)	Equally shared
Cooking					
Doing the dishes					
Buying food					
Washing the clothes					
Cleaning the house					
Repairs					
Caring for children (if any)					
Picking up the children					
Caring for older people (if any)					
Caring for sick people					

2. The private-domestic realm II: domestic employment

In the case that you are hiring a domestic employee, you should ask yourself about her or his working conditions.

- Are they in compliance with the minimum standards established by ILO Convention 189?
- Are they in compliance with the laws of your country if your country has improved on Convention 189?
- Do they improve on the most favourable norm, whether Convention 189 or national laws?
- Is your domestic worker a migrant who left behind care responsibilities in her or his country of origin? If this is the case, could the working conditions be improved in order to facilitate caring from a distance?

This table might help you to reflect on working conditions:

	Your employee's working conditions	Your country's standards*	Convention 189**
Minimum age for working			
Daily and weekly work hours			
Hours of rest and whether these are paid			
Weekly rest time			
Minimum wage			
Payment in kind			
Obligation to provide written contract			
Social Security (healthcare and pension)			
Maternity leave			
Illness leave			
Existence of intermediary agencies			
Collective bargaining			
Regulations regarding migrant workers			
Labour inspections			
Freedom of association			

* In this database you can find information on the regulation of domestic work compared to other sectors (see "special categories") http://www.ilo.org/dyn/travail/travmain.home*

** Here you can check the basic rights protected by Convention 189 http://ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_161104.pdf

3. The public sphere: your professional life

How can individuals working in different aspects of development apply the material learned in this course to their work? Let's discuss some basic guidelines by doing another practical exercise.

- Are you working in any of those areas (left column)? If you are not, please write your work area.
- What did you learn in the course that can be applied to your work? Please fill in the corresponding box in the right column.

Area	What did you learn in the course that can be applied to your work?
Economic empowerment	
Domestic employment issues	
Economic policy (fiscal, macroeconomic, monetary or otherwise)	
Development and protection of children	
Water, sanitization and disaster reduction	
Gender institutionalism	
Migrants' rights	

Area	What did you learn in the course that can be applied to your work?
Human resources	
OTHER (please, specify)	

Hopefully you were able to give detailed answers, but if you're not sure how to translate the knowledge obtained into skills for your daily job, you can find a brief aid here.

Are you working in any of those areas?	What did you learn in the course that can be applied to your work?
Participants who work in economic empowerment...	...now have elements that will allow them to more clearly identify the obstacles that prevent or limit women's entry into the labour market and engagement in productive activity. These participants will have a broader vision of what development is, especially what economic development is. They will understand the need to insist upon the unequal value attributed to remunerated and non-remunerated work and to achieve an egalitarian distribution of work between the sexes, social classes, ethnicities, indigenous and migrant populations, amongst others.
Participants who work in domestic employment...	...can now see (1) that care can become a potential source of employment if it goes from being non-remunerated to remunerated, as part of care service provision and (2) the on-going risk of care provision continuing to be part of a secondary market, e.g., poorly remunerated, conducted in poor working conditions, or in the informal sector. Especially, those who work in the areas of women's economic empowerment can now include the need to promote ILO Convention 189, focusing attention on a labour sector of great importance to women throughout the world.
Participants who work in economic policy, whether fiscal, macroeconomic, monetary or otherwise...	...now understand the impact that certain types of measures have on care and consequently, on women. They are able to revise these measures and explore alternative ones

Participants who work in favour of development and the protection of children...	...now better comprehend the enormously positive impact that those public policies directed at guaranteeing the right to care have on the rights of the child. These policies, if designed with a gender perspective, not only guarantee the right to childcare, but they also no longer compromise the rights of women.
Participants who work in water and sanitation and disaster reduction...	...can more clearly spot the effects that the lack of potable water and lack of adequate sanitation systems have on the care-giving work-loads assumed by women and how this effects women's participation in mitigation actions. Specifically, those who work in humanitarian aid can also be wary of the effects that the burden of caregiving has on women in the post-disaster recovery period.
Participants who work in the strengthening of gender institutionalism...	...can contribute to incorporating mechanisms for gender equality: care as a central theme in terms of the strategic needs of women; a theme that is crucial to achieving gender equality. And, as a consequence, these workers can help promote the design of public policies that guarantee the right to care, along with policies that strive to revalue, redistribute and reformulate care.
Participants who work in favour of migrants' rights...	...can now pay specific attention to the situation of migrant domestic workers. They can bring into light that this is one of the most vulnerable groups and are prepared to denounce the labour and human rights violations that may take place. They can also contribute to reform national laws to come into compliance with Convention 189 and to guarantee that migrant workers are equally protected. They can also denounce the situation of precarious care arrangements that migrant family might be suffering in host countries. They can value whether care policies respond to their needs or not. Finally, they can help to avoid the stigmatization of migrant families in origin countries; and support them in order to avoid that the household rearrangements that migration usually provokes does not imply vulnerability for those who are left behind.
Participants who work in human resources...	...now better comprehend the wide range of measures and practices that can be applied to facilitate the reconciliation of working and care responsibilities. They also understand the importance of both men and women workers' ability to fully enjoy those rights. Especially important is to be aware that flexible working arrangements are available for UN staff. The challenge is achieving a state where our colleagues value the relevance of such measures and promote their implementation.

GLOSSARY

Care

The term "care" refers to all those activities that allow for the day-to-day regeneration of people's physical and emotional well-being. It involves direct care tasks (personal interaction to maintain physical and emotional health), material tasks establishing the preconditions for care (closer to what is traditionally understood as domestic work), and management (coordination, supervision and planning). All people need care over their lifetime. Care may be provided in households or by public or private institutions. It also may be done free of charge or in exchange for wages.

Care policies

This is a set of policies for ensuring the right to care. These policies can be classified according to the diverse spheres that should be involved in the constitution of co-responsibility between all social and economic actors: (1) Measures that improve the conditions of unpaid care provision within the domestic realm (including measures to advance toward a fairer distribution of care responsibilities between women and men, and measures that provide compensation for supplying unpaid care at home). (2) Measures that ease the interaction between employment in the public sphere and unpaid care in the domestic realm, also called work-life balance or reconciliation policies (including measures granting time for care and flexible working arrangements). And (3) Measures establishing care services, which take care responsibilities out of the domestic sphere and position them in the public sphere. Care policies are characterized by establishing measures that identify the right to care as an objective in and of itself; they are not tools for the pursuit of other goals, such as the right to education or health. They are based on a virtuous circle between the different dimensions of the right to care. That is, the measures they establish for guaranteeing the right to receive care do not conflict with the right to transfer care or with labour rights and vice versa.

Cooperative conflict

This term refers negotiation and decision-making processes related to resources, jobs, care, etc. within the household. On the one hand, in households there is cooperation e.g., there is a certain amount of organization in common with the goal of accomplishing shared objectives. Indeed, a household is such precisely because its members are united by the management of their common economy. On the other hand, there is conflict. The existence of common objectives and strategies does not mean they are the result of consensus or democratic decision-making, nor does it mean that all household members have the same interests or that they profit equally from the arrangement. Within households there are significant power relations at play between generations, but above all between men and women. The negotiating power of each member of the household is different and is affected by a series of factors: not only by the resources available, but also by social norms. Decision-making processes can be complicated and negotiation is often not explicit. The organization of care is frequently rife with cooperation and conflict; both may be present at once. For example, in the decision to care for someone there may be both concern for the well-being of others alongside a feeling of obligation or imposition.

Co-responsibility (in care)

This refers to the situation in which responsibility for the provision of care is shared equally and simultaneously between four agents: the household, the State, the market and the community. At the level of the household, co-responsibility must also be between men and women. Co-responsibility in care is only possible if care is recognized as a necessity and as work, and it entails the redistribution of care throughout society as a whole. In other words it implies (1) that we all be responsible for our own care and take co-responsibility for those who cannot take care of themselves, (2) that collective structures

be mounted for managing that co-responsibility, principally via the State, and (3) that new forms of organization of daily life be implemented.

Crisis of care

This is a situation in which care is widely performed in precarious circumstances, that is, that arrangements for care are insufficient or unsatisfactory (both in the way care is provided and in the way it is received) and not freely chosen. The crisis of care is the result of the breakdown of a previous model in which care was guaranteed through the classic gender division of labour. When this model breaks down - in the wake of the incorporation of women into the labour market, changes in the expectations and subjectivity of women, the aging of the population, the model of urban growth, the "precarization" of the labour market and the loss of neighbourhood and community networks - and there are no adequate responses to this change from other social agents - e.g., the state does not offer care services, companies do not modify their concept of the worker as someone unconditionally available, and men do not increase their participation in care work within their families - there is a lot of tension. Women are forced to seek work-family reconciliation strategies and the responses they can provide to this situation vary depending on social class. Lower class women generally suffer precarious and vulnerable care situations while upper and middle class women transfer part of care work by buying care services on the market. .

Crisis of social reproduction

We say that a country suffers from a crisis of social reproduction when the majority of a population does not have access to adequate living standards, when there are high rates of poverty and social inequality, when there are no decent job opportunities, and when the State plays a very small role in guaranteeing well-being. That is, the levels of "defamilization" and "decommodification" are very low. In a crisis of social reproduction, with high rates of male unemployment, it is common to find that women serve as the final guarantors of household well-being, deploying various strategies for combining remunerated and unremunerated work. In the last decades migration has become one of the strategies developed by women to confront the crisis of social reproduction, hence the increasing feminization of migration.

Decommodification

This is the dissociation of well-being from the position that a person occupies in the labour market, or his or her purchasing power of goods, services, and insurance in the market. That is, the possibility of being disconnected from the market e.g., from remunerated work, and to maintain an acceptable standard of living. In the context of care, this means guaranteeing both the right to care by allowing people to not be subject to tempos driven by the labour market, and the right to receive the care needed regardless of individual access to income.

Defamilization

This is the dissociation of well-being from the position that a person occupies in the labour market, or his or her purchasing power of goods, services, and insurance in the market. That is, the possibility of being disconnected from the market e.g., from remunerated work, and to maintain an acceptable standard of living. In the context of care, this means guaranteeing both the right to care by allowing people to not be subject to tempos driven by the labour market, and the right to receive the care needed regardless of individual access to income.

Economy of care (care economy)

This term represents the effort to understand how the network of economic spheres (households, social networks, market, domestic work, public institutions) which together cover care needs, functions, taking into account the conditions in which care work is carried out, who performs it, where, in exchange for what, who receives it and who covers the costs. In the broadest sense, this term refers to an approach that looks at the whole of the economic system as an integrated production-reproduction circuit that is not limited to markets, but that also encompasses the non-market spheres of homes and social networks. The results of this system must be assessed in terms of their impact

on the sustainability of life. Care forms an essential part of sustaining life. Looking at the economy of care means understanding how life is maintained day to day as well as how the work force that eventually reaches the market is reproduced.

"Familism"

This term refers to a social conception of care that considers the family the natural, best and/or only place for care. It is often connected to a narrow conception of family, understood as family by blood and/or a legally constituted family rather than as a set of people who may make up a household based on different kinds of ties, although notions of "family" may vary from the nuclear family (heterosexual couple and their offspring) to the extended family. It is a discourse that individual subjects may bear but which also shapes the functioning of public institutions and other organizations such as companies, NGOs and religious groups.

Gender

"Gender" is a set of elements that define what "being a man" and "being a woman" mean in society. They imply a correlation between the social and economic place a person occupies and the biological sex assigned to that person. Society is built in a binary form, attributing roles and distinct and opposite characteristics to masculinity and femininity. It is also assumed that all people should fit into this dual construction. In addition to being dual, such a construction is hierarchical, because the elements associated with masculinity are more valued than those associated with femininity. Relations between women and men are unjust because they are based on inequality. One of the defining elements of this framework is the "essentialization" of care, which is understood as a woman's innate ability and life purpose. The gender division of labour is another key dimension of unequal gender construction.

Gender division of labor

We use this concept to refer to an organization of work characterized by the following:

1. It distributes work according to the sex of individuals - some types of work are associated with women and others with men;
2. It is a distribution that reflects social relations and structural mechanisms that operate beyond the reach of what individuals may negotiate; and
3. It is an unequal and unjust distribution because it assigns the less-valued jobs to women.

The content of the work may vary but these three characteristics remain. For example, education may be a task assigned to women, but the more valued education is, the more it is associated with men: there may be a high presence of women in primary education but there are more men in university education. In capitalist economies, the least-valued work is that which is unpaid, and this sort of work is usually done by women. Care is a kind of work that is always associated with women.

The gender role of women (with regard to care)

This term refers to the social conception of care that sees care work as a task that should be performed by women. Care work is naturalized as an innate quality of women and their life purpose. It ceases to be seen as a job that requires a training process, negotiation regarding its distribution and a system of recognition and payment. It joins with the idea of "maternalism", which sees being, or being able to be, a mother as a defining element of being a woman. The gender role not only associates women with the responsibility for care, it also implies that women do not make their own care needs a first priority. That is, the idea of sacrifice is imposed: a good woman is one who sacrifices herself for her family. This too is a discourse that individual subjects bear, but that also shapes the functioning of public institutions and other organizations - companies, NGOs, or religious groups, for example.

Household satellite accounts

The United Nations System of National Accounts measures the value of what is produced in a country's

market and on that basis calculates the Gross Domestic Product (GDP). But care and domestic work undertaken without pay in households are excluded from the System of National Accounts, obstructing a full view of how a country's economic system functions. To calculate the value of unremunerated production in households, the Household Satellite Accounts were developed. These accounts are compiled using the results of time use surveys, giving monetary value to the hours of work reflected in the survey. Through them the percentage of the GDP that corresponds to care and unremunerated domestic work may be calculated and it is usually very high.

Human development

Human development is "the expansion of people's freedoms to live long, healthy and creative lives; to advance other goals they have reason to value; and to engage actively in shaping development equitably and sustainably on a shared planet" (UNDP 2010). It is a concept that emerged in 1990 as an alternative to the vision of development as an increase in consumption, measured as increased per capita income. Since then the United Nations Development Programme (UNDP) publishes the annual Human Development Report, focused on various aspects of development in the broadest sense using its Human Development Index, which measures achievements in health, education and living standards. It also analyses questions of inequality between women and men (from 1995 to 2010, the Development Indexes were calculated in relation to Gender and Gender Empowerment, since 2010 this has been succeeded by the Gender Inequality Index).

Interdependence

This is the notion that care in particular, and the economy in general, are realities in which people and social groups depend on one another. This idea enters into conflict with another more common one that assumes that some subjects are self-sufficient (and support themselves) while others are dependent (and are supported by the self-sufficient ones). That is, the population in the labour market supports the one that has no remunerated work; adults support dependents - children, older people, persons with disabilities, etc. The idea of interdependence implies that those who perform remunerated work also depend on unremunerated work outside of the market, that there are a variety of jobs to do and that their importance in sustaining society is not equal to their value in the market. With respect to care, it implies that we all need care all the time, that for most of our lives we are capable of caring for both ourselves and for others, and that frequently we both give and receive care. The claim that people are interdependent is linked to the question of whether this interdependence is recognized and established in terms of reciprocity - giving and receiving equally - or in terms of exploitation. In the economy in general there is no reciprocity: work in the market is valued, non-market work is done for free. The case is the same with care: care is unequally distributed so unequal chains are created.

Production/Reproduction

In order to survive, all societies need to produce goods and services and to "reproduce" people. In capitalist economies, we use this distinction to speak of those economic processes that occur within the market (production) and those that occur outside the market (reproduction). Non-market processes are based on unremunerated work, the majority of which take place in households. Production within the market pursues the objective of profit (accumulating capital), while non-commercial reproduction pursues the objective of sustaining life. For the market, the reproduction of people is a necessary process for production. On the other hand, from the perspective of reproduction, production is a process that only makes sense if it sustains life. Therefore we say that there is a conflict between production and reproduction.

Public/Private-domestic

This refers to the separation of spaces characteristic of the modernizing project, which considers life to be organized in two spaces: (1) the public sphere, where people engage in economics, politics, science and culture, becoming citizens through their "signing" of the social contract; this is the collectively regulated sphere; and (2) the private-domestic sphere of the household, where collective regulation does not interfere. Critiques

of this division have been made from different perspectives. In public, citizens are supposed to act the same, but really it is a sphere constructed by and for the privileged subject - male, White, bourgeois, Western, without disabilities. All other kinds of people in the best of cases only access partial or deficient forms of citizenship. Feminist projects have criticized the fact that, for men, the private sphere represents a space of freedom but for women it requires dedication to others. They claim that the private-domestic sphere is regulated by a hidden sexual contract. They also claim that the division, ultimately, is false: what happens in the private sphere depends on the public - "the personal is political" - and vice versa. This dichotomy is connected to others: production/reproduction, man-provider/woman-caregiver, market/household, etc.

Remunerated and unremunerated work (paid and unpaid work)

Remunerated work is work that is done in exchange for money, whether in the form of wage labour or self-employment. Unremunerated work does not generate income and is done for free. The majority of jobs done in the market are remunerated, but not all. There are also some that are done for free, especially for family businesses. The majority of unremunerated work is done in the home and is domestic, care or subsistence work. But some are done outside the home, mostly for the community - volunteer or community work. Finally, it should be noted that it is not always easy to distinguish remunerated work from unremunerated work, especially in rural environments. For example, a small piece of land on a property can be cultivated for one's own consumption as well as for selling if there is excess. The remunerated/unremunerated distinction is characteristic of capitalism and most applicable in the urban environment or in the formalized economy. Most unremunerated work is done by women.

Right to care

This refers to the universal and particular right of every citizen on the basis of his or her twofold role as someone who gives care and receives care. It is a multidimensional right that implies (1) the right to receive care needed in different circumstances or moments of the life cycle, regardless of the personal availability of income or family or affective ties and (2) the right to chose to give care or not, combining a right to care in dignified conditions with the right to transfer care activities (such that there not be an obligation to care under gender roles, or when caregiving conflicts with the enjoyment of other rights).

Rights-based approach

The rights-based approach is a conceptual framework for the process of human development that, from the regulatory point of view, is based on international norms of human rights. From the operational point of view, it is oriented toward the promotion and protection of human rights. Its purpose is to analyse the inequalities at the core of development problems, and correct discriminatory practices and the unjust distribution of power impeding developmental progress. Though a universal recipe for a rights-based approach doesn't exist, United Nations agencies have agreed on a series of fundamental characteristics: (1) When policies and developmental programs are formed, the principal objective should be the fulfilment of human rights; (2) An approach based on human rights identifies the bearers of rights and that to which they are entitled, and the corresponding duty-bearers and their obligations, and works to strengthen the capacity both of rights-bearers to claim their rights and of duty-bearers to meet their obligations.

Self-sufficiency (self-sufficient citizen/worker)

Social, economic and political systems are based on the notion of self-sufficiency whenever people are treated as if they had no care needs or responsibilities. This is the model of a citizen who behaves within the public sphere without any responsibility for the care of other people that might interfere or condition his or her life and work. The self-sufficient subject also has no care needs to cover - he or she is an adult, independent and healthy. When we refer to the labour market we speak of the self-sufficient

worker as someone who is fully flexible and available for the company. It is a normative, masculinized figure because it is associated with the masculine role in the economy and politics, and has a hidden feminized side: the non-citizen and non-worker who resolves all care needs in the private-domestic sphere.

Social organization of care

The social organization of care is the way in which each society establishes a correlation between its care needs - specific to each society - and the ways in which it responds to them, e.g., the way in which the four social actors that can play a role in care provision (the household, the State, the market and the community) combine to provide it, and the role each one assumes. Generally, the social organization of care determines who cares for whom, within what structures, how, and in exchange for what. In most contexts we find social organizations of care based upon care performed by women in the home for free.

The social organization of care forms part of the welfare regime - as care is a basic dimension of well-being - which defines what corresponds to whom in the production of well-being. When the social organization of care is principally supported by the unremunerated work of women within households, we speak of "familist" care systems. When the social organization of care relies heavily on the contracting of services in the market, we speak of "commodified" care systems. When the social organization of care is based upon a strong role of the State - through the provision of care services and other provisions, such as time and money for caring - we speak of "decommodified" and "defamilized" care systems.

Time-use surveys

Time-use surveys are the principal instrument used for measuring unremunerated care work in households. These surveys ask people how they distribute their time during a period, normally throughout the 24 hours of a day or the seven days of the week. Activities recorded in time use surveys cover all the activities to which people dedicate time to throughout the day, such as remunerated work, household chores, caring for people, time dedicated to leisure and entertainment, voluntary work, time dedicated to transportation, eating, etc.

Total (or global) workload

This is a concept linked to time use surveys. It refers to the amount of time devoted to remunerated work plus the time dedicated to unremunerated work. It can be measured at a personal level to calculate how much total time a person dedicates to work, or at a social level to understand the total amount of work a society needs in order to function. What part of the total workload corresponds to remunerated work and what part corresponds to unremunerated work can also be calculated. Although exact details vary, the percentage corresponding to unremunerated work is usually almost half the total. That is, the non-market economy is not a small or supplementary part of the whole economy. Rather, it is another pillar next to the market. One can also calculate what part of the global workload is taken on by different social groups: what most look at is the proportion corresponding to women and men. In general, more than half of the global workload is borne by women. That is, there is an unequal distribution according to sex.

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