Race and feminist care ethics: intersectionality as method

Parvati Raghuram*

The Open University

Milton Keynes

UK

MK7 6AA

Parvati.Raghuram@open.ac.uk

ORCID: https://orcid.org/0000-0002-1841-5613

AKC: N

CN: Y

Word Count:

Race and feminist care ethics: intersectionality as method

Abstract

Gender has been the privileged optic through which care ethics has been theorised. However, a long line of theorists has argued that gender intersects with other vectors such as race, class and disability in the social world, including in caring practices. This paper contributes to the emergent literature on intersectionality and care ethics by focusing on how racialised difference affects care practices and therefore care ethics. It argues that slavery and colonialism have underpinned racial hierarchies marking contemporary racialised care encounters. As a result, racially marked people's skills are often undervalued and their competency questioned even as race becomes an increasingly important difference between who cares and who receives care. Secondly, racial hierarchies in who gets care and what that care looks like can make care so distinctive as to be unrecognisable both to the care giver and those who need care. Lack of care is as productive of subjectivities as care so that care needs simply may not be articulated. Finally, given these differences in what care means, caring can become risky. The paper concludes by suggesting that thinking through intersectionality as method allows us to focus on moments and events where care can become unsettled. Care ethics should learn not only from its successes but also from instances when care has failed. We need a feminist care ethics that responds to the distance and difference that race brings to care. That is the promise of good care.

Keywords: care ethics, competence, intersectionality, race, recognition, risk

Race and feminist care ethics: intersectionality as method

Introduction

Care has been defined as "a species of activity that includes everything we do to maintain, contain, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment" (Tronto and Fisher 1996 36, 40). In doing so it spans between an ethics, (based on) a practise and a process. It has become one of the keystones for shaping normative thinking for feminists. Feminists writing in varied fields - education (Noddings 1984), philosophy (Held 2005), political science (Tronto 1994) and psychology (Gilligan 1982) - have utilised care ethics as a way of thinking relationally, arguing that humans (and later non-humans), were ontologically relational. Moreover, and despite some differences between those theorising care ethics, they have also suggested that it involves close attention to the specificities of particular caring interactions rather than a pallet of pre-defined notions about what is virtuous or just.

Feminist care ethics has drawn on women's caring roles as the basis for thinking of care as a universal good. While feminists have varied in the extent to which they view care as a disposition intrinsic to women, the fact that most care work globally is done by women, and that care is also inherent to mothering (Ruddick 1980), has meant that women and care are closely tied together. Besides, as they have argued, the experience of being cared for as a child is a foundational experience for most people globally, irrespective of their gender, extending the relevance of gendered care beyond women to encompass everyone (Gilligan 1982, Hollway 2006). It is thus, inspired by the experiences of women, the desire to use these experiences to theorise for and on behalf of women (feminist care ethics).

One of the fundamental questions raised by feminist care ethics is whether care is gender neutral or feminine. Although Gilligan (1982) began by inserting gendered difference as the basis for a new ethic, this has subsequently been challenged, including by herself (1995), in her explorations of care ethics and justice. Carol Gilligan argued in 1995 that justice can sometimes be seen as universal and male while care is equated with self-sacrifice and with 'ethics' on the terms of others (see also Laugier 2015). This has led to a complex debate on the relation between ethics (of various kinds), justice and masculinity and femininity through, for instance, an exploration of injustice (Robinson 2013). This paper primarily focuses on women and care ethics before concluding with how and why black masculinity and care requires its' own exposition. It uses gender to refer to unequal structures of power which women experience at the cross sections of race and class.

In the years that have passed since first care ethics was first theorised, there has been a large literature on the differences between women, based on class (McDowell 2006), race (Collins 2000), sexuality (Butler 1999), ability (Thomas 2006) and location amongst others (Mohanty 1984). As the power hierarchies between women are seen to be as important as those between men and women, the politics around feminism has multiplied and differentiated (Combahee River Collective 1977, Crenshaw 1991, Collins 2000). We now talk of feminisms, rather than feminism. These variations are political and based on the embodied experiences of women, as evidenced in debates in a wide variety of disciplines.

The differences between women have also been addressed within *care ethics* (Barker 2012, Boyd 2013, Conradi 2015a). One set of interventions highlight the need to think about how gendered care intersects with identity categories - axes of diversity which have become such an important part of contemporary feminisms. Thus, a

number of authors argue for the need to adopt an intersectional approach to the ethics of care (Hankivsky 2014, Hamington 2015, Ward 2015; and for early interventions see Collins 1995, Nicholson 1993), one which goes beyond the a priori use of gender as the privileged analytic through which care is analysed. They insist on the importance of the relations between gender and other identity categories as significant to reshaping care. Implicit in this discussion of the dominance of gender is the recognition that race and class make a difference to how gendered care is practised, and hence, to how care should be theorised.

Another set of differences relate to the multiple ways in which women are implicated in *care practices*, such as the distinctions and overlaps between care-giving and care-receiving (Tronto 1993, Kittay 1999). It has led to important debates between scholars working in disability studies and care ethics (Kröger 2009, Kelly 2013), for instance, as one's position within a caring relationship differs depending on whether they are care receiver or care giver. These arguments are neatly summarised by Hamington (2015) who suggests performativity as a way of thinking intersectionally. Similarly, Ward (2015) introduces the cared for and carer into the scope of the identities that need consideration in intersectional thinking, while Hane (2017) extends these arguments to include those who are employed in non-caring activities in the global South. In doing so, these authors also make space for thinking about how the identity categories through which Hankivsky (2014) interrogates care ethics can be brought together with the practice-based differences discussed by Hamington (2015).

Another set of differences arise from different forms of feminism. These are neatly summarised by Sander-Staudt (2006, 34): 'Liberal feminists might emphasize care as a gender-neutral virtue of an individual that should be chosen autonomously,

while radical feminists might emphasize care as a social and individual virtue that partakes in dichotomous understandings of sex and gender and that requires revision. Radical and liberal feminisms also tend to stress different forms of political and moral agency. Liberal feminists highlight formal agency and individual autonomy against a background of social relations (which may or may not include care), while radical feminists highlight informal agency and misogynist social relations against a background of socially embedded individuals.' However, the differences between these feminists across the world as it relates to racialised care are important too. They are, however, yet to be explored.

The differences between feminine and masculine care have also been explored. For instance, Hanlon (2012) points to how men 'care-about' rather than 'care-for' with care being recast as protection - financial or personal (Montes 2013). Caring-for, especially by fathers, is widely seen within the context of new masculinities although these new masculinities take novel forms in migrant households. For instance, care and emotion have to be provided by men in households where women have migrated (Asis et al. 2004), while men both lack care and have to rewrite their care as wage earning when it is the men who move (Zelizer 2000). Men are also enrolled into caring waged work – as workers in the socially reproductive sectors of the labour market (Kilkey et al. 2013). For instance, over half of all male migrant domestic workers are in the Arab States where over 10% of all domestic workers are men (ILO 2015). However, there has been little sustained thought into how masculinity intersects with care ethics.

One notable exception is the work of Karla Elliott (2016) who suggests a normative framework for rethinking masculinities and care. She identifies domination as a key characteristic that has to be traded-in by men who care but points to the

potential for caring masculinities (Jordan 2018). Crucially, Elliott argues for thinking about caring practices as a way of undoing and redoing masculinity.

This paper contributes to this practice-based way of thinking intersectionality in care ethics, focusing specifically on racialised women. It elaborates on how race reshapes care as practice, and therefore it's ethics. Methodologically, it unpicks some key moments as examples of caring practices that are central to care ethics and highlights how racialised care throws up conundrums which are important for care ethics to consider (Narayan 1995, Siddle Walker and Snarey 2004).

The rest of this essay is divided into four sections. The next (first) section introduces how and why race matters to care practices and hence to care ethics (and for an extended discussion of the relations between care practice and ethics, see Raghuram 2012, 2016). In the following three sections I explore some ways in which these racial differences are played out. In the second section I focus on competence and alterity and how race leads to different valuations of skills. Competence is the least studied of the four core elements of care ethics set out by White and Tronto (2004) but care competence is deeply racialised in multiple ways as I will show. The following section outlines the difficulties in recognition and dialogue across difference. It suggests that those who have had little access to care have little recognition of their care needs or their right to care and even if these are recognised they are incompletely and inadequately communicated. It thus focuses on how the assumption of a sovereign rights-bearing person who knows they need care and can articulate this need can come unstuck when dealing with populations who have received so little care. The final section suggests that given the lack of coherence of care as a set of activities care is risky. By pointing to these three aspects, the paper prises open care as a set of practices to which race makes a difference in order to

highlight what this means for care ethics. The paper suggests that the instability of care requires that we disassemble the ethics of care into some of its' constituent care practices and see how each involves power relations that need to be carefully addressed if care is to be ethical.

The paper draws on examples from varied contexts, in each of which both race and care have very specific historical and spatial connotations. Race and gender therefore matter differently in these examples. Given the many differences between women, including between racialised women, who is the '(black) woman' of feminist theory? This is a question for feminist care ethics too. Yet, feminists see repetitive patterns of sexism and gendered oppression, albeit varied by race and class, including in care practices (Hankivsky 2015). How can these variations be squared with this repetition?

Toril Moi (2015) draws on the writings of Ludwig Wittgenstein (1960) to address this conundrum. She argues that feminists need to move beyond the search for generality suggesting instead that thinking through examples 'shows us how to escape from the logic of representation—the logic of inclusion/exclusion—that dominates feminist theory today' (191). She contends that examples are descriptions of particular cases, not representations of a concept. Thus, using one example of a particular racialised incident, or indeed a pattern of racism (as evidenced, say in labour market statistics), does not invalidate the existence of other examples. Rather, examples are used in place, for particular purposes, not to generalise or to suggest a necessary relationship. Nor are these examples complete. Further examples may add, alter or challenge the findings of one set of examples.

Following Moi, I too use examples do provide the ground from which to theorise. The examples neither claim to point to the essence of race and gender, nor

indeed all instances of this intersectionality. This is where philosophy begins – to raise questions which are tentative and whose grounds may need to be rewritten. I use these examples as a method to think intersectionally about care ethics. Intersectionality has become a much repeated phrase across the social sciences (Crenshaw 1991) but how can intersectionality be applied to care ethics? I use race as one example to explore this question.

Race and care

Race has been central to the division of caring labour in the postcolonial world. In many societies, slavery and colonialism defined who cared and who received care (Stoler 2004; and for an excellent discussion see Glenn 2010). Slavery in the US, for instance, restructured care globally by relocating and fracturing caring units and by demanding new heightened levels of care from some while relegating their own care as inconsequential (Morrison 1987, Smith 2011). It led to the removal of care from racialised and enslaved bodies in previously unknown ways. Colonialism too led to new racialised divisions of care globally with a rich literature describing both the horrors and the pleasures that accompanied this (see for instance, Stoler 2004). Moreover, welfare systems and economies were structured around the care that was coerced from racialised people (Glenn 2010). That is the history of race and care on which new narratives of the two are scripted.

The dimensions of race and care today are shaped by past and ongoing histories of mobility (van Riemsdijk 2013) that bring together differently racialised people (Kofman and Raghuram 2015). There at least four ways in which these racialised encounters are being played out today:

1. *mobility of racialised carers*: migrants who move as domestic workers, social workers, nurses and doctors (Pratt 1999, Graham 2007).

2. *racialised minorities as carers*: the long as well as more recent histories of migration mean that there is a significant population of racialised minorities (Gunaratnam 2008) who require care.

3. *moving to access care from racialised majority populations*: rich, and usually racially dominant populations, have moved historically (Cock 1989) and are still moving and depending on numerically large racialised populations for their care. More recently they have moved specifically in search of caring labours of those who are racially hierarchised – sometimes through this labour (Bender et al. 2014). This may include short term medical care (Whitmore, Crooks and Snyder 2015) or relocation of white populations to countries where women are racially ascribed as inherently caring (Howard 2008).

4. *carers racialised as different groups of migrants move*: the globalisation of the care industry brings together different groups of carers whose caring abilities are valued differently because of how their care is racialised. They have to work in highly racialised environments where racial differences are negotiated while giving (and receiving) care (Batnitzky and McDowell 2011; Gunaratnam 2008).

These are some of the different permutations of race and care that exist today. Care practices are therefore deeply imbued with racial politics present and past. Moreover, the gendered ascriptions of care are always being written and rewritten in these racialised settings. Some men are taking on, intensifying or simply continuing with caring activities, as women migrate leaving behind caring roles. Others are entering

the care sector as the increasing globalisation of care provision provides new employment opportunities for women as well as men (Locke 2017) in both the paid and unpaid sectors (Kofman and Raghuram 2015).

Geographers have made significant contributions to debates in care ethics. One body of work discusses how care ethics contributes to debates on *ethics* in geography (Popke 2006, Lawson 2007). Another focuses on *sites of care* as varied as hospices (Brown 2003), homes (Cloutier et al. 2015), markets (Daya 2016) and the university (Lopez and Gillespie 2016) and their implications for care ethics. Moreover, the implicit location of care ethics in the global North (Raghuram 2016) and the importance of local definitions of care and how they get incorporated into a globalising discourse around care ethics (Raghuram 2012) have also been discussed. Care is deeply contextualised by cultural factors, the political economies which underpin care delivery and the geohistories that have shaped care but the specificities of care practices mean that care ethics too may need to be nuanced for different locales (2016). These interventions highlight the importance of place not only in care practices but also in reshaping care ethics. A third set of writings within geography help to reposition who is, should or could be the *object of care*, from animals (Taylor and Carter 2018) to the environment (McEwan and Goodman 2010). Finally, as in some of the feminist literature, the *carer* is the focus of many studies. The carer is helpfully seen at the intersection of multiple identities including gender (Johnson 2017), age (Ansell 2009), sexuality (Radicioni and Weicht 2018), ability (Chouinard 2000) and migration status (Raghuram 2016). However, race has received much less attention in geographical discussions on *care ethics* even though it is so crucial to shaping care practices. Moreover, even though there is work on racialisation and care practices, the difference this makes to care ethics has not been explored, i.e. the

particular activities and frameworks of care ethics have not been explicitly considered in this literature.

Race not only shapes care practices but must also be seen to reflect back on care ethics because racialised differences in care practices have implications for care ethics (Narayan 1995, Siddle Walker and Snarey 2004). Siddle Walker and Snarey's (2004) edited collection brings together a number of scholar activists, especially those in the skilled caring professions such as education, to explore how care is enacted differently in strongly racialised settings. They dislocate care from the unnamed white body through which much care ethics is theorised. They point out that for feminists writing about care ethics the divide between those who care and the cared for has largely been drawn across gender lines. However, gender differences also intersect with, and are complicated by, differences across class and race, in particular, so that some versions and visions of care are much more likely to be reproduced. Similarly, Uma Narayan (1995) has argued that the ideological purposes for which moral theory has been utilised needs attention. She suggests that care and justice were both handmaidens of colonialism. Racial difference and coloniality were produced and justified using the language of care. For her, this is an important, but often ignored, part of care ethics.

On the other hand, some care ethicists have also attempted to reclaim the promise of care including for racialised populations. For instance, Maurice Hamington (2015) suggests that embodiment provides one basis on which to share and communicate about care needs. He unsettles the notion that such care simply exists or can be known a priori; it must be learnt.

The rest of this paper takes a step back from this position to shine light on what it is that might need to be learnt. Where are some of the fault lines that trouble

racialised caring practices and what are the challenges they pose? This paper addresses this by suggesting that race operates as in and through care practices and focusing on these practices has implications for the core terms and concepts that have been used to understand care ethics.

Competence and Alterity

Care is seen to require a combination of: attentiveness (what are the care needs in any context?); responsibility (who should be responsible for meeting the needs for care?) responsiveness (how far does care meet the needs of the cared for and the carer?) and competence (does the carer have the skills required to care?) (White and Tronto 2004). Each of these is contextually specific but as they are performed across difference there will be limits to how attentiveness, responsiveness, responsibility and competence are calibrated and understood (Raghuram 2012, 2016). How do we reframe the analytical frameworks of care to take account of incommensurable distance and difference? This is the question I first turn to, focusing specifically on care competence. In particular, I emphasise how care competence is recognised and the embodied valuations and uneven geohistories of care that these calibrations draw upon in the skilled sectors of the labour market. Focusing on professionalised skilled caring sectors brings a set of challenges which are often missed when care and care ethics are primarily viewed in the private sphere, and particularly through mothering (Kofman and Raghuram 2015).

Questions of competence become particularly crucial when addressed across difference. While care ethics has focused on attentiveness, responsibility and responsiveness there is much less recognition in discussions of care ethics of the competence required to care (but see van Poser 2017, Hamington 2017). This

competence is not natural or obvious but is diverse because care itself is defined differently in different parts of the world. Secondly, it also circulates in a world where skills are geopolitically coded and ascribed differentially based on colour. Finally, these racialised notions of skills have geographical referents that hierarchise people, places and credentials. Caring therefore comes with a set of preconceptions and of structural frameworks whereby competence comes to be racially marked. It does not exist in a vacuum; nor is it an empty category. It is these racialised and politicised versions of difference that pose interesting questions for care ethics as I explore below.

An excellent example of racialised difference in caring is offered by Yasmin Gunaratnam (2008). She uses the case of death and dying among migrants in the UK and the limits of professional competence in negotiating racial difference. She suggests that cultural awareness courses and the professionalisation of this difference does not adequately take account of individual variations in care needs. When care is defined differently then how competence in care-giving should be calibrated is itself unsettled. Similarly, Catherine Locke (2017) too points to the ethnocentrism of defining care content and competence while van Poser's analysis of care giving in Papua New Guinea reminds us of the extent to which care is culturally defined and how different competence can look for different groups and over time (2017). All these authors highlight the multiplicity of the notion of competence in a diverse world.

Secondly, these differences in notions of care competence are hierarchical with some people's competencies valued more highly than that of others. Underpinning valuations of caring skills are complex geopolitical histories which operate to complicate the value placed on care (Kofman and Raghuram 2013). For

instance, whiteness operates along with colonial history to differentiate white Europeans and Filipinas providing childcare in Canada (Pratt 1999). Filipinas were deemed to be servants while white Europeans undertaking the same tasks were portrayed and remunerated more highly as nannies. For Geraldine Pratt this difference can, at least in part, be ascribed to colonial discourses that have led to the 'the production of borders that define workers as worthy or unworthy, competent or incompetent, skilled or unskilled' (Pratt 1999, 234).

Historical relations not only produce divides between races but also racialises categories in very specific ways. Micheline van Riemsdijk (2013) found that Polish migrant nurses in Norway, who may be deemed white, have their knowledge devalued because of the history of how Poland has been viewed in Norway, as part of a 'less advanced' Eastern Europe. The embodied value of whiteness was tarnished because of this history making whiteness too a complex category. The importance of geopolitical formations in the valuing of skills takes skills outside the individual alone and places it centrally within the politics surrounding the reproduction of societies (Kofman and Raghuram 2015).

As Pratt (1999) has argued the privileging of nurturance as a core element of care resonates more closely with the experiences of white women. Using the Canadian case, she argues, that when care is provided by upper-middle-class, ethnically European woman, it is cast as pure and as embodying the qualities (skills such as attentiveness and affect such as love and empathy) cited by care ethicists (Tronto 1993). However, this excludes the experiences of poor women and women of colour (Duffy 2011, 2005), many of whom are engaged in backroom, menial and manual tasks of care (Barker and Feiner 2009). The distinctive qualities that define

care as paid work also need to be redefined if it is to take cognisance of racialised women.

Colonialism has sedimented, contorted and reframed existing social divisions through which care was organised and received but it has also left a legacy in how it is remembered and accounted for. When care is not reciprocal the value of the caring task is reinscribed and redefined. For example, Stoler and Strassler (2000) invoke and counterpose the memories of families of Dutch colonisers in Java and those who had cared for the children in these families. The stark differences between the memories of the domestic workers and those who had employed them lay bare some of the complexities of care as practice, as memory and the ensuing responsibilities for interpretation by those who undertake such research (and for a recent example of care from South Africa, see Swartz 2012). The caring memories (marked by feelings of belonging and warmth) of the employers who remember loving servants differed from, and were sometimes at odds with, the more prosaic memories of servants who remember duties and salaries more easily than acts of kindness and unkindness. Clearly, the caring activities inhabited different worlds of valuation. These differences mean that care can be unrecognised or misunderstood but can also then become a site of struggle (Noxolo et al. 2012) as it is practised on a deeply politicised terrain. It is denied as often as it is claimed.

Finally, these notions of competence and skill also have their own histories which draw together different places which are themselves implicated in the hierarchisation of skills. Place matters when considering competence. This short but incredibly rich extract from Coolie Doctor (1991), the autobiography of a South African Tamil doctor Dr. K.G. Naidoo (1906-1997, also known as Goonam) provides a short, sharp reminder of how race, place and skills come to matter in the caring

professions. She relates the story of her imprisonment after she led the 1946 Passive Resistance Campaign against the anti-Indian Land Act. The warden of the prison asks her:

> 'What work do you do?'
> 'I am a medical practitioner. I do gynecology and obstetrics.'
> 'You what?'
> 'I am a doctor.'
> 'A witchdoctor?'
> 'They don't teach witchcraft in Scotland'

Clearly race is central to both medical skills and her citations of it (Burton 2011). The warden attempts to situate the medical knowledge of this non-white woman in less credible caring practices and to belittle her skills. But Goonam counters this by drawing upon the global authority of medical education from Scotland, as she did in her political career. These skills are valued by the white interlocutor. Being a witchdoctor, on the other hand, does not have the power of spatial referents such as attachment to the UK (the apex of medical hierarchies in the Commonwealth countries) or the authority that Western medical knowledge accrued in Scotland has (Raghuram 2009). The spatial stretch and authority of this selective Western medicine, produced through colonial histories of medical knowledge, provides the framework for assessing competence and skills for caring. Thus, competence is imbued with geohistories not only of care but of what good care looks like. Notions of care are imbricated in global patterns of power that go beyond 'who cares' to 'how care is defined and validated' (see below).

This excerpt touches upon very different notions of skills. It points to the need to theorise care as ethic across radically different notions of competence. There are groups for whom 'witch doctor' is a perfectly competent way of caring but these are

erased and downgraded by both the warden and Dr. Goonam, cast into the outer world

of this multiracial society. Moreover, England had its own history of witchcraft which

too never attained the authority associated with, and imparted through, Empire. Race

is not dyadic here but scored with the hierarchies of colour as they cut across class.

Access to a Scottish education enables Goonam to align on the same side,

momentarily, as the white warden in marking out some forms of caring as competent.

Difference and distinction can be troubling for caring practice, but it also

needs to be put to work to trouble care ethics (Bartos 2018). Although several care

theorists writing about the ethics of care argue for the recognition of particulars, and

for contingent mutually agreed definitions of care (Held 2006, Noddings 2013) many

assume that the differences in the definitions, motives and outcomes of care can be

agreed. Thus, Held (2006) suggests that 'with the ethics of care, global suspicions of

Western claims about universal reason may be circumvented' (p. 157-158). But care

also involves alterity, even radical alterity. Can engagement with the practices or

philosophies of non-Western care or indeed of global feminist thinking beyond the

West (see Mahadevan 2014) really leave the ethics of care untroubled? As Cooper

says '(m)oral reasoning, tending, attachment, therapeutic labour and repairing the

world all require teasing apart through application of an extended lexicon, as much to

explore the connections as the disjunctions' (2007, 258). Care is 'situated and non-

innocent' (Cuomo 2007, 14).

Hannah Stark (2014) poses these as problems of recognition of care and caring

skills in the context of alterity and the risk that 'what is at risk of erasure is actually

difference, contradiction, and incoherence' (p. 96). The challenge of looking through

the optic of race is the possibility of radical alterity in definitions (and ethics) of care.

These different notions of competence are not only sites where inequalities of power

come to light but also where new coalitions around care can be formed (Keller 2010).
That is why these variations (should be made to) matter (Conradi 2015b).

Recognition and Communication

This section begins with examples of caring but where the content of care may be so
different as to be unrecognisable to others or to oneself. I then move on to highlight
the ability to articulate care needs as a right that those without a history of receiving
care find difficult. Underpinning these arguments is the removal of care that racism
has wrought and how it rewrites care practices and the questions this then raises for
ethics.

Mothering has been a central anchor for thinking about care and its
constitutive quality in producing the subject (Holloway 2007). Maternal affect and the
ensuing care practices are therefore core to care ethics (Ruddick 1980). However, as
Keller (2010) argues, this thinking is often based on the experiences of a particular
group of unnamed white women. This is mothering in the abstract or at least where
there is some degree of certainty of care. Mothers who are raising children in highly
racialised must teach their children to deal with the unjust racialised world outside.
Mothering is preparation for the lack of care. As Noah (2016) remembers mothering
consisted of familiarising him with the pain just around the corner for being born the
wrong colour. 'They're trying to discipline you before the system does.' (p. 267). It
was always tough love!

This recognition of the differential definition of care also seeps into the skilled
caring professions. Thus, Audrey Thompson (2004) illustrates how teachers make
different assumptions about what constitutes care. In her example, only Black
teachers recognised the different care needs of children of colour and they use

'colourtalk' to assist Black students in combating racism. Colour talk 'decentres and denormalises Whiteness' (Thompson 2004, 33). These different requirements of care are most stark in writings on enslaved families, where 'caring for' may involve killing the child who is born into slavery (Noxolo et al. 2008). Race and racism redefine care in the most intense and painful ways imaginable.

Just as caring activities are racially marked so too are there variations in who cares. For instance, the role of community in helping to combat the effects of racism can be crucial. As Siddle Walker and Snarey (2004) argue, a wide variety of social networks are essential to buffering African Americans from racism. As a result, children are cared for 'by other mothers' and not only birth parents, in a practice called allomothering. Looking through the lens of racialised and disadvantaged, but also socially varied groups beyond the West, shows us that not only what care constitutes, but also who cares and how care is arranged, is much more varied than is often presumed in care ethics (Otto and Keller 2014). What may appear careless parenting involves different, perhaps not very easily recognisable forms of caring.

Care patterns and processes may be unrecognisable across difference but this also means that the talk of care may be unrecognisable to those for whom care is only a task. White and Tronto (2004) argue that middle class parenting is based around 'privileged irresponsibility' whereby some groups – men, the upper class and racialised majorities – do not expect to care as they are seen as undertaking more important tasks. By implication there will also be a group of the *unprivileged responsible* whose labour is not only necessary but also must be made invisible in order to facilitate privileged responsibility. This care is sometimes not even visible to those who provide it – it is naturalised, so that they may not see themselves as either possible beneficiaries or as potential claimants of care (see Butler 2012).

Because care stretches across both public and private spheres, neither care-receiving capacities nor care-expecting ones are wholly self-generated. The state, welfare regimes and domestic life all have huge effects on subject formation, our ability to recognise and enunciate care needs and to recognise our entitlements to care. Although care ethicists recognise that care recognition is crucial to good care, most existing debates centre on recognition of the needs of the other, not self-recognition. However, lack of recognition also undermines self-care. Amartya Sen (1987) found that rural Indian women who were asked about their welfare found the question unintelligible as they think and respond with the family as their basic unit. This unintelligibility may be multi-layered – a lack of recognition of rights, a recognition of how familialism is the route to rights, a refusal to understand rights through individualism and so on. However, this lack of recognition of the need for self-care draws on and can reinforce gendered familalism in care policy and public discourses. The intersection of gender and class then leads to stratified care (Palriwala and Neetha 2011). Thinking through (and about) the family could, in effect, make it difficult, even where desirable, to formulate any clear notion of individual care needs. The autonomy of the individual and the necessity of protecting that autonomy is not what is at stake here – that is a notion much critiqued by those writing about care, particularly in Global South contexts (Evans and Atim 2011). Rather, what I want to highlight is the extent to which this lack of recognition is itself a condition of subjugation. Care-less practices are as productive of subjectivity as careful ones.

Similarly, Michelle Murphy (2015) discusses this productive capacity within the context of negative experiences of care, arguing that fear and anxiety are also productive of affect (Ahmed 2010). Appropriation and exploitation are productive of subjectivities and hence limit the claim making and the claim recognition of subjects.

When discussing caring relationships between able-bodied people care ethics may presume a knowing subject who has a sense of care entitlements. However, looking through the lens of those who have been disadvantaged, including racialised populations disenfranchised through colonial and postcolonial violence, poses the issue of how one might entitle care givers to recognise their own care needs. How do we ensure that care is not defined by those who have been privileged enough to have received care? This is an important question because as Murphy suggests 'feminist projects of care are within a skein of appropriation and re-appropriation, of antagonistic and yet enabling relations, of uneasy animations that are not merely political, economic, and complicit, and yet also not merely reparative or oppositional or better. Projects of care, feminist and otherwise, are full of romantic temptations that disconnect acts that feel good from their geopolitical implications. (Murphy 2015, 724-25).

Thus, care entitlements are socially, culturally and politically contingent and are not easily universalisable (Raghuram 2012, 2016). If care is theorised as a practice, then we should also recognise that practices are indelibly inflected by these complex geohistories of *existing* practices of care. The definition of care does not precede its practice but arises from geographically variegated practices of care. And these go beyond individual definitions of care and instead encompass the ambit of social relations through which the entitlements to care enable a recognition of the need for care. However, this is not to uphold methodological relativism, theoretical attachment to post-modernism (see Hallstein 1999 for the latter), or to suggest that all different understandings of care should necessarily be defended. Rather, it is to recognise the need to engage difference with all that this implies – including radical alterity.

Secondly, these care needs are not necessarily readily or easily communicable. We do not all have the modes of sharing what care means to us. What happens when the meanings are not shared? Barnett (2005) emphasises the importance of the circumstance within which decisions about care are taken, i.e. the process of caring involves a communicative process. But these circumstances not only influence decisions about care for the other but also the ability to articulate the need for self-care. The racialised migrant body suggests that care entitlements are generated differently in different places. Can we then adequately express our care needs to others even if they are recognised by the self?

Calder (2015) discusses deliberation in the context of a set of workshops where care was discussed amongst a mix of care-givers, receivers, professionals and academics. He points out that spaces were created for dialogue and engagement and that multiple voices were heard. Nevertheless, professional's voices carried extra weight and their language was more likely to be adopted. Public validation of competence counted. What is not clear in his example is how factors such as race, age and gender too may have influenced the deliberation. Moreover, this discussion focused on a formal setting (see also Barnes 2011); what happens in everyday care practices, domestic spaces and where the power differentials are more acute? What are the processes through which care needs are communicated, deliberated, decided?

Unsurprisingly, it is care practitioners, in this case those researching nursing studies, who address this best. Cloyes (2002) suggests that in order to address issues of power we need to think of care as a particular form of political agency within a productive context of power (p. 210). For Cloyes, the multiplicity of ethical systems and the diversity of contexts and principles through which care is defined means that disagreement about the nature of care is fundamental to its definition. She, therefore,

argues that caring is a political process. However, if the politics of communication and of deliberation are weighted against the subaltern (Spivak 1988), then how can their care needs be recognised and acted upon?

Postcolonial theory offers some suggestions. For instance, Bhabha (1994) argues that although the communication of needs occurs within an overarching hegemony this hegemony is always fractured and hence offers spaces for intervention. Spivak (1988) on the other hand, emphasises the need to sensitise those who are more powerful while they in turn need to make extra efforts to listen. Engaging with these insights on communication and dialogue, I would suggest, complicates the politics of recognition and communication that are central to care (Noxolo et al. 2012).

Care as risk

So far, we have seen that the bundle of activities, emotions and responses that constitute care as an ethic can't always be held together through care as practice. Moreover, differences within the qualities that make up care become amplified in the context of race and class. Care for the other is also always fractured or distorted by 'feelings of obligation, burden and frustration' (Chakravarti 2008, 359). Globally this instability of care arises from its performance across the intimate boundaries of race, class and gender. Moreover, care involves a varied set of practices which articulate with the political, economic and social in geo-historically distinct ways.

Noxolo et al. (2012) theorise the importance of difference for notions of responsibility. For them 'responsible, caring action therefore involves an openness and vulnerability to that which most resists European thought: those aspects of the 'other' that are not shared and are not comfortable' (p. 424). Responsibility is therefore risky. Similarly, care too is risky as I explore below.

Care is open ended and therefore risky because its quality can't be known in advance. Lisa Bass (2012) writes about how Black teachers in a school in an urban conurbation in the American mid-West recognise and validate the forms of marginality that their Black students have experienced by drawing on their own experiences of discrimination. Questionnaires and focus group interviews with five educational leaders who are faced with challenging situations in educational settings demonstrate the ways in which these African American women draw on historical notions and ways of caring, which were developed to cope with the starkness of slavery. Crucially, in adopting this form of caring, what Baas calls Black Feminist Caring, they also expose themselves to risks to their professional status and reputation as also to the law, which has been framed in universalising ways. In one case her interviewees, the Black teachers, talk about how they bend institutional rules about reporting finds of marijuana amongst students as an act of care. Bass points out that the ethics of care are also, in this context, an ethics of risk because for Bass this risk may involve foregoing the demands of justice.

> Breaking the rules in an educational setting involves tremendous risk; the risk of damaging one's professional reputation, the risk of losing job security, and, in some cases, the risk of litigation. Despite the high stakes, risk-taking often accompanies care because the ethic of care is based on the best interest of the child, and demands corrective action – regardless of personal cost (Gilligan 1982; Noddings 1984; Thompson 1998). Further, the ethic of risk often presses caring educators to implement nontraditional or creative teaching and leading strategies in order to effectively educate disenfranchised students. Therefore, caring teachers and administrators are willing to take radical measures to provide a secure, fair, and productive learning environment for their students. (p. 81)

This risk to themselves is fraught with ambivalences, as explored by Deevia Bhana (2015) in the context of the highly racialised sexual politics of South Africa. One of

colonialism and apartheid's legacies is a history of violence and of crumbling family structures, which together manifest in high rates of sexual violence, especially against black girls and women. The government, in an attempt to address this, has made it mandatory for teachers to report incidences of violence against their girl students. On the other hand, faced with the threat of violent retribution for reporting, teachers are left with little option but to be silent (Bhana 2015), a silence which is, however, policed by the state. Care involves finding intermediaries such as social workers to report the sexual violence. For 'teachers, managing care in the context of sexual violence is also about managing silences' (p. 266). Deevia Bhana tellingly titles her essay on this 'When caring is not enough'!

In care ethics care is calibrated at the point of care completion but if we privilege care as practice, then the outcomes of caring practices are always emergent and can therefore be open to risk. For Conradi (2015a), care is learnt by doing. However, this means that despite the best of intentions the fact that caring will result in 'care' can't be known in advance; nor can it be guaranteed. Care as practice and care as outcome can, therefore, be wedged apart (and see Noxolo et al. 2012 for a similar discussion on responsibility). Care is risky.

Conclusions

Geographers have an inherent interest in care as it appeals to two foundational elements of geographical thinking – relationality and sensitivity to context, particularly to the difference that place makes to identities. Moreover, geographers have also adopted care ethics as a route to place based normative thinking. Thus, the ways through which caring lives are enacted have come to be explored through a wide variety of case studies. Locating care in diverse places provides us with the

opportunity of opening up care ethics to this diversity.

However, care not only requires locating. It also requires dislocating from the normative white body through which much care is theorised. Unlike explorations of embodiment, I use the term racialised body figuratively to disturb the anaemic landscape of feminist care ethics and draw attention to the disruptive potential of that physical presence. Colonial 'caring' encounters have shaped transnational hierarchies but also ordered postcolonial racialised violence (Stoler 2004). The meaning, nature and value of care are all deeply racialised. That is why care ethics must also be (dis)located and viewed through the racialised body. While care practices have been considered as deeply racialised, how can care ethics be reconstituted to take on insights from racialised bodies? What challenges do these bodies throw up for care ethics? This paper has explored these issues by focusing on specific components of care ethics. Moreover, in this instance, the body is used figuratively to disturb the anaemic landscape of feminist care ethics, but further research should also focus on the disruptive potential of that physical presence.

Locating care in racialised bodies, I argue, raises new questions for care. How will care ethics deal with alterity? How do we provide care when both recognition and dialogue occur across difference? Finally, given that care is a bundle of activities and dispositions whose outcomes cannot be known in advance how far is care risky? This paper has explored these elements of care – competence, recognition and dialogue, and risk - as inherent to care in a racially unequal (and not simply diverse) world. The embodied nature of care and the different ways in which bodies are evaluated influence what we define as good care. Hence, recognizing the racialised nature of care makes clear the inequalities inherent in how care competence is calibrated and the embodied valuations and uneven geohistories of care that care ethics necessarily

draws upon. Similarly, care cannot always be recognised either by those who provide care or even those who require it. Poor care and lack of care constitutes subjects whose care demands and needs may be unrecognisable or un-articulable. All these mean that caring across difference, in this case, racial difference, can be risky.

The examples in the paper aim to draw us into the challenges in caring in a racialised world. In doing so the paper seeks to focus on care as a set of intimate practices played out across racial difference and as experienced primarily by black women in caring roles. It suggests that both care and race are produced inter-subjectively, but to get a glimpse into this we need to think of particular events and moments in caring practices as it is experienced and valued. Such moments provide a place to stop and interrogate (racialised) care (Moi 2015). They offer a method for thinking intersectionally. They also provide an invitation for others writing on care ethics to 'stake themselves' – to think through examples, but also to look at what is at stake – in this case, to think of care ethics as it intersects with race (and other identities).

Focusing on race and care highlights one instance where social differences are composed and recomposed through intimate performances. These differences are performed across race and gender. In this paper I have focused on racialised bodies but have looked primarily at care relating to women. The black male body situates itself somewhat differently within care ethics. First is the question of ethics. As suggested earlier, theories of justice, which have, in part, been seen as masculine, have often been produced by and for white men. Does justice as ethic hold differential value for black men? Secondly, masculinities also vary across men. The experiences of black men differ from those of white men as well as from women in different parts of the world. In countries like the US and UK where colonialism wrought havoc in

societies, black men play a very particular part in care giving and receiving, situated as they are, within hegemonic white masculinities which push not only white and black women into particular positions but also leaves very little space for caring black men. The infantilization of black carers who were employed as domestic workers in white households in colonial Zambia (Hansen 1989) alongside their representation as sexual threats speaks to the complexity of men and care. Moreover, male domination (Elliott 2016) is both more acute and more contingent for black men in racialised societies. They are both dominated within white dominated societies and dominating as there is a projection of hypermasculinity on to some black bodies. Other black bodies do caring work while simultaneously have care ripped from their bodies. What can the experiences of black men tell us about care as feminist ethic? Thirdly, seeing care as inherent to, and important for exposing injustice (Robinson 2013), becomes particularly poignant when applied to black men as evidenced by slavery and its' ongoing presence in racialised labour markets.

This subject of black masculinities and care ethics is an area which needs further research and reflection. But it also asks for greater thinking about how the normativity of *in*justice - whereby injustice begets further injustice - produced particular gendered subjectivities and gendered violence. It points to the complexities of normative thinking whereby ethics and experiences are both produced in practice at the intersection of class, race and gender in specific geographical locations through its' own histories.

It is not only gendered subjectivities that are place sensitive, but also ideas of good care, of how care is provided and hence the ethic of care (see Raghuram 2016 for an extended discussion of the geographies of care ethics). Variations in care (Laugier 2015) emanating from the experiences of gendered subjects situated in

different parts of the world have to inflect ethics in order to prevent it from situating itself in either cosmopolitan or communitarian claims to generalisability (Robinson 2013). So it requires that care is disassembled as well as put together as a critical practice in order to shape care ethics.

However, in doing so, it is important to retain care as hopeful, what Cooper (2013) calls an everyday utopia. In tracing the uneven terrain of care practices and its implications for care ethics, it does not aim to fall back into critique; rather it suggests narrating care as a set of practices that can engage and re-engage with the questions that care across different groups raises. Racial identities arise in and through action.

Race and care can be done differently but this requires an openness to the politics and ethics of care (Hamington 2015). As Okano (2016) suggests 'the ethic of care does not teach us how to heal wounded people effectively but rather teaches us how difficult it is to do so. To heal the wounded requires an unpredictably long time, for their sufferings are caused not only by direct injuries but also by the structural violence inflicted on their historical and political situation' (95). It requires that we are mindful of the hard work that is required to achieve a re-acting of care and the fact that its outcomes are not guaranteed (Spivak 1988).

That is the promise of care as a relational ethic. But we also need to ask: how do we accommodate the failed promise of good care into these theories of care? That is, how do we take on the ethical imperative of racialised caring bodies across the globe as academics and researchers? I hope I have taken one step towards this in this paper.

was presented. I would also like to thank the Feminist Discussion Group and members of the OpenSpace research centre at The Open University, Nick Bingham, Sophie Bowlby, Nigel Clark, Davina Cooper, Maurice Hamington, Victoria Lawson, Jane McCarthy, Fiona Robinson and the reviewers and editors at Gender, Place and Culture for their generous comments on versions of this paper. Finally, particular thanks to Eleonore Kofman, Clare Madge and Pat Noxolo with whom I have engaged on issues around care for many years. All errors remain my own.

Contributor Notes:

Parvati Raghuram is Professor in Geography and Migration at the Open University. She has published widely on gender, migration and development and on postcolonial theory. Her most recent ESRC funded projects are Gender, skilled migration and the IT sector: a comparative study of India and the UK and Facilitating equitable access and quality education for development: South African International Distance Education. She has co-authored *Gender, Migration and Social Reproduction* (Palgrave), *The Practice of Cultural Studies* (Sage), *Gender and International Migration in Europe* (Routledge) and co-edited *South Asian women in the diaspora* (Berg) and *Tracing Indian diaspora: Contexts, Memories, Representations* (Sage). She has written for policy audiences having co-authored research papers for a number of think-tanks such as IPPR, UNRISD, the Hamburg Institute of International Economics and Heinrich Böll Stiftung and co-edited a special issue of the journal *Diversities* for UNESCO. She co-edits the Palgrave Pivot series *Mobility and Politics* with Martin Geiger and William Walters, both at Ottawa.

References

Ahmed, Sara. 2010. *The Promise of Happiness*. Duke University Press: North Carolina.

Ansell, Nicola. 2009. 'Producing Interventions for AIDS-Affected Young People in Lesotho's Schools: Scalar Relations and Power Differentials'. *Geoforum*, Themed Issue: The 'view from nowhere'? Spatial politics and cultural significance of high-resolution satellite imagery, 40 (4): 675–85.

Asis, Maruja M. B., Shirlena Huang, and Brenda Yeoh. 2004. "When the Light of Home is Abroad: Unskilled Female Migration and the Filipino Family." *Singapore Journal of Tropical Geography* 25(2): 198–215.

Barker, Drucilla. 2012. "Querying the Paradox of Caring Labor". *Rethinking Marxism: A Journal of Economics, Culture & Society* 24(4): 574-591.

Barker, Drucilla and Feiner, Susan. 2009. "Race, Affect and Class: An Interpretative Reading of Caring Labour". *Frontiers: A Journal of Women Studies* 30(1): 41-54

Barnes, Marian. 2011. *Care in Everyday Life: An Ethic of Care in Practice*. Policy Press: Bristol.

Bartos, Ann. 2018. "The uncomfortable politics of care and conflict: Exploring nontraditional caring agencies" *Geoforum* 88: 66-73.

Barnett, Clive. 2005. "Who Cares?" In *Introducing Human Geographies* Edited by Paul Cloke, Phil Crang and Mike Goodwin (2nd Edition), Arnold, pp. 588-601.

Bass, Lisa. 2012. "When care trumps justice: the operationalisation of Black feminist caring in educational leadership". *International Journal of Qualitative Studies in Education* 25(1): 73-87.

Batnitzky, Adina and McDowell, Linda 2011. "Migration, nursing, institutional discrimination and emotional/affective labour: ethnicity and labour stratification in the UK National Health Service". *Social & Cultural Geography* 12(2): 181-201.

Bender, Désirée, Hollstein, Tina, Horn, Vincent, Huber, Lena, and Schweppe, Cornelia 2014. "Old age care facilities and care-seeking elderly on the move". *Transnational Social Review. A Social Work Journal* 4(2–3): 290–293

Bhabha, Homi (1994) *The location of culture*. Routledge: London.

Bhana, Deevia. 2015. "When caring is not enough: The limits of teachers' support for South African primary school-girls in the context of sexual violence". *International Journal of Educational Development* 41: 262-270.

Boyd, Susan. 2013. "'Marriage is more than just a piece of paper': Feminist Critiques of Same Sex Marriage" *National Taiwan University Law Review* 8(2): 263-298.

Brown, Michael. 2003. 'Hospice and the Spatial Paradoxes of Terminal Care'. *Environment and Planning A: Economy and Space* 35 (5): 833–51.

Burton, Antoinette. 2011. "The pain of racism in the making of a 'Coolie Doctor'". *Interventions: International Journal of Postcolonial Studies* 13(2): 212-235.

Butler, Judith. 1999 *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge.

Butler, Samuel. 2012. "The fourth subject position of care" *Hypatia* 27(2): 390-406.

Calder, Gideon. 2015. "Caring about Deliberation, Deliberating about Care" *Ethics and Social Welfare* 9(2): 130-146.

Chakravarti, Upali. 2008. "Burden of Caring: Families of the Disabled in Urban India". *Indian Journal of Gender Studies* 15(2): 341–363.

Chouinard, Vera. 2000. 'Disability, Geography and Ethics: Getting Ethical: For Inclusive and Engaged Geographies of Disability'. Philosophy & Geography 3 (1):

Cloutier, Denise S., Anne Martin-Matthews, Kerry Byrne, and Faye Wolse. 2015. 'The Space between: Using "Relational Ethics" and "Relational Space" to Explore Relationship-Building between Care Providers and Care Recipients in the Home Space'. Social & Cultural Geography 16 (7): 764–82.

Cloyes, Kirstin. 2002. "Agonizing care: care ethics, agonistic feminism and a political theory of care" *Nursing Inquiry* 9(3): 203–214.

Cock, Jacklyn. 1989. *Of Maids and Madams: domestic workers under apartheid*. Women's Press. Cape of Good Hope.

Collins, Patricia Hill. 2000. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. 2nd ed. New York: Routledge.

Collins, Patricia H. 1995. "Black Women and Motherhood." Pp. 117–135 in Justice and Care: Essential Readings in Feminist Ethics, edited by Virginia Held. Boulder, CO: Westview Press.

Combahee River Collective. 1977. "A Black Feminist Statement." *Reprinted in The Second Wave: A Reader in Feminist Theory*, ed. Linda Nicholson. New York: Routledge, 63–70.

Conradi, Elisabeth. 2015a. "Redoing Care: Societal Transformation through Critical Practice" *Ethics and Social Welfare* 9(2), 113-129.

Conradi, Elisabeth. 2015b. European ethics of care: Drawing distinctions. Paper presented at the summer school 'Caring about care. The concept of care in the healthcare system. A comparison between Germany and the Netherlands'. Frieburg. Available here: http://ethicsofcare.org/wp-

content/uploads/2015/10/Presentation-Conradi-Care-9-2015.pdf. Accessed 17
September 2017.

Cooper, Davina. 2014. *Everyday Utopias: The Conceptual Life of Promising Spaces*.
Durham: Duke University Press.

Cooper, Davina. 2007. "'Well, you go there to get off": Visiting Feminist Care Ethics
through a Women's Bathhouse". *Feminist Theory* 8: 243-262.

Cuomo, Chris. 1997. *Feminism and ecological communities: An ethic of flourishing*.
New York: Routledge.

Crenshaw, Kimberle 1991. "Mapping the Margins: Intersectionality, Identity Politics,
and Violence against Women of Color" *Stanford Law Review* 43(6): 1241-
1299

Daya, Shari 2016. Ordinary ethics and craft consumption: A Southern perspective.
Geoforum 128-135.

Duffy, Mignon. 2011. *Making Care Count: A Century of Gender, Race, and Paid
Care Work*. Piscataway, NJ: Rutgers University Press.

Duffy, Mignon. 2005. "Reproducing Labor Inequalities: Challenges for Feminists
Conceptualizing Care at the Intersections of Gender, Race, and Class". *Gender
& Society* 19(1): 66-82.

Elliott, Karla. 2016. 'Caring Masculinities: Theorizing an Emerging Concept'. *Men
and Masculinities* 19(3): 240-259.

Evans, Ruth and Atim, Agnes. 2011. "Care, Disability and HIV in Africa: diverging
or interconnected concepts and practices?" *Third World Quarterly* 32(8):1437-
1454.

Gilligan, Carol. 1982. *In A Different Voice*. Cambridge, Mass.: Harvard University
Press.

Glenn, Evelyn Nakano. 2010. *Forced to Care: Coercion and Caregiving in America*.
Cambridge, Mass: Harvard University Press.

Goonam, K. 1991. *Coolie Doctor*. Durban: Madiba Press.

Graham, Medaka. 2007. "The Ethics of Care, Black Women and the Social
Professions: Implications of a New Analysis". *Ethics and Social Welfare* 1(2):
194–206.

Gunaratnam, Yasmin. 2008. "Care, artistry and what might be" *Ethnicity and
Inequalities in Health and Social Care* 1(1): 9-17

Hamington, Maurice. 2015. "Care Ethics and Engaging Intersectional Difference
through the Body" *Critical Philosophy of Race* 3(1): 79-100.

Hamington, Maurice. 2017. Social Readiness: Care Ethics and Migration' In: Steven
Bender and William Arrocha (eds) *Compassionate Migration and Regional
Policy in the Americas*. Palgrave Macmillan, London pp 237-252.

Hane, Douglas. 2017. "Left Out/Left Behind: On care theory's other". *Hypatia*. 32(3):
523-539.

Hankivsky, Olena**. 2014. "**Rethinking Care Ethics: On the Promise and Potential of an
Intersectional Analysis"**.** *American Political Science Review* 108(2): 252-264**.**

Hansen, Karen Tranberg. 1989. *Distant Companions: Servants and Employers in
Zambia, 1900-1985*. Ithaca: Cornell University Press.

Held, Virginia. 2006. *The Ethics of Care*. New York, NY: Oxford University Press.

Hollway, Wendy. 2006. *The Capacity to Care*. London: Routledge.

Howard, Robert. 2008. 'Western retirees in Thailand: motives, experiences,
wellbeing, assimilation and future needs.' *Ageing and Society* 28(2) 145-163.

ILO. 2015. *Global Estimates on Migrant Workers*. Geneva: ILO.

Johnson, Mark. 2017. 'Gendering Pastoral Power: Masculinity, Affective Labour and
Competitive Bonds of Solidarity among Filipino Migrant Men in Saudi
Arabia'. *Gender, Place & Culture* 24 (6): 823–33.

Jordan, Ana. 2018. 'Masculinizing Care? Gender, Ethics of Care, and Fathers' Rights
Groups'. *Men and Masculinities*.

Keller, Jean. 2010. "Rethinking Ruddick and the Ethnocentrism Critique of Maternal
Thinking". *Hypatia* 25(4), 834-851.

Kilkey, Majella, Diane Perrons, and Ania Plomein, Pierrette Hondagneu-Sotelo, and
Hernan Ramirez. 2013. *Gender, Migration and Domestic Work:
Masculinities, Male Labour and Fathering in the UK and the USA*.
Basingstoke: Palgrave Macmillan

Kittay, Eva Feder. 1999. *Love's Labor: Essays on Women, Equality, and Dependency*.
New York, NY: Routledge.

Kofman, Eleonore and Raghuram, Parvati. 2015. *Gendered migrations and global
social reproduction*. London: Palgrave.

Kofman, Eleonore and Raghuram, Parvati. 2013. 'Changing Mobility
Regimes, Knowledge and Gender Equalities in Europe', in *Mobilities,*

Knowledge, and Social Justice. Edited by Suzanne Ilcan. McGill-Queen's University Press. pp. 59-75.

Kofman, Eleonore and Raghuram, Parvati. 2012. 'Women, Migration and Care: explorations of diversity and dynamism in the South' *Social Politics* 19(3): 408-432.

Laugier, Sandra. 2015. "The ethics of care as the politics of the ordinary" *New Literary History* 46(2): 217-240.

Lawson, Victoria. 2007. 'Geographies of Care and Responsibility'. *Annals of the Association of American Geographers* 97 (1): 1–11.

Locke, Catherine. 2017. "Do male migrants 'care'? How migration is reshaping the gender ethics of care." *Ethics and Social Welfare* 11 (3): 277–295.

Lopez, Patricia J., and Kathryn Gillespie. 2016. 'A Love Story: For "Buddy System" Research in the Academy'. *Gender, Place & Culture* 23 (12): 1689–1700.

Mahadevan, Kanchana. 2014. Between Femininity and Feminism: colonial and postcolonial perspectives on care. New Delhi: Indian Council of Philosophical Research.

McDowell, Linda. 2006. "Reconfigurations of Gender and Class Relations: Class Differences, Class Condescension and the Changing Place of Class Relations". Antipode 38: 825–850

McEwan, Cheryl, and Michael K. Goodman. 2010. 'Place Geography and the Ethics of Care: Introductory Remarks on the Geographies of Ethics, Responsibility and Care'. Ethics, Place & Environment 13 (2): 103–12.

Mohanty, Chandra Talpade. 1984. "Under Western Eyes: Feminist Scholarship and Colonial Discourse". *Boundary2* 12(3): 333-353.

Moi, Toril. 2015. 'Thinking Through Examples: What Ordinary Language Philosophy Can Do for Feminist Theory'. *New Literary History* 17(2): 191-216.

Montes, Veronica. 2013. "The Role of Emotions in the Construction of Masculinity: Guatemalan Migrant Men, Transnational Migration and Family Relations." *Gender and Society* 27: 469–490.

Murphy, Michelle. 2015. "Unsettling care: Troubling transnational itineraries of care in feminist health practices" *Social Studies of Science* 45(5): 717-737.

Narayan, Uma. 1995. "Colonialism and Its Others: Considerations On Rights and Care Discourses". *Hypatia* 10(2): 133-140.

Nicholson, Linda J. 1993. "Women, Morality, and History." Pp. 87–101 in An Ethics of Care: Feminist and Interdisciplinary Perspectives, edited by Mary J. Larrabee. New York: Routledge.

Noah, Trevor. 2016. *Born a Crime and other stories*. Macmillan: Johannesburg.

Noddings, Nel. 1982. *Caring: A Feminine Approach to Ethics and Moral Education*. Berkeley: University of CA Press.

Noxolo, Pat. Raghuram, Parvati, and Madge Clare. 2012. "Unsettling responsibility: postcolonial interventions". *Transactions of the Institute of British Geographers* 37(3): 418-429.

Noxolo, Pat, Raghuram, Parvati and Madge, Clare. 2008. "'Geography is pregnant' and 'Geography's milk is flowing': metaphors for a postcolonial discipline?" *Environment and Planning D: Society and Space* 26: 146-168.

Okano, Yayo, 2016. "Why Has the Ethics of Care Become an Issue of Global Concern?" *International Journal of Japanese Sociology* 25: 85-99.

Palriwala, Rajni and Neetha, N. 2011. Stratified Familialism: The Care Regime in India through the Lens of Childcare. *Development and Change* 42(4), 1049–1078.

Popke, Jeff. 2006. 'Geography and Ethics: Everyday Mediations Through Care and Consumption'. *Progress in Human Geography* 30 (4): 504–512.

Pratt, Geraldine. 1999. "From registered nurse to registered nanny: Discursive geographies of Filipina domestic workers in Vancouver, BC". *Economic Geography* 75(3): 215-236.

Radicioni, Silvia, and Bernhard Weicht. 2018. 'A Place to Transform: Creating Caring Spaces by Challenging Normativity and Identity'. *Gender, Place & Culture* 25 (3): 368–83.

Raghuram, Parvati 2016. 'Migration and feminist care ethics', in Alex Sager (ed) *The Ethics and Politics of Immigration: Core issues and emerging trends*. Rowman and Littlefield. pp. 183-200.

Raghuram, Parvati. 2012. "Global care, local configurations: challenges to conceptualizations of care". *Global Networks* 12(2): 155-174.

Raghuram, Parvati. 2009. "Caring about the brain drain in a postcolonial world". *Geoforum* 40(1): 25-33.

van Riemsdijk, Micheline. 2013. "Everyday geopolitics, the valuation of labour and the socio-political hierarchies of skill: Polish nurses in Norway". *Journal of Ethnic and Migration Studies* 39(3): 373-390.

Robinson, Fiona. 2013. "Global care ethics: Beyond distribution, beyond justice". *Journal of Global Ethics* 9(2): 131-143.

Ruddick, Sara. 1989. *Maternal thinking*. Boston: Beacon Press.

Sen, Amartya. 1987. *Gender and co-operative conflict*. UNU WIDER Working Papers.

Siddle Walker, Vanessa and Snarey, John. 2004. *Race-ing Moral Formation: African American perspectives on care and Justice*. New York: Teacher's College Press.

Spivak, Gayatri. 1988. 'Can the subaltern speak?' in *Marxism and the Interpretation of Culture* Edited by Grossberg L and Nelson C Macmillan, Basingstoke 271-313

Smith, David. 1998. "How far should we care? On the spatial scope of beneficence". *Progress in Human Geography* 22(1): 15-28.

Stark, Hannah. 2014. "Judith Butler's post-Hegelian ethics and the problem with recognition". *Feminist Theory* 15(1): 89-100.

Stoler, Ann. 2004. "Tense and Tender Ties: The Politics of Comparison in North American History and (Post) Colonial Studies" *The Journal of American History* 88(3): 829-865.

Swartz, Leslie. 2012. "Race, gender and the impossibilities of care". *Medical Humanities* 38(1):34-37.

Taylor, C. Scott, and Jennifer Carter. 2018. 'Care in the Contested Geographies of Dolphin-Assisted Therapy'. *Social & Cultural Geography*, March, 1–22.

Thomas, Carol. 2006. "Disability and gender : some reflections on theory and research" *Scandinavian Journal of Disability Research* 8(2-3): 177-185

Tronto, Joan. 2010. "Creating Caring Institutions: Politics, Plurality, and Purpose". *Ethics and Social Welfare* 4(2): 158–171

Tronto, Joan. 1994. *Moral Boundaries: A Political Argument for an Ethic of Care*. New York, NY: Routledge.

Thompson, Audrey. 2004. Caring and Colortalk: Childhood innocence in White and Black. In *Race-ing Moral Formation: African American perspectives on care*

and Justice. Edited by Siddle Walker, Vanessa and Snarey, John. New York: Teacher's College Press (23-37).

Ward, Nicky. 2015. 'Care Ethics, Intersectionality and Post-structuralism', in *Ethics of care: Critical Advances in International Perspective* edited by Barnes, Mariam, Branelly, Tula, Ward, Lizzie and Ward, Nicki. Policy Press, Bristol. Pp 53-68.

White, Julie and Tronto, Joan. 2004. "Political practices of care: Needs and Rights. *Ratio Juris* 17(4): 425-453.

Zelizer, Viviana A. 2000. "The Purchase of Intimacy." *Law and Social Inquiry* 25 (3): 817–848.