LOCATING CARE ETHICS BEYOND THE GLOBAL NORTH

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Abstract
In care ethics, caring is seen to be embedded in practice and locally contingent. However, despite a large and thriving literature on care practices as they vary across the globe, the implications of the different meanings and geohistories of care for the ethics of care have hardly been addressed. Rather, most theorisations of care ethics have implicitly conceptualised care as a universal practice or drawn on care as practised in the global North. This paper argues that care ethics needs *emplacing* and this emplacement should extend beyond sites in the global North so that feminist theories of care can take account of the diversity of care practices globally. Moreover, given the increasing globalisation of care, different notions of care meet. As care is relational and enacted across space, the differences in care ethics between places have to be negotiated. This paper, therefore, calls not just for recognising multiplicity in care ethics or even multicultural care ethics, but for theorising the relations between different kinds of care and the ethics that drive them. Finally, both care relations and understandings of care are dynamic; they alter as people migrate which too needs consideration. This paper argues that such a relational and dynamic understanding of varied care offers new theoretical, political and empirical agendas both within geography and for feminist theory.

Keywords: care ethics, place, relationality, geography, global South, global North

DIS/LOCATING CARE ETHICS: PLACE AND RELATIONALITY IN A GLOBALISING WORLD

Introduction

Care has been adopted as a way of thinking relationality in a globalising world. It is conceptualised as an ethic (Gilligan, 1982; Noddings, 1984), as the basis for organising social and economic life, and as a focus for policy and political activities (Mahon and Robinson, 2011). It also has an expanding remit in a range of disciplines and approaches including geography (Lawson, 2007), politics (Engster, 2005), sociology (Duffy, 2011), economics (Folbre, 2006; Himmelweit, 1999), social policy (Williams, 2011), philosophy (Sander-Staudt, 2006) and science and technology studies (Mol, 2008; Puig de la Bellacasa, 2011). The caring professions too have a huge interest in care as ethic and practice (see for instance, Bhana, 2015 on education; Cloyes, 2002 on nursing; Lloyd, 2006 on social work). Given the vast literature that has been assembled around care what more is to be said about care? And specifically, what can geographers contribute to these discussions?

In this paper I suggest that geographers, through their attentiveness to the spatial variations in the meaning and practice of care across different locations and constituencies, can tease out some of the tensions in normative versions of care. This paper argues for the need to remain alive to these tensions within care and to see the productive potential that they offer in theorising care, not only in terms of practice, but also as an ethic.

The rest of the paper is organised in five parts. The first outlines how care has come to be an important concern across the social sciences and humanities, including within geography. It suggests that as a relational ethic geographers gain a normative perspective on relationality that helps spatial theorising. The following (second) part highlights what geographers can contribute to these discussions of care. Care, unlike responsibility, is strongly based in practice; care as a norm is based on and requires care completion (Sander-Staudt, 2006). Yet, local variations in the architecture and institutions of care, in its histories and its preferred constituencies means that despite the mobility of carers in a globalising world, the definition and understandings of care may be less dynamic. Part three, therefore, explores some of the place-based variations in care. It *locates* care beyond the implicit but often unspecified global North and addresses what the different meanings of care might be. The fourth part explores some issues that such variations could pose. It suggests that *localising* care ethics implies *discloating* it from its unspoken but often implicit locatedness in vary particular locations and practices of care. It argues that this dislocation is crucial if we are to have a care ethics which is attuned to the difference that place makes. The localisation of care raises new questions for thinking around care as I will go on to conclude in the final part of the paper.

In invoking the 'global South'[1] as a location I aim to not just emplace care practices through the lens of difference but to place on the agenda what the geohistories of care, the structural conditions of caring (which are place sensitive), the uneven geographies of colonial and postcolonial development, and the political concerns and solidarities that emerge from this do to caring practices as well as care ethics.

Coming to care

Care has become an important focus of feminist theorising, acknowledging the distinctive and often unshifting role that care plays in women's lives. Interest in care

has had both empirical and theoretical resonance. There are a number of reasons for this. First, are demographic changes such as the increase in older people globally, the growth of two wage families as many countries shift away from the breadwinner model to the adult worker model and the rise of the social investment state with much emphasis being placed on bringing up children (Peng, 2011). All this has led to the outsourcing of some forms of care. The resurgence of paid care work globally, largely done by women, has forced this sector back into public consciousness.

Secondly, care has increasingly become globalised. Saskia Sassen (2002) draws on Marxist inspired core-periphery theories to suggest that the working out of the forces and processes of economic globalization (structural adjustment programmes, opening up to foreign capital and removal of state subsidies) has squeezed the lives of women in the Global South forcing them to pursue alternative survival strategies, particularly migration. The growth of two-wage families along with the personalisation of care arrangements in the global North, on the other hand, creates a care deficit within households in the North. The global North, therefore, increasingly depends on careworkers from the global South (Hochschild, 2000; Parreňas, 2001; see also Yeates, 2008). It is not only labour that is moving but also those who receive care (Connell and Walton-Roberts, forthcoming). The transfer of care policies, often (but not always) through the rubric of international non-governmental organisations such as the World Health Organisation and large aid organisations, and the movement of capital that is used to provide care, too play a huge part in globalising care (Bedford, 2010; Williams, 2011).

Care also resonates with many of the contemporary areas of concern in social theory, particularly those on affect and emotion, a third reason for the rise of interest in care. Care, unlike reproduction and the domestic labour debate, the rubric under which discussions of much of what is now considered caring labour in the 1970s and early 1980s were conducted (Molyneux, 1979), encompasses affective labour on which there is much written (Hochschild, 1983). Care is provoked by ordinary emotions such as love, laughter, guilt, empathy and sympathy among others and it is by highlighting these registers of feeling that care has come to be analysed. Affect and emotions are not only personal; they are also geopolitical. Thus, emotive care is inherent to the making of colonial relations (Stoler, 2004) as well as global capitalist relations (Berlant, 2011).

Finally, care is at the heart of debates on how we reproduce society. The economics of care (Fraser, 2014), the relationship between choice and need (Mol, 2008), who deserves care (Clarke, 2005), and how these questions relate to issues of justice (Engster, 2005), to autonomy and dependence (a particular concern for disability studies researchers – see for instance, Kröger, 2009; Shakespeare, 2006; and for an excellent analysis of the tensions between feminism and disability perspectives on care see Kelly, 2013)[2] and hence to both moral philosophy and social practice (Conradi, 2015) engage academics and policy makers globally. This work on care has provided a route to thinking beyond capitalism (Fraser, 2014) and masculinism (Gilligan, 1982), challenging dominant structures of gendered and classed inequality in the world. Care thinking is therefore a political project; it aims to address some of the shortcomings of other normative theories. It offers 'an alternative political/theoretical language to disrupt other claims within social sciences' (Lawson, personal communication) about how the world ought to be (and often is). Given that there is such a vast literature on care what more can geographers contribute?

Why do geographers care?

The ability to bring together emotive, moral and political registers has meant that care offers a route into thinking ethically about relationships between self and others – both proximate and distant. The geographies of responsibility and care were eloquently discussed by Victoria Lawson (2007) in her presidential address at the AAG 2006. As such, there is a rich vein of work on geographies of care (McEwan and Goodman, 2010), focusing on various aspects of care: the places and spaces in which care is performed ranging from the intimate (Bowlby et al., 2010), institutional settings (Brown, 2003; England, 2010; Milligan, 2003) and online (Crooks, 2006); the challenge of distance in caring for and about people (Silk, 2000) and how far care can be used to invoke feelings of responsibility for distant others (Milligan and White, 2010; Smith, 1997). The situated and interrelational nature of care relations (Conradson, 2003), and the extent to which care is being reorganised, respatialised and commodified through the changing welfare state (Power, 2010, 2014) and through migration (Datta et al., 2010; McDowell, 2004; Gunaratnam, 2013) have also been of interest (England and Henry, 2013; Kofman and Raghuram, 2015). Care is also being conceptualised as including non-humans (Adams and Donovan, 2007) and particularly the environment (Cuomo, 1997) and these theorisations of connectedness are used to address the low status of care work (Cox, 2010). Another large strand of work within geography explores the political institutions of care-giving and receiving (Atkinson et al., 2011; Milligan and White, 2010); multiple recipients of care i.e. those who engage in care as a reciprocal relationship (Bowlby, 2011); those who primarily receive care as dependants (Brown, 2003) and those who receive care even though they could care for themselves (Sybylla, 2001).

Care also offers another route to thinking though the geographies of ethics. Geographers, keen to address the one-way flow from philosophy and ethics to geography (Smith, 1997), have provided a rich vein of thinking on a variety of ethics including on care (see for instance, Barnett, 2005; Popke, 2006). Care offers one route to shaping the ethics of everyday living.

Moreover, 'care' also 'works' for geographers. It helps us to embed relational thinking across proximity and distance and to have a way of theorising spatial relations in an ethical register (Barnett and Land, 2007; Popke, 2006). Much of the literature on care ethics within geography has done precisely that. However, geographers, through their sensitivity to spatial variation and to place, also offer the potential to *emplace* care ethics, to respond to the challenges offered by place to care in non-normative ways, to think through the embodied challenges of care, and in doing so, to think through how the practice of care can be better integrated into care ethics. This project is already underway (see for instance, Green and Lawson, 2011). I extend this work by locating care thinking in unfamiliar places, specifically, in order to 'trouble' care. In doing so I do not intend to suggest that we jettison the conceptual possibilities offered by care as a way of theorising relationality in geography and across feminist theorising. Rather, I argue that in adopting care we interrogate the specific deployments of these terms in the context of a diverse and dynamic world. The next part therefore turns to some of the place based variations in care and the challenge that these differences in location pose for theorising care as ethic.

Locating *care practices*

Most geographical writing on care focuses on the varied practices, locations and spatial connections of care but in doing so they draw their normative framework, and therefore the process of argumentation, from the framework of care ethics. Intervening into notions of justice as ethics and on virtue ethics the first generation of

care theorists, Sara Ruddick (1980), Carol Gilligan (1982) and Nel Noddings (1984) wrote about how care was foundational to women and counterposed (in the case of Noddings, 1984) to the attitudes of men. Later feminists like Joan Tronto (1993) unpicked the necessary relationship between femininity and caring and refined notions of care to incorporate the varieties of relations encompassed in care. Hence, (and this is my first point), for many (although not all) feminists, care is not explicitly or only located in the feminine.

Secondly, neither (and in part following on from this) is care located in individual identities. Care is produced inter-subjectively, in relation, and through practice. This is fundamental to much recent thinking on care as it overcomes troublesome divides between caring about and care-giving. Arising from critiques of men's attitude to care, whereby some men profess to 'care about', but rarely engage in care-giving, Joan Tronto (1993) distinguished between the four elements of care: giving, receiving, caring about and caring for. The distinctions between the latter two echo that between care as ethic and care as practice (Popke, 2006) For Maureen Sander-Staudt (2006), this division also summarises many of the distinctions between care as motivation and care as an end. She suggests that while care-of and care-about are located in discussions of rationality and reason, the latter two are seen as embodied work. These distinctions may also be seen to parallel the male disembodied world of ethics and the feminised care-giving discourses (Gilligan, 1982; Noddings, 1984). For instance, while discussions of care as ethic have been tied up in normative notions of what good care looks like, *care as practice* ultimately focuses on caring as embodied, physical and emotional work.

However, for feminists concerned with the ways in which care is often feminised work, the practice of care is central to developing an ethic of care. They argue that caring can only be effective at the point of care completion - expressing an intention to care is simply not enough. Care as ethics is developed through care as practice; the two can therefore never be wholly held apart (Sander-Staudt, 2006). As in discussions of responsibility, relations of power in carework are ultimately seen as worked out inter-subjectively, in and through inter-relational and contingent acts of care-giving/care-receiving (Noxolo et al., 2012). Fiona Robinson puts this neatly when she suggests that notion of subjectivity and the role of care therein 'recognizes that the self is relational 'all the way down'' (2013, 140). For Wendy Hollway (2006), this inter-subjectivity is foundational – it produces who we are. Hence, care is not only relational; it is also constitutive of identities. Moreover, the qualities that make up a good caring relationship involve not only a recognition of practice but also of normative criteria on what makes up 'good care'. In short, care work is usually driven by its own internal, often implicit, calibration around justice or virtue but these are, crucially, developed through practice (and for an extended debate on the relationship between care and virtue see Sander-Staudt, 2006). Care is therefore not defined or located individually[3].

Thirdly, in dislocating the individual as the site for care, feminists have argued that care is also not personal (Kittay, 1999); it is a public issue of wider concern to society and hence care concerns go beyond the domestic, the familial and the household. This line of thought is particularly developed by economists and social policy theorists. The care diamond encapsulates the four sites through which care may be organised – household, market, community and the state (Razavi, 2007).

Locating care practices away from the global North

Clearly, locating care in feminist care ethics has also always involved various dislocations. Care theorists have argued that care ethics involves dislocating care from the feminine, the individual and from the private. Hence, the previous part of this essay may, as easily, have been titled dislocating care ethics. But in effect much of this writing and thinking on care ethics has also occurred from and through unnamed locatedness in the global North. That is the unspoken locale of some of this care thinking. This locatedness is embedded through the histories that the literature on care ethics draws upon - feminist theorisations of care from a stellar cast of women, reflecting on care and ethics and within the context of late twentieth century feminist politics in the global North. This history, but also the desire to be true to this history in theorising care ethics (Li, 2015), necessarily emplaces care ethics in particular ways.

This is not to say that the differential nature of care is not recognised. For instance, Robinson (1999) suggests that care ethics should be seen as a 'phenomenology of moral life that recognises that addressing moral problems involves first, an understanding of identities, relationships and contexts (p. 31). Importantly, these contexts are not just individual but also involve the conditions for caring.

However, there is little work that explores what the variations within care mean for care ethics although care is indeed fundamental to all our lives globally. As care practices vary so should care ethics if it is to be meaningful universally. The duties involved in care, who pays for it, where it is situated, who regulates it (if at all) and what are the relationships through which care is mediated at each of these sites where caring occurs all vary. Even within one site, such as the household, there can be many distinctions. Thus, the household may be the site for care but the nature of care will vary according to the degree and nature of dependency in the caring relationship (child, older adults, disabled, able adult and so on). Care within the household can be paid for by individuals, through state subsidies or through non-governmental organisations. Moreover, caring work within the household may also be organised through corporate organisations, by individuals who are paid by the cared for or through familial relations. These differences also occur across each of the sites so that the differences within care are large. The relative importance of these different sites, and how care is organised within them, will be influenced by the history and the institutional architecture of care (Peng, 2011) leading to different welfare regimes (Esping-Andersen, 1999; Sharkh and Gough, 2010).

Importantly, even within one site, the rationale for care provision can vary between different countries and cultures. So, for instance, the rubric under which care occurs is very different in Scandinavia than in the UK. In Scandinavia, care is seen as an inherent duty of the state. Here, the state is seen as responsible for care, not just the safety net which is offered when familial and community care fails. Underpinned by what Borchorst and Siim (2008) call 'state feminism', countries like Sweden have gone a long way towards producing the universal care-giver model (Fraser, 1997). This is significantly different from the ways in which care debates and practices have evolved in the UK, let alone in parts of the Global South (Raghuram, 2012), so that how care comes to be understood can itself vary. Care provided within the home, one site of care, will reflect these variations.

Because care is public, the varied institutional architecture of care globally matters (Raghuram and Kofman, 2015). Importantly, for countries that are chasing economic development, social care has not been a central aspect of national planning and where it exists, may be targeted towards identified vulnerable groups- particularly

children and to disadvantaged minority groups who are seen as being left out of development policy and practice. In India, for instance, government policies have funded the development of various target groups, like women, scheduled castes and scheduled tribes alongside those who live in particular parts of the country, i.e. special targeted areas. Developmentalism is the normative framework applied here and it is modernizing notions of development that haunts thinking around care (see Raghuram, 2012 for an extended discussion). Care is, therefore, always enmeshed in particular teleologies of notions of appropriateness around who requires care and what the purpose of this care might be.

Another formative influence on care in many countries of the global South has been the history of colonialism and its handmaiden – missionary activity (Narayan, 1995). Religious institutions, especially the Christian Church, with its strongly professed ethic of 'compassion' and 'care', alongside its civilizing mission in the colonial project, meant that it had a defining role in rearranging whom to care for and how to deliver care (George, 2005). Thus, the first national survey of domestic workers, for instance, was conducted on behalf of the Catholic Bishops Conference of India in the late 1970s (Roshini Nilaya, 1983). They set out a manifesto in order to improve the conditions of work for domestic workers in India. The emphasis here was on lifting domestic work from the feudal conditions under which it was often conducted, and on modernizing the conditions of labour, better pays and holiday entitlements. This model of care did not, however, question the class boundaries which enabled the continuation of domestic work. The Church as saviour meant that tribal women were converted to Christianity and recruited as domestic workers who were brought to work in cities. These young women domestic workers, however, retained the Church as a nominal home. They were asked to attend Church regularly on Sundays and were also offered skills training, such as sewing classes, run by members of the church. The rules of femininity were, therefore, left intact. This Church-led domestic worker movement came up against a more rights-based domestic worker movement organised by feminists, who objected to the maternalism inherent to the Christian organisation of care (Raghuram, 1993). However, they also recognised a common cause – altering the feudalism of domestic work arrangements. In these two versions of the same issue, both the nature of the care providers and the quality of what was deemed to be care were set within very different frameworks. However, these frameworks are themselves changing – neither religion nor care is fixed. For instance, in recent years the Christian Church has become involved in organizing domestic worker unions (Chigateri, 2007). One implication of this history of care is that the goals of care are likely to be tinged with particular teleologies, aspirations and aims, depending on who exactly inhabits the field of care (Raghuram, 2012). In the Global South the impact of colonial and postcolonial politics on the nature of the family, how care is provided and funded have been notable (Kofman and Raghuram, 2012, 2015).

Importantly, in some countries, especially those in the global South, the role of the state in care has actually increased (Barrientos et al., 2008). There are many reasons for this. First is the post-Washington consensus, which argues for the continuing role of the developmental state in order to mitigate the effects of economic restructuring. These initiatives have got a fillip through initiatives such as the Global Social Protection Floor set by the UN after the 2009 crisis in recognition of the fact that economic security depends on social well being. The low base of formal care provision in many parts of the Global South has meant that these initiatives make a positive difference. The election of more social democratic governments in some parts

of the world, such as of President Lula in Brazil has led to the establishment of both contributory and non-contributory benefit systems that target large sections of the poor (Paes-Sousa, Ribeiro Dantas de Teixeira Soares and Kleiman, 2011). Moreover, some of these initiatives go beyond the social investment state – i.e. where social welfare is targeted at improving and underpinning economic growth, such as policies that target children. Instead, Korea and Japan have also tried to address inequalities arising from the demography of the country by addressing older people (Peng, 2014). The divisions around care are not simply national – they also vary across the spaces through which care is performed (institutional, home, community) as geographers have shown us. They vary across race and class too (see Raghuram, forthcoming).

This trend towards a 'social turn' is in contrast to the retrenchment in social provision in some countries of the Global North. In much of the Global North, care is being relocated from women to men, from public to private and from medical to social worlds (Sevenhuijsen, 2003). The forms that this redistribution takes can vary. For instance, as food is increasingly consumed outside the household men are involved in catering and the associated cleaning, jobs that they rarely did when the household was the overwhelmingly dominant site of food consumption. Similarly, the legalisation of same-sex marriages has meant that same-sex couples too are affected by the privatisation of welfare into the family through the spouse and hence its removal from the state (Boyd, 2013). Finally, the outsourcing of health care to communities has also grown apace in parts of the Global North. These patterns are not exactly mirrored in the Global South. Thus, care is dynamic - but differently so - globally.

Moreover, care is also understood and represented differently in different parts of the world based on political persuasion and epistemological viewpoints. The nature of the questions one asks of care also varies amongst feminists of different political persuasions. Thus, Sander-Staudt (2006, 34), presumably locating her argument in feminism in some part of the global North, argues that '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 care are important too. They are, however, yet to be explored.

Locating care ethics – tactics of place

Clearly, care practices are located across multiple relations, institutions and infrastructures of care which are public as well as private. Moreover, each of these has its own geohistories which makes the whole bundle of care complex, diverse and locationally sensitive. There is also a vibrant discussion of some of these variations across the disciplines and across the caring professions as we saw earlier. Moreover, care in social policy aims to build a picture of how care should be done through its own instruments, i.e. care policy (Williams, 2011). It addresses the normativity sought in care philosophies, albeit in a different register.

This diversity has implications not only for care as practice but also for care ethics because care ethics is dependent on and defined by care as practice. As care is

calibrated at the point of completion the actually existing variable practices of care not only define care but also set the parameters of the ethics of care. The ethics of care is then wholly dependent on care as practice. This makes it distinctive from other ethical theories such as justice ethics, which is calibrated through rational discussion of what constitutes the ethical. In care ethics, the practice and completion of care is paramount. Theoretically, the context of care and local contingency are therefore crucial in defining care and care ethics.

Yet, theories of care ethics are yet to fully draw upon or build on the contextualised stories of care practices available in disciplines such as social policy as there has been some disjuncture between the bodies of feminist work on care ethics and that emanating from those studying care practices and infrastructures in specific locales. They have 'for the most part, been treated separately' (Mahon and Robinson, 2011, 1).

There are at least three tactics around place adopted in care ethics theorising. One way in which place and its variability has been handled is to argue for the universality of care as a bundle of practices. For Held (2015, 22) 'the ethics of care is based on experience, experience that really is universal, the experience of having been cared for, without which we would not exist, and the experience of caring.' As a result, care in much of care ethics is not explicitly located in any one place –it includes dispositions, emotions and a set of social, cultural, economic and political frameworks for enacting these as a set of practices. Moreover, it also provides a moral meta-structure for these frameworks, although this may be less acknowledged. But these practices and dispositions are seen as universally present. For instance, Engster and Hamington (2015) argue that although care is practised differently in different places because dependency (interdependency?) is universal then care as a political theory is also universal.

A second tactic that may be surmised is that although arguing for the locatedness of care, care ethics has based its theorisations on an unspecified location, while implicitly focusing on the Global North. Many of the theorists writing about care ethics are located in the global North and they also draw on patterns and issues that have valency in the North. For example, the overarching emphasis of care as primarily divided along the lines of gender may actually obscure class relations, which in many ways, override gender in some parts of the global South. Moreover, the growth in inequalities, often seen through the lens of production and of the economy, is also leading to a growing inequality in care amongst social classes, a concern that receives much less attention. What would care ethics look like if class and not gender was the privileged optic through which care ethics was theorised?

A third tactic of place aims to dislodge care from what may be seen as its Eurocentric origins. It offers a set of more located engagements between care ethics and other philosophies, particularly Confucianism (Lijun, 2002) but also ubuntu (Harding, 1989; Metz, 2013) and Maori ethics (Boulton and Brannelly, 2015). These parallel bodies of knowledge, which have emerged in other parts of the world, are framed through their locatedness. Ubuntu and Confucianism thus have a named place referent – Africa and China. These philosophies are clearly related to place. This body of work relates to and compares itself with an unlocated feminist care ethics. The aim of the engagement between feminist care ethics, Ubuntu and Confucianism has been to recognise the manifold ways in which interdependence and interrelationality have been recognised as a moral good in different philosophical traditions. However, feminist care ethics, unlike the other two traditions, has rarely been framed as a located care ethics.

Of course, contextualisation also has its pitfalls. For instance, Dalmiya (2009) in her discussion of comparative care ethics argues that while respecting the need to decentre feminist care ethics, which has derived from Western philosophy, should be lauded, the dangers of instead rooting it in other philosophies puts feminist care ethics in danger of buying into their possible national or patriarchal biases. Metz (2013), on the other hand, favours African communitarian ethics as a better basis for combating paternalism. Philosophically, care ethics then sits alongside a set of other philosophical traditions. Yet, unlike ubuntu and Confucianism it does not locate its philosophy in a particular place and not even in a single group (i.e. women).

In sum, there is not yet enough recognition in theories of care ethics of how 'tending, therapy and attachment', the elements that go to make up care (Cooper, 2007, 258) are all culturally variable and are influenced by the conditions of their making. In prioritising the histories of care ethics we begin some distance away from the practical registers through which care is enacted. Care then becomes set up as a normative framework, albeit one which is contextually and interrelationally attuned. However, these norms have to take account of, and be attentive to, their own histories and varied geographies. This is best expressed by Davina Cooper (2007, 2012) in her call for a contextualised reading of care. She suggests that the highly idealised and abstracted nature of discussions of care can lead to a 'disembodied, disembedded utopianism' (p. 252). Recognising the situated nature of care will lead to the explicit reckoning of the plurality of care, the diverse practices through which it is enacted, circulated, struggled over and transformed. For Cooper (as for me) then, care practices as well as ethics need to be investigated or rather an understanding of the diversity of care practices is necessary for thinking through an ethic of care.[4] We need to recognise not only how care varies over time and space and the predicaments in caring but to recognise this variability in constituting our thinking about care ethics.

Implications of locating care practices away from the global North for rethinking care ethics

What are the implications of a different point of reference and of location in theorising care? In this part I will outline three reasons why theorising care ethics from different geographical locations, social systems and cultural practices is important for theorising care ethics.

First, care practices increasingly bring people together from across the world, as care provision in many countries draws on, and is shaped by, mobility (see Williams 2001). There are at least four elements to this mobility: that of caregivers, codes and frameworks, institutions and of care-receivers. Most researched, is the embodied mobility of caregivers (domestic workers, nurses, care assistants, doctors, teachers) although what exactly this means with regard to the different meanings of care that the caregivers carry with them has not yet been recognised. Rather, care is seen as invariant. Institutional frameworks and organisations such as the World Health Organisation, which provide overarching guidelines on care standards, also force a negotiation of the multiple meanings of care into a straitjacket, usually defined placelessly. They operate to standardise care in an uneven and differentiated world. The corporatisation of care giving institutions (particularly hospitals) and their globalisation has meant that large firms are coming to dominate care transnationally. Finally, care-receivers (so called 'health tourists') are also on the move. Together, these kinds of mobility bring people, institutions and codes together across space, in different places globally to provide care. Within that context, the variability in the meanings of care across place must be recognised if care is to be understood and

practiced ethically. In a world of mobile care what happens when different meanings of care come into contact and have to be negotiated and what are the implications of the difference between the sites at which these meanings of care are generated compared to that in which care is practiced? Philosophically too, migration means that comparisons between different kinds of ethics – care ethics, ubuntu and Confucianism – are inadequate; we have to ask what happens when they meet (perhaps confront?) each other in care settings[5] populated by migrants? How do these distinctive ethics and moral epistemologies learn to negotiate each other and co-exist in mobile care settings? And what are the challenges that one must consider in this context?

Secondly, these forms of migration and mobility do not only bring different meanings of care together; it also puts *distance* between people who may have shared the same understanding of care. Keezhangatte (2007) graphically depicts how those in the home country had very different understandings of care than those who had left; these differences will only grow over time. Sometimes care simply ceases; caring relationships are broken. Global mobility also brings together and creates new bonds as lost relationships are remade through fictive kinship relations (Bastia, 2015). These definitions and understandings around care are, therefore, mutable and transient – they alter as they are carried across the globe and over time. How do these meanings and understandings of care get reformulated as it is stretched across distance as when parents and children are separated[6]? In sum, caring relations have to be negotiated through disconnection as much as through connections.

Finally, understanding the multiplicity of care is a critical exercise for feminist theory per se. In her discussion of maternal thinking Jean Keller (2010) draws on Lugone's critique of feminist theorising: "When I do not see plurality stressed in the very structure of a theory, I know that I will have to do lots of acrobatics—like a contortionist or tight-rope walker—to have this theory speak to me without allowing the theory to distort me *in my complexity*" (Lugones, 1991/2003, 74). Geographers are attuned to these empirical differences; yet they do not yet adequately address the implications of these differences for care ethics.

Instead, on the whole, the rich vein of work done by geographers researching care in multiple locations has simply *drawn down* on care ethics and *applied* it to their cases, not explored how this care ethics may be variable in different places. They have also not built care ethics back up through a deliberate and sustained engagement with their empirical research.

Towards an opening (up of care): Implications of care variations for theorising care ethics

In geography, as in many other disciplines, care has become a foundational concept through which to think about the emotional and physical registers of many everyday practices, as well as offering a set of norms about how relationality could be envisaged and practised ethically. Care is, then, both an aspiration and a way of life. However, the locatedness of these care practices will also shape how care is envisaged, and what norms of care will emerge. The different geo-histories of care are crucial to how people come to understand care. The implications of placing care, and potentially of displacing care ethics from its implicit locatedness in care practices of the global North are threefold. It contributes to thinking about care ethics, to drawing together care ethics and care in social policy and to thinking about ethics more widely in geography.

First, sensitivity to location is also at the heart of theorising care ethics. Emplacing and displacing care ethics highlights the differences within care but also

similarities.

Although care itself may be considered universal, the insistence on practice and on care completion as the basis for defining whether any particular act was actually caring means that care is contingent and located. Significantly, the implications of the first point above, – the importance of location, of its public as well as private nature and its relationality – is yet to be fully brought together with the second, that care is ultimately defined by practice. As a result, the implications of this locatedness for the multiplicity of possible definitions of care, or how caring relations are played out or for care ethics are still to be addressed. The social sciences and the humanities have had the opportunity to, but not fully realised the potential of, thinking care across spatial difference – of the challenges to care offered by thinking of ethics through differentially located care practices and bodies. Rather, the normativity of care as ethic has tended to eclipse recognition of important variations in how care institutions and the architecture of care will be played out ethically. I have suggested, in this paper, that we need more spatially sensitive geohistories of care which open up 'care as ethics' and 'care as practice' to interrogation.

Care arrangements across the world are not only marked by difference, but also have many similarities – most notably in the gendered division of caring work. Class and race distinctions through which care is organised, although not identical, too find resonance globally. Besides, the increasing domestication of care and the reduction of state support for care in parts of the global North may be diminishing the differences between these countries and those in other parts of the world where state provided care has, at best, been patchy. Hence, care arrangements in different parts of the world may be increasingly aligning. However, mobilising for a more caring society and the routes towards achieving an ethic of care should resonate with the diverse starting points from which care practices and policies have emerged.

The multitude of relations between the global south and global North, and particularly how care in the South is embedded in and productive of care in the North and vice versa, requires that we go beyond thinking of the similarities and differences as empirical realities. These relationships of care are points of struggle and solidarity. The politics around care will be embedded in and emerge from previous practices of, arrangements for, and expectations around care and how they are altering. The tactics for delivering an ethics of care will, therefore, vary. That is why sensitivity to located practices is crucial for care. And by spatialising care we can think through the complex intimacies of practice as a way of holding care open to dialogue across different places.

Secondly, as Mahon and Robinson (2011) point out the literature on care ethics and care in social policy have largely been distinct. While social policy researchers may refer to, and draw upon, the norms and guidances of care as an ethical philosophy, they have not yet fully contributed to rethinking care ethics from and through their empirical practices. This is despite the fact that unlike in many other forms of ethics, care ethics is precisely tuned to practice and to local contingency. Hence, care ethics is continuously being produced and enacted through its located practices. These practices have been at the heart of debates in social policy but have not contributed to a variegated care ethics. This paper calls for developing precisely such locally contextualised care ethics. Doing so will also help to address the divide between debates in care in social policy and care ethics. However, this is not simply a call for a multiplicity of care ethics (Hallstein et al., 1999) or even a multicultural one; it rather requests that these located care ethics are seen in relation to each other. Moreover, it demands that the importance of these historical relations in constituting

care ethics is recognised. It is both contemporary and constitutive relationality between different notions of care and norms around care that needs exploration in care ethics. Comparison is not enough. And this gesture of a deeper notion of relationality aims to enrich care ethics to reflect a globally variegated world; not to tear down care ethics.

These divisions in care thinking have some resonance within geography as the literature which focuses on care as a set of ethical spatial relations does not dwell on the difference that place makes to caring practices, emotions and affect. But when we stretch care across different and distinct places then we draw in different meanings and practices of care. In effect, care as ethics needs to be sensitive to the distinctiveness of place in what ethics means. What difference do the variations in notions of care in disparate places involved in these spatial relations mean for theorising care? This is a question for future research.

Thirdly, this paper also contributes towards thinking around ethics in geography. Jane Jacobs (2010) argues for a 'sophisticated geography' which draws on the sophist tradition, one where local contingency is recognised and validated in philosophy. She suggests that inserting the importance of place into the normativity of ethics has been the Holy Grail for philosophers and geographers. For Smith – this is a recognition of the 'moral force of place' (2000, 99). However, Jacobs rightly identifies the problem of relativism and the challenge this presents to the normativity of ethical theories. By emphasising relationality between different parties in care, care ethics, unlike say virtue ethics, avoids this conundrum. That is the promise of care ethics. But delivering this promise requires another step from those working with, and thinking about, care. It requires that we creatively engage with, and contribute to, understandings of care ethics from different places. It demands that we think of care not only through place but also what this means for the spatial relations and ethics of care.

Empirically, this paper suggests the need to dig deep into how care has come to be practiced as it has. Care ethics is not a snapshot of present day care practices; it has deep roots in the geohistories of care, which themselves have emerged relationally. Just as places are made through historical and contemporary relations, so too are care practices. The colonial roots and postcolonial figurations of care affect the meanings and practices of care (Raghuram et al. 2009); how do they shape situated care ethics? Bringing these multiple definitions of care as they have emerged historically together and exploring how they are negotiated across difference and through similarities is an important task for care academics and practitioners.

In doing so we should not be holding out for methodological or theoretical holism around care. Rather, we should be alive to moments of identification and dis-identification in care across places. We need to focus on uncomfortable relations inherent in care and to use those to re- think care as practice and ethics (see Raghuram, forthcoming). Instead of *applying* care ethics to different places we could ask what difference it makes to the ethics of care if we start from care as practiced differently in different places. How then will the ethics of care be rewritten in, and for, diverse contexts? I argue that a 'call to care' as a necessary part of a relational ethic in contemporary geography (and some other disciplines) must also recognise the contestations over care as practice that appear when we consider the varied geographies of care. This is key for future researchers because care is an important site through which not only connections but also disconnections are played out. That is why we need to do a lot more thinking about care. Geographically.

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[1] This global South is also acknowledged as variegated and dynamic, occurring not just below the 30 degree latitude but in multiple places.
[2] And for a queer critique of care see Barker (2012)
[3] This care may, however, not be reciprocal as Kittay (2001) argues.
[4] Similarly, Puig de la Ballasca (2011) in discussing care for the bios argues that care is a necessity but this does not mean it is universally the same.
[5] This is particularly important in institutional care settings where protocols for expectations attempt to dissolve variability. However, informal care settings in everyday life too are significant sites of care (Cooper, 2012).
[6] Including as refugees as the summer of 2015 has strongly reminded us.