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Care

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There are many universal assumptions about what care is and how it ought to be provided. Such assumptions are widely embedded in public debates, government policies, and institutional forms of support. This entry presents three areas of anthropological work on how care is practised around the world in order to challenge these assumptions and demonstrate how care varies in unexpected ways. First, the entry explores how care is structured and, in particular, how it is organised by contemporary states and global markets. Second, the entry provides an overview of how, in everyday relationships of support, the political, economic, and moral dimensions of care become entangled in one another. This demonstrates how ethnography offers a different way to approach ethical and practical questions about what makes care good or effective in different cultural contexts and in different settings—such as in medical institutions or in the relationships between carers and those for whom they care. Finally, the entry shows how the different ways that care works in families and in communities challenge taken-for-granted assumptions about what care ought to look like and where it should take place. Overall, the entry illustrates that care varies greatly across social contexts. Anthropology distinctively illuminates how deeply these variations change the experience and consequences of care in ways that require our detailed attention.

Introduction

Humans sustain each other's lives through giving and receiving care. We often think of acts of care—such as a primary caregiver looking after a child—as central to what it means to be human. Such relationships of dependence, support, and sustenance are, indeed, universal—something we necessarily find in all societies. But precisely because care is a relationship, rather than a biological quality of individuals, this universal varies along with other forms of social variation. Societies imagine, structure, and practise caring relationships so differently as to create significant differences at the level of who has responsibility to provide care, who is seen to need and to deserve it, and what care aspires to do and be.

Policies, philosophies, and practices are often founded on universal assumptions about what care is and ought to be. States may cut welfare on the basis that it can and ought to be provided by families. Clinicians can care for patients with the idea that the best, even only, thing they can do for them is to cure them. Families may give women the responsibility to care on the basis that they are supposedly 'naturally' inclined to do so. Paying for care can be regarded suspiciously when people hold that care ought to emanate from personal and sentimental concerns, rather than instrumental ones. Informal care might be judged as inadequate on the basis that it lacks the expertise and rigour of professional forms of it. We have a panoply of ideas about what, where, how, and by whom care is to be provided—ideas that we often take

to be natural, universal, and immovable.

This entry explores care in its different guises, in order to see more expansively what care means around the world, to illuminate its diversity and to question our assumptions. Anthropological work on care demonstrates how many dominant assumptions about care arise from specific ways that care is structured in contemporary Euro-American capitalist states. It shows that such assumptions do not help us understand how care appears in other societies, and risk blinding us to the complexity of caring relationships within Euro-American societies themselves. Anthropological studies of care thus illustrate that to understand the actual role of care in human life, we must expand our imagination about what, where, and how it is given.

Structures of care

Nation states and economic markets play a central role in distributing and regulating care in contemporary societies. They function to define who is worthy of care, who should be responsible for giving it, and the contexts in which it is given. Attending to these diverse ways of structuring care reveals how different they are from one another—and thus the significant effect they can have on the kind of care people receive and, in some cases, on the possibility of receiving care at all.

Capitalist economies typically connect care work and dependence with the private sphere as opposed to the public sphere of the market and politics. Relatedly, care is often held in these contexts to be a natural feminine activity while the independent ‘breadwinner’ is regarded as traditionally male (Ferguson 2015; Fineman 2005; Held 2006). A large amount of care work is thus performed by female kin within households and receives no fiscal compensation or legal recognition (Fraser & Gordon 2003). When care work is performed by non-kin in exchange for money, it is typically poorly compensated in contrast to jobs more closely associated with the centres of economic and political power (Folbre & Nelson 2000; Constable 2009; Zelizer 2009). Professional care receives little of the social status of other professions and those who perform informal care often occupy even lower statuses – their work receiving stigma and moral scrutiny for its conflation of the sentimental realm of care with economic modes of exchange (Ehrenreich & Hochschild 2004; Glenn 2012).

The structuring of societies according to the values of rationality, independence, individualism, and productive work thus shapes caring relationships in distinctive ways. It often obscures the time, expertise, effort, and costs of ‘women’s work’ and of ‘emotional labour’ in the home and beyond (Hochschild 1983; Abel & Nelson 1990). It also creates the impression that care work is only necessary for specific classes of ‘dependents’ and that it can be confined to specific social contexts (Ferguson 2015; Siebers 2007; Kittay 1999; Fineman 2005; Rivas 2004). Anthropological approaches to care challenge these assumptions by examining how it is actually practised and distributed in people’s daily lives. They also demonstrate that such socio-cultural and gendered assumptions about care nevertheless continue to determine how care is

distributed in different societies (Zelizer 2009).

States and markets

No nation state has ever fully taken on the responsibility and fiscally compensated for all forms of care. Kinship, charity, community-based and privately financed care continue to play a vital role. Contemporary European welfare states, especially those in Scandinavia, have taken on probably the most responsibility for care within human history in their provision of expansive welfare payments for parental leave, child support, disability care, and elderly care as well as free healthcare. In such countries, kin are less often expected to provide care without state compensation, while the state also offers extensive alternatives for people to be professionally cared for by non-kin (Altermark 2018). This kind of expansive welfare government is accompanied by active intervention into the care of citizens through medical, psychiatric, and public health institutions (Foucault 2009b; 2009a; 1975). Such state intervention in turn generates classifications of certain classes of citizens as more ‘vulnerable’ than others.

Among developed capitalist countries, the US offers a stark contrast to Scandinavian states. The American state takes on far less responsibility for the care of its citizens, most notably in relation to healthcare and long-term nursing care. Organisations that provide long-term care for the elderly are typically owned and run privately, and are thus often beholden to logics of profit-making (Diamond 1995). Meanwhile, healthcare is largely funded through payments to private health insurance companies, who have ample legal room to evade the responsibility to actually provide care to many of those who would seem to need it. For example, when clinicians and potential patients claim to need support for eating disorders such as bulimia and anorexia, insurance companies can justify their refusal by reclassifying the very diagnostic symptoms such people initially use to make their claim to dependence as, instead, a wilful refusal of self-care (Lester 2019). Clinicians, operating within this mode of financing healthcare, can only obtain care for their patients by framing their conditions in the categories that insurance companies recognise as legitimate. Their clinical evaluations of patients thus become infused with insurance logics (Lester 2009; Brodwin 2013; see also Davis 2012; Biehl 2005).

In spite of this largely market-based approach to care, the American state is no less involved in its citizens’ lives. It makes ‘caring’ interventions through other institutions such as the military, justice, and carceral systems. War veterans, for instance, are entitled to kinds of healthcare assistance comparable to a comprehensive European welfare state (Wool 2015; Zogas 2021). Once someone with a mental-health disorder has committed a criminal offence, US courts can authorise otherwise-prohibited interventions in their lives to wean people off addiction or provide them with access to housing (Brodwin 2013; see also Cooper 2018). Prisons play a similarly unexpected role in providing healthcare to incarcerated pregnant mothers, making medical and emotional care simultaneously more available to some lower-income women of colour at the same time as entangling it with logics of incarceration (Sufrin 2017; see also Foucault

1995).

The opposite of this situation can also occur. States may attempt to maintain the idea that they are intervening to protect their citizens while, in reality, unburdening themselves of any responsibility to do so—often by bureaucratically distinguishing between supposedly legitimate and illegitimate forms of dependence (Foucault 2008). As Ukraine reeled from the Chernobyl explosion, the socialist and then post-socialist government was faced with unprecedented claims upon state assistance. It used biomedical institutions in order to reclassify people's radiation damage as the result of an alternative condition that entitled citizens to nothing (Petryna 2013; see also Phillips 2011). When China introduced expansive new legislation to provide economic support to those with disabilities, the bureaucratic means for becoming certified as disabled turned out to be so complicated that few were able to claim it (Kohrman 2005).

A neoliberal logic, where governments redistribute responsibility to citizens by actively encouraging them to care for themselves (Foucault 2008), is present across many kinds of state intervention. This logic can make it easier for state institutions, and even families, to classify those who depend extensively on others, such as chronically ill or 'unwanted' populations, as 'abnormal'—with the consequence that they may end up neglected in 'zones of social abandonment' (Biehl 2005; see also Marrow & Luhrmann 2012). Even the most well-meaning and charitable attempts to help those abandoned to these settings can unwittingly replicate the demands of neoliberal forms of government for citizens to take on more responsibility for their own care—rather than criticising the state for not providing it (Zigon 2010).

Humanitarianism and migrant care labour

Care is not confined to the borders of nation states, as humanitarian aid distributes it across regions in light of sharp global economic inequalities. States, together with non-profit organisations, make decisions about which populations in other parts of the world need, or are deserving of, humanitarian care. Much state-sponsored humanitarianism is shaped by ideals of a shared universal humanity that requires intervention to rescue and care for suffering victims. This logic can depoliticise the inequalities that produce such suffering in the first place (Beckett 2019; Feldman & Ticktin 2013; Ferguson 1994), creating unintended similarities between contemporary efforts and ideologies of benevolence underpinning colonial 'civilising missions' to reform those deemed vulnerable, deficient, suffering, or sick (Englund 2006). Lisa Malkki (1996) highlights how the category of 'the refugee' in programmes of humanitarian care for Hutus in East Africa reduces the complex identities and political subjectivities of those being 'helped' into a static, homogenous category of de-historicised victimhood. Similarly, children in conflict settings may come to be represented as fundamentally innocent and 'needy' through infantilising and at times futile 'gifts of care', such as hand-knitted toys (Malkki 2015).

A similar logic plays out when it comes to migrants and refugees at European state borders. The contemporary French state's rhetoric of humanitarian care plays a role in categorising only certain

undocumented migrants (*sans-papiers*) as vulnerable and ‘morally legitimate’ care-recipients—for instance, those who are sick or victims of sexual violence. This distinguishes them from migrants who might have been disenfranchised in other ways (Ticktin 2011). Such selective compassion by the state to care for specific bodies is a distinct political logic, one that may render issues of care apolitical and forecloses the possibility of contestation (see also Fassin 2011).

Global inequalities also shape, and are reinforced by, the international distribution of migrant care labour. Such labour is disproportionately performed by immigrant women from lower-income countries who move to engage in low-wage employment in the domestic and care work sectors of higher-income economies (Ehrenreich & Hochschild 2004; Glenn 2012; R. S. Parreñas 2015), such as from the Philippines to Hong Kong, Mexico and Central American countries to the US, and South Asia to the Gulf states. Precarious livelihoods in migrants’ countries of origin and aspirations to care for family futures often motivate these journeys abroad, while households in wealthier countries outsource care work to migrant women as sources of cheap labour.

Migrants may lack the legal rights of citizens in ways that are entangled with the marginalisation of care workers and care labour more widely. When migrant women enter into these already precarious and vulnerable forms of labour, their experience of this gendered devaluation of care intersects with their discrimination along the lines of class, race, and citizenship (Constable 1997; Rosenbaum 2017; Muehlebach 2012). This ‘global care chain’ has knock-on effects on women’s families in their country of origin, requiring them to find other kin or paid carers to take over caring responsibilities in their absence (Hochschild 2001).

The ethics of care

Political and economic logics distribute responsibility for care in such a way as to produce its presence or absence in different settings. How do people relate to one another within caring relationships themselves? What does care look like and involve in practice?

Ethics of care in professional settings

Many forms of health and social care now place a high value on autonomy, consent, and patient choice as they move away from paternalistic models. This ‘logic of choice’ (Mol 2008) limits many forms of caring intervention based on the authority of professional expertise. Social workers in the US bound by these values of autonomy cannot intervene in the lives of those with drug-addictions and mental-health problems, even when they find people sleeping in the snow without a blanket (Brodwin 2013). The logic of choice creates particular problems for those who need care when their mental capacity to choose is affected by conditions such as dementia, intellectual disability, or mental health problems (Driessen 2018b; Marrow & Luhrmann 2017). Many forms of care exist precisely because people are judged to be incapable of choosing

for themselves—but strict adherence to a logic of choice leaves no room for this kind of intervention (Pols, Althoff & Bransen 2017).

Actual caring relationships tend to work in far more complex ways than the logic of choice, and its binary division of paternalism from autonomy, allows. In practice, many caring relationships work through constant intervention in the life of the care-recipient—some of which are paternalistic, and some of which can less easily be classified in this way (Mol, Moser & Pols 2010; see also Kittay 2007, 2019). Chinese parents, for instance, ‘tinker’ (Mol 2008) behind the scenes to create conditions that will be conducive to their children succeeding in a highly competitive economy, in order to avoid directly commanding their already stressed children (Kuan 2015). And many contemporary Euro-American forms of care try to combine intervention with freedom through different forms of pedagogy or persuasion (Pols 2006; Ochs & Izquierdo 2009; Driessen, van der Klift & Krause 2017; McKearney 2021).

Logics of care contrast, also, with another important standard within medical institutions: the goal-oriented focus of curing (Kleinman 2015; 2013). The role of such care comes into focus in settings where curing is not possible—such as in end-of life care (Kaufman 2014; Pols, Pasveer & Willems 2018; Shield 1988). Julie Livingston shows how, when doctors in resource-deprived hospitals in Botswana have little hope of curing their patients, they carefully attend to dressing wounds, managing pain, and providing emotional support (see also Kleinman 2009; Street 2014). They practise medicine as a form of solidarity with the sick—a care that exceeds standard biomedical forms of evaluation (Chambliss 1995). Medicine’s funding and regulation with the ideal of curing leads many in medical professions to miss the centrality of care to their own work, and to other people’s moral projects—as, for instance, when clinicians in the US misrecognise how parents pursue meaningful lives for their critically-ill children despite the improbability of curing them (Mattingly 2010; 2014).

The relational and hard-to-measure qualities of care often make it hard to justify in quantitative or economic terms. Interventions that work through the solidary logic of caring—such as long-term psychotherapy—often receive less funding (Lester 2019; Luhrmann 2001; Davis 2012). The impossibility of economically justifying long-term support for those with those mental disorders that incline them to reject care can lead clinicians to identify such patients as ‘incurable’—even when there is no strictly clinical reason to do so (Davis 2012; Lester 2009). A focus on such impersonal quantitative outcomes in the Canadian government’s response to a crisis of Inuit suicides ignored the sources of and the solutions to the crisis among the Inuit themselves, who see life as inherently bound up with relations of care with ancestors and relatives (Stevenson 2014).

Relations of care produce outcomes that the logics of choice and cure miss. A focus on autonomy can have the effect of wearing our relations thin, to the point that changes in cognitive capacity end up spelling social death (Biehl 2005; Cohen 2000; Marrow & Luhrmann 2012). Instead, a focus on relations of care can

build sustaining ties between us as social beings (Taylor 2010). Athena McClean (2015) demonstrates the concrete effects of taking such hard-to-measure logics of care seriously by contrasting two long-term dementia care homes in the US: one which primarily treats care as an instrumental task, and the other as a relational form of solidarity. She demonstrates that the latter maintains not only the dignity but also the cognitive capacities of those in receipt of care—producing also far fewer incidents of conflict or distress.

It is for this reason that feminist scholars writing about the ‘ethics of care’ have long advocated for placing concerns about care at the centre of our moral imaginations and as integral to public and political life. They take care to be a relational practice that refers to all that people do to maintain, continue, and repair the world in which they live (Tronto & Fisher 1990; Tronto 2009).

Challenging moralities

Caring relationships that operate outside of the logics of cure, choice, and the market do not all look the same. Around the world, care takes many forms that challenge our moral intuitions about what it should look like—disrupting, in particular, the dichotomies we hold between good care and its opposites (Duclos & Criado 2020; McKearney 2020).

Professionalism, instrumentalism, and commodification are often set against the moral and emotional qualities we typically associate with care—of sentiment, connection, and warmth (see H. Brown 2010: 129). But, in practice, contractual relationships of care are frequently sites for human intimacy, connection, and flourishing. In the context of paid eldercare work in the US, precariously employed immigrant women who perform this work develop meaningful, if ambivalent, relationships with the older people they care for. Care is thus generative both of inequalities and of new forms of personhood, interdependence, and relatedness (Buch 2018) and thereby of moral engagement. Rather than telling a story about love or intimacy versus money, anthropologists have demonstrated how different ways of relating emerge in and through their very intersection. This has led them to question the assumption that a capitalist world is necessarily marked by a ‘lack’ of care (Constable 2009; Gutierrez Garza 2019; Zelizer 2009).

Some professional logics of care try to restrict these possibilities of intimacy. But other organisations deliberately use these possibilities to enable closer forms of personal connection for those whose dependence can deprive them of it (McKearney 2017; 2018; Marrow & Luhrmann 2017; Nakamura 2013; Kulick & Rydström 2015; Haeusermann 2018). These possibilities for human connection can also be important to care-givers, especially when their work is stigmatised and reproduces their social exclusion more widely (Muehlebach 2012; Rivas 2004). In Singapore, Filipino migrant nurses who might initially be rejected by their Chinese patients for being of ‘different skin’ can later find ways to connect with these patients through personal connections such as a shared religious orientations (Amrith 2017). Such everyday affective, intimate, and material exchanges within care work can constitute a form of political belonging for migrant carers, especially in the absence of formal citizenship rights (Coe 2019; see also T.

M. Brown 2011).

The idea that care must take a particularly involved form of empathetic engagement does not hold everywhere (Otto & Keller 2018; Mezzenzana 2020). The warm and sentimental relationality we often associate with caring for another may be taken to get in the way of ‘good’ care. In Thailand, care is a matter of practical work, bodily ritual, and karmic morality. Here, care as the concrete, habituated, and mundane act of providing for others decentres more abstract, sentimentalised and morally loaded notions of care that have long dominated in Europe and America (Aulino 2016). Don Kulick and Jens Rydstrom (2015) demonstrate this in their study of carers in Denmark who support people with disabilities to have sexual encounters. These carers do not try, themselves, to be visible and involved. Instead, they aim to turn themselves into mere background influences—as do many carers supporting those who rely on extensive care throughout their daily lives (Rivas 2004; Stacey 2016; Buch 2018). At the other end of the spectrum, ‘warmth’ can arise in elderly care even when it is mediated by ‘cold’ objects like robots, as is the case in the Netherlands (Pols & Moser 2009; Mol, Moser & Pols 2010). Intimacy may similarly arise even in the apparent absence of human care relationships. Against the grain of popular discourses in Japan, which presume that elderly people living alone are socially abandoned, older adults can find their own ethical practices for living meaningfully in later life through daily rituals making offerings to departed ancestors (Daneely 2015).

Control, confinement, and aggression are often imagined to stand in direct contrast to care. Anthropologists, by contrast, show how they can be central to the form that care takes in reality (Foucault 2009a; Johnson and Lindquist 2020; Mulla 2016). In many contexts, violence and deception do not compromise the purity of a more sentimental care but are instead central to how people imagine and practise good care (Brown 2010; Garcia 2015; Livingston 2012). In India, clinicians care for those with schizophrenia by hiding information about the diagnosis from these individuals, and enlisting the support of the family to regulate and control the care-recipient (Marrow & Luhrmann 2017; see also Luhrmann 2007). These paternalistic dynamics within and beyond the family may well be a key of part of the explanation as to why schizophrenia takes a far less severe form in this context. The line between abusive and affirming forms of care is thus much less clear, in practice, than our ideals of care may suggest (Garcia 2010; 2014). In these studies of alternative forms of professional care, hierarchy, paternalism, control, or detachment are not such grave dangers to the person as we often imagine. Rather, they are part of different ways of understanding what it means to be a person, to be cared for, and to be respected. These alternative caring ethics can have remarkably positive outcomes for conditions that mainstream Euro-American care struggles to handle, such as mental illness, dementia, intellectual disability, and addiction.

Care, kinship and communities

The majority of care around the world is still provided outside the direct purview and funding of the state

and its institutions, within families and in communities. During the latter part of the twentieth century, many states closed long-stay institutions and shifted away from centralised hospitals on the idea that care is best provided in the ‘community’ (Horden Smith 2013). But this modernising narrative glosses over the fact that families and ‘communities’ rarely fit the imaginations of policy-makers and vary considerably in the way they distribute care.

Families are a primary site through which caring obligations are distributed—kinship roles themselves often being defined, in part, through one’s obligations to or entitlements to care at different life-stages (Goody 1971). But there are profound differences in normative cultural patterns about what families should look like, how care should be distributed within and beyond them, and what ought to constitute proper care. Children, in some contexts, may not have a single dedicated caregiver, nor any dedicated caregiver at all (Otto & Keller 2018), nor are they always regarded as the responsibility of parents in a concrete way, in no small part because they may not be defined as vulnerable to begin with (Lancy 2014). Children as young as five among the Runa of the Pastuza region in the Ecuadorian Amazon are left to look after themselves in very practical ways through building shelter and acquiring food on their own (Mezzenzana 2020). The Runa consider leaving children to their own devices as the best way to let them learn self-reliance, concern for others, and a capacity to manage themselves. This is connected to the self-reliant ‘obstinate individualism’ of the region, in which each person is their own responsibility and no one else’s (Mezzenzana 2020). Such alternative forms of childcare do not just challenge how childhood can be imagined; they also affect the extent to which adults are required to provide care and to which children can care for themselves (Ochs & Izquierdo 2009).

Kinship-care goes far beyond the nuclear family. There are many configurations of kinship that involve a different set of characters in providing care: grandparents, changing romantic partners (Zelizer 2009), or non-genetic close connections who may be described as kin (Edwards & Strathern 2000; Pande 2015). Domestic work by non-kin, more or less assumed into a family structure, has a long and continuous history (Delap 2011; Ray & Qayum 2009) as does the adoption of non-kin. In some societies, the very definition of a partner, parent, or child may not be a permanent genetic or legal bond (Sahlins 2013; Conklin & Morgan 1996). Kinship can also be created through acts of care; for instance, the day-to-day sharing of cooked meals in Langkawi in Malaysia (Carsten 1997; see also Parkes 2005). In these cases, kinship is often not defined at birth but rather is built between people through repeated transfers of care and exchanges of substances such as food or bodily fluids (Carsten 1989; 2000; Stasch 2009).

Kinship roles can also follow a more prescribed and structured set of normative expectations that concretely shape caring responsibilities. In rural Uganda, patrilineal family structures shape the different kinds of grandparental care that sons and daughters’ children receive (Whyte & Whyte 2004). In many South Asian families, one’s status as a child of one’s parents continues to define the care one receives and gives throughout the life course. Parents frequently refer to their adult children who have not yet married

as *bacche*, ‘children’ in Hindi (Mody 2020a). Parental intervention in the sphere of marriage may also be seen as legitimate well into adulthood. The forms of pressure that it may take to make children conform to a parent’s decisions on suitable marriage partners are often expressed and justified through a language of care. Marriage-decisions gain part of their importance from the role that daughters-in-law play in providing care to their parents-in-law (Lamb 2000; Marrow & Luhrmann 2017).

These forms of kinship can give a stability, givenness, and intimacy to the kinship bond that makes the transfer of care obligatory and uncalculated. But that does not mean that care’s role in kinship is stable even in these contexts. One’s role shifts across the course of the lifetime with gendered transitions through childhood, adulthood, and elderhood (Goody 1971; Faubion 2001). The expectations of care that such transitions bring are negotiated and contested extensively. When kinship takes the burden of care, it is typically a weighty, complex, and fraught affair (Mody 2020b; Pinto 2014; Trawick 1990; Reece 2020).

Social and political changes brought about through processes of urbanisation and globalisation can also re-configure the role of kinship in caring relationships. Popular narratives in India lament the demise of the ‘Indian joint family’ to stress the importance of what they see as the legitimate way to look after elders: by caring for them within that familial context (Cohen 1992). But international migration from India has led to the growth of novel care arrangements: privatised eldercare homes and local care services as an alternative, or complement, to kinship care for elders who stay in India while their kin live abroad. A closer look at the lives of people living in these communities demonstrates that care homes are not merely impositions of Euro-American models but are culturally legitimate spaces for middle-class diasporic Indian families (Lamb 2009). In low-income settings in Sub-Saharan Africa, while the care of children, elders, and those with chronic health problems is often undertaken by family members, migration, urbanisation, and increasing inequalities constrain the capacities of households to care. Family care then becomes a dynamic space within which people do not only act according to emotional or moral obligations, but according to the resources available (Reece 2020; Read & van der Geest 2019; see also Han 2012 for an example from Chile). In Ghana, when family care becomes less viable on its own, other spaces such as church become important to providing health and social care, as well as acting as a form of ‘fictive’ family (Coe 2019b). Meanwhile, those living with HIV/AIDS in Uganda, may find new ‘(quasi) relatives’ among health workers, volunteers, and strangers who are seen to be more trustworthy than family members (van der Geest, Dapaah & Kwansa 2019).

Among families rendered transnational through global care chains, creative care arrangements challenge normative understandings of what a family should look like. Care amidst family separation can be mobilised as an intergenerational resource and form of solidarity. Nicaraguan transnational family life draws extensively on extended kinship networks, while grandmothers and grandchildren who care for each other in these contexts challenge constructions of those ‘left behind’ by migrants as passive care recipients (Yarris 2017). Care at a distance is increasingly mediated by digital technologies and expressed through

remittances, gifts, and goods, while the ‘family’ itself may involve multiple actors, including paid care workers, distant relatives, and neighbours (Hromadžić & Palmberger 2018; Ahlin 2020; Baldassar and Wilding 2020). Transnational care challenges the distinctions between family, paid, informal, professional, communal, and state-based care, demonstrating the interconnection between all these categories.

The expectations within policy about where care is to be performed, and by whom, are influenced by and reproduce the legal recognition of only certain types of relatedness as legitimate. But care often exceeds these classifications. The narrow confines of kinship categories deployed by the state and the law are frequently rooted in biological or heteronormative assumptions and thus often exclude other forms of partnership, intimacy, and mutual care (Weston 1997; Dave 2012; see also Strathern 2005). Gay and lesbian relationships, for example, may not fit into many legal definitions of kinship precisely because they are founded upon the very idea of ‘caring and being cared for’ (Borneman 1997).

In other contexts, kinship’s importance can be exaggerated. Migrant care workers’ absences from their families are often framed by state and public discourses as having damaging impacts on heterosexual family structures (Manalansan 2008). However, this narrative overlooks the novel caring relationships based on love, intimacy, and friendship that migrants develop in communities abroad that go beyond kinship categories yet remain deeply significant to their experiences and identities (Johnson & Werbner 2010; Liebelt 2011).

Religious, political, and ethical movements also decentre kinship by structuring distributions of care beyond the family. Religious groups can create relationships of care and compassion between previously unrelated social groups and social concerns (Copeman 2009; Evans 2016; Kertzer 1980; Mair & Evans 2015). Christianity, for instance, created new forms of spiritual kinship within the church—most strikingly in monastic communities where people renounced existing relations and future marital prospects to form new kinds of brotherhood and sisterhood in Christ (Brown 1988; Banner 2014). These alternative moral imaginations created new categories of dependents worthy of care (such as children and the ‘poor’) as well as social practices and institutions to distribute care to them—many of which have decisively influenced the shape of contemporary forms of charity, healthcare, and education (Bakke 2005; Brown 1980, 2002; Scherz 2014).

Contemporary small-scale intentional communities can distribute responsibility for care within more limited and controlled environments—whether that be for those with dementia, intellectual disabilities, or the environment (Haeusermann 2018; McKearney 2017; Schiffer 2018). There is also increasing interest in how caring communities extend beyond the boundaries of humanity, both historically and in this age of climate change. One example is the relationship between orangutans, their local human caretakers, and the wider environment in rehabilitation centres in Sarawak (J. Parreñas 2018). Contrary to (post)colonial practices of conservation that are based on establishing control over other species and the environment,

orangutans and their caretakers are embedded in a relationship of interdependence and shared vulnerability (through, for instance, land dispossession).

Volunteering can also be an important space for providing care and creating communities. In Greece, as people struggle to access national healthcare in times of economic crisis, networks of community-based clinics/pharmacies have emerged to redistribute donated medicines and provide care through networks of volunteers. These forms of care as social solidarity reanimate Greek citizenship, since it becomes a key location for caring relationships, instead of the family or the state (Cabot 2016). Similar kinds of solidarity can be found in Northern Italy in the context of austerity and diminishing state support. Here it is pensioners who take on the voluntary work of caring for each other, helping those more vulnerable in their neighbourhoods with their shopping, medical appointments and providing them with companionship. This unexpectedly correlates with a denigration of other forms of care, so that when migrant domestic workers in these regions provide similar kinds of care for little pay, their labours are ignored or stigmatised as profit-seeking (Muehlebach 2012). Such community-based caring solidarities are then bound up with questions around what kind of care is visible, and who or what is excluded from the moral framings of these movements.

Conclusion

Social relationships offer the possibility of sustaining another's life, and of being sustained beyond what one is capable of. If these relationships are necessary for individuals and societies to survive, they are also as variable and open-ended as human life itself. When we attend to the vast diversity of meanings and practices of care around the world, many of our assumptions about it crumble. When care manifests as connection, asymmetric dependence, coercion, refusal, belonging, affirmation, desire, and neglect, all at the same time, we are forced to question what constitutes good care, and how clearly we can separate it from what we assume bad care to be. When we explore how care is structured by different social mechanisms, from kinship to the welfare state, we must take a much wider view about who provides care and in what settings. Within a globalised world of different economic regimes, we see how care is unequally distributed within and across societies, producing ambivalent and uncertain forms of intimacy and relatedness. In its everyday expressions, what care looks like in practice does not always fit in with the rigid pre-established normative ideals about how it ought to be. A detailed look at how care takes place outside of state and market overturns any easy or simple ideas about what care in the 'community' looks like and about how caring roles are taken on and negotiated. Care is a human universal. But humans universally structure, practise, and imagine it differently, creating vital differences to people's lives.

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