MIDS WORKING PAPER NO. 247

RETHINKING CARE LABOUR IN THE INDIAN CONTEXT

THROUGH AN EXPANDED NOTION OF URBAN CARE INFRASTRUCTURE

AISHWARYA G V N

MIDS Working Paper No. 247
March 2025

Rethinking Care Labour in the Indian Context

Through an Expanded Notion of Urban Care Infrastructure

Aishwarya G V N

© 2025, Madras Institute of Development Studies (MIDS)

The views expressed in this publication are those of the author and do not necessarily reflect the official policy or position of the Madras Institute of Development Studies.

MIDS Working Paper No. 247

Rethinking Care Labour in the Indian Context: Through an Expanded Notion of Urban Care Infrastructure

by Aishwarya G V N

Published by
Madras Institute of Development Studies
79, Second Main Road, Gandhi Nagar, Adyar
Chennai 600020 India
Phone: 044 2441 1574/2589/9771
pub@mids.ac.in | www.mids.ac.in

Rethinking Care Labour in the Indian Context

Through an Expanded Notion of Urban Care Infrastructure

Aishwarya G V N[1]

Abstract

This study draws from feminist geography and social policy scholarship that expands the notion of care to include life-sustaining activities in cities. Although there is a burgeoning literature on care, more attention is needed towards understanding care labour in the context of the Global South. This paper contributes to the scholarship on urban care by locating care in the context of welfare schemes in Indian cities and assessing the implications of such expanded notions of care on the organisation of care labour. Based on a qualitative study of the state-run public canteens called 'Amma Unavagams' in Chennai, the paper argues that canteens along with other child-care and nutritional support schemes form part of a much needed care infrastructure. Towards recognition and valorisation of women's work, the study questions the precarious organisation of labour in public schemes and makes the case for using the term 'urban care workers' to signify the importance of this labour.

[1] PhD Student, Madras Institute of Development Studies

Introduction

Care has been at the forefront of feminist scholarship's pursuit of visibilising women's work and alternative imaginations of a 'just' world. Joan Tronto's pathbreaking work *Moral Boundaries* (1993), which called attention to the power relations in care provision, has opened the door for the extensive scholarship on the political possibilities of care. According to Sevenhuijsen (2003), the relocation of care—from women to men, from the private to the public and from curative to preventative—has important implications for social policy. Yet, as Cox (2010) suggests, caring is full of problems and possibilities, and therefore, one has to grapple with the paradoxes that care presents. This study dwells on the literature on feminist perspectives of care to foreground the need for collectivised care in the Indian context and underscore the potential it holds for recognising and valuing care labour. Although social policy in India has evolved in terms of recognising the gendered inequalities in care provisioning, it is yet to recognise other intersectional vulnerabilities of class and caste. Moreover, the quest towards valorising care labour continues to be elusive as the social sector policies devalue and invisibilise a large women workforce. The aim here is to expand the notion of care to include direct and indirect arrangements of collectivised care, along with a proposal to recognise the labour deployed for such endeavours as 'care labour'. For empirical grounding, this study uses excerpts from the author's qualitative study of the public canteen programme in Chennai apart from other studies and reports on the health and care workforce in India[2].

[2] The interviews quoted in the paper were conducted as part of the field study undertaken for the author's doctoral project, which aims to understand the linkages between welfare provisioning, women's labour, and state capacity through a qualitative study of the Amma canteens in Chennai. The study included participant

Expanding the notion of care – An infrastructural approach

Fisher and Tronto (1990) define care as 'a species activity that includes everything that we do to maintain, continue, and repair our "world" so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web'. This definition enabled feminist scholars to bring to the fore the centrality of care in people's lives. Further scholarship has problematised care by emphasising its relational, provisional and embodied nature (Conradson, 2003a). Held (2004) and M. J. Williams (2017) focus on the political possibilities of the ethics of care and its implications for justice. Williams contends that the lens of care ethics allows the appraisal of the normative versus the situated nature of justice in the urban contexts. Such a conceptualisation allows the dissolution of the binaries between care and justice, enabling the quest for justice through everyday caring spaces. Her work, along with that of others like Conradson (2003b), reveals the ability of certain sites of routine activity to become spaces of care at particular moments and to act as microsites of intervention against injustice.

According to Power and Williams (2020), feminist geographical scholarship on care has evolved along three domains: spaces of care, materialities of care and subjects of care. Many studies focus on how care is emergent in particular spaces in the urban such as drop-in centres, asylums, parks, libraries, social housing and food-based support programmes (Conradson, 2003b; Mee, 2009). Power and Williams (2020) call for an expanded urban theory of care based on Fisher and Tronto's definition, which recognises the 'universal need

---

observations and interviews with the stakeholders of the scheme including the workers, users, and local government officials.

for care'. They encourage researchers to study the assemblages that sustain the conditions of life such as affordable food, housing and other ecological conditions. Alam and Houston (2020) further build on this line of scholarship to state that different forms of caring work consolidate to form a life-sustaining network that influences democracy and justice in cities. Stringing together the literature on care and those on infrastructure that view cities as a socio-technical system, they bring in a new perspective on urban care by construing 'the possibilities for care as alternative infrastructure'. Everyday care spaces and their potential to recenter alternative infrastructures are seen as important towards achieving urban democracy. An infrastructural approach to care brings together the spatial and material aspects of care. Urban infrastructures are seen to be entangled with different urban processes such as uneven development and marginalisation (Rodgers & O'Neill, 2012, as cited in Alam & Houston, 2020). Thus, a feminist ethic of care can serve as a guide to social policy towards democratising caregiving and receiving (Sevenhuijsen, 2003).

Ethics of care as a guide to social policy

Tronto's (1998) proposition that care occurs across institutions and settings is an important contribution towards ungendering and unbounding care. One important reason for the undervaluation of care according to her is the traditional division between public and private spheres and the relegation of care to the latter. Hence, caring occupations given the tag of 'woman's work' are considered to be unskilled, low in status and underpaid. Thus, care and care workers continue to be devalued. Liberal theories propagated the view that only those considered to be 'dependent' needed care, in the process valorising the autonomous (mythical) individual as the archetypical citizen. On the contrary, Staeheli and Brown (2003) point out that the feminist conceptualisation of justice is inclusive – no social

group should face systematic marginalisation; actions and relationships in the private sphere are also deemed political; and acts circumscribed by emotional logic can also be political acts. This broadened notion of inclusiveness dilutes the distinctions between public and private and between justice, welfare and care. It starts from a different moral grounding than the liberal theory, namely a relational ethic characterised by interdependence. In the words of Barnes (2012), 'care is fundamental to the human condition and necessary both to survival and flourishing'. Yet, social policies tend to have a restricted view confining the state's responsibility to care to a smaller section of the population, namely children, the elderly, sick and people with special needs. There are two implications for care policies from the above scholarship of feminist ethics of care: First is that social care policies should address the care needs of all, especially the poor and the marginalised apart from those seen as 'dependents'; second, it should support those who perform care activities personally and professionally. Policies should actively seek to address the structural inequities in care provisioning along the lines of class, race, immigrant status and, in the case of India, caste.

According to Daly and Lewis (2000), demographic, financial and social factors have contributed to the need for social policy to address care. Although a lot of care work happens within the intimate relationships in households as unpaid care work, care is also organised by the marketplace, state and the community as a paid activity. They develop the concept of 'social care' to capture the social and political economy of care arrangements and use it as an analytical tool to study welfare states. They describe the multiple dimensions of social care in the following manner. First, care is labour and hence needs to be placed in a comparative framework with other forms of work and labour. It cannot be relegated as an altruistic act of individuals. Just as in other forms of labour, the state has an indispensable role in shaping the conditions under which

care labour is performed. It can be arranged in paid/unpaid, formal/informal ways. Second, a normative sense of obligation and responsibility pervades care as it is carried out within social or familial relations. Third, there are financial and emotional costs involved in caring activities that need to be justly redistributed among individuals and the society at large. The analytical strength of the concept lies in its ability to map changes in the distribution of care among the different sectors at the macro-level and the changes among individuals and families at the micro-level. From the conceptualisation of 'social care', it is clear how social policies shape care provisioning in multiple ways. Legal provisions such as maternity benefit schemes and parental leaves support caregivers and augment their resources to provide care for their dependents. Direct provisioning of care services such as day care centres, elderly homes, subsidised food provisioning, school meals and nutritional supplement schemes enables social reproduction, especially of the poor and marginalised sections of people. In the context of India, such interventions assume importance due to the largely informal nature of employment whereby legal measures of social protection are reserved only for the privileged few.

Inequalities in care and care work and the need for collectivised care

Two kinds of inequalities exist in relation to care: unequal distribution of resources for care and the devaluation of care work resulting in wage gaps. The notion of 'care chains' and 'stratified social reproduction' are useful concepts towards understanding such inequities. The idea of 'care deficit' or 'crisis of care' in the context of the Global North is attributed to changing norms of caregiving stemming from increased female labour force participation, demographic changes that lead to an ageing population and a restructured welfare state. Such care gaps

resulting from changing gender roles are filled by the commodification of child and elder care through the transnational supply of care labour. The global care chain literature has highlighted the gender and racial inequities in care provisioning as paid care work is taken up largely by racial minorities and immigrants for lesser pay and benefits. Transnational migration of care workers also leads to care deficits in the nations that export these workers by 'intensifying the lack of care resources in the countries of their origin' (F. Williams, 2010). In a similar vein, Palriwala and Neetha (2011) argue that the care regime in India is stratified as care practices are differentiated across social groups. Households of the poor and labouring classes face 'care deficits' as they are neither able to retain caregivers at home nor fill this care gap through institutional support. Moreover, gendered familialism continues to underpin social policy in India with care being seen as a familial and female responsibility.

'Stratified social reproduction' is a concept used to signify the unequal resources at the disposal of different hierarchically arranged social groups, leading to social and economic inequity (Ginsburg & Rapp, 1995, as cited in Binet et al., 2023). This means that groups lower down in the social hierarchy have to take on the additional burdens of poverty and precarity while trying to fulfil their needs and those of the dependent others in their communities. Binet et al. (2023) go a step further to explain how cities become 'landscapes of stratified social reproduction' as the gendered notions of differentiation between productive and social reproductive activities get reflected in urban development. They explain that it gets manifested through the strict demarcation of public and private spheres, leading to the devaluation of the latter apart from the racial segregation of communities with restricted access to urban resources. In the Indian context, there has been extensive scholarship on inequality in the urban manifested through insufficient access to basic services and resources along economic

and spatial (informal settlements[3] and resettlement colonies) differentiations (Chinnakali et al., 2014; Coelho et al., 2012; Sivam & Karuppannan, 2002). Care deficits in the Indian context are primarily a problem of poor public services and inadequate social infrastructures that do not address the health and educational needs of a vast majority of the population. Many factors such as precarious organisation of work, low wages and rising costs of essential commodities intensify the care crisis in the urban areas. Moreover, large-scale migration of workers from rural to urban areas in search of economic opportunities necessitates new arrangements for care for these workers in the host cities. The COVID-19 pandemic brought to the fore multiple issues related to social reproduction: hunger was as much a threat to lives as was the disease-causing virus; the need for a social safety net for informal workers as they lost their livelihoods; the plight of migrant workers who had to undertake arduous journeys back to their home states; and the pre-eminence of care workers and essential workers who risked their lives on the line of duty. Rao (2021) argues that beyond the pandemic, the 'crisis of social reproduction of labour' is an ongoing one. She calls for the 'socialisation of care work' through which the state can subsidise the cost of social reproduction and redistribute such labour (Rao, 2020). Rao further notes that the question of socialising care is not just a women's issue but concerns the sustainability of the economic development of a country. It is in this context that the idea of an 'urban infrastructure of care' assumes significance or in her words 'public infrastructure of social reproduction', which ensures 'means to access food, clean water, healthcare and a safe living situation regardless of the economic situation of the individual'.

[3] This paper acknowledges the threads in recent scholarship that informal settlements/slums are not homogeneous entities or hubs of urban poverty but are diverse and complex systems (Chinnakali et al., 2014).

Binet et al. (2023) advocate for an infrastructural approach to plan for care in the city by explaining how caregivers rely on the spatial, social and material affordances of the urban environment. Focussing on childcare, they explain how the components of the urban environment can either enable or inhibit the goals and strategies of caregivers. They identify private space, public space, economic opportunity, material resources, social support, safety, childcare and activities and accessibility as constituting the urban components required to successfully carry out caregiving strategies. The availability, accessibility and proximity of the above urban components had a significant influence on caregiving strategies in terms of caring for the dependent others and care for one's own self and community. The important takeaway from the approach of Binet et al. is that the urban environment is seen as a crucial resource for care. Using the expanded notion of urban care, one can see how the above urban components constitute an infrastructure of care not just in the specific realm of childcare, elder care or care for the sick but also for the poor and the marginalised who face multiple forms of structural oppression. Public provisioning of socialised care in the cities could be an antidote to the process of cities becoming 'landscapes of stratified social reproduction' by augmenting the resources for caring among the marginalised groups. Through enabling access to cheap healthy meals, subsidising health care and childcare, 'collectivised care' eases the burdens of social reproduction for those who cannot afford to retain caregivers at home or access market facilities. If the urban environment is unsupportive, it would lead to increased burdens, sacrifices and trade-offs resulting in unmet basic needs. In this context, it is also useful to consider the threats of commodification of care. According to Green and Lawson (2011) when care operates within the market logic of choice, those who cannot afford to transact care as a product are excluded to the point of becoming destitute.

The struggle for the rights of frontline health and care workers

When care is taken into the public sphere as paid work, it is highly feminised along with high degree of horizontal and vertical occupational segregation and wide gender pay gaps (ILO, 2018). The growing trend of feminisation of the health workforce in the context of low- and middle-income countries, especially at the lower levels, has been well documented (Joshi et al., 2024). It has been pointed out in the previous section that the state has an important role in shaping the conditions of care labour, both paid and unpaid. In the words of Wichterich (2021), 'the feminisation, casualisation, and informalisation of work in state-funded social welfare schemes are examples of care extractivism'. Many scholars have highlighted the struggles of the largely female workforce employed as community health workers, domestic workers, nurses and midwives and early childcare workers (John, 2013; Joshi et al., 2024; Palriwala & Neetha, 2010; Power, 2019; Sinha et al., 2021; Swaminathan, 2015). Women's work in the care sector is marked by precarity, low wages, lack of social security and the lack of recognition as rights bearing workers. Moreover, the Indian state actively contributes to the informalisation of its health and care workforce (Swaminathan, 2015). Using Accredited Social Health Activists (ASHA), Anganwadi workers (early child care workers) and para-teachers as case studies, Swaminathan (2015) illustrates that this mode of 'doing development through gender' is prevalent in the health, education and social sectors. In the above cases, the state makes use of women's labour, as 'volunteers' ,'contract workers' or 'para-teachers' – to meet its welfare objectives, in the process entrenching women in low-paid, low-status, insecure jobs. Marwah (2023), through her study of ASHA workers, argues that volunteerism of women subsidises the state. She finds that the incentive payment system 'disregards a vast portion of labour that ASHAs perform, compensating them only for a fraction of their

work'. She makes use of the concept of liminality to point out that the liminal status of women workers lowers their wages, thereby entrenching the gender wage gap. Some of the studies have also focussed on the intersectional vulnerabilities experienced by care workers in India along the lines of caste apart from gender. Recruitment in scheme work in India can be seen as a form of positive discrimination as women from deprived households and those who are deserted or widowed are given preference (Palriwala & Neetha, 2010). Also, studies conducted at regional scales point out the overrepresentation of women from SC, ST, and OBC communities in comparison with their population in the Anganwadi and ASHA workforce (Marwah, 2021; Seema, 2001). Caste hierarchies within the organisation and at the site of work lead to experiences of caste-based discrimination and stigma towards Dalit women workers adding to the burdens of low wages, lack of social security and accentuated health risks of frontline work. Accounts of discrimination faced by auxiliary nurses and midwives and ASHA workers from the Dalit community stand testimony to this (Joshi et al., 2024).

While the struggle for recognition of the rights of health and care workers is ongoing, certain other categories of women workers are left out of the ambit of academic analysis and women's solidarity initiatives on the ground. Most studies on frontline workers in India have included for analysis the following set of workers – nurses and midwives, community health workers (ASHA) and Anganwadi workers. A study by Palriwala and Neetha (2010) included domestic workers in the care category. Karpagam and Dsouza (2021) call for a more comprehensive category of healthcare workers to include those who work in municipal solid-waste management and hospital sanitation departments, suffering from exploitative conditions due to their caste position. Yet, other women workers employed by the central and state governments under various health and nutrition support schemes are not brought under

the care category. An illustration of the paradox of care and uncare taken up by this paper is the precarious organisation of women's work in a well-intentioned scheme, namely the public canteen program run by city corporations in the state of Tamil Nadu.

Locating care in welfare – The case of a public canteen project

This study construes the state-run public canteens that provision subsidised food in the city of Chennai, as part of the 'care infrastructure that sustains life in cities'. The Amma Unavagams (Canteen, in Tamil) are a network of public canteens, currently numbering 393 in the city of Chennai, serving freshly cooked meals to its clientele. The scheme was inaugurated in 2013 by the then Chief Minister of the state J Jayalalitha, to combat food insecurity and serve timely and healthy meals to the urban working population, shielding them from the pressures of food inflation[4]. It continues to be a popular scheme even today serving close to 1.5 lakh beneficiaries a day despite a reduction in patronage over the years (*The Times of India*, 2022). These canteens are a 'careful' endeavour (M. J. Williams, 2017) as they reflect the state's sense of responsibility for the well-being of the urban residents instead of ascribing to the dominant neoliberal notion of self-responsibility. By cognising care in the activities of the state, it can be seen to operate beyond the ambit of individual relations within households and professional settings such as hospitals. In such a context, social provisioning of care has two important implications: Firstly, it redistributes care work away from women within households to state actors, and secondly, it allows care to flow towards the less

[4] The rates are fixed as follows: Breakfast – Rs. 1 for Idli (sambhar will be provided), Rs. 5 for pongal; Lunch – Rs. 5 for sambar rice, Rs. 5 for variety rice (Karuvepilai rice / Lemon rice) and Rs. 3 for curd rice; and for Dinner – 2 Chapatis with dal for Rs. 3. The rates have not been changed since the inauguration of the scheme in 2013.

privileged sections of the urban populations. Public canteens and free meal programmes at schools are all initiatives that enable food access to the underprivileged and thereby 'care'. Through public provisioning of food, the state steps in to fulfil an important aspect of social reproduction, which is traditionally considered the responsibility of private individuals, especially mothers. Although the public canteens are used as a vantage point to talk about urban care, they are to be seen as one aspect of a comprehensive care infrastructure in Indian cities, which would include school meal centres, day care centres and home shelters among others.

One can clearly locate care and care labour in the urban governance processes by using Fisher & Tronto's (1990) framework of the four phases in the caring process. The phases are *caring about, taking care of, caregiving and care receiving,* with each phase acting as a precondition for the subsequent ones and different groups being involved with the different phases. This explains the complexities and problems in the care process as these stages may be, in their words, 'intertwined in chaotic and contradictory styles'. 'Caring about' and 'taking care of' are governance processes involving political will, policy-making and allocation of financial and personnel resources. In the case of Chennai's public canteens, these operate at the level of higher officials and departments who choose to fund and operationalise the scheme. 'Caregiving' requires the deployment of workers who would perform the tasks of cooking and serving freshly cooked meals to the urban clientele. Finally, the care process can be successful only when receivers perceive adequate care. Hence, by looking at the provisioning of subsidised food as care, the labour involved in it can be valorised as care labour. It needs to be acknowledged that care is fragile and provisional. These spaces hold possibilities for care yet necessitate multiple conditions for such care to be practised. Financial constraints, infrastructural deficits, logistical failures and other such factors negatively affect

state capacity, resulting in inadequate care for the recipients and caregivers.

The paradox of 'spaces of care' and unjust labour arrangements

The following are excerpts from interviews conducted by the author with the users of the scheme in the city of Chennai:

> 'I can eat on time. I eat as much as I need to carry out my work for the day. It is much cheaper here. I satisfy my hunger and save some money too'
>
> —A young male who works as a helper in a bakery.

> 'We have been eating all three meals of the day here for the past ten days as we don't have the facility to cook. They have given us a room, but we need gas stove and cooking utensils. We have not received our first payment yet as we have just joined this company'
>
> — A migrant labourer working in a rubber factory.

These quotes exemplify the myriad ways in which food, care and justice interlace in the urban areas. Public canteens are an instance of socialised care, as they allow public resources to be used for caregiving, especially for the most vulnerable groups. The feminist call to socialise care (Hamington & Miller, 2006) and the justice call to democratise access to food can be seen to come together in the form of subsidised canteens that provide cooked food in the city. A recent study conducted by Reetika Khera (2024) on the government canteens in three different states assumes significance given that public canteens have received little attention in development debates in India. In her report, she highlights the importance of subsidised canteens in ensuring food security to the marginalised groups in the urban area through the supply of safe and hygienic goods. She also suggests that the canteens should be seen as complementing the Public Distribution System, a view that

is in line with the idea of care infrastructures discussed in the previous section – assemblages that provide care in the city.

Turning attention to the working conditions and muted struggles of workers deployed for the scheme shows that the state continues to shape care labour in unjust ways as discussed in the previous section. Each canteen employs a maximum of 12 workers (the numbers have come down due to retrenchment over the years) who work in two shifts to cook, serve, clean and ensure the upkeep of the canteens. The head worker is responsible for overall supervision including maintenance of sales and attendance records and tracking of stocks. Other workers report to the head worker. The canteens are open on all days of the year serving three meals a day – breakfast, lunch and dinner. Currently, there are a total of 3030 employed in the program in Chennai (based on official data shared by the Amma Unavagam Department). Although the scheme enabled the creation of job opportunities for low-skilled low-educated urban women, the informal nature of their employment has a bearing on multiple aspects of their work. The workers labour in precarious conditions, distanced from the state as contract employees, yet carry the burden of welfare delivery as frontline workers of the state. This is another illustration of 'doing development through gender' as pointed out by Swaminathan (2015), who argues that welfare programmes designed by the Indian state have led to feminisation of responsibilities. The women are not categorised as workers but continue to function as Self-Help Group (SHG) members despite putting in more than a decade of service. They were paid a daily wage of Rs. 300 since the inception of the scheme in 2013 with a raise of Rs. 25 enacted in 2024 (*The Hindu*, 2024). Wages of Rs. 325 per 8-hour day are still below the minimum wage of Rs. 376 stipulated by the Tamil Nadu Department for Labour in 2022 for domestic cooking, which is categorised as semi-skilled. Moreover, the workers are forced to take a pay cut on days of absence. They do not have access to any form of social security

such as health insurance, pensions or provident funds. A look at the socio-economic profile of the women employed in the project is necessary to understand their motivations to enter work and expectations from the job. There is an over-representation of widowed or single women, in the sample selected for this study, signalling that the jobs were reserved for the most vulnerable. Of the forty workers sampled for this study, 16 women identified themselves as widowed or separated. Moreover, female headship cannot be discerned only through the marital status of the household head. Alcoholism, sickness, or old age of the spouse forces women to be the breadwinner of the household. Six women identified themselves as breadwinners despite living with their spouse. Their spousal incomes varied between Rs. 9,000 and Rs. 20,000. In terms of educational status, only 5 women had completed graduation. Most of the workers reported having studied between 3rd and 10th standard with a couple of them reporting as not educated. Thirteen of the 40 workers belonged to Backward Caste, while the majority of the workers belonged to Most Backward Caste or Scheduled Caste. Only 5 of them reported owning a house, whereas the others were dwelling in housing board tenements or rented units. Most of the workers were in their 40s and 50s with only seven of them in their 30s. From these details, it is clear the women faced multiple vulnerabilities stemming from their caste, marital status, low household income and low educational level.

As a single mother who raised her children through the wages from the job, Suganthi expressed contrasting emotions while describing her experience of work:

> '... The Amma hotel job is a handout from Amma (referring to former Chief Minister J. Jayalalitha), on which I have sustained my life. If not for this job, I don't know how my life would have been. This is a really good measure that she has done for women. The problem is that we are not permanent workers. Even after ten years, we are akin to "Adi maadu" (cattle with lowest value). Our job is like any other daily wage job. We get the coolie for the day we work and nothing more'.

Precarity and absence of social protection continue to shape the labour conditions of many of India's frontline labour force including the canteen workers.

A call for an expanded category of 'care work' based on an infrastructural approach to urban care

An infrastructural approach to care anchored on equitable distribution of care resources can enable the valorisation of care workers too. The different components of the care infrastructure need to be planned for and assembled. Some of the components such as childcare institutions and public canteens require the deployment of labour for their continuous operation. Such labour needs to be seen as a crucial input for a functioning care infrastructure, thereby constituting the human component of the urban infrastructure of care. They need to be called as 'urban care workers' to ensure recognition and fair compensation. Such a conceptualisation would help to bring together workers deployed under different welfare schemes, which are currently organised in an ad hoc manner in precarious conditions. When public canteens and day care centres are recognised as constituents in the 'urban care infrastructure', the workers deployed in these programmes can be recognised as care workers. This paper calls for an expanded category of care work to include workers who perform direct and indirect caregiving activities – as such mid-day meal workers and workers of public canteens. Although it may not be feasible to draw up an exhaustive list of care workers at the global level, feminist research should be sensitive to the arrangements of health and care work at national and regional levels. Joshi et al. (2024) in their analysis of the health and care sector in India include the following set of workers – those employed in hospitals, primary health care and frontline health and care workers such as Anganwadi workers and ASHA workers. As many of the social care programmes are not

seen as such, the workers employed in various welfare schemes are not included in this definition of health and care workers. In effect, neither the public canteen workers nor the Anganwadi workers are 'project-based workers' because they have been engaged in the occupation for decades. As they are recruited under particular schemes, they continue to be just 'scheme workers' without any formal status. A coalition of 'scheme workers' has been formed to bring together the disparate set of women workers employed under various welfare schemes in their struggles for justice (Yadav & Prasad, n.d.). Care is a useful analytical tool to categorise the scheme workers as they directly or indirectly provide 'care' in the spaces they work in. Bringing them under the umbrella of care work would be the first step in enabling them to be recognised as workers.

The foot soldiers of development are invisibilised with no formal categorisation of their labour. The nomenclature of 'urban/rural care workers' highlights the importance of the job they are engaged in, identifying them with the work they perform and the outcomes they produce. Another important step in recognising 'workers' is the identification of the 'employers'. The term 'urban care workers' places the responsibility of care with the state institutions though markets and the voluntary sector will continue to play a significant role. It also makes the 'frontline' aspect of their work pronounced as the care worker is the one who is performing the activity of 'caring giving'. Authorities in other levels of government may be engaged in 'caring about' and 'taking care of' through framing legislations and assembling resources (borrowing from Tronto's multiple phases of care). It also highlights the specific vulnerabilities that stem from performing essential services such as the enhanced risk of infection during the time of the pandemic or braving flooded roads during monsoons. Binet et al. (2023) urge urban infrastructure of care to be treated as an essential public good. Deriving from this, the labour employed for organised care should also be treated as an essential service. The recognition as urban care

workers would serve the purpose of visibilising the scheme workers so that they would be included as subjects in care policies and other social security-related legislations.

What is missing in the policy for care in India?

On a final note, this paper will conclude with an appraisal of current policy thinking on care in the Indian context. The Confederation of Indian Industry with support from the Ministry of Women and Child Development and the Bill and Melinda Gates Foundation released a policy brief titled 'Formulating a Strategy for India's Care Economy: Unlocking Opportunities' in March 2024. The policy brief acknowledges the need for a care economy strategy for India and spells out ways to reimagine care ecosystems. The five pillars identified for a revamped care economy are leave policies, subsidies for care services, investment in care infrastructure through centrally sponsored schemes and public–private partnerships, skill training for care workers and institutional mechanisms for quality assurance. A commendable aspect of the policy brief is the broader consideration of care work that encompasses paid and unpaid work that involves direct, personal care and indirect activities such as cooking and cleaning. Hence, domestic services by unpaid carers and paid domestic workers are included. A notable suggestion is to ensure the participation of men in caregiving responsibilities through leaves and flexible work options. The focus of the policy brief is towards addressing low female labour force participation by bridging the gender gaps in unpaid care work and unlocking the economic potential of the care sector towards generating more jobs for women. With respect to care labour, the focus is more on skilling and professionalising rather than on rights. The vociferous calls for recognition of labour rights by women's organisations, and trade unions are not addressed. Ideals of efficiency, productivity and quality control overshadow the quest for decent wages, better

conditions of work and access to social security. Although the policy brief acknowledges the role of women caregivers within families, it does not spell out clear responsibilities for the state. The brief advocates for private investment and voluntary sector's role in the operation of care services by unleashing the entrepreneurial spirit of women through SHGs. Although the idea of care infrastructure has found its way into policy vocabulary, it is used loosely to mean care facilities. What the care policy brief misses to acknowledge is that the inequities in care provisioning are not just a question of gender but also a question of caste and class. This begs the question – why is the state reluctant to be a model employer by ensuring decent jobs for women of the marginalised caste and class who bear the cost of social reproduction of the masses?

Conclusion

The political possibilities that an ethic of care holds is brought to fruition when care is socialised as a deliberate public policy measure. It allows care, in this case through provisioning of good cooked food, to flow towards those who have difficulties in accessing it. Through redistribution of food, care is redistributed too. As can be seen from the experiences of the users of the scheme, such care is not without its problems. The unjust arrangement of work relations for the care-givers, in this case the women workers at the Amma canteen, reveals that a feminist call to socialise social reproduction might not always lead to empowerment of women. Gendered caring spaces, neoliberal logic of contractual work and bureaucratic apathy towards maintenance of public infrastructure coalesces to reproduce the plague of 'devaluation of care'. The fact that this devaluation happens at the very site that holds promise for a 'just' city is testament to the messy and contested ways of doing justice in the urban where care/carelessness and justice/injustice are co-present. An urban food system enacted through provisioning

of subsidised meals can be considered 'just' only when the needs of the carer and the cared-for are taken into consideration.

An expanded notion of care as operating in an urban scale puts an impetus on governments to come up with comprehensive care policies instead of ad hoc arrangements that entrench precarity. Recognising certain forms of labour as care labour enables the valorisation of work performed largely by women lower down in the caste and class hierarchy. The idea is not to consider care as a residual category but to recognise the contribution of an invisibilised workforce and enable the organisation of decent jobs through public policies that enable the social organisation of care.

References

Alam, A., & Houston, D. (2020). Rethinking care as alternate infrastructure. *Cities*, *100*, 102662.

Barnes, M. (2012). *Care in everyday life: An ethic of care in practice*. Policy Press.

Binet, A., Houston-Read, R., Gavin, V., Baty, C., Abreu, D., Genty, J., Tulloch, A., Reid, A., & Arcaya, M. (2023). The Urban infrastructure of care: Planning for equitable social reproduction. *Journal of the American Planning Association*, *89*(3), 282–294. https://doi.org/10.1080/01944363.2022.2099955

Chinnakali, P., Upadhyay, R. P., Shokeen, D., Singh, K., Kaur, M., Singh, A. K., Goswami, A., Yadav, K., & Pandav, C. S. (2014). Prevalence of household-level food insecurity and its determinants in an urban resettlement colony in north India. *Journal of Health, Population, and Nutrition*, *32*(2), 227.

Coelho, K., Venkat, T., & Chandrika, R. (2012). The spatial reproduction of urban poverty: Labour and livelihoods in a slum resettlement colony. *Economic and Political Weekly*, *47*(47–48), 53–63. https://www.jstor.org/stable/41720410

Conradson, D. (2003a). Geographies of care: Spaces, practices, experiences. *Social & Cultural Geography*, *4*(4), 451–454. https://doi.org/10.1080/1464936032000137894

Conradson, D. (2003b). Spaces of care in the city: The place of a community drop-in centre. *Social & Cultural Geography*, *4*(4), 507–525. https://doi.org/10.1080/1464936032000137939
Cox, R. (2010). Some problems and possibilities of caring. *Ethics, Place & Environment*, *13*(2), 113–130. https://doi.org/10.1080/13668791003778800
Daly, M., & Lewis, J. (2000). The concept of social care and the analysis of contemporary welfare states. *The British Journal of Sociology*, *51*(2), 281–298. https://doi.org/10.1111/j.1468-4446.2000.00281.x
Fisher, B., & Tronto, J. (1990). Toward a feminist theory of care. In E. Abel & M. Nelson (Eds.), *Circles of care: Work and identity in women's lives* (pp. 35–62). SUNY Press.
Green, M., & Lawson, V. (2011). Recentring care: Interrogating the commodification of care. *Social & Cultural Geography*, *12*(6), 639–654. https://doi.org/10.1080/14649365.2011.601262
Hamington, M., & Miller, D. C. (2006). *Socializing care: Feminist ethics and public issues*. Rowman & Littlefield.
Held, V. (2004). Care and justice in the global context. *Ratio Juris*, *17*(2), 141–155. https://doi.org/10.1111/j.1467-9337.2004.00260.x
International Labour Organisation. (2018). *Care work and care jobs for the future of decent work*. ILO. https://www.ilo.org/sites/default/files/wcmsp5/groups/public/@dgreports/@dcomm/@publ/documents/publication/wcms_633135.pdf
John, M. E. (2013). The problem of women's labour: Some autobiographical perspectives. *Indian Journal of Gender Studies*, *20*(2), 177–212. https://doi.org/10.1177/0971521513482213
Joshi, D., Abhishek, S., Nandi, S., & Sinha, D. (2024). Feminization of the health and care workforce in India and south Asia: Implications for women's labor and decent work. In T. S. Ravindran, M. Sivakami, A. Bhushan, S. F. Rashid, K. S. Khan (Eds.), Handbook on Sex, Gender and Health. Springer. https://doi.org/10.1007/978-981-19-9265-0_37-1
Karpagam, S., & Dsouza, J. (2021). Occupational hazards in healthcare settings. *Economic and Political Weekly*, *56*(17). https://www.epw.in/journal/2021/17/review-womens-studies/occupational-hazards-healthcare-settings.html
Khera, R. (2024, July 1). *Why are government canteens important when 80 crore people get free grains?* The India Forum.

https://www.theindiaforum.in/public-policy/why-are-government-canteens-important-when-80-crore-people-get-free-grains
Marwah, V. (2021). *Reproducing the state: Women community health volunteers in north India* [Doctoral Thesis]. https://repositories.lib.utexas.edu/handle/2152/87668
Marwah, V. (2023). Liminality as wage penalty for India's women community health workers. *Gender, Work & Organization*, *30*(2), 412–430. https://doi.org/10.1111/gwao.12938
Mee, K. (2009). A space to care, a space of care: Public housing, belonging, and care in Inner Newcastle, Australia. *Environment and Planning A: Economy and Space*, *41*(4), 842–858. https://doi.org/10.1068/a40197
Ministry of Women and Child Development. (2014). *Formulating a strategy for India's care economy: Unlocking opportunities*. Government of India. https://static.pib.gov.in/WriteReadData/specificdocs/documents/2024/mar/doc202435319501.pdf
Palriwala, R., & Neetha, N. (2010). Care arrangements and bargains: Anganwadi and paid domestic workers in India. *International Labour Review*, *149*(4), 511–527. https://doi.org/10.1111/j.1564-913X.2010.00101.x
Palriwala, R., & Neetha, N. (2011). Stratified familialism: The care regime in India through the lens of childcare. *Development and Change*, *42*(4), 1049–1078. https://doi.org/10.1111/j.1467-7660.2011.01717.x
Power, E. R. (2019). Assembling the capacity to care: Caring-with precarious housing. *Transactions of the Institute of British Geographers*, *44*(4), 763–777. https://doi.org/10.1111/tran.12306
Power, E. R., & Williams, M. J. (2020). Cities of care: A platform for urban geographical care research. *Geography Compass*, *14*(1), e12474. https://doi.org/10.1111/gec3.12474
Rao, S. (2020). Lessons from the Coronavirus: The socialization of care work is not 'just' a women's issue. *Paid and Unpaid Care Work*. https://digitalcommons.wcl.american.edu/wlpcarework/2
Rao, S. (2021). Beyond the coronavirus: Understanding crises of social reproduction. *Global Labour Journal*, *12*(1). https://mulpress.mcmaster.ca/globallabour/article/view/4307
Seema, T. N. (2001). *Performance of Anganwadi Centres in Kerala: An evaluation and experiment to develop a model centre with community participation* (Discussion paper no. 28). Kerala Research Programme on

Local Level Development, Centre for Development Studies. http://www.cds.ac.in/krpcds/seema.pdf

Sevenhuijsen, S. (2003). The place of care: The relevance of the feminist ethic of care for social policy. *Feminist Theory*, *4*(2), 179–197. https://doi.org/10.1177/14647001030042006

Sinha, D., Gupta, M., & Shriyan, D. (2021). *High risk without recognition: Challenges faced by female front-line workers.* https://www.cabidigitallibrary.org/doi/full/10.5555/20210504567

Sivam, A., & Karuppannan, S. (2002). Role of state and market in housing delivery for low-income groups in India. *Journal of Housing and the Built Environment*, *17*(1), 69–88. https://doi.org/10.1023/A:1014831817503

Staeheli, L. A., & Brown, M. (2003). Where has welfare gone? Introductory remarks on the geographies of care and welfare. *Environment and Planning A: Economy and Space*, *35*(5), 771–777. https://doi.org/10.1068/a35132

Swaminathan, P. (2015). The formal creation of informality, and therefore, gender injustice: Illustrations from India's social sector. *Indian Journal of Labour Economics*, *58*(1), 23–42. https://doi.org/10.1007/s41027-015-0006-z

The Hindu. (2024, June 24). Chennai Corporation hikes daily wages of Amma canteen workers from ₹300 to ₹325. https://www.thehindu.com/news/cities/chennai/chennai-corporation-hikes-daily-wages-of-amma-canteen-workers-from-300-to-325/article68327368.ece

The Times of India. Close Amma canteens that are loss-making: Councillor. https://timesofindia.indiatimes.com/city/chennai/close-amma-canteens-that-are-loss-making-councillor/articleshow/95870392.cms

Tronto, J. C. (1998). An ethic of care. *Generations: Journal of the American Society on Aging*, *22*(3), 15–20.

Wichterich, C. (2021). Protection and protest by "voluntary" community health workers. *Historical Social Research/Historische Sozialforschung*, *46*(4), 163–188.

Williams, F. (2010). Migration and care: Themes, concepts and challenges. *Social Policy and Society*, *9*(3), 385–396. https://doi.org/10.1017/S1474746410000102

Williams, M. J. (2017). Care-full justice in the city. *Antipode*, *49*(3), 821–839. https://doi.org/10.1111/anti.12279
Yadav, S., & Prasad, R. (n.d.). *Scheme workers and their struggles*. AICCTU. https://www.aicctu.org/workers-resistance/v1/workers-resistance-june-2021/scheme-workers-and-their-struggles

Madras Institute of Development Studies (MIDS) was founded in 1971 by Malcolm S. Adiseshiah. It studies development problems of India, with a special focus on Tamilnadu. Since 1977, MIDS is a national institute funded jointly by the Indian Council of Social Science Research (ICSSR) and the Government of Tamilnadu.

Madras
Institute of
Development
Studies

79, Second Main Road, Gandhi Nagar
Adyar, Chennai 600020, India
Phone: 044-2441 1574 / 2589 / 9771
pub@mids.ac.in | www.mids.ac.in