

# Gender Implications of Care Migration for the Operation of Care Diamond in Ukraine

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## Abstract

The main goal of this paper is to identify the impact of the out-migration of females from Ukraine on the structure and operation of care services and to analyse its gender implications for the family and society in Ukraine. The key analytical concept used in the study is the 'care diamond', understood as the architecture that explains the relationship between the state, the market, the family, and the community in care provision. The argument of the paper is that the out-flow of women from Ukraine results in a 'care deficit' in the sending society and alters the operation of the care diamond due to the increasing role of the family in its structure, which in turn tends to outsource its care functions to the market while preserving the responsibility for the organisational and financial backing of paid home care. The paper shows that the emerging 'care crisis' in Ukraine results from the strategy of 'crisis transfer' employed by post-industrial nations to shift the burden of multiple crises from the nucleus of the world system to its periphery. In conclusion, the paper offers policy proposals for the development of coherent policy strategies aimed toward covering key sectors of the Ukrainian care diamond.

**Key words:** care diamond in Ukraine, Ukrainian care migration, gender implications of care drain

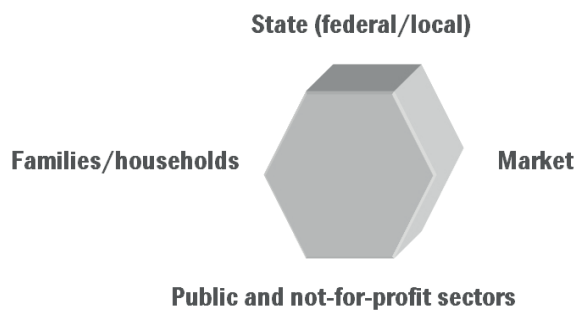
## Introduction

The main goal of this paper is to identify the impact of the out-migration of females from Ukraine on the structure and operation of care services and to analyse its gender implications for the family and society in Ukraine. Its social relevance is defined by the social demand in gendered analyses of the dynamics of the 'care economy' in Ukraine under conditions of demographic change and the feminisation of migration fluxes (for more on the feminisation of migration from Ukraine, see Tolstokorova 2009, 2012). This issue has never received focused attention from the academic community in Ukraine or internationally, which explains the research novelty of the current study. 'Care economy' is understood here as the provision for others' needs within and

outside the household without reciprocation and remuneration. 'Care' is regarded as the work of looking after physical, psychological, emotional and developmental needs of other people. Paid care work is viewed as household activities with practical and social dimensions, which may be aimed toward 'caring for', i.e. cooking, cleaning and nursing, and 'caring about' (caring and loving as emotional work and social support) (Lutz and Palenga-Mollenbeck 2010).

The key analytical concept used to study the operation of the Ukrainian care economy in this paper is the 'care diamond' introduced by Razavi (2007) to outline 'the architecture through which care is provided, especially for those with intense care needs such as young

children, the frail elderly, the chronically ill and people with physical and mental disabilities.’ This architecture embraces human services requiring personal and emotional attachment (childcare, health care, eldercare, social work), and explains the relationship between the state, the market, the family, and the community through the ‘care diamond diagram’:



The components of the care diamond are interconnected with each other while the boundaries between them are flexible. Current research departs from the observation that the out-migration of females is likely to alter the operation of the care diamond in that remittances inject finances which may expand the recourse to paid labour and commodification in the families left behind at home and represent some recognition or compensation for caring activities, especially by family members and extended kin (Kofman and Raghuram 2009). That is, earnings made abroad may be used to pay extended kin or a hired domestic worker for outsourced care-giving in the family in the home country. In this way, the care diamond operation is being reshaped due to the increasing role of its market component.

The project draws from the results of a multi-sited field research which consisted of 25 in-depth expert interviews and semi-structured interviews with 40 Ukrainian labour migrants and members of their families (28 females and 12 males), interviewed both at home and in the countries of work (Italy, Germany, Austria). In Ukraine, members of migrants’ families and extended migrants’ networks (neighbours, relatives, co-workers) were interviewed through individual conversations and through two focus

group discussions. Initially, the field research included only females as its aim was to study care migration, which is allegedly a mainly female preserve. Yet, during the focus group discussions with extended families, it became clear that men should be also interviewed, because it turned out that the labour market of care services is heavily divided along gender lines. Interviews showed that migrant males are often involved in care services, although mainly as a part-time and temporary/occasional supplement to their principal employment. Additionally, males are invisible in the research on the care economy, given that they inhabit a different niche in the labour market than females, involving minimal inter-personal contact and less emotional investment. For instance, men, especially at the initial stage of the migratory experience, may agree to work in pet care, gardening, yacht and car care, body care (as massagers and barbers), house care (small repairs, walls/window painting, etc.), dish-washing at cafes and restaurants, cleaning in public places and institutions. Some responders were employed in cleaning train carriages, as was the case in Poland. At the same time, these gender specificities evince the necessity to expand the concept of care work to include the specifically male sector of this labour market.

The interviews were based on a semi-structured questionnaire with open-ended questions that aimed to cover different stages of the migration cycle and to reflect on the gendered experiences of migrants. The interviewing started with existing contacts with migrants and their families, followed by a snowball sampling method whereby new respondents were contacted through preceding respondents. Occasional meetings with migrants or members of their social networks were also used for interviewing. For confidentiality reasons, the names of responders have been changed.

#### **Ukrainian “care economy” in the context of population aging**

A growing body of care research evidences the interdependence of different regions of the world through the migration of care workers, given that in response to new challenges spurred

by globalisation, care migration transforms welfare systems in both source and recipient societies (Parreñas 2001; Raghuram et al 2009; Williams 2009; Yeates 2009). Migration enables welfare systems to respond to a growing number of needs, but also brings them face-to-face with the emergence of a parallel market built on a direct and little-institutionalised relationship between migrants and families. In Ukraine, hiring domestic workers has become a fashion among middle-class families, serving as 'symbolic capital' (Bourdieu 1979), which enables them to exhibit the economic superiority of households in a position to employ servants and to consolidate the identity and life-style images of middle-class families. The causality behind the growth of the demand in paid domestic services is the socio-economic polarisation of the post-socialist society, the nuclearisation of the family, and the formation of a new life-style and attitude to privacy among the emerging middle class and the emancipation of its women from domestic chores due to the emergence of the class of 'new servants'. Additionally, the rise of the demand for home carers, child-minders in particular, results from the increase in birth-rates in Ukraine throughout the last few years, which was not accompanied by the expansion of the network of pre-school public institutions, most of which were destroyed during the years of transition to a market economy.

The demand in long-term care for the elderly is also on the rise, as a result of the fact that the share of retired seniors among the general stock of the Ukrainian population has been growing throughout the last decades. Thus, according to the UN world aging rate, which bases its calculations on the share of seniors aged over 65, the Ukrainian population reached the threshold of aging in 1959, when people of this age group amounted to 6.9% of the population. In 1989, when their share reached 11.7%, Ukraine could already be categorised as an old-aged society. According to the census of 2001, this age group had increased to 14.4%, and in 2005 it had climbed to 16% of the population (Stelmakh 2006), rising to 23.9% in 2007. Currently the share of seniors is equal to 24.7% of the

total population (UA Club 2011), while by mid-century this index is expected to rise to 38.1% (Chajkovska 2010). At present, Ukraine ranks eleventh in the world aging rate and is expected to move to ninth place by 2025. At the same time, experts warn that a unified system of state-governed long-term care (LTC), particularly for the elderly, is almost non-existent, and there is no overarching policy or programme specifically addressing LTC (Bezrukov 2002; FISCO 2011).

Hence, the total of potential clients for home care in Ukraine is steadily increasing. The pool of available carers is simultaneously shrinking as a result growing out-migrating of Ukrainian females to employment abroad (Tolstokorova 2009), 11% of whom are professional doctors (Chaloff and Eisenbaum 2008). This mismatch between the increasing demand in home caregiving and the decrease of the pool of potential carers is proof of the emergence of a 'care gap' (Himmelweit 2002) in the Ukrainian care regime. According to a World Bank report (World Bank 2007), this challenge is not unique to Ukraine, but reflects the general trend observed in Eastern Europe. The report raised the alarm regarding the increase in the demand for social and healthcare services in Eastern Europe on the part of the elderly due to a reduced presence of informal caregivers (women willing to care for them) and the simultaneous aging of the population. The high rate of aging of the Ukrainian population renders this country particularly at risk.

An overview of advertisements of employment agencies in Kyiv, carried out for this project, showed that the wage offered for domestic/care work in a private house in the Ukrainian capital noticeably exceeds the expected job remuneration for skilled labourers such as interpreters/translators, sales managers, nurses at public nurseries or kindergartens, or even university professors. Furthermore, the content analysis of employment advertisements showed that throughout the last two to three years, the cost of domestic work has increased by nearly half. The requirements for potential employees, however, have also increased and the job has acquired a very competitive character. A poten-

tial highly paid domestic worker is expected to be 45 to 50 years of age, a professional teacher or a doctor, preferably married and with children, skilled in cooking, especially dietary cuisine, and capable of getting along well with children. Additional requirements include foreign language skills, computer literacy, knowledge of methods of early age teaching, and readiness to provide elementary training to employers' children. Last but not least, the carer's personal qualities are listed: she is expected to be tactful, patient, sociable, and easy-going. However, recruiters contend that currently the key challenge is the qualifications of domestic employees, as there are no educational institutions offering training to potential personnel in this newly emerging sector of the labour market. It is argued that native carers, although well qualified professionally, often lack the emotional discipline necessary for employees in private houses. For this and other reasons, native carers are increasingly disregarded in favour of 'global nannies' (Ehrenreich and Hochschild 2003) from exotic countries such as the Philippines.

Experts ascribe this preference to a more advanced work ethic among foreign workers. In contrast to native home carers, they are prone to distance themselves emotionally from employers, refrain from intimating their personal problems to them, and prefer to stay invisible, which is valued by the latter (Tyuryukanova 2011). Additionally, as nannies from other countries often enter the country illegally, they are noticeably cheaper than native employees. Due to the absence of a legal status, they lack any access to social welfare and the protection of their human rights. Lacking linguistic skills, they are not in a position to protect themselves and are exposed to exploitation and overexploitation. In advertisements of employment agencies, foreign nannies are portrayed not only as 'servants and slaves' (Anderson 1997), but practically as animals, for instance dogs, who are smart enough to understand and fulfil commands. This trend testifies that in the context of the global care economy, Ukraine is redefining itself from 'the end of global care chain' into 'a new loop'.

### **Discussion of field research findings. Impact of the out-migration of care labour on the care diamond structure in Ukraine**

#### *The state sector of the care diamond*

Under state socialism, every citizen was guaranteed free basic medical assistance, health care and insurance from birth to death. Although the public system of elderly care homes existed, its infrastructure was insufficient to meet the requirements of the population. The quality of care provision was so low that it was not widely used by the population. Additionally, traditional culture and public opinion did not welcome families who outsourced the responsibilities of elderly care to public institutions. For that matter, elder-care homes were mainly used by single frail people who were not in a position to provide for themselves. In those conditions, families requiring elder care developed a tradition of informal home care as a coping strategy. It relied on a kind of 'inter-family migration' (Tolstokorova 2011: 241) through which the older generation, mainly single or widowed senior women, after retirement moved to live with the families of their adult children. In this way, dual earner working families could solve three care challenges at one time. Due to this arrangement, grandmothers (less often grandfathers) took care of their grandchildren and assumed responsibilities for daily domestic chores in the household of their working children. On top of that, they themselves were taken care of by their off-spring and could count on their support in case of emergency or health disability. Such care arrangements did not require hired care givers for the young, disabled or older family members. Yet, on the flip side, this strategy relied heavily on the informal and therefore unpaid reproductive labour of women, both of retired grandmothers and their working daughters or daughters-in-law. While in big industrial centres this tradition is gradually declining, it still persists in small towns. In conditions when women as prime-line reproductive workers are increasingly departing for earning money abroad, this creates a 'care gap' in families that rely on this care arrangement.

The constitution of independent Ukraine preserved the rights for free health care, medi-

cal treatment and insurance intact. However, in reality the quality of institutional care provided is dependent on the financial resources of the patient. There is no clear distinction between social and medical care. Social care is generally the responsibility of the Ministry of Labour and Social Policy, with nursing centres as the main residential facilities for those requiring external assistance for daily living. Institutional social care is provided mainly in public institutions for dependent groups, including seniors, war and labour veterans, and other cohorts with special needs. After the demise of the USSR, state expenditures on health care tangibly decreased, currently amounting to around 2.7% of GDP, compared to 14.1% in the United States (Ivanov 2009). This level of spending can meet only the minimal health care requirements of the population. In terms of elder care, the situation is especially dramatic. The share of the elderly who have access to medical home care varies from 3% to 40% depending on the region (Amjaddeen 2008); in rural areas this share is noticeably lower than in urban settlements. The demand for institutional elderly care exceeds available possibilities by far, with waiting lists increasing while available beds decrease.

Recently, some municipalities have introduced palliative care facilities (hospices) for frail patients and the oldest of the old. They are usually financially backed by local governments as well as public and religious institutions and are incorporated into the system of the Ministry of Health Care, which allocated them quotas for personnel. However, the network of hospices is only in its infancy and can meet but a small share of the current demand in palliative care, which is growing rapidly. The quality of services leaves much to be desired, especially in regard to emotional and spiritual support to clients. Recently, responding to the needs of its ageing society, Ukraine developed home-based care services including health and personal care, as well as a home-making service.

A serious challenge to the operation of the state component of the care diamond lies in the embedded nepotism, structural erosion and absence of transparency. This was evidenced by

stories of informants in this project. One was a woman whose bed-ridden mother required the services of a qualified nurse to provide injections at home. The woman offered an extra out-of-pocket remuneration for these services, despite the fact that they are a part of the professional responsibilities of institutionally employed nurses.

I asked in the local clinic if they have a nurse who could provide paid home care. Yet my request was turned down. The argument was bad lack of nurses among medical personnel. Soon after that, quite incidentally, I met my ex-schoolmate, a skilled nurse with certified professional experience. It turned out that she was unemployed and her financial situation was rather poor. So, I brought her to the head of the outpatient department at our clinic and told her: 'Here you go. Now you have a qualified nurse in your staff and I have a person to give injections to my Mom at home.' Yet the reply was that it was hardly possible, because the administration of the clinic received an unofficial prescription from top health-care officials to avoid employing nurses with official residence permit in Kyiv, and instead to give priority to those who reside in Kyiv clandestinely. As you understand, the former are usually better educated, know their rights well and are in position to defend them, while the latter are more vulnerable and more prone to manipulation and exploitation and for that matter more convenient for the administration. So, my ex-classmate did not get this job, despite her qualifications and work experience. Soon after that I learned that she had found employment abroad and left Ukraine (Kyiv, 20.05.2010).

A similar experience was reported by another informant, a woman in her fifties and a resident of Kyiv, who decided to quit her work at a publishing house for a while to take care of her new-born grandchild so that her daughter could preserve her well-paid job. When the child was old enough to go to a day-care centre, the grandmother decided to resume working. When she started looking for a new occupation, she quickly found a few possibilities offered for unskilled workers, including in care services:

I bought a huge lot of papers with job ads and started calling to recruitment agencies in response to job possibilities they advertised. Some of them told me: 'All right, we have a job for you, and in

addition we can offer you a placement in a hostel room with four other women for a decent rent. So, you don't have to worry about the place to live.' But as soon as I told them that I am a Kyivite and have my own apartment and don't need housing, they were telling 'Sorry, but if so, we don't need you.' (Kyiv, 17.08.2011).

These interviews show how mercenary motives of top-level state officials create conditions which push out from the national system of health care its best, most skilled and experienced personnel. With few possibilities to find a place for themselves at home, they are forced to seek means of survival abroad, where their work is more required. Due to this, the collapsing care systems of affluent northern economies receive cheap skilled care and nursing labour. It enables tangible budget savings both on wage pay-outs and on the investments into human capital (training of qualified care and nursing personnel), necessary to meet the demands of their ageing population and to raise the competitiveness of their economies. In other words, the so-called 'golden billion' benefit from the dysfunctions of care economies in the 'bottom billion' through dividends received from them. This process demonstrates the emergence of globalised institutional and economic contexts that facilitate corrupt practices and other forms of institutional misconduct among top decision-makers in labour-exporting societies such as Ukraine. At the same time, it demonstrates that the strategy of 'crisis transfer' (Souhorukov 2004a), employed by post-industrial nations to shift the burden of multiple crises in the nucleus of the world system to the periphery, is applicable to the care economy as well. In particular, it confirms the claim that the absorption of unprotected intellectual products and resources from the source countries is one of key tools in the implementation of strategies.

In reference to Ukraine, the 'crisis transfer strategy' may be helpful in explaining how the emerging care gap and the subsequent care crisis result from the care crisis in post-industrial societies, and how the latter translates into 'care drain' from low-income nations via global care chains. As demonstrated by Souhorukov's theory (2004b: 16), crisis transfer consists of

conscious actions of one country with regard to another country (generally less developed), entailing disastrous consequences for the latter, such as profound multiple crises, decrease of competitiveness of the national economy, diminishing exposure to the world market, deterioration of entrepreneurial and investment climate, degradation of social and ecological situation.

Within this framework, the chain transfer of crisis is defined as a consecutive (chain-driven) transfer of crises from better developed societies onto less developed ones, involving more than one country. An illustrative example of this strategy is the so-called 'global care chains', which represent networks, aiming to maintain daily life in the so-called 'transnational households' by transferring care provision from one to another based on power structures, such as gender, ethnicity, social class, and place of origin. In the framework of feminist economics, a near-global trend of massive entrance into paid labour and the acquisition of financial independence by middle-class women in industrialised nations is interpreted as coming at the cost of the freedom of their domestic and care workers. The latter have to sacrifice their own family life and responsibilities to enable their female employers to reconcile career and family life, while their own families are left bereft of care. Through this sort of 'gendered and racialized international division of caring labor' (Ally 2005), the global capitalism and neoliberal economic restructuring have enforced a 'new world domestic order' (Hondagneu-Sotelo 2001) that requires the emigration of the so-called 'new servants', i.e. poor women from the periphery of the world system, to provide low-cost care in wealthier 'core countries'.

The claim of 'crisis transfer strategy' as a tool by which 'care drain' is crafted may be supported by observations, highlighting a discernible link between two concomitant processes: a growing demand for female labour in post-industrialised economies, and a concurrent increase in female labour supply from transitional societies after the demise of the USSR. As highlighted by a UNIFEM report (UNIFEM 2006), the connection between these two processes explains the sup-

ply of cheap migrant care-workers to the West. Thus, it was noticed that the process of paid job acquisition and demand for equal treatment inside and outside the labour force by women from most developed Western capitalist societies in the 1980s strikingly coincided with a reverse tendency in countries of state socialism, where women were granted long maternity leaves and started to drop out of paid work for lengthy periods early in their careers. These simultaneous trends converged more pronouncedly in the 1990s after the collapse of state socialism and the related escalation in economic globalisation. Even more strikingly, as the report shows, East European women were forced out of the labour force in unprecedented numbers, *exactly at the time* when their Western counterparts started to take up paid employment at the encouragement of national and transitional governments as well as corporate employers. It explains an oft-repeated phrase in the Ukrainian media that in the early 1990s borders were opened as soon as enterprises were closed down. This enabled the sudden supply of relatively cheap and flexible immigrant labour that has accelerated female paid economic activity in migrant recipient societies (Lyberaki 2008). The obvious connection between these two processes points to the 'Deae ex Machina effect' of the so-called 'just-in-time' women's migration (Karjanen 2008) as well as to a 'prêt-a-porter character' of the emerging 'care gap' in care exporting societies.

The dysfunctions of care systems in sending countries, resultant from the 'crisis transfer strategy', enhance changes in the architecture of the care diamond by relocating the functions of the state and the family onto the market, thus contributing to the 'global commodification of care'. Illustrative of this trend was a personal experience of an interviewer in this project, seeking an official status of a paid home carer for a bed-ridden family member, which requires a document officially verifying that a frail patient is not in a position to take care of his/her daily needs and requires personal home care. Officially, the status of personal home carer entitles a care-giver to a small allowance (less than €10 per month). More importantly, it enables a home carer to

preserve his/her job placement while working at home and to maintain an un-interrupted labour history, with the time spent in home care recorded as paid work. Additionally, a carer may be entitled to some welfare subsidies available for low-income groups, such as reduced rent, etc. Although not wide-spread due to minuscule financial provisions, this care arrangement was required and used by many families.

Yet, it turned out that due to recent legislative amendments, securing a formal status for a home elder-carer has become a complicated venture. First, the category of patients entitled to formal home care provision was markedly reduced due to the scaling-up of the age limit, newly set at 80 years old and over. Therefore the relatives who could afford to sacrifice their careers and incomes to provide decent care to their dear ones aged below 80 had to resign from jobs and interrupt their employment histories, with salient implications for their own financial security in old age. Secondly, the district physician in charge of the relative's medical care was reluctant to confirm that her frail bed-ridden patient was care dependent. In a private conversation, the physician intimated that the personnel of her clinic had received unofficial instructions to avoid issuing such permits by all possible means to clients as long as they were entitled to government welfare provisions. In this condition the remaining option for care-dependent families was to employ a paid care-giver to provide home-based services to their frail relatives, i.e. to turn either to the informal market for domestic services or to the commercial sector for public social services. Interestingly, when the required papers were obtained to apply for the latter, the medical confirmation of the frailty and care dependence of the client was issued without delay. Hence, the 'care burden' (Abe 2010) was forcefully shifted from the family onto the commercial sector by means of the structural pressure of the health-care system on the family, despite the willingness of the latter to shoulder this care challenge through internal human resources. In this way the family was deprived of its 'right to provide care'.

*The family sector of the care diamond*

As observed by the WHO (2002:19), informal care is by far the dominant form of care throughout the world, while paid services - either at home or in institutions - play a relatively small role, except in a few countries. The results of the current field research confirmed an earlier finding (Tolstokorova 2009) that in the situation when women as principle carers depart abroad, the caring roles are redistributed among members of extended families, being mainly assumed by grandmothers and less often among the community. However, this is more likely to happen in rural areas and in small towns, where family and community connections are stronger, rather than in highly alienated urban settlements, which currently face the challenge of an emerging 'care deficit', exacerbated by the demographic change in Ukrainian society. In urban and less often in rural families, the absence of women for work abroad often entails the redistribution of gender role models among transnationals. The males left behind may assume household duties and often cope well with their new roles. This was intimated by one of our interviewees:

I decided that it is me who has to go [for earnings abroad], because I knew that although my man was not the best possible husband, he was a good dad and my boys loved and obeyed him. Now, I see that although I am away from home, my boys are taken care of well, and all my guys get along well with each other. Now that I am going home for a short leave, I am busy with present-hunting for my ex, to thank him for being a good father to our sons. (Anastasia, working in services business in Monaco, Nice, France, 08.12.2007,)

Another responder commented that such instances are quite common in transnational families, in which the new 'gender contract' with wives as breadwinners is gaining currency:

Here, in small towns in the South of Ukraine, around 40% of men live on remittances sent by their migrant wives and take care of the household. In the West of Ukraine their share is even higher, probably over 50% and since my sister lives in Moldova and I know that there such men make no less than 70% of the total male population. (Varvara, mother of a man working in Russia, Kherson region, 26.07.2011) )

One woman assumed that the share of 'househusbands' might be even higher than that, thus confirming the observation that spouses/partners may provide a critical safety net for care-dependent family members (Hoffmann and Rodrigues 2010). However, in our research the caring roles of males, if any, were limited mainly to the care for their children, but seldom extended to assuming responsibility for their own elderly parents, let alone for the parents of their migrant wives. At best, men contributed to elder-care through fiscal support, but not through daily care-giving and emotional work. Hence, the reconstitution of gender role models in 'mother-away families' with fathers left behind occurs mainly while women are absent from home. After the women come back, however, they are expected to re-assume their traditional gender roles of homemakers, while their husbands return to their roles of heads of families, although not necessarily as the main breadwinners.

*The non-profit sector*

During state socialism the national health-care system was heavily biased towards institutional care, while transition to a free market economy enhanced a shift towards services that are more community centred (WHO 2002). In Ukraine, the network of NGOs involved in care provision is a fairly new development that operates on the national, regional and municipal levels. The Red Cross is an asset in providing informational services and training to families of long-term carers, yet overall, the system of such training in Ukraine is practically non-existent. The operation of this sector of the care diamond lacks state involvement, especially in terms of the scarcity of financial provision and insufficient legislative backing. As the director of an NGO providing care services stated in an interview:

Unfortunately, in this country social services exist only on the state level. This is a monopoly of the state. NGOs have no right to provide social services. Charity activity or support to those who need it is allowed, but it is not qualified as social services. There is no law which stipulates which social services can be provided by NGOs. .... Therefore



people who really need care services can not buy them. They can hire a person in a private way, but then they do it unofficially. In this case no one can guarantee professional care-service. If there was a labour market of these services at least partly covered by the state, then women would not go to make money abroad. Because currently there is a huge demand in care services in Ukraine (Kyiv, 26.06.2008).

Experts' data were confirmed by the information received through informal communication with members of families seeking home care. Thus, one informant reported that she was unable to find a qualified nurse to provide home care for her elderly mother, who was suffering from Alzheimer's disease. All the proposals for this offer came from people with no experience with frail patients, especially ones with this profile. The informant's experience with families of patients suffering from the same disease suggested that all of them had faced the same care challenge. Being a PhD holder, an experienced social scientist and entrepreneur, she decided to organise training courses aiming to provide skills in home elderly care. She succeeded in finding premises for her classes and invited qualified professionals of this profile who were ready to share their expertise to make her venture work. However, it soon became clear that this goal was a hard nut to crack, because all her enthusiastic attempts encountered indifference if not resistance on the part of decision-makers. As a result, this project has never been implemented, despite the informant's efforts and a demand for such professional activity. This is another example of how bureaucracy and the reluctance of decision-makers create constraints to progressive developments in the non-profit component of the care diamond. Due to this, the national care economy forfeits not only perspectives for development, but also the health and lives of patients deprived of required home care.

#### *The market component of the care diamond*

The field research for current project showed that throughout last years the process of commodification of caring labour in migrants' households increased. Some of responders reported

using paid care in their families left behind, as in the case of Marina, a domestic carer in Italy:

When I worked in Italy, my two sons were left behind for the care of my elderly mother. But the boys did not get along well with each other, while my Mom was too old to cope with them. Their frequent collisions exhausted her and had a salient effect on her health, so that she developed a serious disease and became bedridden. As a result I had to hire a woman to take care of her, because she could not help herself any more. Meanwhile my boys had to take care of themselves (Kherson, 20.05.2011).

Although not prominent yet, this process *per se* is significant since it evidences transformations in the operation of the care diamond through its enforcement of the market component. The tendency of outsourcing care from the family to hired care-givers and to the irregular market was confirmed by experts:

The situation is that care services have never been developed here at the level as they are in Western Europe. It's only recently, as I noticed, that care giving started to involve people who are being hired and paid for that. It has not been so before. Traditionally, it was the responsibility of the family. These functions were assumed by family members. (Interview with expert in migration issues, Lviv, 01.07.2008)

It is notable that since the delegation of care provision to the market is a new phenomenon in Ukrainian families, and is often associated with a lack of emotional connection between generations, it may acquire the form of 'concealed care', which is why it is neither clearly visualised nor perceived as a market-based activity. Interviews showcased a tendency among affluent adult children of the elderly to hire care-givers or companions for their parents, recruiting them from close friends or neighbours. In this arrangement the clients themselves are unaware that their carers are paid for, and perceive them as volunteers driven by altruism. This enables a belief that they are required by members of their habitual social networks and are cared for because they deserve love and devotion, and not due to commercial interests involved.

Throughout the last few years, an increase in people ready to work in private homes has been observed in Ukraine, accompanied by the expansion of the network of employment agencies with a home care division. The fact that employment agencies have moved into providing domestic services signals both that a global labour market has emerged in this area and that there is an effort to standardise these services. Additionally, job offers are extended through informal networks and recruiters from amongst those who have experience in this labour market. Thus, our responders related the common practice of 'job selling' by more experienced women-domestics to newcomers.

Very often if, say, a woman seeks a temporal leave from her work, and wants to resume working at the same family upon return, she finds a candidate to take her place for the time of her absence from work.

You see, on the one hand, she insures that her job placement is preserved for her, and on the other hand, she usually takes a fee for offering a job placement to a beginner, who does not yet have connections in the new place and for who it is a lucky chance to get this job. (Inna, a domestic worker in Moscow, Kherson region, 15.04.2011).

The job may be 'sold' if a woman wants to move to another place on short notice and wants to maintain good relationships with former employers. In such instances, she does a favour for both her old employer and a new candidate, and receives remuneration for her services from both sides. Sometimes, after having experience of selling her jobs a few times, a woman may acquire sufficient marketing skills to make such employment brokerage her informal occupation.

The expansion of the pool of available carers owes to a magnitude of determinants, some of them mentioned above. However, interviews showed that one of the reasons why highly skilled women might agree to enter the precarious labour market of low-status care services upon returning home is the experience they acquired abroad. Before they had become involved in foreign employment, many of interviewees held high-ranking positions at home, e.g. as civil servants in municipalities, lectures at colleges and

universities, etc. However, they decided to take the risk of de-skilling by temporarily working in low-status jobs abroad to financially support their high social status at home. Most of them regarded their 'downward social mobility' as a short-term occasional project necessary to sustain the reputation of middle-class belonging. For example, Lilia, a civil servant for a municipality, held a high-status managerial position but had a salary below the level of poverty accompanied by frequent suspense of salary payments. This resulted in a gap between her high social standing and low financial status, which she managed to bridge by developing a strategy of circular migration to domestic work in Germany. Once every two or three years she secured an unpaid sabbatical at her institution to work for a few months as a cleaner in Germany. The earnings made abroad enabled her to purchase a new apartment for herself and renovate that of her retired mother, to furnish and buy new modern appliances for both households as well as to earn for subsistence, sufficient to enable her to resume working in local administration at home.

The fieldwork showed that this 'win-win strategy' was favoured by many middle-class women. Interestingly, some of them became accustomed to their low-status but well-paid jobs and no longer perceived them as precarious since they enabled financial empowerment. Often upon returning home, these migrant women were ready to accept similar positions if they promised a decent income. Importantly, by that time they were already well established on the labour market of domestic services and had sufficient experience, skills, credentials and social capital to ensure better employment opportunities than those they could afford when leaving for earnings abroad for the first time. For instance, Mila, a former civil servant for a municipality, was employed as a home carer in Moscow, where she lived with a few families and throughout two years of employment managed to increase her income to nearly double. After she had decided to stop commuting to Moscow, Mila resumed working in her native town as a deputy head at a local library. Soon, her former recruiter in Mos-

cow called her to offer a well-paid job as a child minder in Odessa (Southern Ukraine), which she agreed to take only for the time-being, until a permanent carer was found for this position. Another responder, Valentina, after a few years of commuting to Moscow as a domestic and having secured extensive experience of 'selling' her job to other colleagues, decided to reinvest her social capital into financial capital. Using her social networks among employers and landlords in Moscow, she organised an informal recruitment business, offering job placements and accommodation to beginners.

These examples show that the Ukrainian market of domestic care services is gradually becoming institutionalised. However, this trend generates new gender challenges in their own right. First, this market is not 'just another labour market', but has its own specific conditions, derived from the social construction of household chores and care-giving as 'women's work'. Second, care workers, whether native or immigrant, are mainly females who are in the lowest echelons of the social ladder. Even when care services are decently paid, the work remains culturally undervalued primarily due to the said association with 'women's work'. This situation is leading to the emergence of a new category of gender inequalities in the Ukrainian labour market that must be addressed in policy-making.

### **Conclusions and policy proposals**

The findings of the current research showed that under the conditions of demographic change in Ukraine, the structure of the care diamond is being reshaped on account of the increasing role of the extended family in care work, which is in line with a Europe-wide trend of the relocation of (unpaid) care work from the public sector to the family. This puts more care pressure on the latter, which in turn starts outsourcing its 'care burden' to the market, while preserving the responsibility for the organisation and financing of paid home care. The role of the market, therefore, is also expanding, although it still functions mainly on the un-institutionalised and informal level. Meanwhile, the contribution of both the state and the public (non-profit) sectors to

care provision, especially in elder-care, remains minuscule.

Ukrainian experts contend that in the context of demographic shifts, the role of the family in caring for the elderly will hardly become the dominant mode of care provision, especially in long-term care. Therefore, the key role in the organisation of care-giving for the elderly should be assumed by the state. However, under the current conditions of chronic budget constraints in Ukraine, exacerbated by the global financial downturn, the state will hardly be able to assume these responsibilities. This increases the pressure on the market and the non-profit sectors of the care diamond, which respectively require more attention from the society regarding the process of home care institutionalisation. Meanwhile, experience shows that when care-giving moves from the private to the public sphere, tensions emerge in technical-professional competencies, relational and emotional skills, etc.

For that matter, the care labour market requires closer attention related to recruitment, skill requirements, admissions, mobility, residency issues, attitudes and expectations of employers and clients, training for care workers, and the discrimination that pervades some of the sectors (IOM 2010). These challenges must be given priority in policy-making. It is necessary to develop coherent policy strategies aiming to cover all sectors of the care diamond, yet with a special focus on the market and non-profit sectors as potential successors able to bear the home care burden. Above all, it is critical to enhance strategic linkages between the key stakeholders in the care diamond to ensure their policy coordination both on the national and local levels and to construct a balance of care provision, enhancing the 'continuum of care' with an optimal interplay of public, home-based and community-based care grounded on the needs of the population.

Secondly, it is imperative to provide a legislative framework for the efficient functioning of the market and the non-for-profit sectors of the care diamond, as the lack thereof creates great constraints to the institutionalisation of non-state care provision in Ukraine. This will enable the creation of public organisations of carers,

empowered to lobby their interests, advocate their rights, and speak on their behalf.

Thirdly, it is of paramount importance to attract the attention of the academic community to the formation of the Ukrainian care economy in the context of the new global division of reproductive labour and the emergence of global care. In this regard, emphasis should be placed on the feminisation of migratory flows from Ukraine and the gender implications of this process for care arrangements and care regimes in the home society. To this end, the launch of longitudinal projects is required, drawing on the accumulation of statistics sensitive to gender, age and other social parameters of the migrant populace.

Importantly, the family sector should be more closely addressed. Currently, the financial benefits for care provision are insufficient to stimulate the stronger participation of individuals and families in self- or elder-care. Yet, it is argued that putting more public money into home care provision for the elderly and disabled might free up more unpaid carers to remain in or return to the labour market, and that those carers would be contributing to the economy via taxation and social insurance contributions. Therefore, the formation of a care labour market should be addressed in terms of the interrelationship between paid work and care-giving and the cost of the care for both care workers and client families.

A necessary contribution to the development of family care is awareness-raising, counselling, education, training and support. This may include the provision of specific skills, emotional counselling through support groups, a 'respite care' aiming to provide caregivers with temporary relief, and the regulation of labour initiatives that may cover laws guaranteeing workers unpaid leave if they have to care for sick relatives. Also, 'pension credits' for informal carers could

be offered, meaning that the level of pension benefits depends on years of paid work, including home care (WHO 2003).

Of particular importance is to attract and retain natives in the care sector, thus minimising care migration and limiting care drain. To this end, public policy should be aimed at the enhancement of a women-friendly labour market, the creation of working places and decent working conditions for women, especially single mothers, enabling them to reconcile work and family life at home without seeking employment abroad and leaving their children behind unattended. Additionally, emphasis must be placed on policies aiming to enhance men's caring roles in ways that break down gender stereotyping and open up possibilities for men to be more actively involved in family care.

Care work is an international market requiring that respect be given to international standards of policy-making in care provision and migration. Therefore, it is necessary for Ukraine to join the European Agreement on 'Au pair' Placement of 1969 and Recommendation of 2004, the WHO 'Global Code of Practice on the International Recruitment of Health Personnel' of 2010, the ILO 'Convention on Decent Work for Domestic Workers' of 2011, among others. These documents have to be signed and incorporated into national legislative practices if Ukraine wants to be reputed as a state that upholds the human rights of its people.

To achieve these goals it is critical to make the dynamics of care more central to public concerns and efforts while practices of care should receive increasing attention from activists, researchers, and policy-makers in terms of the recognition of the practical, moral, and political importance of care and generating normative commitments to guide thinking, practices, and public policies through a 'care lens'.

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